By Senator Campbell

32-87B-04

1 A bill to be entitled
2 An act relating to motor vehicle insurance
3 costs; amending s. 627.732, F.S.; defining the
4 terms "biometrics" and "biometric time date
5 technology"; amending s. 627.736, F.S.;
6 providing presumptions and revising procedures
7 with respect to billing and payment for
8 treatment of injured persons under personal
9 injury protection benefits; providing an
10 effective date.
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12 Be It Enacted by the Legislature of the State of Florida:
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14 Section 1. Subsections (16) and (17) are added to
15 section 627.732, Florida Statutes, to read:
16 627.732 Definitions.--As used in ss. 627.730-627.7405,
17 the term:
18 (16) "Biometrics" means a computer-based biological
19 imprint.
20 (17) "Biometric time date technology" means technology
21 that uses biometric imprints to document the exact date and
22 time a biological imprint was made or recognized.
23 Section 2. Paragraphs (a), (b), and (e) of subsection
24 (5) of section 627.736, Florida Statutes, are amended to read:
25 627.736 Required personal injury protection benefits;
26 exclusions; priority; claims.--
27 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--
28 (a) Any physician, hospital, clinic, or other person
29 or institution lawfully rendering treatment to an injured
30 person for a bodily injury covered by personal injury
31 protection insurance may charge the insurer and injured party

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only 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. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of 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, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply. It shall be presumed that the insured received the treatment or services specified in the bill for services if the provider uses biometric time date technology that verifies that the insured was present in the provider's office for the time the billed services were rendered.

(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;

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1 c. To any person who knowingly submits a false or
2 misleading statement relating to the claim or charges;
3 d. With respect to a bill or statement that does not
4 substantially meet the applicable requirements of paragraph
5 (d);
6 e. For any treatment or service that is upcoded, or
7 that is unbundled when such treatment or services should be
8 bundled, in accordance with paragraph (d). To facilitate
9 prompt payment of lawful services, an insurer may change codes
10 that it determines to have been improperly or incorrectly
11 upcoded or unbundled, and may make payment based on the
12 changed codes, without affecting the right of the provider to
13 dispute the change by the insurer, provided that before doing
14 so, the insurer must contact the health care provider and
15 discuss the reasons for the insurer's change and the health
16 care provider's reason for the coding, or make a reasonable
17 good faith effort to do so, as documented in the insurer's
18 file. It shall be presumed that the insured received the
19 treatment or services specified in the bill for services if
20 the provider uses biometric time date technology that verifies
21 that the insured was present in the provider's office for the
22 time the billed services were rendered; and
23 f. For medical services or treatment billed by a
24 physician and not provided in a hospital unless such services
25 are rendered by the physician or are incident to his or her
26 professional services and are included on the physician's
27 bill, including documentation verifying that the physician is
28 responsible for the medical services that were rendered and
29 billed.
30 2. Charges for medically necessary cephalic
31 thermograms, peripheral thermograms, spinal ultrasounds,

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1 extremity ultrasounds, video fluoroscopy, and surface
2 electromyography shall not exceed the maximum reimbursement
3 allowance for such procedures as set forth in the applicable
4 fee schedule or other payment methodology established pursuant
5 to s. 440.13.
6 3. Allowable amounts that may be charged to a personal
7 injury protection insurance insurer and insured for medically
8 necessary nerve conduction testing when done in conjunction
9 with a needle electromyography procedure and both are
10 performed and billed solely by a physician licensed under
11 chapter 458, chapter 459, chapter 460, or chapter 461 who is
12 also certified by the American Board of Electrodiagnostic
13 Medicine or by a board recognized by the American Board of
14 Medical Specialties or the American Osteopathic Association or
15 who holds diplomate status with the American Chiropractic
16 Neurology Board or its predecessors shall not exceed 200
17 percent of the allowable amount under the participating
18 physician fee schedule of Medicare Part B for year 2001, for
19 the area in which the treatment was rendered, adjusted
20 annually on August 1 to reflect the prior calendar year's
21 changes in the annual Medical Care Item of the Consumer Price
22 Index for All Urban Consumers in the South Region as
23 determined by the Bureau of Labor Statistics of the United
24 States Department of Labor.
25 4. Allowable amounts that may be charged to a personal
26 injury protection insurance insurer and insured for medically
27 necessary nerve conduction testing that does not meet the
28 requirements of subparagraph 3. shall not exceed the
29 applicable fee schedule or other payment methodology
30 established pursuant to s. 440.13.
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1 5. Effective upon this act becoming a law and before
2 November 1, 2001, allowable amounts that may be charged to a
3 personal injury protection insurance insurer and insured for
4 magnetic resonance imaging services shall not exceed 200
5 percent of the allowable amount under Medicare Part B for year
6 2001, for the area in which the treatment was rendered.
7 Beginning November 1, 2001, allowable amounts that may be
8 charged to a personal injury protection insurance insurer and
9 insured for magnetic resonance imaging services shall not
10 exceed 175 percent of the allowable amount under the
11 participating physician fee schedule of Medicare Part B for
12 year 2001, for the area in which the treatment was rendered,
13 adjusted annually on August 1 to reflect the prior calendar
14 year's changes in the annual Medical Care Item of the Consumer
15 Price Index for All Urban Consumers in the South Region as
16 determined by the Bureau of Labor Statistics of the United
17 States Department of Labor for the 12-month period ending June
18 30 of that year, except that allowable amounts that may be
19 charged to a personal injury protection insurance insurer and
20 insured for magnetic resonance imaging services provided in
21 facilities accredited by the Accreditation Association for
22 Ambulatory Health Care, the American College of Radiology, or
23 the Joint Commission on Accreditation of Healthcare
24 Organizations shall not exceed 200 percent of the allowable
25 amount under the participating physician fee schedule of
26 Medicare Part B for year 2001, for the area in which the
27 treatment was rendered, adjusted annually on August 1 to
28 reflect the prior calendar year's changes in the annual
29 Medical Care Item of the Consumer Price Index for All Urban
30 Consumers in the South Region as determined by the Bureau of
31 Labor Statistics of the United States Department of Labor for

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1 the 12-month period ending June 30 of that year. This
2 paragraph does not apply to charges for magnetic resonance
3 imaging services and nerve conduction testing for inpatients
4 and emergency services and care as defined in chapter 395
5 rendered by facilities licensed under chapter 395.
6 6. The Department of Health, in consultation with the
7 appropriate professional licensing boards, shall adopt, by
8 rule, a list of diagnostic tests deemed not to be medically
9 necessary for use in the treatment of persons sustaining
10 bodily injury covered by personal injury protection benefits
11 under this section. The initial list shall be adopted by
12 January 1, 2004, and shall be revised from time to time as
13 determined by the Department of Health, in consultation with
14 the respective professional licensing boards. Inclusion of a
15 test on the list of invalid diagnostic tests shall be based on
16 lack of demonstrated medical value and a level of general
17 acceptance by the relevant provider community and shall not be
18 dependent for results entirely upon subjective patient
19 response. Notwithstanding its inclusion on a fee schedule in
20 this subsection, an insurer or insured is not required to pay
21 any charges or reimburse claims for any invalid diagnostic
22 test as determined by the Department of Health.
23 (e)1. At the initial treatment or service provided,
24 each physician, other licensed professional, clinic, or other
25 medical institution providing medical services upon which a
26 claim for personal injury protection benefits is based shall
27 require an insured person, or his or her guardian, to execute
28 a disclosure and acknowledgment form, which reflects at a
29 minimum that:
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a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. That the physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; ~~and~~

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer; and~~.~~

f. Countersignatures may be done by biometric or electronic means.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

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1 4. The licensed medical professional rendering
2 treatment for which payment is being claimed must sign, by his
3 or her own hand, the form complying with this paragraph.
4 5. The original completed disclosure and
5 acknowledgment form shall be furnished to the insurer pursuant
6 to paragraph (4)(b) and may not be electronically furnished.
7 6. This disclosure and acknowledgment form is not
8 required for services billed by a provider for emergency
9 services as defined in s. 395.002, for emergency services and
10 care as defined in s. 395.002 rendered in a hospital emergency
11 department, or for transport and treatment rendered by an
12 ambulance provider licensed pursuant to part III of chapter
13 401.
14 7. The Financial Services Commission shall adopt, by
15 rule, a standard disclosure and acknowledgment form that shall
16 be used to fulfill the requirements of this paragraph,
17 effective 90 days after such form is adopted and becomes
18 final. The commission shall adopt a proposed rule by October
19 1, 2003. Until the rule is final, the provider may use a form
20 of its own which otherwise complies with the requirements of
21 this paragraph.
22 8. As used in this paragraph, "countersigned" means a
23 second or verifying signature, as on a previously signed
24 document, and is not satisfied by the statement "signature on
25 file" or any similar statement.
26 9. The requirements of this paragraph apply only with
27 respect to the initial treatment or service of the insured by
28 a provider. For subsequent treatments or service, the provider
29 must maintain a patient log signed by the patient, in
30 chronological order by date of service, that is consistent
31 with the services being rendered to the patient as claimed.

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1 The requirements of this subparagraph for maintaining a
2 patient log signed by the patient may be met by a hospital
3 that maintains medical records as required by s. 395.3025 and
4 applicable rules and makes such records available to the
5 insurer upon request.
6 Section 3. This act shall take effect July 1, 2004.
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9 SENATE SUMMARY

10 Provides that it is presumed an insured received personal injury protection billed treatment and services if the
11 healthcare provider uses biometric time date technology to substantiate that the insured was in the provider's
12 office at the time stated on the bill for services. Authorizes countersignatures to be made biometrically or
13 electronically.
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