COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

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1 Committee/Subcommittee hearing bill: Commerce Committee
2 Representative Santiago offered the following:
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4 **Amendment (with title amendment)**
5 Remove lines 127-130 and insert:
6 Section 3. Paragraph (a) of subsection (5) and subsection
7 (10) of section 627.736, Florida Statutes, are amended to read:
8 627.736 Required personal injury protection benefits;
9 exclusions; priority; claims.—
10 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
11 (a) A physician, hospital, clinic, or other person or
12 institution lawfully rendering treatment to an injured person
13 for a bodily injury covered by personal injury protection
14 insurance may charge the insurer and injured party only a
15 reasonable amount pursuant to this section for the services and
16 supplies rendered, and the insurer providing such coverage may

17 pay for such charges directly to such person or institution
18 lawfully rendering such treatment if the insured receiving such
19 treatment or his or her guardian has countersigned the properly
20 completed invoice, bill, or claim form approved by the office
21 upon which such charges are to be paid for as having actually
22 been rendered, to the best knowledge of the insured or his or
23 her guardian. However, such a charge may not exceed the amount
24 the person or institution customarily charges for like services
25 or supplies. In determining whether a charge for a particular
26 service, treatment, or otherwise is reasonable, consideration
27 may be given to evidence of usual and customary charges and
28 payments accepted by the provider involved in the dispute,
29 reimbursement levels in the community and various federal and
30 state medical fee schedules applicable to motor vehicle and
31 other insurance coverages, and other information relevant to the
32 reasonableness of the reimbursement for the service, treatment,
33 or supply.
34 1. The insurer may limit reimbursement to 80 percent of
35 the following schedule of maximum charges:
36 a. For emergency transport and treatment by providers
37 licensed under chapter 401, 200 percent of Medicare.
38 b. For emergency services and care provided by a hospital
39 licensed under chapter 395, <u>200 percent of Medicare</u> ~~75 percent~~
40 ~~of the hospital's usual and customary charges~~.
41 c. For emergency services and care as defined by s.

42 395.002 provided in a facility licensed under chapter 395
43 rendered by a physician or dentist, and related hospital
44 inpatient services rendered by a physician or dentist, <u>200</u>
45 <u>percent of Medicare</u> ~~the usual and customary charges in the~~
46 ~~community~~.
47 d. For hospital inpatient services, ~~other than emergency~~
48 ~~services and care,~~ 200 percent of the Medicare Part A
49 prospective payment applicable to the specific hospital
50 providing the inpatient services.
51 e. For hospital outpatient services, ~~other than emergency~~
52 ~~services and care,~~ 200 percent of the Medicare Part A Ambulatory
53 Payment Classification for the specific hospital providing the
54 outpatient services.
55 f. For all other medical services, supplies, and care, 200
56 percent of the allowable amount under:
57 (I) The participating physicians fee schedule of Medicare
58 Part B, except as provided in sub-sub-subparagraphs (II) and
59 (III).
60 (II) Medicare Part B, in the case of services, supplies,
61 and care provided by ambulatory surgical centers and clinical
62 laboratories.
63 (III) The Durable Medical Equipment Prosthetics/Orthotics
64 and Supplies fee schedule of Medicare Part B, in the case of
65 durable medical equipment.
66

67 However, if such services, supplies, or care is not reimbursable
68 under Medicare Part B, as provided in this sub-subparagraph, the
69 insurer may limit reimbursement to 80 percent of the maximum
70 reimbursable allowance under workers' compensation, as
71 determined under s. 440.13 and rules adopted thereunder which
72 are in effect at the time such services, supplies, or care is
73 provided. Services, supplies, or care that is not reimbursable
74 under Medicare or workers' compensation is not required to be
75 reimbursed by the insurer.
76 2. For purposes of subparagraph 1., the applicable fee
77 schedule or payment limitation under Medicare is the fee
78 schedule or payment limitation in effect on March 1 of the
79 service year in which the services, supplies, or care is
80 rendered and for the area in which such services, supplies, or
81 care is rendered, and the applicable fee schedule or payment
82 limitation applies to services, supplies, or care rendered
83 during that service year, notwithstanding any subsequent change
84 made to the fee schedule or payment limitation, except that it
85 may not be less than the allowable amount under the applicable
86 schedule of Medicare Part B for 2007 for medical services,
87 supplies, and care subject to Medicare Part B. For purposes of
88 this subparagraph, the term "service year" means the period from
89 March 1 through the end of February of the following year.
90 3. Subparagraph 1. does not allow the insurer to apply any
91 limitation on the number of treatments or other utilization

92 limits that apply under Medicare or workers' compensation. An
93 insurer that applies the allowable payment limitations of
94 subparagraph 1. must reimburse a provider who lawfully provided
95 care or treatment under the scope of his or her license,
96 regardless of whether such provider is entitled to reimbursement
97 under Medicare due to restrictions or limitations on the types
98 or discipline of health care providers who may be reimbursed for
99 particular procedures or procedure codes. However, subparagraph
100 1. does not prohibit an insurer from using the Medicare coding
101 policies and payment methodologies of the federal Centers for
102 Medicare and Medicaid Services, including applicable modifiers,
103 to determine the appropriate amount of reimbursement for medical
104 services, supplies, or care if the coding policy or payment
105 methodology does not constitute a utilization limit.
106 4. If an insurer limits payment as authorized by
107 subparagraph 1., the person providing such services, supplies,
108 or care may not bill or attempt to collect from the insured any
109 amount in excess of such limits, except for amounts that are not
110 covered by the insured's personal injury protection coverage due
111 to the coinsurance amount or maximum policy limits.
112 5. An insurer may limit payment as authorized by this
113 paragraph only if the insurance policy includes a notice at the
114 time of issuance or renewal that the insurer may limit payment
115 pursuant to the schedule of charges specified in this paragraph.
116 A policy form approved by the office satisfies this requirement.

117 If a provider submits a charge for an amount less than the
118 amount allowed under subparagraph 1., the insurer may pay the
119 amount of the charge submitted.
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122 ---
123 **T I T L E A M E N D M E N T**
124 Remove line 24 and insert:
125 s. 627.736, F.S.; revising allowable maximum medical charges;
126 specifying information required as