By Senator Perry

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A bill to be entitled

An act relating to medical services and insurance; creating s. 395.0176, F.S.; providing definitions; requiring the Department of Health to adopt statewide fee schedules for services, supplies, and care provided in hospitals and ambulatory surgical centers; providing requirements for diagnostic testing; requiring the department to adopt rules; creating s. 456.0535, F.S.; providing definitions; providing requirements for specified licensed medical professionals for diagnostic testing and treatment plans; providing disciplinary actions; requiring the department to adopt rules; amending s. 456.072, F.S.; providing additional grounds for disciplinary actions in health professions and occupations; amending s. 627.736, F.S.; revising the medical benefits requirements under personal injury protection coverage; providing a definition; conforming provisions to changes made by the act; revising circumstances under which an insurer or insured is not required to pay a claim or charges; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.0176, Florida Statutes, is created to read:

395.0176 Fee schedules and standards of care in licensed facilities.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Dentist" means a dentist licensed under chapter 466.

(b) "Physician" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a chiropractic physician licensed under chapter 460.

(2) FEE SCHEDULES.—

(a) Effective July 1, 2020, and each year thereafter, the department shall adopt statewide fee schedules for services, care, and supplies provided in a licensed facility as follows:

1. For emergency transport and treatment during transport by providers licensed under chapter 401 or by the licensed facility's medical staff, 200 percent of Medicare.

2. For emergency services and care provided by the licensed facility, 200 percent of the Medicare Part A prospective payment applicable to the specific licensed facility providing the emergency services and care.

3. For emergency services and care provided in the licensed facility by a physician or dentist, and related inpatient services provided in the licensed facility by a physician or dentist, 200 percent of the participating physician's fee schedule of Medicare Part B.

4. For inpatient services other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific licensed facility providing the inpatient services.

5. For outpatient services other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification applicable to the specific licensed facility providing the outpatient services.

6. For all other services, supplies, and care, except for medication:

a. Two-hundred percent of the allowable amount under:

(I) The participating physician's fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B in the case of durable medical equipment.

b. If services, supplies, or care in this subparagraph is not reimbursable under Medicare Part A or Part B, 200 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder that are in effect at the time the services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not reimbursable under a no-fault insurance.

7. For medication dispensed in the licensed facility, 150 percent of the average wholesale price.

(b) For purposes of paragraph (a), the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered

during that service year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part A for 2007 for inpatient admitted hospital and skilled nursing coverage or Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. For purposes of this paragraph, the term "service year" means the period from March 1 through the end of February of the following year.

(3) DIAGNOSTIC TESTING.—The physician or dentist who orders a diagnostic test must document the test results and the clinical rationale for ordering the test.

(4) RULEMAKING.—The department shall adopt rules necessary to administer and enforce this section.

Section 2. Section 456.0535, Florida Statutes, is created to read:

456.0535 Standards of care for medical services.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Evaluation and management CPT coding" or "E/M coding" means the process by which an interaction between a patient and a licensed medical professional is translated into a five-digit Current Procedural Terminology (CPT) code. CPT code is a medical code set maintained by the American Medical Association that is used to report medical, surgical, and diagnostic procedures and services. The E/M codes, a category of CPT codes, are used for billing purposes and are categorized according to the site or type of service provided, such as office, outpatient, consultation, or emergency. Within these categories, the codes are subdivided according to initial versus subsequent care.

(b) "Licensed medical professional" means:

1. A physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a chiropractic physician licensed under chapter 460;

2. A physician assistant licensed under chapter 458 or chapter 459;

3. An advanced practice registered nurse licensed under chapter 464; or

4. A dentist licensed under chapter 466.

(c) "Treatment plan" means a documented course of treatment based on a patient's medical history and an examination or diagnostic study of the patient.

(2) DIAGNOSTIC TESTING.—A licensed medical professional who orders a diagnostic test must document the test results and the clinical rationale for ordering the test and, if a treatment plan is developed, use the test results in the formulation of the patient's treatment plan.

(3) TREATMENT PLANS.—A licensed medical professional's treatment plan must be supported by a written clinical rationale that the treatment is reasonable and necessary and would be considered appropriate for the patient's condition by another licensed medical professional of the same specialty and with similar experience, education, and training.

(a) An initial treatment plan and all subsequent updates to the treatment plan must include diagnostic codes from the most recent International Classification of Diseases.

(b) An initial treatment plan may not exceed 6 weeks. Subsequent treatment plans may not exceed 8 weeks between being updated, changed, or extended via E/M coding.

(c) Interaction between the patient and a licensed medical professional must occur at a minimum every 2 weeks or every fourth patient visit, whichever occurs first, between treatment plans. For each interaction, the patient's medical record must show that:

1. The licensed medical professional's presence was inherent to the service provided to the patient during the interaction; or

2. The patient's interaction with the licensed medical professional was translated into an evaluation and management CPT code.

(d) If a patient is insured under a no-fault insurance:

1. A licensed medical professional ordering a course of treatment that extends to more than three patient interactions must submit to the no-fault insurer the medical record of the interaction during which the initial treatment plan was developed. The medical record must include the details of the proposed treatment plan.

2. In order for the licensed medical professional to be reimbursed for additional treatment that goes beyond the treatment specified in the initial treatment plan, the licensed medical professional must update the patient's treatment plan pursuant to paragraph (c).

3. Any service or treatment that is reimbursable under the no-fault insurance must be reasonable and necessary to the extent that the service or treatment would be considered appropriate for the patient's condition by another licensed medical provider of the same specialty and with similar experience, education, and training.

4. Any medical benefits covered under a no-fault insurance that are withdrawn, reduced, or denied by a licensed medical professional based on this subsection must comply with s. 627.736(7).

(4) DISCIPLINARY ACTIONS.—The department shall review each complaint of a violation of this section and determine whether the incident involves conduct by a health care practitioner which is subject to disciplinary action under s. 456.073. Disciplinary action, if any, must be taken by the appropriate regulatory board or by the department if no such board exists.

(5) RULEMAKING.—The department shall adopt rules to administer this section.

Section 3. Paragraph (pp) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(pp) Violating any provision of s. 395.0176 or s. 456.0535.

Section 4. Effective July 1, 2020, paragraph (a) of subsection (1) and paragraphs (a) and (b) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the

motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—

1. Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to sub-subparagraph a. ~~subparagraph 1.~~ within 30 ~~14~~ days after the motor vehicle accident. The medical benefits provide reimbursement only for:

a.~~1.~~ Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

b.~~2.~~ Upon referral by a provider described in sub-subparagraph a. ~~subparagraph 1.~~, followup services and care consistent with the underlying medical diagnosis rendered pursuant to sub-subparagraph a. ~~subparagraph 1.~~ which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic

physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

(I) ~~a.~~ A hospital or ambulatory surgical center licensed under chapter 395.

(II) ~~b.~~ An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

(III) ~~c.~~ An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

(IV) ~~d.~~ A physical therapist licensed under chapter 486, based upon a referral by a provider described in this sub-subparagraph ~~subparagraph~~.

(V) ~~e.~~ A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(A) ~~(I)~~ Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(B) ~~(II)~~ Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States

Securities and Exchange Commission as a national securities exchange; and

(C) ~~(III)~~ Provides at least four of the following medical specialties:

~~(A)~~ general medicine~~,~~.

~~(B)~~ radiography~~,~~.

~~(C)~~ orthopedic medicine~~,~~.

~~(D)~~ physical medicine~~,~~.

~~(E)~~ physical therapy~~,~~.

~~(F)~~ physical rehabilitation~~,~~.

~~(G)~~ prescribing or dispensing outpatient prescription medication, and~~.~~

~~(H)~~ laboratory services.

c.~~3. Reimbursement for~~ Services and care provided in sub-subparagraph a. or sub-subparagraph b. ~~subparagraph 1. or subparagraph 2.~~ up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464 has determined that the injured person had an emergency medical condition. Services and care rendered during the interaction in which the emergency medical condition is determined may occur in a traditional office or facility visit or via telemedicine.

d.~~4. Reimbursement for~~ Services and care provided in sub-subparagraph a. or sub-subparagraph b. up ~~subparagraph 1. or subparagraph 2. is limited~~ to $2,500 if a provider listed in sub-subparagraph a. or sub-subparagraph b. ~~subparagraph 1. or subparagraph 2.~~ determines that the injured person did not have

an emergency medical condition. Services and care rendered under this sub-subparagraph may occur in a traditional office or facility visit or via telemedicine.

e. Upon referral by a provider described in sub-subparagraph a.:

(I) A treatment plan, as defined in s. 456.0535, that is submitted, along with the medical record of the interaction during which the treatment plan was established, within 30 days after the start date of the treatment plan.

(II) Diagnostic testing, the results of which are documented by the ordering provider and, if a treatment plan is developed, used in the formulation of the treatment plan.

(III) Additional treatment after the initial treatment plan if:

(A) The treatment plan is updated on a regular basis in accordance with s. 456.0535.

(B) Interaction between the patient and the licensed medical professional occurs between treatment plans at the intervals specified in s. 456.0535. For each interaction, the patient's medical record must show that the licensed medical professional's encounter with the patient was translated into an evaluation and management CPT code or that the licensed medical professional's presence was inherent to the service provided to the patient during the interaction. As used in this section, the term "licensed medical professional" has the same meaning as provided in s. 456.0535.

(IV) Reasonable and necessary services and treatment that conform with s. 456.0535.

2.~~5.~~ Medical benefits do not include massage as defined in

s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

3.~~6.~~ The ~~Financial Services~~ commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-sub-subparagraph 1.b.(II), sub-sub-subparagraph 1.b.(III), or sub-sub-subparagraph 1.b.(V) ~~sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.c.~~ to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving

the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only an ~~a reasonable~~ amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount specified in the fee schedules established by the Department of Health in s. 395.0176 ~~the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply~~.

1. The insurer may limit reimbursement to 80 percent of the

following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 200 percent of Medicare Part A prospective payment applicable to the hospital providing the emergency services and care ~~75 percent of the hospital's usual and customary charges~~.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, 200 percent of the participating physician's fee schedule of Medicare Part B ~~the usual and customary charges in the community~~.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physician's ~~physicians~~ fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical

laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of 150 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered during that service year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. For purposes of this subparagraph, the term "service year" means the period from March 1 through the end of February of the following year.

3. Subparagraph 1. does not allow the insurer to apply any

limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. An insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines have been improperly or incorrectly upcoded or unbundled and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, if, before doing so, the insurer contacts the health care provider and discusses the reasons for the insurer's change and the health care provider's reason for the coding, or makes a reasonable good faith effort to do so, as documented in the insurer's file; ~~and~~

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed;~~.~~

g. For any service requiring a treatment plan, as defined

in s. 456.0535, and a treatment plan was not provided to;

h. For any additional treatment after the initial treatment plan if:

(I) The treatment plan is not updated on a regular basis in accordance with standards of care; or

(II) Interaction between the insured and a licensed medical professional does not occur and is not properly documented pursuant to s. 456.0535; and

i. For services and treatment that are not reasonable and necessary under s. 456.0535.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an invalid diagnostic test as determined by the Department of Health.

Section 5. Except as otherwise expressly provided in this act, this act shall take effect January 1, 2020.