By Senator Grimsley

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1 A bill to be entitled
2 An act relating to compensation for personal injury or
3 wrongful death arising from a medical injury; amending
4 s. 456.013, F.S.; requiring the Department of Health
5 or certain boards thereof to require the completion of
6 a course relating to communication of medical errors
7 as part of the licensure and renewal process;
8 providing a directive to the Division of Law Revision
9 and Information; creating s. 766.401, F.S.; providing
10 a short title; creating s. 766.402, F.S.; providing
11 definitions; creating s. 766.403, F.S.; providing
12 legislative findings and intent; specifying that
13 certain provisions are an exclusive remedy for
14 personal injury or wrongful death; providing for early
15 offer of settlement; prohibiting compensation for
16 certain persons that file an application for wrongful
17 death; creating s. 766.404, F.S.; creating the Patient
18 Compensation System; creating a board; specifying the
19 membership, meetings, and certain compensation of the
20 board; specifying staff, offices, committees, and
21 panels and the powers and duties thereof; prohibiting
22 certain conflicts of interest; authorizing rulemaking;
23 creating s. 766.405, F.S.; establishing an application
24 process; providing for notice to providers and
25 insurers; requiring applications be filed within a
26 certain time period; creating s. 766.406, F.S.;
27 providing for disposition, support, and review of
28 applications; providing for a determination of
29 compensation upon a prima facie claim of a medical

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30 injury having been made; requiring that compensation
31 for an application be offset by any past and future
32 collateral source payments; providing for
33 determinations of malpractice for purposes of a
34 specified constitutional provision; providing for
35 notice of applications determined to constitute a
36 medical injury for purposes of professional
37 discipline; providing for payment of compensation
38 awards; creating s. 766.407, F.S.; providing for
39 review of awards by an administrative law judge;
40 creating s. 766.408, F.S.; requiring annual
41 contributions from specified providers to provide
42 administrative expenses; providing maximum
43 contribution rates; specifying payment dates;
44 providing for disciplinary proceedings for failure to
45 pay; providing for deposit of funds; authorizing
46 providers to opt out of participation; providing
47 requirements for such an election; creating s.
48 766.409, F.S.; requiring notice to patients of
49 provider participation in the Patient Compensation
50 System; creating s. 766.410, F.S.; requiring an annual
51 report to the Governor and the Legislature; providing
52 for retroactive applicability; providing severability;
53 providing effective dates.
54
55 Be It Enacted by the Legislature of the State of Florida:
56
57 Section 1. Subsection (7) of section 456.013, Florida
58 Statutes, is amended to read:

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59 456.013 Department; general licensing provisions.—
60 (7) The boards, or the department when there is no board,
61 shall require the completion of a 2-hour course relating to
62 prevention and communication of medical errors as part of the
63 licensure and renewal process. The 2-hour course shall count
64 towards the total number of continuing education hours required
65 for the profession. The course shall be approved by the board or
66 department, as appropriate, and shall include a study of root-
67 cause analysis, error reduction and prevention, ~~and~~ patient
68 safety, and communication of medical errors to patients and
69 their families. In addition, the course approved by the Board of
70 Medicine and the Board of Osteopathic Medicine shall include
71 information relating to the five most misdiagnosed conditions
72 during the previous biennium, as determined by the board. If the
73 course is being offered by a facility licensed pursuant to
74 chapter 395 for its employees, the board may approve up to 1
75 hour of the 2-hour course to be specifically related to error
76 reduction and prevention methods used in that facility.
77 Section 2. The Division of Law Revision and Information is
78 directed to designate ss. 766.101-766.1185, Florida Statutes, as
79 part I of chapter 766, Florida Statutes, entitled "Medical
80 Malpractice and Related Matters"; ss. 766.201-766.212, Florida
81 Statutes, as part II of that chapter, entitled "Voluntary
82 Binding Arbitration"; ss. 766.301-766.316, Florida Statutes, as
83 part III of that chapter, entitled "Birth-Related Neurological
84 Injuries"; and ss. 766.401-766.410, Florida Statutes, as created
85 by this act, as part IV of that chapter, entitled "Patient
86 Compensation System."
87 Section 3. Section 766.401, Florida Statutes, is created to

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88 read:
89 766.401 Short title.—This part may be cited as the "Patient
90 Injury Act."
91 Section 4. Section 766.402, Florida Statutes, is created to
92 read:
93 766.402 Definitions.—As used in this part, the term:
94 (1) "Applicant" means a person who files an application
95 under this part requesting the investigation of an alleged
96 occurrence of a medical injury.
97 (2) "Application" means a request for investigation by the
98 Patient Compensation System of an alleged occurrence of a
99 medical injury.
100 (3) "Board" means the Patient Compensation Board as created
101 in s. 766.404.
102 (4) "Collateral source" means any payment made to the
103 applicant, or made on his or her behalf, by or pursuant to:
104 (a) The federal Social Security Act; any federal, state, or
105 local income disability act; or any other public program
106 providing medical expenses, disability payments, or other
107 similar benefits, except as prohibited by federal law.
108 (b) Any health, sickness, or income disability insurance;
109 any automobile accident insurance that provides health benefits
110 or income disability coverage; and any other similar insurance
111 benefits, except life insurance benefits available to the
112 applicant, whether purchased by the applicant or provided by
113 others.
114 (c) Any contract or agreement of any group, organization,
115 partnership, or corporation to provide, pay for, or reimburse
116 the costs of hospital, medical, dental, or other health care

117 services.
118 (d) Any contractual or voluntary wage continuation plan
119 provided by employers or by any other system intended to provide
120 wages during a period of disability.
121 (5) "Committee" means, as the context requires, the Medical
122 Review Committee or the Compensation Committee.
123 (6) "Compensation schedule" means a schedule of damages for
124 medical injuries.
125 (7) "Department" means the Department of Health.
126 (8) "Independent medical review panel" or "panel" means a
127 multidisciplinary panel convened by the chief medical officer to
128 review each application.
129 (9)(a) "Medical injury" means a personal injury or wrongful
130 death due to medical treatment, including a missed diagnosis,
131 which injury or death could have been avoided for care provided
132 by:
133 1. An individual participating provider, under the care of
134 an experienced specialist provider practicing in the same field
135 of care under the same or similar circumstances or, for a
136 general practitioner provider, an experienced general
137 practitioner provider practicing under the same or similar
138 circumstances; or
139 2. A participating provider in a system of care, if such
140 care is rendered within an optimal system of care under the same
141 or similar circumstances.
142 (b) A medical injury only includes consideration of an
143 alternate course of treatment if the injury or death could have
144 been avoided through a different but equally effective manner of
145 treatment for the underlying condition. In addition, a medical

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146 injury only includes consideration of information that would
147 have been known to an experienced specialist or readily
148 available to an optimal system of care at the time of the
149 medical treatment.
150 (c) For purposes of this subsection, the term "medical
151 injury" does not include an injury or wrongful death if the
152 medical treatment conformed with national practice standards for
153 the care and treatment of patients as determined by the
154 independent medical review panel.
155 (10) "Office" means, as the context requires, the Office of
156 Compensation, the Office of Medical Review, or the Office of
157 Quality Improvement.
158 (11) "Panelist" means an individual listed under the
159 definition of a provider.
160 (12) "Participating provider" means a provider who, at the
161 time of the medical injury, had paid the contribution required
162 for participation in the Patient Compensation System for the
163 year in which the medical injury occurred.
164 (13) "Patient Compensation System" means the organization
165 created in s. 766.404.
166 (14) "Provider" means a birth center licensed under chapter
167 383; a facility licensed under chapter 390, chapter 395, or
168 chapter 400; a home health agency or nurse registry licensed
169 under part III of chapter 400; a health care services pool
170 registered under part IX of chapter 400; a person licensed under
171 s. 401.27, chapter 457, chapter 458, chapter 459, chapter 460,
172 chapter 461, chapter 462, chapter 463, chapter 464, chapter 465,
173 chapter 466, chapter 467, part I, part II, part III, part IV,
174 part V, part X, part XIII, or part XIV of chapter 468, chapter

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175 478, part III of chapter 483, or chapter 486; a clinical
176 laboratory licensed under part I of chapter 483; a multiphasic
177 health testing center licensed under part II of chapter 483; a
178 health maintenance organization certificated under part I of
179 chapter 641; a blood bank; a plasma center; an industrial
180 clinic; a renal dialysis facility; or a professional association
181 partnership, corporation, joint venture, or other association
182 pertaining to the professional activity of health care
183 providers.
184 Section 5. Effective July 1, 2015, section 766.403, Florida
185 Statutes, is created to read:
186 766.403 Legislative findings and intent; exclusive remedy;
187 early offers; wrongful death.—
188 (1) LEGISLATIVE FINDINGS.—The Legislature finds that:
189 (a) The lack of legal representation, and, thus,
190 compensation, for the majority of patients with legitimate
191 medical injuries is creating an access-to-courts crisis.
192 (b) Seeking compensation through medical malpractice
193 litigation is a costly and protracted process, such that legal
194 counsel may only afford to finance a small number of legitimate
195 claims.
196 (c) Even for patients who are able to obtain legal
197 representation, the delay in obtaining compensation averages 5
198 years, creating a significant hardship for patients and their
199 caregivers who often need access to immediate care and
200 compensation.
201 (d) Because of continued exposure to liability, an
202 overwhelming majority of physicians practice defensive medicine
203 by ordering unnecessary tests and procedures, increasing the

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204 cost of health care for individuals covered by public and
205 private health insurance coverage and exposing patients to
206 unnecessary clinical risks.
207 (e) A significant number of physicians intend to
208 discontinue providing services in this state as a result of the
209 cost and risk of medical liability, particularly obstetricians.
210 (f) Recruiting physicians to practice in this state and
211 ensuring that current physicians continue to practice in this
212 state is an overwhelming public necessity.
213 (2) LEGISLATIVE INTENT.—The Legislature intends:
214 (a) To supersede medical malpractice litigation by creating
215 a new remedy whereby patients are fairly and expeditiously
216 compensated for medical injuries. As provided in this part, this
217 alternative is intended to significantly reduce the practice of
218 defensive medicine, thereby reducing health care costs; increase
219 patient safety; increase the number of physicians practicing in
220 this state, and provide patients fair and timely compensation
221 without the expense and delay of the court system. The
222 Legislature intends that this part apply to all health care
223 facilities and health care providers who are either insured or
224 self-insured against claims for medical malpractice.
225 (b) That an application filed under this part not
226 constitute a claim for medical malpractice, any action on such
227 an application not constitute a judgment or adjudication for
228 medical malpractice, and, therefore, professional liability
229 carriers not be obligated to report such applications or actions
230 on such applications to the National Practitioner Data Bank.
231 (c) That the definition of the term “medical injury” be
232 construed to encompass a broader range of personal injuries as

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233 compared to a negligence standard, such that a greater number of
234 applications qualify for compensation under this part as
235 compared to claims filed under a negligence standard.
236 (d) That, because the Patient Compensation System has the
237 primary duty to determine the validity and compensation of each
238 application, an insurer not be subject to a statutory or common
239 law bad faith cause of action relating to an application filed
240 under this part.
241 (3) EXCLUSIVE REMEDY.—Except as provided in part III, the
242 rights and remedies granted by this part due to a personal
243 injury or wrongful death exclude all other rights and remedies
244 of the applicant and his or her personal representative,
245 parents, dependents, and next of kin, at common law or as
246 provided in general law, against any participating provider
247 directly involved in providing the medical treatment resulting
248 in such injury or death, arising out of or related to a medical
249 negligence claim, whether in tort or in contract, with respect
250 to such injury. Notwithstanding any other law, this part applies
251 exclusively to applications submitted under this part.
252 (4) EARLY OFFER.—This part does not prohibit a self-insured
253 provider or an insurer from providing an early offer of
254 settlement or apology in satisfaction of a medical injury. A
255 person who accepts a settlement or apology offer may not file an
256 application under this part for the same medical injury. In
257 addition, if an application has been filed before the offer of
258 settlement, the acceptance of the settlement offer by the
259 applicant shall result in the withdrawal of the application.
260 (5) WRONGFUL DEATH.—Compensation shall not be provided
261 under this part for an application that requests an

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262 investigation of an alleged wrongful death due to medical
263 treatment if such application is filed by an adult child on
264 behalf of his or her parent or by a parent on behalf of his or
265 her adult child.
266 Section 6. Section 766.404, Florida Statutes, is created to
267 read:
268 766.404 Patient Compensation System; board; committees.—
269 (1) PATIENT COMPENSATION SYSTEM.—The Patient Compensation
270 System is created and shall be administratively housed within
271 the department. The Patient Compensation System is a separate
272 budget entity that shall be responsible for its administrative
273 functions and is not subject to control, supervision, or
274 direction by the department in any manner. The Patient
275 Compensation System shall administer this part.
276 (2) PATIENT COMPENSATION BOARD.—The Patient Compensation
277 Board is a board of trustees as defined in s. 20.03 and is
278 established to govern the Patient Compensation System. The board
279 shall comply with the requirements of s. 20.052, except as
280 provided in this subsection.
281 (a) *Members.*—The board shall be composed of 11 members who
282 represent the medical, legal, patient, and business communities
283 from diverse geographic areas throughout the state. Members of
284 the board shall serve at the pleasure of the Governor and shall
285 be appointed by the Governor as follows:
286 1. Five members shall be appointed by the Governor, one of
287 whom shall be an allopathic or osteopathic physician who
288 actively practices in this state, one of whom shall be an
289 executive in the business community who works in this state, one
290 of whom shall be a hospital administrator who works in this

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291 state, one of whom shall be a certified public accountant who
292 actively practices in this state, and one of whom shall be a
293 member of The Florida Bar who actively practices in this state.
294 2. Three of the members shall be persons who have been
295 selected by the Governor from a list of persons who were
296 recommended by the President of the Senate, one of whom shall be
297 an allopathic or osteopathic physician who actively practices in
298 this state and one of whom shall be a patient advocate who
299 resides in this state.
300 3. Three of the members shall be persons who have been
301 selected by the Governor from a list of persons who were
302 recommended by the Speaker of the House of Representatives, one
303 of whom shall be an allopathic or osteopathic physician who
304 actively practices in this state and one of whom shall be a
305 patient advocate who resides in this state.
306 (b) *Terms of appointment.*—Each member shall be appointed
307 for a 4-year term. For the purpose of providing staggered terms,
308 of the initial appointments, the five members appointed by the
309 Governor shall be appointed to 2-year terms and the remaining
310 six members shall be appointed to 3-year terms. If a vacancy
311 occurs on the board before the expiration of a term, the
312 Governor shall appoint a successor to serve the remainder of the
313 term.
314 (c) *Chair and vice chair.*—The board shall annually elect
315 from its membership one member to serve as chair of the board
316 and one member to serve as vice chair.
317 (d) *Meetings.*—The first meeting of the board shall be held
318 no later than August 1, 2014. Thereafter, the board shall meet
319 at least quarterly upon the call of the chair. A majority of the

320 board members constitutes a quorum. Meetings may be held by
321 teleconference, web conference, or other electronic means.
322 (e) *Compensation.*—Members of the board shall serve without
323 compensation but may be reimbursed for per diem and travel
324 expenses for required attendance at board meetings in accordance
325 with s. 112.061.
326 (f) *Powers and duties of the board.*—The board shall have
327 the following powers and duties:
328 1. Ensuring the operation of the Patient Compensation
329 System in accordance with applicable federal and state laws,
330 rules, and regulations.
331 2. Entering into contracts as necessary to administer this
332 part.
333 3. Employing an executive director and other staff as
334 necessary to perform the functions of the Patient Compensation
335 System, except that the Governor shall appoint the initial
336 executive director.
337 4. Approving the hiring of a chief compensation officer and
338 chief medical officer, as recommended by the executive director.
339 5. Approving a schedule of compensation for medical
340 injuries, as recommended by the Compensation Committee.
341 6. Approving medical review panelists as recommended by the
342 Medical Review Committee.
343 7. Approving an annual budget.
344 8. Annually approving provider contribution amounts.
345 (g) *Powers and duties of staff.*—The executive director
346 shall oversee the operation of the Patient Compensation System
347 in accordance with this part. The following staff shall report
348 directly to and serve at the pleasure of the executive director:

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349 1. Advocacy director.—The advocacy director shall ensure
350 that each applicant is provided high-quality individual
351 assistance throughout the process, from initial filing to
352 disposition of the application. The advocacy director shall
353 assist each applicant in determining whether to retain an
354 attorney, which assistance shall include an explanation of
355 possible fee arrangements and the advantages and disadvantages
356 of retaining an attorney. If the applicant seeks to file an
357 application without an attorney, the advocacy director shall
358 assist the applicant in filing the application. In addition, the
359 advocacy director shall regularly provide status reports to the
360 applicant regarding his or her application.
361 2. Chief compensation officer.—The chief compensation
362 officer shall manage the Office of Compensation. The chief
363 compensation officer shall recommend to the Compensation
364 Committee a compensation schedule for each type of medical
365 injury. The chief compensation officer may not be a licensed
366 physician or an attorney.
367 3. Chief financial officer.—The chief financial officer
368 shall be responsible for overseeing the financial operations of
369 the Patient Compensation System, including the annual
370 development of a budget.
371 4. Chief legal officer.—The chief legal officer shall
372 represent the Patient Compensation System in all contested
373 applications, oversee the operation of the Patient Compensation
374 System to ensure compliance with established procedures, and
375 ensure adherence to all applicable federal and state laws,
376 rules, and regulations.
377 5. Chief medical officer.—The chief medical officer must be

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378 a physician licensed under chapter 458 or chapter 459 and shall
379 manage the Office of Medical Review. The chief medical officer
380 shall recommend to the Medical Review Committee a qualified list
381 of multidisciplinary panelists for independent medical review
382 panels. In addition, the chief medical officer shall convene
383 independent medical review panels as necessary to review
384 applications.
385 6. Chief quality officer.—The chief quality officer shall
386 manage the Office of Quality Improvement.
387 (3) OFFICES.—The following offices are established within
388 the Patient Compensation System:
389 (a) *Office of Medical Review.*—The Office of Medical Review
390 shall evaluate and, as necessary, investigate all applications
391 in accordance with this part. For the purpose of an
392 investigation of an application, the office shall have the power
393 to administer oaths, take depositions, issue subpoenas, compel
394 the attendance of witnesses and the production of papers,
395 documents, and other evidence, and obtain patient records
396 pursuant to the applicant's release of protected health
397 information.
398 (b) *Office of Compensation.*—The Office of Compensation
399 shall allocate compensation for each application in accordance
400 with the compensation schedule.
401 (c) *Office of Quality Improvement.*—The Office of Quality
402 Improvement shall regularly review application data to conduct
403 root cause analyses and develop and disseminate best practices
404 based on such reviews. In addition, the office shall capture and
405 record safety-related data obtained during an investigation
406 conducted by the Office of Medical Review, including the cause

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407 of, the factors contributing to, and any interventions that may
408 have prevented the medical injury.
409 (4) COMMITTEES.—The board shall create a Medical Review
410 Committee and a Compensation Committee. The board may create
411 additional committees as necessary to assist in the performance
412 of its duties and responsibilities.
413 (a) *Members.*—Each committee shall be composed of three
414 board members chosen by a majority vote of the board.
415 1. The Medical Review Committee shall be composed of two
416 physicians who are licensed in this state and a board member who
417 is not an attorney who resides in this state. The board shall
418 designate a physician committee member as chair of the
419 committee.
420 2. The Compensation Committee shall be composed of a
421 certified public accountant who practices in this state and two
422 board members who are not physicians or attorneys who reside in
423 this state. The certified public accountant shall serve as chair
424 of the committee.
425 (b) *Terms of appointment.*—Members of each committee shall
426 serve 2-year terms concurrent with their respective terms as
427 board members. If a vacancy occurs on a committee, the board
428 shall appoint a successor to serve the remainder of the term. A
429 committee member who is removed or resigns from the board shall
430 be removed from the committee.
431 (c) *Chair and vice chair.*—The board shall annually
432 designate a chair and vice chair of each committee.
433 (d) *Meetings.*—Each committee shall meet at least quarterly
434 or at the specific direction of the board. Meetings may be held
435 by teleconference, web conference, or other electronic means.

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436 (e) *Compensation.*—Members of the committees shall serve
437 without compensation but may be reimbursed for per diem and
438 travel expenses for required attendance at committee meetings in
439 accordance with s. 112.061.
440 (f) *Powers and duties.*—
441 1. The Medical Review Committee shall recommend to the
442 board a comprehensive, multidisciplinary list of panelists who
443 shall serve on the independent medical review panels as needed.
444 2. The Compensation Committee shall, in consultation with
445 the chief compensation officer, recommend to the board:
446 a. A compensation schedule, formulated such that the
447 aggregate cost of medical malpractice and the aggregate of
448 provider contributions are equal to or less than the prior
449 fiscal year's aggregate cost of medical malpractice. In
450 addition, damage payments for each injury shall be no less than
451 the average indemnity payment reported by the Physician Insurers
452 Association of America or its successor organization for similar
453 medical injuries with similar severity. Thereafter, the
454 committee shall annually review the compensation schedule and,
455 if necessary, recommend a revised schedule, such that a
456 projected increase in the upcoming fiscal year's aggregate cost
457 of medical malpractice, including insured and self-insured
458 providers, does not exceed the percentage change from the prior
459 year in the medical care component of the Consumer Price Index
460 for All Urban Consumers.
461 b. Guidelines for the payment of compensation awards
462 through periodic payments.
463 c. Guidelines for the apportionment of compensation among
464 multiple providers, which guidelines shall be based on the

465 historical apportionment among multiple providers for similar
466 injuries with similar severity.
467 (5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical
468 officer shall convene an independent medical review panel to
469 evaluate each application to determine whether a medical injury
470 occurred. Each panel shall be composed of an odd number of at
471 least three panelists chosen from a list of panelists that
472 represent the same or similar specialty as the provider shall
473 convene, either in person or by teleconference, upon the call of
474 the chief medical officer. Each panelist shall be paid a stipend
475 as determined by the board for his or her service on the panel.
476 In order to expedite the review of applications, the chief
477 medical officer may, whenever practicable, group related
478 applications together for consideration by a single panel.
479 (6) CONFLICTS OF INTEREST.—A board member, panelist, or
480 employee of the Patient Compensation System may not engage in
481 any conduct that constitutes a conflict of interest. For
482 purposes of this subsection, the term "conflict of interest"
483 means a situation in which the private interest of a board
484 member, panelist, or employee could influence his or her
485 judgment in the performance of his or her duties under this
486 part. A board member, panelist, or employee shall immediately
487 disclose in writing the presence of a conflict of interest when
488 the board member, panelist, or employee knows or should
489 reasonably have known that the factual circumstances surrounding
490 a particular application constitute or constituted a conflict of
491 interest. A board member, panelist, or employee who violates
492 this subsection is subject to disciplinary action as determined
493 by the board. A conflict of interest includes, but is not

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494 limited to:
495 (a) Conduct that would lead a reasonable person having
496 knowledge of all of the circumstances to conclude that a board
497 member, panelist, or employee is biased against or in favor of
498 an applicant.
499 (b) Participation in an application in which the board
500 member, panelist, or employee, or the parent, spouse, or child
501 of a board member, panelist, or employee, has a financial
502 interest.
503 (7) RULEMAKING.—The board shall adopt rules to implement
504 and administer this part, including rules addressing:
505 (a) The application process, including forms necessary to
506 collect relevant information from applicants.
507 (b) Disciplinary procedures for a board member, panelist,
508 or employee who violates the conflict of interest provisions of
509 this part.
510 (c) Stipends paid to panelists for their service on an
511 independent medical review panel, which stipends may be scaled
512 in accordance with the relative scarcity of the provider's
513 specialty, if applicable.
514 (d) Payment of compensation awards through periodic
515 payments and the apportionment of compensation among multiple
516 providers, as recommended by the Compensation Committee.
517 (e) The opt-out process for providers who do not want to
518 participate in the Patient Compensation System.
519 Section 7. Effective July 1, 2015, section 766.405, Florida
520 Statutes, is created to read:
521 766.405 Filing of applications.—
522 (1) CONTENT.—In order to obtain compensation for a medical

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523 injury, an applicant, or his or her legal representative, shall
524 file an application with the Patient Compensation System. The
525 application shall include the following:
526 (a) The name and address of the applicant or his or her
527 legal representative and the basis of the representation.
528 (b) The name and address of any participating provider who
529 provided medical treatment allegedly resulting in the medical
530 injury.
531 (c) A brief statement of the facts and circumstances
532 surrounding the medical injury that gave rise to the
533 application.
534 (d) An authorization for release to the Office of Medical
535 Review of all protected health information that is potentially
536 relevant to the application.
537 (e) Any other information that the applicant believes will
538 be beneficial to the investigatory process, including the names
539 of potential witnesses.
540 (f) Documentation of any applicable private or governmental
541 source of services or reimbursement relative to the medical
542 injury.
543 (2) INCOMPLETE APPLICATIONS.—If an application is not
544 complete, the Patient Compensation System shall, within 30 days
545 after the receipt of the initial application, notify the
546 applicant in writing of any errors or omissions. An applicant
547 shall have 30 days after receipt of the notice in which to
548 correct the errors or omissions in the initial application.
549 (3) TIME LIMITATION ON APPLICATIONS.—An application shall
550 be filed within the time periods specified in s. 95.11(4) for
551 medical malpractice actions. The applicable time period shall be

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552 tolled from the date an application is filed until the date the
553 applicant receives the results of the initial medical review
554 under s. 766.406.
555 (4) SUPPLEMENTAL INFORMATION.—After the filing of an
556 application, the applicant may supplement the initial
557 application with additional information that the applicant
558 believes may be beneficial in the resolution of the application.
559 (5) LEGAL COUNSEL.—This part does not prohibit an applicant
560 or participating provider from retaining an attorney to
561 represent the applicant or participating provider in the review
562 and resolution of an application.
563 Section 8. Effective July 1, 2015, section 766.406, Florida
564 Statutes, is created to read:
565 766.406 Disposition of applications.—
566 (1) INITIAL MEDICAL REVIEW.—Individuals with relevant
567 clinical expertise in the Office of Medical Review shall, within
568 10 days after the receipt of a completed application, determine
569 whether the application, prima facie, constitutes a medical
570 injury.
571 (a) If the Office of Medical Review determines that the
572 application, prima facie, constitutes a medical injury, the
573 office shall immediately notify, by registered or certified
574 mail, each participating provider named in the application and,
575 for participating providers that are not self-insured, the
576 insurer that provides coverage for the provider. The
577 notification shall inform the participating provider that he or
578 she may support the application to expedite the processing of
579 the application. A participating provider shall have 15 days
580 after the receipt of notification of an application to support

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581 the application. If the participating provider supports the
582 application, the Office of Medical Review shall review the
583 application in accordance with subsection (2).
584 (b) If the Office of Medical Review determines that the
585 application does not, prima facie, constitute a medical injury,
586 the office shall send a rejection letter to the applicant by
587 registered or certified mail informing the applicant of his or
588 her right of appeal. The applicant shall have 15 days after the
589 receipt of the letter in which to appeal the determination of
590 the office pursuant to s. 766.407.
591 (2) EXPEDITED MEDICAL REVIEW.—An application that is
592 supported by a participating provider in accordance with
593 subsection (1) shall be reviewed by individuals with relevant
594 clinical expertise in the Office of Medical Review within 30
595 days after notification of the participating provider's support
596 of the application to determine the validity of the application.
597 If the Office of Medical Review finds that the application is
598 valid, the Office of Compensation shall determine an award of
599 compensation in accordance with subsection (4). If the Office of
600 Medical Review finds that the application is not valid, the
601 office shall immediately notify the applicant of the rejection
602 of the application and, in the case of fraud, shall immediately
603 notify relevant law enforcement authorities.
604 (3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review
605 determines that the application, prima facie, constitutes a
606 medical injury and the participating provider does not elect to
607 support the application, the office shall complete a thorough
608 investigation of the application within 60 days after the
609 determination by the office. The investigation shall be

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610 conducted by a multidisciplinary team with relevant clinical
611 expertise and shall include a thorough investigation of all
612 available documentation, witnesses, and other information.
613 Within 15 days after the completion of the investigation, the
614 chief medical officer shall allow the applicant and the
615 participating provider to access records, statements, and other
616 information obtained in the course of its investigation, in
617 accordance with relevant state and federal laws.
618 (a) Within 30 days after the completion of the
619 investigation, the chief medical officer shall convene an
620 independent medical review panel to determine whether the
621 application constitutes a medical injury. The independent
622 medical review panel shall have access to all redacted
623 information obtained by the office in the course of its
624 investigation of the application and shall make a written
625 determination within 10 days after the convening of the panel,
626 which written determination shall be immediately provided to the
627 applicant and the participating provider.
628 (b) If the independent medical review panel determines
629 that:
630 1. The medical intervention conformed to national practice
631 standards for the care and treatment of patients, then the
632 application shall be dismissed and the provider shall not be
633 held responsible for the patient's medical injury.
634 2. All of the following criteria exist by a preponderance
635 of the evidence, then the panel shall report that the
636 application constitutes a medical injury:
637 a. The provider performed a medical service on the
638 applicant.

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639 b. The applicant suffered damages.
640 c. The medical service was the proximate cause of the
641 damages.
642 d. One or more of the following, as determined in
643 accordance with subsection (9) of section 766.402:
644 (I) An accepted method of medical services was not used for
645 treatment.
646 (II) An accepted method of medical services was used for
647 treatment, but executed in a substandard fashion.
648 (III) An accepted method was used, but evaluated by a
649 prospective analysis, damages could have been avoided by using a
650 less hazardous, but equally effective, treatment.
651 (c) If the independent medical review panel determines that
652 the application constitutes a medical injury, the Office of
653 Medical Review shall immediately notify the participating
654 provider by registered or certified mail of the right to appeal
655 the determination of the panel. The participating provider shall
656 have 15 days after the receipt of the letter in which to appeal
657 the determination of the panel pursuant to s. 766.407.
658 (d) If the independent medical review panel determines that
659 the application does not constitute a medical injury, the Office
660 of Medical Review shall immediately notify the applicant by
661 registered or certified mail of the right to appeal the
662 determination of the panel. The applicant shall have 15 days
663 from the receipt of the letter to appeal the determination of
664 the panel pursuant to s. 766.407.
665 (4) COMPENSATION REVIEW.—If an independent medical review
666 panel finds that an application constitutes a medical injury
667 under subsection (3) and all appeals of that finding have been

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668 exhausted by the participating provider pursuant to s. 766.407,
669 the Office of Compensation shall, within 30 days after either
670 the finding of the panel or the exhaustion of all appeals of
671 that finding, whichever occurs later, make a written
672 determination of an award of compensation in accordance with the
673 compensation schedule and the findings of the panel. The office
674 shall notify the applicant and the participating provider by
675 registered or certified mail of the amount of compensation and
676 shall also explain to the applicant the process to appeal the
677 determination of the office. The applicant shall have 15 days
678 from the receipt of the letter to appeal the determination of
679 the office pursuant to s. 766.407.
680 (5) LIMITATION ON COMPENSATION.—Compensation for each
681 application shall be offset by any past and future collateral
682 source payments. In addition, compensation may be paid by
683 periodic payments as determined by the Office of Compensation in
684 accordance with rules adopted by the board.
685 (6) PAYMENT OF COMPENSATION.—Within 14 days after either
686 the acceptance of compensation by the applicant or the
687 conclusion of all appeals pursuant to s. 766.407, the
688 participating provider, or the insurer for a participating
689 provider who has insurance coverage, shall remit the
690 compensation award to the Patient Compensation System, which
691 shall immediately provide compensation to the applicant in
692 accordance with the final compensation award. Beginning 45 days
693 after the acceptance of compensation by the applicant or the
694 conclusion of all appeals pursuant to s. 766.407, whichever
695 occurs later, an unpaid award shall begin to accrue interest at
696 the rate of 18 percent per year.

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697 (7) DETERMINATION OF MEDICAL MALPRACTICE.—For purposes of
698 s. 26, Art. X of the State Constitution, a physician who is the
699 subject of an application under this part must be found to have
700 committed medical malpractice only upon a specific finding of
701 the Board of Medicine or Board of Osteopathic Medicine, as
702 applicable, in accordance with s. 456.50.
703 (8) PROFESSIONAL BOARD NOTICE.—The Patient Compensation
704 System shall provide the department with electronic access to
705 applications for which a medical injury was determined to exist,
706 related to persons licensed under chapter 458, chapter 459,
707 chapter 460, part I of chapter 464, or chapter 466, where the
708 provider represents an imminent risk of harm to the public. The
709 department shall review such applications to determine whether
710 any of the incidents that resulted in the application
711 potentially involved conduct by the licensee that is subject to
712 disciplinary action, in which case s. 456.073 applies.
713 Section 9. Effective July 1, 2015, section 766.407, Florida
714 Statutes, is created to read:
715 766.407 Review by administrative law judge; appellate
716 review; extensions of time.—
717 (1) REVIEW BY ADMINISTRATIVE LAW JUDGE.—An administrative
718 law judge shall hear and determine appeals filed pursuant to s.
719 766.406 and shall exercise the full power and authority granted
720 to him or her in chapter 120, as necessary, to carry out the
721 purposes of that section. The administrative law judge shall be
722 limited in his or her review to determining whether the Office
723 of Medical Review, the independent medical review panel, or the
724 Office of Compensation, as appropriate, has faithfully followed
725 the requirements of this part and rules adopted thereunder in

726 reviewing applications. If the administrative law judge
727 determines that such requirements were not followed in reviewing
728 an application, he or she shall require the chief medical
729 officer to either reconvene the original panel or convene a new
730 panel, or require the Office of Compensation to redetermine the
731 compensation amount, in accordance with the determination of the
732 judge.
733 (2) APPELLATE REVIEW.—A determination by an administrative
734 law judge under this section regarding the award or denial of
735 compensation under this part shall be conclusive and binding as
736 to all questions of fact and shall be provided to the applicant
737 and the participating provider. An applicant may appeal the
738 award or denial of compensation to the District Court of Appeal.
739 Appeals shall be filed in accordance with rules of procedure
740 adopted by the Supreme Court for review of such orders.
741 (3) EXTENSIONS OF TIME.—Upon a written petition by either
742 the applicant or the participating provider, an administrative
743 law judge may grant, for good cause, an extension of any of the
744 time periods specified in this part. The relevant time period
745 shall be tolled from the date of the written petition until the
746 date the administrative law judge issues a determination.
747 Section 10. Effective July 1, 2015, section 766.408,
748 Florida Statutes, is created to read:
749 766.408 Expenses of administration; opt out.—
750 (1) The board shall annually determine a contribution that
751 shall be paid by each provider, unless the provider opts out of
752 participation in the Patient Compensation System pursuant to
753 subsection (6). The contribution amount shall be determined by
754 January 1 of each year and shall be based on the anticipated

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755 expenses of the administration of this part for the next state
756 fiscal year.
757 (2) The contribution rate may not exceed the following
758 amounts:
759 (a) For an individual licensed under s. 401.27, a
760 chiropractic assistant licensed under chapter 460, or an
761 individual licensed under chapter 461, chapter 462, chapter 463,
762 chapter 464 with the exception of a certified registered nurse
763 anesthetist, chapter 465, chapter 466, chapter 467, part I, part
764 II, part III, part IV, part V, part X, part XIII, or part XIV of
765 chapter 468, chapter 478, part III of chapter 483, or chapter
766 486, $100 per licensee.
767 (b) For an anesthesiology assistant or physician assistant
768 licensed under chapter 458 or chapter 459 or a certified
769 registered nurse anesthetist certified under part I of chapter
770 464, $250 per licensee.
771 (c) For a physician licensed under chapter 458, chapter
772 459, or chapter 460, $600 per licensee. The contribution for the
773 initial fiscal year shall be $500 per licensee.
774 (d) For a facility licensed under part II of chapter 400,
775 $100 per bed.
776 (e) For a facility licensed under chapter 395, $200 per
777 bed, except that the contribution for the initial fiscal year
778 shall be $100 per bed.
779 (f) For any other provider not otherwise described in this
780 subsection, $2,500 per registrant or licensee.
781 (3) The contribution determined under this section shall be
782 payable by each participating provider upon notice delivered on
783 or after July 1 of the next state fiscal year. Each

784 participating provider shall pay the contribution amount within
785 30 days after the date the notice is delivered to the provider.
786 If a provider fails to pay the contribution determined under
787 this section within 30 days after such notice, the board shall
788 notify the provider by certified or registered mail that the
789 provider's license shall be subject to revocation if the
790 contribution is not paid within 60 days from the date of the
791 original notice.
792 (4) A provider that has not opted out of participation
793 pursuant to subsection (6) who fails to pay the contribution
794 amount determined under this section within 60 days after
795 receipt of the original notice shall be subject to a licensure
796 revocation action by the department, the Agency for Health Care
797 Administration, or the relevant regulatory board, as applicable.
798 (5) All amounts collected under this section shall be paid
799 into the Patient Compensation Trust Fund established in s.
800 766.4105.
801 (6) A provider may elect to opt out of participation in the
802 Patient Compensation System. The election to opt out must be
803 made in writing no later than 15 days before the due date of the
804 contribution required under this section. A provider who opts
805 out may subsequently elect to participate by paying the
806 appropriate contribution amount for the current fiscal year.
807 Section 11. Section 766.409, Florida Statutes, is created
808 to read:
809 766.409 Notice to patients of participation in the Patient
810 Compensation System.—
811 (1) Each participating provider shall provide notice to
812 patients that the provider is participating in the Patient

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813 Compensation System. Such notice shall be provided on a form
814 furnished by the Patient Compensation System and shall include a
815 concise explanation of a patient's rights and benefits under the
816 system.
817 (2) Notice is not required to be given to a patient when
818 the patient has an emergency medical condition as defined in s.
819 395.002(8)(b) or when notice is not practicable.
820 Section 12. Section 766.410, Florida Statutes, is created
821 to read:
822 766.410 Annual report.—The board shall annually, beginning
823 on October 1, 2015, submit to the Governor, the President of the
824 Senate, and the Speaker of the House of Representatives a report
825 that describes the filing and disposition of applications in the
826 preceding fiscal year. The report shall include, in the
827 aggregate, the number of applications, the disposition of such
828 applications, and the compensation awarded.
829 Section 13. This act applies to medical incidents for which
830 a notice of intent to initiate litigation has not been mailed
831 before July 1, 2015.
832 Section 14. If any provision of this act or its application
833 to any person or circumstance is held invalid, the invalidity
834 does not affect other provisions or applications of the act
835 which may be given effect without the invalid provision or
836 application, and to this end the provisions of this act are
837 severable.
838 Section 15. Except as otherwise expressly provided in this
839 act, this act shall take effect July 1, 2014.