A bill to be entitled

An act relating to compensation for personal injury or wrongful death arising from a medical injury; amending s. 456.013, F.S.; requiring the Department of Health or certain boards thereof to require the completion of a course relating to communication of medical errors as part of the licensure and renewal process; providing a directive to the Division of Law Revision and Information; 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; specifying that certain provisions are an exclusive remedy for personal injury or wrongful death; providing for early settlement offers and apologies; prohibiting compensation for certain wrongful deaths; creating s. 766.404, F.S.; creating the Patient Compensation System; providing for a board; providing for membership, meetings, and certain compensation; providing for specific staff, offices, committees, and panels and the powers and duties thereof; prohibiting certain conflicts of interest; authorizing rulemaking; creating s. 766.405, F.S.; providing a process for filing applications; providing for notice to providers and insurers; providing procedures for incomplete applications; providing an application filing period;

allowing applicants to provide supplemental information; permitting applicants to be represented by legal counsel; creating s. 766.406, F.S.; providing for disposition, support, and review of applications; providing for a determination of compensation upon a prima facie claim of a medical injury having been made; providing that compensation for an application shall be offset by any past and future collateral source payments; providing for determinations of malpractice for purposes of a specified constitutional provision; providing for notice of applications determined to constitute a medical injury for purposes of professional discipline; providing for payment of compensation awards; creating s. 766.407, F.S.; providing for review of awards by an administrative law judge; providing for appellate review; creating s. 766.408, F.S.; requiring annual contributions from specified providers to provide for administrative expenses; providing maximum contribution amounts; specifying payment dates; providing for disciplinary proceedings for failure to pay; providing for deposit of funds; authorizing providers to opt out of participation; providing requirements for such an election; creating s. 766.409, F.S.; requiring notice to patients of provider participation in the Patient Compensation System; creating s. 766.410, F.S.;

requiring an annual report to the Governor and Legislature; providing for retroactive applicability; providing severability; providing effective dates.

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 Law Revision and Information is directed to designate ss. 766.101-766.1185, Florida Statutes, as part I of chapter 766, Florida Statutes, entitled "Medical Malpractice and Related Matters"; ss. 766.201-766.212, Florida Statutes, as part II of that chapter, entitled "Presuit Investigation and Voluntary Binding Arbitration"; ss. 766.301-766.316, Florida Statutes, as part III of that chapter, entitled "Birth-Related Neurological Injuries"; and ss. 766.401-766.410, Florida Statutes, 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 Compensation System."

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 payment" 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)(a) "Medical injury" means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, which injury or death could have been avoided for care provided by:

1. An individual participating provider, under the care of an experienced specialist provider practicing in the same field of care under the same or similar circumstances or, for a general practitioner provider, an experienced general practitioner provider practicing under the same or similar circumstances; or

2. A participating provider in a system of care, if such care is rendered within an optimal system of care under the same or similar circumstances.

(b) For purposes of determining whether a medical injury exists:

1. An alternate course of treatment may only be considered if the personal injury or wrongful death could have been avoided by using a different but equally effective method of medical treatment for the underlying condition.

2. Only information that would have been known to an experienced specialist or readily available to an optimal system of care at the time of the medical treatment may be considered.

(c) For purposes of this subsection, the term "medical injury" does not include a personal injury or wrongful death if the independent medical review panel determines that the medical treatment given conformed with national practice standards for

the care and treatment of patients with the underlying condition.

(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 provider as defined in subsection (14).

(12) "Participating provider" means a provider who, at the time of the medical injury, had paid the contribution required for participation in the Patient Compensation System for the year in which the medical injury occurred.

(13) "Patient Compensation System" or "system" means the organization created in s. 766.404.

(14) "Provider" means a birth center licensed under chapter 383; a facility licensed under chapter 390, chapter 395, or chapter 400; 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; a person licensed under s. 401.27, 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 laboratory 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 pertaining to the professional activity of health care providers.

Section 5. Effective July 1, 2016, section 766.403, Florida Statutes, is created to read:

766.403 Legislative findings and intent; exclusive remedy; early offers; wrongful death.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds that:

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

(b) Seeking compensation through medical malpractice litigation is a costly and protracted process, such that legal counsel may only afford to finance a small number of legitimate claims.

(c) Even for patients who are able to obtain legal representation, the delay in obtaining compensation averages 5 years, creating a significant hardship for patients and their caregivers who often need access to immediate care and compensation.

(d) 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) A significant number of physicians, particularly obstetricians, intend to discontinue providing services in Florida as a result of the costs and risks of medical liability in this state.

(f) Recruiting physicians to practice in this state and ensuring that current physicians continue to practice in this state is an overwhelming public necessity.

(2) LEGISLATIVE INTENT.—The Legislature intends:

(a) To supersede medical malpractice litigation by creating a new remedy whereby patients are fairly and expeditiously compensated for medical injuries. As provided in this part, this alternative is intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs; increase patient safety; increase the number of physicians practicing in this state; and provide patients fair and timely compensation without the expense and delay of the court system. The Legislature intends that this part apply to all health care facilities and health care providers who are either insured or self-insured against medical malpractice claims.

(b) That an application filed under this part not constitute a claim for medical malpractice, any action on such application not constitute a judgment or adjudication for medical malpractice, and, therefore, professional liability

carriers not be obligated to report such applications or actions on such applications to the National Practitioner Data Bank.

(c) 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) That, because the Patient Compensation System has the primary duty of determining the validity and compensation of each application, an insurer 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.—Except as provided in part III of this chapter, the rights and remedies granted by this part due to a personal injury or wrongful death exclude all other rights and remedies of the applicant and his or her personal representative, parents, dependents, and next of kin, at common law or as provided in general law, against any participating provider directly involved in providing the medical treatment resulting in such injury or death, arising out of or related to a medical negligence claim, whether in tort or in contract, with respect to such injury or death. Notwithstanding any other law, this part applies exclusively to applications submitted under this part.

(4) EARLY OFFER.—This part does not prohibit a self-insured provider or an insurer from providing an early

settlement offer or apology in satisfaction of a medical injury. A person who accepts a settlement offer or apology may not file an application under this part for the same medical injury. In addition, if an application has been filed before the settlement offer, the acceptance of the settlement offer by the applicant shall result in the withdrawal of the application.

(5) WRONGFUL DEATH.—Compensation may not be provided under this part for an application requesting an investigation of an alleged wrongful death due to medical treatment, if such application is filed by an adult child on behalf of his or her parent or by a parent on behalf of his or her adult child.

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

766.404 Patient Compensation System; Patient Compensation 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 shall be 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 a board of trustees as defined in s. 20.03 and is established to govern the Patient Compensation System. The board shall comply with s. 20.052, except as provided in this

subsection.

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

1. Five members, 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 who works in this state, one of whom shall be a hospital administrator who works in this state, 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 who actively practices in this state.

2. Three members from a list of persons recommended by 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 who resides in this state.

3. Three members from a list of persons recommended by 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 who resides in this state.

(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 pursuant to subparagraph (a)1. shall be appointed to 2-year terms and the six members appointed pursuant to subparagraphs (a)2. and 3. shall be appointed to 3-year terms. If a vacancy occurs on the board before the expiration of a term, the Governor shall appoint a successor to serve the remainder of the term.

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

(d) Meetings.—The first meeting of the board shall be held no later than August 1, 2015. 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, web conference, or other electronic means.

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

(f) Powers and duties of the board.—The board shall:

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

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

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

System. However, the Governor shall appoint the initial executive director.

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

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

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

7. Approve an annual budget.

8. Annually approve 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. The advocacy director shall assist each applicant in determining whether to retain an attorney and explain possible fee arrangements and the advantages and disadvantages of retaining an attorney. If the applicant seeks to file an application without an attorney, the advocacy director shall assist the applicant in filing the application. In addition, the advocacy director shall regularly provide status reports to each applicant regarding his or her 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 medical 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 must be a physician licensed under chapter 458 or chapter 459 and 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 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 shall have the power to 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 Office of Compensation shall allocate compensation for each application in accordance with the compensation schedule.

(c) Office of Quality Improvement.—The Office of Quality Improvement shall regularly review application data to conduct root cause analyses and develop and disseminate best practices based on such reviews. In addition, the office shall capture and record safety-related data obtained during an investigation conducted by the Office of Medical Review, including the cause of, the factors contributing to, and any interventions that may have prevented the medical injury.

(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 licensed in this state and a board member who is not an attorney who resides in this state. The board shall designate a physician committee member to serve as chair of the committee.

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

(b) Terms of appointment.—Members of each committee shall serve 2-year terms concurrent with their respective terms as board members. If a vacancy occurs on a committee, the board shall appoint a successor to serve the remainder 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 for each committee as provided in paragraphs (a) and (b) and shall also annually designate a vice chair of each committee.

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

(e) Compensation.—Members of the committees shall serve without compensation but may be reimbursed for per diem and

travel expenses for required attendance at committee meetings in accordance with s. 112.061.

(f) 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. A compensation schedule, 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's aggregate cost of medical malpractice. Thereafter, the committee shall annually review the compensation schedule and, if necessary, recommend a revised schedule, such that a projected increase in the upcoming fiscal year's aggregate cost of medical malpractice, including insured and self-insured providers, does not exceed the percentage change from the prior year in the medical care component of the Consumer Price Index for All Urban Consumers.

b. Guidelines for the payment of compensation awards through periodic payments.

c. Guidelines for the apportionment of compensation among multiple providers, which guidelines shall be based on the historical apportionment among multiple providers for similar medical injuries with similar severity.

(5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical

officer shall convene an independent medical review panel to evaluate each application to determine whether a medical injury occurred. Each panel shall be composed of an odd number of at least three panelists chosen from a list of panelists representing the same or similar specialty as the participating provider identified in the application and shall convene, either in person or by electronic means, 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 on the panel. 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, the term "conflict of interest" means 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 shall immediately disclose in writing the presence of a conflict of interest when the board member, panelist, or employee knows or should reasonably have known that the factual circumstances surrounding a particular application constitutes 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) Conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a board member, panelist, or employee is biased against or in favor of an applicant.

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

(7) RULEMAKING.—The board shall adopt rules to implement and administer this part, including 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 adjusted in accordance with the relative scarcity of the panelist's specialty, if applicable.

(d) Payment of compensation awards through periodic payments and the apportionment of compensation among multiple providers, as recommended by the Compensation Committee.

(e) The opt-out process for providers who do not want to participate in the Patient Compensation System.

Section 7. Effective July 1, 2016, section 766.405,

Florida Statutes, is created to read:

766.405 Filing of applications.—

(1) CONTENT.—In order to obtain compensation for a medical injury, an applicant, or his or her legal representative, shall file an application with the Patient Compensation System. The application shall include the following:

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

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

(c) A brief statement of the facts and circumstances surrounding the medical injury 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 benefit the investigatory process, including the full names and addresses of potential witnesses.

(f) Documentation of any applicable private or governmental source of services or reimbursement relating to the medical injury.

(2) INCOMPLETE APPLICATIONS.—If an application is incomplete, 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 after receipt of the notice in which to correct the errors or omissions in the initial application.

(3) TIME LIMITATION ON APPLICATIONS.—An application shall be filed within the time periods specified in s. 95.11(4) for medical malpractice actions. The applicable time period shall be tolled from the date the application is filed until the date the applicant receives the results of the initial medical review under s. 766.406.

(4) SUPPLEMENTAL INFORMATION.—After filing an application, the applicant may supplement the initial application with additional information that he or she believes may be beneficial in the resolution of the application.

(5) LEGAL COUNSEL.—This part does not prohibit an applicant or participating provider from retaining an attorney to represent the applicant or participating provider in the review and resolution of the application.

Section 8. Effective July 1, 2016, section 766.406, Florida Statutes, is created to read:

766.406 Disposition of applications.—

(1) INITIAL MEDICAL REVIEW.—Individuals with relevant clinical expertise in the Office of Medical Review shall, within 10 days after the 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 participating provider named in the application and, for participating providers that are not self-insured, the insurer that provides coverage for the provider. The notification shall inform the participating provider that he or she may support the application to expedite the processing of the application. A participating provider shall have 15 days after the receipt of notification of an application to support the application. If the participating 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 informing the applicant of his or her right to appeal. The applicant shall have 15 days after receipt of the rejection letter to appeal the office's determination pursuant to s. 766.407.

(2) EXPEDITED MEDICAL REVIEW.—An application that is supported by a participating provider in accordance with subsection (1) shall be reviewed by individuals with relevant clinical expertise in the Office of Medical Review within 30 days after notification of the participating 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, 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 participating provider does not elect to support the application, the office shall complete a thorough investigation of the application within 60 days after the office's determination. The investigation shall be conducted by a multidisciplinary team with relevant clinical expertise and shall include a thorough investigation of all available documentation, witnesses, and other information. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the participating provider to access records, statements, and other information obtained in the course of its investigation, in accordance with relevant state and federal laws.

(a) Within 30 days after the completion of the investigation, the chief medical officer shall convene an independent medical review panel 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 make a written determination within 10 days after the convening of the panel, which written determination shall be immediately provided to the applicant and the participating provider.

(b)1. If the panel determines that the medical intervention conformed to national practice standards for the care and treatment of patients, then the application shall be dismissed and the participating provider shall not be held responsible for the applicant's medical injury.

2. If the panel determines, by a preponderance of the evidence, that all of the following criteria exist, then the panel shall report that the application constitutes a medical injury:

a. The participating provider performed a medical treatment on the applicant.

b. The applicant suffered medical harm.

c. The medical treatment was the proximate cause of the injury.

d. One or more of the following occurred, as determined in accordance with s. 766.402(9):

(I) An accepted method of medical treatment was not used.

(II) An accepted method of medical treatment was used but was executed in a substandard fashion.

(III) An accepted method of medical treatment was used but, after evaluation by the panel, the medical injury could have been avoided by using a less hazardous, but equally

effective method of medical treatment.

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

(d) If the panel determines that the application does not constitute a medical injury, the Office of Medical Review shall immediately notify the applicant by registered or certified mail of his or her right to appeal the panel's determination. The applicant shall have 15 days after receipt of the letter to appeal the panel's determination pursuant to s. 766.407.

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

determination of the office. The applicant shall have 15 days from the 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. In addition, compensation may be paid by periodic payments as determined by the Office of Compensation in accordance with rules adopted by the board.

(6) PAYMENT OF COMPENSATION.—Within 14 days after the earlier of the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.407, the participating provider, or the insurer for a participating provider who has insurance coverage, shall remit the compensation award to the Patient Compensation System, which shall immediately provide compensation to the applicant in accordance with 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 annually.

(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 the 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 for which a medical injury was determined to exist, related to persons licensed under chapter 458, chapter 459, chapter 460, part I of chapter 464, or chapter 466, when the person represents an imminent risk of harm to the public. The department shall review such applications to determine whether any of the incidents that resulted in the application potentially involved conduct by the person that is subject to disciplinary action, in which case s. 456.073 applies.

Section 9. Effective July 1, 2016, section 766.407, Florida Statutes, is created to read:

766.407 Review by administrative law judge; appellate review; extensions of time.—

(1) REVIEW BY ADMINISTRATIVE LAW JUDGE.—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 that section. 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 independent medical review panel or convene a new panel, or require the Office of Compensation to redetermine the compensation amount, in accordance with the determination of the judge.

(2) APPELLATE REVIEW.—A determination by an administrative law judge under this section regarding the award or denial of compensation under this part shall be conclusive and binding as to all questions of fact and shall be provided to the applicant and the participating provider. An applicant may appeal the award or denial of compensation to the District Court of Appeal. Appeals shall be filed in accordance with rules of procedure adopted by the Supreme Court for review of such orders.

(3) EXTENSIONS OF TIME.—Upon a written petition by either the applicant or the participating provider, an administrative law judge may grant, for good cause, an extension of any of the time periods specified in this part. The relevant time period shall be tolled from the date of the written petition until the date of the determination by the administrative law judge.

Section 10. Effective July 1, 2016, section 766.408, Florida Statutes, is created to read:

766.408 Expenses of administration; contribution; opt out.—

(1) The board shall annually determine a contribution that shall be paid by each provider, unless the provider opts out of participation in the Patient Compensation System pursuant to subsection (6). 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 amount may not exceed:

(a) For a person licensed under s. 401.27, a chiropractic assistant licensed under chapter 460, or a person licensed under chapter 461, chapter 462, chapter 463, chapter 464, excluding 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 license.

(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 license or certification.

(c) For a physician licensed under chapter 458, chapter 459, or chapter 460: $600 per license. For the initial fiscal year, the contribution amount shall be $500 per license.

(d) For a facility licensed under part II of chapter 400: $100 per bed.

(e) For a facility licensed under chapter 395: $200 per bed. For the initial fiscal year, the contribution amount 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 shall

be payable by each participating provider upon notice delivered on or after July 1 of the following state fiscal year. Each participating provider shall pay the contribution amount within 30 days after the date the notice is delivered to the provider. If the 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 that has not opted out of participation pursuant to subsection (6) who fails to pay the contribution amount determined under this section within 60 days after receipt of the original notice shall be subject to license revocation by the department, the Agency for Health Care Administration, or the relevant regulatory board, as applicable.

(5) All amounts collected under this section shall be paid into the Patient Compensation System Trust Fund established in s. 766.4105.

(6) A provider may elect to opt out of participation in the Patient Compensation System. The election to opt out must be made in writing no later than 15 days before the due date of the contribution required under this section. A provider who opts out may subsequently elect to participate in the system by paying the appropriate contribution amount for the current fiscal year.

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

766.409 Notice to patients of participation in the Patient Compensation System.—

(1) Each participating provider shall provide notice to patients that the provider is participating in the Patient Compensation System. Such notice shall be provided on a form furnished by the Patient Compensation System and shall include a concise explanation of a patient's rights and benefits under the system.

(2) Notice is not required to be given to a patient when the patient has an emergency medical condition as defined in s. 395.002(8)(b) or when notice is not practicable.

Section 12. Section 766.410, Florida Statutes, is created to read:

766.410 Annual report.—The board shall annually, beginning on October 1, 2016, 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 preceding fiscal year. The report shall include, in the aggregate, the number of applications, the disposition of such applications, and the compensation awarded.

Section 13. This act applies to medical incidents for which a notice of intent to initiate litigation has not been mailed before July 1, 2016.

Section 14. 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 15. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2015.