Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Rivera offered the following:

Amendment (with title amendment)

On page 37, line 31,

remove: all of said line,

and insert:

repealed.

Section 21. Paragraphs (b) and (e) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

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

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(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 to 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, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make 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.

2. Charges for medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity

ultrasounds, video fluoroscopy, and surface electromyography shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule or other payment methodology established pursuant to s. 440.13.

3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing when done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 who is also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor.

4. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing that does not meet the requirements of subparagraph 3. shall not exceed the applicable fee schedule or other payment methodology established pursuant to s. 440.13.

5. Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor ~~for the 12-month period ending June 30 of that year~~, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the Accreditation Association for Ambulatory Health Care, the American College of Radiology, or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the

South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor ~~for the 12-month period ending June 30 of that year~~. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395.

6. 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 initial list shall be adopted by January 1, 2004, and 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 of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and shall 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 any invalid diagnostic test as determined by the Department of Health.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an

insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

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.

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.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, for services rendered in an ambulatory surgical center as defined in s. 395.002, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form that shall be used to fulfill the requirements of this paragraph, effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.

8. As used in this paragraph, "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider

must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital or ambulatory surgical center that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

========== T I T L E A M E N D M E N T ==========

On page 3, between lines 10 and 11,

insert: amending s. 627.736, F.S.; revising limitations on charges for treatment of injured persons; including ambulatory surgical centers in certain notice requirement provisions;