By Senator Hays

20-00984B-12 20121588__

A bill to be entitled

An act relating to compensation for personal injury or wrongful death arising out of medical injury; amending s. 456.013, F.S.; requiring the boards or the Department of Health to require the completion of a course relating to communication of medical errors; providing a directive to the Division of Statutory Revision to divide ch. 766, F.S., into parts; creating part IV of ch. 766, F.S.; creating s. 766.401, F.S.; providing a short title; creating s. 766.402, F.S.; providing definitions; creating s. 766.403, F.S.; providing legislative findings and intent; providing that the remedy created in the part is an exclusive remedy for personal injury or wrongful death arising out of or related to a medical negligence claim; creating s. 766.404, F.S.; creating the Patient Compensation System; providing for a governing board; providing for membership and terms of appointment; providing for officers and meetings; limiting compensation of members to certain expenses; providing for an executive director and other staff; providing for offices of medical review, compensation, and quality improvement; providing for committees for medical review and compensation and other purposes as needed and providing their membership and terms; providing requirements for damage payments; providing for independent medical review panels and authorizing a stipend for panelists; providing powers and duties of the board, staff, committees, offices, and panels;

prohibiting certain conflicts of interest; requiring rulemaking; creating s. 766.405, F.S.; providing a process for filing applications; providing an application filing period; creating s. 766.406, F.S.; providing for disposition of applications; providing for notice to providers and insurers; providing for support of an application pursuant to expedited medical review; providing for formal medical review when there is no support of application; providing for referral to law enforcement of an invalid application determined to be fraudulent; providing for a determination of compensation upon prima facie proof of medical injury; providing that compensation for a claim shall be offset by any past and future collateral source payments; providing for payment of compensation awards, including interest accruing on unpaid awards; providing for determinations of malpractice for purposes of a specified constitutional provision; providing for notice of applications determined to constitute medical injury for purposes of professional discipline; creating s. 766.407, F.S.; providing for review of appeals by an administrative law judge; providing that determinations of the administrative law judge are conclusive and binding; providing for appeal of such determinations; creating s. 766.408, F.S.; requiring annual contributions from specified providers to provide administrative expenses; providing maximum contribution rates; specifying payment dates; providing for disciplinary

proceedings for failure to pay; providing for deposit of funds; creating s. 766.409, F.S.; requiring an annual report to the Governor and Legislature; providing retroactive application; providing for severability; providing an effective date.

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

Section 1. Subsection (7) of section 456.013, Florida Statutes, is amended to read:

456.013 Department; general licensing provisions.—

(7) The boards, or the department when there is no board, shall require the completion of a 2-hour course relating to prevention and communication of medical errors as part of the licensure and renewal process. The 2-hour course shall count towards the total number of continuing education hours required for the profession. The course shall be approved by the board or department, as appropriate, and shall include a study of root-cause analysis, error reduction and prevention, ~~and~~ patient safety, and communication of medical errors to patients and their families. In addition, the course approved by the Board of Medicine and the Board of Osteopathic Medicine shall include information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the board. If the course is being offered by a facility licensed pursuant to chapter 395 for its employees, the board may approve up to 1 hour of the 2-hour course to be specifically related to error reduction and prevention methods used in that facility.

Section 2. The Division of Statutory Revision is directed

to designate sections 766.101 through 766.1185 of chapter 766, Florida Statutes, as part I of that chapter, entitled "Litigation Procedures"; sections 766.201 through 766.212 as part II of that chapter, entitled "Voluntary Binding Arbitration"; sections 766.301 through 766.316 as part III of that chapter, entitled "Birth-Related Neurological Injuries"; and sections 766.401 through 766.409, as created by this act, as part IV of that chapter, entitled "Patient Compensation System."

Section 3. Section 766.401, Florida Statutes, is created to read:

766.401 Short title.—This part may be cited as the "Patient Injury Act."

Section 4. Section 766.402, Florida Statutes, is created to read:

766.402 Definitions.—As used in this part, the term:

(1) "Applicant" means a person who files an application under this part requesting the investigation of an alleged occurrence of a medical injury.

(2) "Application" means a request for investigation by the Patient Compensation System of an alleged occurrence of a medical injury.

(3) "Board" means the Patient Compensation Board as created in s. 766.404.

(4) "Collateral source" means any payment made to the applicant, or made on his or her behalf, by or pursuant to:

(a) The federal Social Security Act; any federal, state, or local income disability act; or any other public program providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law.

(b) Any health, sickness, or income disability insurance; any automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the applicant, whether purchased by the applicant or provided by others.

(c) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services.

(d) Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.

(5) "Committee" means, as the context requires, the Medical Review Committee or the Compensation Committee.

(6) "Compensation schedule" means a schedule of damages for medical injuries.

(7) "Department" means the Department of Health.

(8) "Independent medical review panel" or "panel" means a multidisciplinary panel convened by the chief medical officer to review each application.

(9) "Medical injury" means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, which would have been avoided under the care of an experienced specialist provider practicing in the same field of care under the same circumstances or, for a general practitioner provider, an experienced general practitioner provider practicing under the same circumstances. Determination of the validity of a medical injury may only include consideration of an alternate

course of treatment if the harm could have been avoided through a different but equally effective manner with respect to the treatment of the underlying condition. The term does not include an injury or wrongful death:

(a) That is the consequence of a necessary procedure to diagnose or treat an illness or an injury which, if left untreated, would be directly life-threatening or lead to severe disability;

(b) Caused by a drug, as defined in s. 499.003, unless the injury or wrongful death is due to a prescription error or administration error; or

(c) Caused by a device, as defined in s. 499.003.

(10) "Office" means, as the context requires, the Office of Compensation, the Office of Medical Review, or the Office of Quality Improvement.

(11) "Panelist" means a hospital administrator, a person licensed under chapter 458, chapter 459, chapter 460, part I of chapter 464, or chapter 466, or any other person involved in the management of a health care facility as deemed by the board to be appropriate.

(12) "Patient Compensation System" means the organization created pursuant to s. 766.404.

(13) "Provider" means a birth center licensed under chapter 383; any facility licensed under chapter 390, chapter 395, chapter 400, or chapter 429; a home health agency or nurse registry licensed under part III of chapter 400; a health care services pool registered under part IX of chapter 400; any person licensed under s. 401.27 or chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,

chapter 464, chapter 465, chapter 466, chapter 467, part I, part II, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468, chapter 478, part III of chapter 483, or chapter 486; a clinical lab licensed under part I of chapter 483; a multiphasic health testing center licensed under part II of chapter 483; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

Section 5. Section 766.403, Florida Statutes, is created to read:

766.403 Legislative findings and intent; exclusive remedy.—

(1) LEGISLATIVE FINDINGS.—

(a) The Legislature finds that the lack of legal representation, and, thus, compensation, for the vast majority of patients with legitimate injuries is creating an access-to-courts crisis.

(b) The Legislature finds that seeking compensation through medical malpractice litigation is a costly and protracted process to the extent that legal counsel may afford to finance only a small number of legitimate claims.

(c) The Legislature finds that, even for patients who are able to obtain legal representation, the delay in obtaining compensation is averaging approximately 5 years, creating a significant hardship for patients and their caregivers who often need access to immediate care and compensation.

(d) The Legislature finds that, because of continued exposure to liability, an overwhelming majority of physicians

practice defensive medicine by ordering unnecessary tests and procedures, increasing the cost of health care for individuals covered by public and private health insurance coverage and exposing patients to unnecessary clinical risks.

(e) The Legislature finds that a significant percentage of physicians are continuing to retire from practice as a result of the cost and risk of medical liability in this state.

(f) The Legislature finds that recruiting physicians to this state and ensuring that physicians currently practicing in this state continue their practice is an overwhelming public necessity.

(2) LEGISLATIVE INTENT.—

(a) The Legislature intends to create an alternative to medical malpractice litigation whereby patients are fairly and expeditiously compensated for avoidable medical injuries. As provided in this part, this alternative is intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs, increasing the number of physicians practicing in this state, and providing patients fair and timely compensation without the expense and delay of the court system. The Legislature intends that the provisions of this part apply to all health care facilities and health care practitioners who are either insured or self-insured against claims for medical malpractice.

(b) The Legislature intends that an application filed under this part does not constitute a claim for medical malpractice and any action on such an application does not constitute a judgment or adjudication for medical malpractice, and, therefore, professional liability carriers are not obligated to

report such applications or actions on such applications to the National Practitioner Data Bank.

(c) The Legislature intends that the definition of the term "medical injury" be construed to encompass a broader range of personal injuries as compared to a negligence standard, such that a greater number of applications qualify for compensation under this part as compared to claims filed under a negligence standard.

(d) The Legislature intends that because the Patient Compensation System has the primary duty to determine the validity and compensation of each application, an insurer shall not be subject to a statutory or common law bad faith cause of action relating to an application filed under this part.

(3) EXCLUSIVE REMEDY.—With the exception of part III, the rights and remedies granted by this part on account of a personal injury or wrongful death exclude all other rights and remedies of the applicant, his or her personal representative, parents, dependents, and the next of kin, at common law or as provided in general law, against any provider directly involved in providing the medical treatment from which such injury or death occurred, arising out of or related to a medical negligence claim, whether in tort or in contract, with respect to such injury. Notwithstanding any other law, this part applies exclusively to applications submitted under this part. An applicant whose injury falls within the scope of part III may not file an application under this part.

Section 6. Section 766.404, Florida Statutes, is created to read:

766.404 Patient Compensation System; board; committees.—

(1) PATIENT COMPENSATION SYSTEM.—The Patient Compensation System is created and shall be administratively housed within the department. The Patient Compensation System is a separate budget entity that is responsible for its administrative functions and is not subject to control, supervision, or direction by the department in any manner. The Patient Compensation System shall administer this part.

(2) PATIENT COMPENSATION BOARD.—The Patient Compensation Board is established to govern the Patient Compensation System.

(a) *Members.*—The board shall be composed of 11 members who represent the medical, legal, patient, and business communities from diverse geographic areas throughout the state. Members of the board shall be appointed as follows:

1. Five members shall be appointed by, and serve at the pleasure of, the Governor, one of whom shall be an allopathic or osteopathic physician who actively practices in this state, one of whom shall be an executive in the business community, one of whom shall be a hospital administrator, one of whom shall be a certified public accountant who actively practices in this state, and one of whom shall be a member of The Florida Bar.

2. Three members shall be appointed by, and serve at the pleasure of, the President of the Senate, one of whom shall be an allopathic or osteopathic physician who actively practices in this state and one of whom shall be a patient advocate.

3. Three members shall be appointed by, and serve at the pleasure of, the Speaker of the House of Representatives, one of whom shall be an allopathic or osteopathic physician who actively practices in this state and one of whom shall be a patient advocate.

(b) *Terms of appointment.*—Each member shall be appointed for a 4-year term. For the purpose of providing staggered terms, of the initial appointments, the five members appointed by the Governor shall be appointed to 2-year terms and the remaining six members shall be appointed to 3-year terms. If a vacancy occurs on the board before the expiration of a term, the original appointing authority shall appoint a successor to serve the unexpired portion of the term.

(c) *Chair and vice chair.*—The board shall annually elect from its membership one member to serve as chair of the board and one member to serve as vice chair.

(d) *Meetings.*—The first meeting of the board shall be held no later than August 1, 2012. Thereafter, the board shall meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, webconference, or other electronic means.

(e) *Compensation.*—Members of the board and the committees shall serve without compensation but may be reimbursed for per diem and travel expenses for required attendance at board and committee meetings in accordance with s. 112.061.

(f) *Powers and duties of the board.*—The board shall have the following powers and duties:

1. Ensuring the operation of the Patient Compensation System in accordance with applicable federal and state laws, rules, and regulations.

2. Entering into contracts as necessary to administer this part.

3. Employing an executive director and other staff as are necessary to perform the functions of the Patient Compensation

System, except that the Governor shall appoint the initial executive director.

4. Approving the hiring of a chief compensation officer and a chief medical officer, as recommended by the executive director.

5. Approving a schedule of compensation for medical injuries, as recommended by the Compensation Committee.

6. Approving medical review panelists, as recommended by the Medical Review Committee.

7. Approving an annual budget.

8. Annually approving provider contribution amounts.

(g) *Powers and duties of staff.*—The executive director shall oversee the operation of the Patient Compensation System in accordance with this part. The following staff shall report directly to and serve at the pleasure of the executive director:

1. Advocacy director.—The advocacy director shall ensure that each applicant is provided high quality individual assistance throughout the application process, from initial filing to disposition of the application.

2. Chief compensation officer.—The chief compensation officer shall manage the Office of Compensation. The chief compensation officer shall recommend to the Compensation Committee a compensation schedule for each type of injury. The chief compensation officer may not be a licensed physician or an attorney.

3. Chief financial officer.—The chief financial officer shall be responsible for overseeing the financial operations of the Patient Compensation System, including the annual development of a budget.

4. Chief legal officer.—The chief legal officer shall represent the Patient Compensation System in all contested applications, oversee the operation of the Patient Compensation System to ensure compliance with established procedures, and ensure adherence to all applicable federal and state laws, rules, and regulations.

5. Chief medical officer.—The chief medical officer shall be a physician licensed under chapter 458 or chapter 459 who shall manage the Office of Medical Review. The chief medical officer shall recommend to the Medical Review Committee a qualified list of multidisciplinary panelists for independent medical review panels. In addition, the chief medical officer shall convene independent medical review panels as necessary to review applications.

6. Chief quality officer.—The chief quality officer shall manage the Office of Quality Improvement.

(3) OFFICES.—The following offices are established within the Patient Compensation System:

(a) *Office of Medical Review.*—The chief medical officer shall manage the Office of Medical Review. The Office of Medical Review shall evaluate and, as necessary, investigate all applications in accordance with this part. For the purpose of an investigation of an application, the office may administer oaths, take depositions, issue subpoenas, compel the attendance of witnesses and the production of papers, documents, and other evidence, and obtain patient records pursuant to the applicant's release of protected health information.

(b) *Office of Compensation.*—The chief compensation officer shall manage the Office of Compensation. The office shall

allocate compensation for each application in accordance with the compensation schedule.

(c) *Office of Quality Improvement.*—The chief quality officer shall manage the Office of Quality Improvement. The office shall regularly review applications data to conduct root cause analyses and develop and disseminate best practices based on such reviews.

(4) COMMITTEES.—The board shall create a Medical Review Committee and a Compensation Committee. The board may create additional committees as necessary to assist in the performance of its duties and responsibilities.

(a) *Members.*—Each committee shall be composed of three board members chosen by a majority vote of the board.

1. The Medical Review Committee shall be composed of two physicians and a board member who is not an attorney. The board shall designate a physician committee member as chair of the committee.

2. The Compensation Committee shall be composed of a certified public accountant and two board members who are not physicians or attorneys. The certified public accountant shall serve as chair of the committee.

(b) *Terms of appointment.*—Members of each committee shall serve 2-year terms, within their respective terms as board members. If a vacancy occurs on a committee, the board shall appoint a successor to serve the unexpired portion of the term. A committee member who is removed or resigns from the board shall be removed from the committee.

(c) *Chair and vice chair.*—The board shall annually designate a chair and vice chair of each committee in accordance

with this subsection.

(d) *Meetings.*—Each committee shall meet at least quarterly or at the specific direction of the board. Meetings may be held by teleconference, webconference, or other electronic means.

(e) *Powers and duties.*—

1. The Medical Review Committee shall recommend to the board a comprehensive, multidisciplinary list of panelists who shall serve on the independent medical review panels as needed.

2. The Compensation Committee shall, in consultation with the chief compensation officer, recommend to the board a compensation schedule. The initial compensation schedule shall be formulated such that the aggregate cost of medical malpractice and the aggregate of provider contributions are equal to, or less than, the prior fiscal year aggregate cost of medical malpractice. In addition, damage payments for each injury shall be no less than the average indemnity payment reported by the Physician Insurers Association of America or its successor organization for like injuries with like severity. Thereafter, the compensation schedule shall be annually reviewed and, if necessary, revised to ensure that a projected increase in the upcoming fiscal year aggregate cost of medical malpractice, including insured and self-insured providers, does not exceed the percentage change from the prior fiscal year in the medical care component of the Consumer Price Index for All Urban Consumers. Damage payments for each medical injury shall be apportioned among multiple providers, if applicable, conforming to historical apportionment among multiple providers reported by the Physician Insurers Association of America or its successor organization for like injuries with like severity.

(5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical officer shall convene an independent medical review panel to evaluate whether an application constitutes medical injury. Each panel shall be composed of an odd number of at least three panelists chosen from the list of panelists recommended by the Medical Review Committee and approved by the board, and shall be convened upon the call of the chief medical officer. Each panelist shall be paid a stipend as determined by the board for his or her service. In order to expedite the review of applications, the chief medical officer may, whenever practicable, group related applications together for consideration by a single panel.

(6) CONFLICTS OF INTEREST.—A board member, panelist, or employee of the Patient Compensation System may not engage in any conduct that constitutes a conflict of interest. For purposes of this subsection, a conflict of interest exists in a situation in which the private interest of a board member, panelist, or employee could influence his or her judgment in the performance of his or her duties under this part. A board member, panelist, or employee must immediately disclose in writing the presence of a conflict of interest when the board member, panelist, or employee knows or should know that the factual circumstances surrounding a particular application constitute or constituted a conflict of interest. A board member, panelist, or employee who violates this subsection is subject to disciplinary action as determined by the board. A conflict of interest includes, but is not limited to:

(a) Any conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a

panelist or employee is biased against or in favor of an applicant.

(b) Participation in any application in which the board member, panelist, or employee, or the parent, spouse, or child of a board member, panelist, or employee, has a financial interest.

(7) RULEMAKING.—The board shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement and administer this part, which shall include rules addressing:

(a) The application process, including forms necessary to collect relevant information from applicants.

(b) Disciplinary procedures for a board member, panelist, or employee who violates the conflict-of-interest provisions of this part.

(c) Stipends paid to panelists for their service on an independent medical review panel, which stipends may be scaled in accordance with the relative scarcity of the provider's specialty, if applicable.

Section 7. Section 766.405, Florida Statutes, is created to read:

766.405 Filing of applications.—

(1) CONTENT.—In order to obtain compensation for medical injury under this part, an applicant must file an application with the Patient Compensation System. The advocacy director shall assist each applicant in filing an application and shall regularly provide status reports to the applicant regarding his or her application. The application must include:

(a) The name and address of the applicant or his or her representative and the basis of the representation.

(b) The name and address of any provider who provided medical treatment allegedly resulting in the medical injury.

(c) A brief statement of the facts and circumstances surrounding the personal injury or wrongful death that gave rise to the application.

(d) An authorization for release to the Office of Medical Review of all protected health information that is potentially relevant to the application.

(e) Any other information that the applicant believes will be beneficial to the investigatory process, including the names of potential witnesses.

(f) Documentation of any applicable private or governmental source of services or reimbursement relative to the personal injury or wrongful death.

(2) INCOMPLETE APPLICATIONS.—If an application is not complete, the Patient Compensation System shall, within 30 days after the receipt of the initial application, notify the applicant in writing of any errors or omissions. An applicant shall have 30 days within which to correct the errors or omissions in the initial application.

(3) LIMITATION ON APPLICATIONS.—Any application that is filed more than 4 years after the personal injury or wrongful death giving rise to the application is barred.

Section 8. Section 766.406, Florida Statutes, is created to read:

766.406 Disposition of applications.—

(1) INITIAL MEDICAL REVIEW.—The Office of Medical Review shall, within 10 days after receipt of a completed application, determine whether the application, prima facie, constitutes a

medical injury.

(a) If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury, the office shall immediately notify, by registered or certified mail, each provider named in the application and, for providers that are not self-insured, the insurer that provides coverage for the provider. The notification shall inform the provider that he or she may support the application to expedite the processing of the application. A provider shall have 15 days after the receipt of notification of an application to support the application. If the provider supports the application, the Office of Medical Review shall review the application in accordance with subsection (2).

(b) If the Office of Medical Review determines that the application does not, prima facie, constitute a medical injury, the office shall send a rejection letter to the applicant by registered or certified mail, which shall inform the applicant of his or her right of appeal. The applicant shall have 15 days after the receipt of the letter in which to appeal the determination of the office pursuant to s. 766.407.

(2) EXPEDITED MEDICAL REVIEW.—An application that is supported by a provider in accordance with subsection (1) shall be reviewed by the Office of Medical Review, within 30 days after notification of the provider's support of the application, to determine the validity of the application. If the Office of Medical Review finds that the application is valid, the Office of Compensation shall determine an award of compensation in accordance with subsection (4). If the Office of Medical Review finds that the application is not valid, the office shall

immediately notify the applicant of the rejection of the application, and, in the case of fraud, the office shall immediately notify relevant law enforcement authorities.

(3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury, and the provider does not elect to support the application, the office shall complete a thorough investigation of the application within 60 days after the determination by the office. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the provider to access records, statements, and other information obtained in the course of its investigation, in accordance with relevant state and federal laws. Within 30 days after the completion of the investigation, an independent medical review panel shall be convened to determine whether the application constitutes a medical injury. The independent medical review panel shall have access to all redacted information obtained by the office in the course of its investigation of the application, and shall conclude its determination within 10 days after the convening of the panel. The standard of review shall be a preponderance of the evidence.

(a) If the independent medical review panel determines that the application constitutes a medical injury, the Office of Medical Review shall immediately notify the provider by registered or certified mail of the right to appeal the finding of the office. The provider shall have 15 days after the receipt of the letter in which to appeal the determination of the panel pursuant to s. 766.407.

(b) If the independent medical review panel determines that

the application does not constitute a medical injury, the Office of Medical Review shall send a rejection letter to the applicant by registered or certified mail, which shall explain, in detail, the reasons for the rejection of the application and the process to appeal the determination of the panel. The applicant shall have 15 days from the receipt of the letter to appeal the determination of the panel pursuant to s. 766.407.

(4) COMPENSATION REVIEW.—If an independent medical review panel finds that an application constitutes a medical injury pursuant to subsection (3), and all appeals of that finding have been exhausted by the provider pursuant to s. 766.407, the Office of Compensation shall, within 30 days after either the finding of the panel or the exhaustion of all appeals of that finding, whichever occurs later, determine an award of compensation in accordance with the compensation schedule and the findings of the panel. The office shall, by registered or certified mail, inform the applicant of the amount of compensation and the process to appeal the determination of the office. The applicant shall have 15 days after receipt of the letter to appeal the determination of the office pursuant to s. 766.407.

(5) LIMITATION ON COMPENSATION.—Compensation for each application shall be offset by any past and future collateral source payments and shall be paid by periodic payments.

(6) PAYMENT OF COMPENSATION.—Within 14 days after either the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.407, the provider, or for a provider who has insurance coverage, the insurer, shall pay the compensation award. Beginning 45 days after the

acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.407, whichever occurs later, an unpaid award shall begin to accrue interest at the rate of 18 percent per year. An applicant may petition the circuit court for enforcement of an award under this part.

(7) DETERMINATION OF MEDICAL MALPRACTICE.—For purposes of s. 26, Art. X of the State Constitution, a physician who is the subject of an application under this part must be found to have committed medical malpractice only upon a specific finding of the Board of Medicine or Board of Osteopathic Medicine, as applicable, in accordance with s. 456.50.

(8) PROFESSIONAL BOARD NOTICE.—The Patient Compensation System shall provide the department with electronic access to applications determined to constitute a medical injury related to persons licensed under chapter 458, chapter 459, chapter 460, part I of chapter 464, or chapter 466. The department shall review such applications to determine whether any of the incidents that resulted in the application potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 456.073 applies.

Section 9. Section 766.407, Florida Statutes, is created to read:

766.407 Review by administrative law judge; appellate review.—

(1) An administrative law judge shall hear and determine appeals filed pursuant to s. 766.406 and shall exercise the full power and authority granted to him or her in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge shall be limited in his or her review

to determining whether the Office of Medical Review, the independent medical review panel, or the Office of Compensation, as appropriate, has faithfully followed the requirements of this part and rules adopted thereunder in reviewing applications. If the administrative law judge determines that such requirements were not followed in reviewing an application, he or she shall require the chief medical officer to reconvene the original panel or convene a new panel or require the Office of Compensation to redetermine the compensation amount in accordance with the determination by the judge.

(2) A determination by an administrative law judge under this section regarding the faithful following of the requirements of this part and rules adopted thereunder shall be conclusive and binding as to all questions of fact. Such determination with findings of fact and conclusions of law shall be provided to the applicant and the provider. An applicant or provider may appeal the determination of the administrative law judge to a district court of appeal. Appeals shall be filed in accordance with rules of procedure adopted by the Supreme Court for the review of such orders.

Section 10. Section 766.408, Florida Statutes, is created to read:

766.408 Expenses of administration.—

(1) The board shall annually determine a contribution to be paid by each provider for the expense of the administration of this part. The contribution amount shall be determined by January 1 of each year and shall be based on the anticipated expenses of the administration of this part for the next state fiscal year.

(2) The contribution rate may not exceed the following amounts:

(a) For an individual licensed under s. 401.27, a chiropractic assistant licensed under chapter 460, or an individual licensed under chapter 461, chapter 462, chapter 463, chapter 464, with the exception of a certified registered nurse anesthetist, chapter 465, chapter 466, chapter 467, part I, part II, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468, chapter 478, part III of chapter 483, or chapter 486, $100 per licensee.

(b) For an anesthesiology assistant or physician assistant licensed under chapter 458 or chapter 459 or a certified registered nurse anesthetist certified under part I of chapter 464, $250 per licensee.

(c) For a physician licensed under chapter 458, chapter 459, or chapter 460, $600 per licensee. The contribution for the initial fiscal year for a licensee described in this paragraph shall be $500 per licensee.

(d) For a facility licensed under part II of chapter 400 or a facility licensed under part I of chapter 429, $100 per bed.

(e) For a facility licensed under chapter 395, $200 per bed. The contribution for the initial fiscal year shall be $100 per bed.

(f) For any other provider not otherwise described in this subsection, $2,500 per registrant or licensee.

(3) The contribution determined under this section is payable by each provider upon notice delivered on or after July 1 of the next state fiscal year. Each provider shall pay the contribution amount within 30 days after the date that notice is

delivered to the provider. If any provider fails to pay the contribution determined under this section within 30 days after such notice, the board shall notify the provider by certified or registered mail that the provider's license shall be subject to revocation if the contribution is not paid within 60 days after the date of the original notice.

(4) A provider who fails to pay the contribution amount determined under this section within 60 days after receipt of the original notice is subject to licensure revocation action by the department, the Agency for Health Care Administration, or the relevant regulatory board, as appropriate.

(5) All amounts collected under this section shall be paid into the Patient Compensation Trust Fund established in s. 766.410.

Section 11. Section 766.409, Florida Statutes, is created to read:

766.409 Annual report.—The board shall annually, by October 1, submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that describes the filing and disposition of applications in the prior fiscal year. The report shall include, in the aggregate, the number of applications, the disposition of such applications, and the compensation awarded.

Section 12. It is the intent of the Legislature to apply this act to prior medical incidents for which a notice of intent to initiate litigation has not been mailed before the effective date of this act.

Section 13. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity

does not affect other provisions or applications of the act which may be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 14. This act shall take effect upon becoming a law.