



Judiciary Committee

March 17, 2014

3:00 PM

404 HOB

Meeting Packet

**Will Weatherford
Speaker**

**Dennis Baxley
Chair**

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Judiciary Committee

Start Date and Time: Monday, March 17, 2014 03:00 pm

End Date and Time: Monday, March 17, 2014 05:00 pm

Location: Sumner Hall (404 HOB)

Duration: 2.00 hrs

Workshop on the following:

HB 739 Compensation for Personal Injury or Wrongful Death Arising from Medical Injury by Brodeur

NOTICE FINALIZED on 03/13/2014 16:10 by Jones.Missy

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 offer of settlement or apology; providing an exception for certain wrongful death claims; 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 an application filing period; creating s. 766.406, F.S.; providing for disposition,

27 support, and review of applications; providing for a
 28 determination of compensation upon a prima facie claim
 29 of a medical injury having been made; providing that
 30 compensation for an application shall be offset by any
 31 past and future collateral source payments; providing
 32 for determinations of malpractice for purposes of a
 33 specified constitutional provision; providing for
 34 notice of applications determined to constitute a
 35 medical injury for purposes of professional
 36 discipline; providing for payment of compensation
 37 awards; creating s. 766.407, F.S.; providing for
 38 review of awards by an administrative law judge;
 39 creating s. 766.408, F.S.; requiring annual
 40 contributions from specified providers to provide
 41 administrative expenses; providing maximum
 42 contribution rates; specifying payment dates;
 43 providing for disciplinary proceedings for failure to
 44 pay; providing for deposit of funds; authorizing
 45 providers to opt out of participation; providing
 46 requirements for such an election; creating s.
 47 766.409, F.S.; requiring notice to patients of
 48 provider participation in the Patient Compensation
 49 System; creating s. 766.410, F.S.; requiring an annual
 50 report to the Governor and Legislature; providing
 51 applicability; providing severability; providing
 52 effective dates.

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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

79 Malpractice and Related Matters"; ss. 766.201-766.212, Florida
 80 Statutes, as part II of that chapter, entitled "Voluntary
 81 Binding Arbitration"; ss. 766.301-766.316, Florida Statutes, as
 82 part III of that chapter, entitled "Birth-Related Neurological
 83 Injuries"; and ss. 766.401-766.410, Florida Statutes, as created
 84 by this act, as part IV of that chapter, entitled "Patient
 85 Compensation System."

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

88 766.401 Short title.—This part may be cited as the
 89 "Patient Compensation System Act."

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

92 766.402 Definitions.—As used in this part, the term:

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

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

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

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

103 (a) The federal Social Security Act; any federal, state,
 104 or local income disability act; or any other public program

105 providing medical expenses, disability payments, or other
 106 similar benefits, except as prohibited by federal law.

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

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

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

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

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

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

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

128 (9) (a) "Medical injury" means a personal injury or
 129 wrongful death due to medical treatment, including a missed
 130 diagnosis, which injury or death could have been avoided:

131 1. For care provided by an individual participating
 132 provider, under the care of an experienced specialist provider
 133 practicing in the same field of care under the same or similar
 134 circumstances or, for a general practitioner provider, an
 135 experienced general practitioner provider practicing under the
 136 same or similar circumstances; or

137 2. For care provided by a participating provider in a
 138 system of care, if such care is rendered within an optimal
 139 system of care under the same or similar circumstances.

140 (b) A medical injury only includes consideration of an
 141 alternate course of treatment if the injury or death could have
 142 been avoided through a different but equally effective manner of
 143 treatment for the underlying condition. In addition, a medical
 144 injury only includes consideration of information that would
 145 have been known to an experienced specialist or readily
 146 available to an optimal system of care at the time of the
 147 medical treatment.

148 (c) For purposes of this subsection, the term "medical
 149 injury" does not include an injury or wrongful death where the
 150 medical treatment conformed with national practice standards for
 151 the care and treatment of patients as determined by the
 152 independent medical review panel.

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

156 (11) "Panelist" means a person who meets the definition of

157 a provider under this section.

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

162 (13) "Patient Compensation System" means the organization
 163 created in s. 766.404.

164 (14) "Provider" means a birth center licensed under
 165 chapter 383; a facility licensed under chapter 390, chapter 395,
 166 or chapter 400; a home health agency or nurse registry licensed
 167 under part III of chapter 400; a health care services pool
 168 registered under part IX of chapter 400; a person licensed under
 169 s. 401.27, chapter 457, chapter 458, chapter 459, chapter 460,
 170 chapter 461, chapter 462, chapter 463, chapter 464, chapter 465,
 171 chapter 466, chapter 467, part I, part II, part III, part IV,
 172 part V, part X, part XIII, or part XIV of chapter 468, chapter
 173 478, part III of chapter 483, or chapter 486; a clinical
 174 laboratory licensed under part I of chapter 483; a multiphasic
 175 health testing center licensed under part II of chapter 483; a
 176 health maintenance organization certificated under part I of
 177 chapter 641; a blood bank; a plasma center; an industrial
 178 clinic; a renal dialysis facility; or a professional association
 179 partnership, corporation, joint venture, or other association
 180 pertaining to the professional activity of health care
 181 providers.

182 Section 5. Effective July 1, 2015, section 766.403,

183 Florida Statutes, is created to read:

184 766.403 Legislative findings and intent; exclusive remedy;
 185 early offers; wrongful death.-

186 (1) LEGISLATIVE FINDINGS.-The Legislature finds that:

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

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

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

199 (d) Because of continued exposure to liability, an
 200 overwhelming majority of physicians practice defensive medicine
 201 by ordering unnecessary tests and procedures, increasing the
 202 cost of health care for individuals covered by public and
 203 private health insurance coverage and exposing patients to
 204 unnecessary clinical risks.

205 (e) A significant number of physicians intend to
 206 discontinue providing services in Florida as a result of the
 207 cost and risk of medical liability in this state, particularly
 208 obstetricians.

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

212 (2) LEGISLATIVE INTENT.—The Legislature intends:

213 (a) To supersede medical malpractice litigation by
 214 creating a new remedy whereby patients are fairly and
 215 expeditiously compensated for medical injuries. As provided in
 216 this part, this alternative is intended to significantly reduce
 217 the practice of defensive medicine, thereby reducing health care
 218 costs; to increase patient safety; to increase the number of
 219 physicians practicing in this state; and to provide patients
 220 fair and timely compensation without the expense and delay of
 221 the court system. The Legislature intends that this part apply
 222 to all health care facilities and health care providers who are
 223 either insured or self-insured against claims for medical
 224 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
 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-
 253 insured 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 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 may not be provided under

261 this part for an application requesting an investigation of an
 262 alleged wrongful death due to medical treatment if such
 263 application is filed by an adult child on behalf of his or her
 264 parent or by a parent on behalf of his or her adult child.

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

267 766.404 Patient Compensation System; board; committees.—

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

275 (2) PATIENT COMPENSATION BOARD.—The Patient Compensation
 276 Board is a board of trustees as defined in s. 20.03 and is
 277 established to govern the Patient Compensation System. The board
 278 shall comply with s. 20.052 except as provided in this
 279 subsection.

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

285 1. Five members shall be appointed by the Governor, one of
 286 whom shall be an allopathic or osteopathic physician who

287 actively practices in this state, one of whom shall be an
 288 executive in the business community who works in this state, one
 289 of whom shall be a hospital administrator who works in this
 290 state, one of whom shall be a certified public accountant who
 291 actively practices in this state, and one of whom shall be a
 292 member of The Florida Bar who actively practices in this state.

293 2. Three members shall be persons selected by the Governor
 294 from a list of persons recommended by the President of the
 295 Senate, one of whom shall be an allopathic or osteopathic
 296 physician who actively practices in this state and one of whom
 297 shall be a patient advocate who resides in this state.

298 3. Three members shall be persons selected by the Governor
 299 from a list of persons recommended by the Speaker of the House
 300 of Representatives, one of whom shall be an allopathic or
 301 osteopathic physician who actively practices in this state and
 302 one of whom shall be a patient advocate who resides in this
 303 state.

304 (b) Terms of appointment.—Each member shall be appointed
 305 for a 4-year term. For the purpose of providing staggered terms,
 306 of the initial appointments, the five members appointed by the
 307 Governor shall be appointed to 2-year terms and the remaining
 308 six members shall be appointed to 3-year terms. If a vacancy
 309 occurs on the board before the expiration of a term, the
 310 Governor shall appoint a successor to serve the remainder of the
 311 term.

312 (c) Chair and vice chair.—The board shall annually elect

313 from its membership one member to serve as chair of the board
 314 and one member to serve as vice chair.

315 (d) Meetings.—The first meeting of the board shall be held
 316 no later than August 1, 2014. Thereafter, the board shall meet
 317 at least quarterly upon the call of the chair. A majority of the
 318 board members constitutes a quorum. Meetings may be held by
 319 teleconference, web conference, or other electronic means.

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

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

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

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

331 3. Employing an executive director and other staff as
 332 necessary to perform the functions of the Patient Compensation
 333 System, except that the Governor shall appoint the initial
 334 executive director.

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

338 5. Approving a schedule of compensation for medical

339 injuries, as recommended by the Compensation Committee.

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

342 7. Approving an annual budget.

343 8. Annually approving provider contribution amounts.

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

348 1. Advocacy director.—The advocacy director shall ensure
 349 that each applicant is provided high-quality individual
 350 assistance throughout the process, from initial filing to
 351 disposition of the application. The advocacy director shall
 352 assist each applicant in determining whether to retain an
 353 attorney, which assistance shall include an explanation of
 354 possible fee arrangements and the advantages and disadvantages
 355 of retaining an attorney. If the applicant seeks to file an
 356 application without an attorney, the advocacy director shall
 357 assist the applicant in filing the application. In addition, the
 358 advocacy director shall regularly provide status reports to the
 359 applicant regarding his or her application.

360 2. Chief compensation officer.—The chief compensation
 361 officer shall manage the Office of Compensation. The chief
 362 compensation officer shall recommend to the Compensation
 363 Committee a compensation schedule for each type of medical
 364 injury. The chief compensation officer may not be a licensed

365 physician or an attorney.

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

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

376 5. Chief medical officer.—The chief medical officer must
 377 be a physician licensed under chapter 458 or chapter 459 and
 378 shall manage the Office of Medical Review. The chief medical
 379 officer shall recommend to the Medical Review Committee a
 380 qualified list of multidisciplinary panelists for independent
 381 medical review panels. In addition, the chief medical officer
 382 shall convene independent medical review panels as necessary to
 383 review applications.

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

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

388 (a) Office of Medical Review.—The Office of Medical Review
 389 shall evaluate and, as necessary, investigate all applications
 390 in accordance with this part. For the purpose of an

391 investigation of an application, the office shall have the power
 392 to administer oaths, take depositions, issue subpoenas, compel
 393 the attendance of witnesses and the production of papers,
 394 documents, and other evidence, and obtain patient records
 395 pursuant to the applicant's release of protected health
 396 information.

397 (b) Office of Compensation.—The Office of Compensation
 398 shall allocate compensation for each application in accordance
 399 with the compensation schedule.

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

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

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

414 1. The Medical Review Committee shall be composed of two
 415 physicians licensed in this state and a board member who is not
 416 an attorney and who resides in this state. The board shall

417 designate a physician committee member as chair of the
 418 committee.

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

424 (b) Terms of appointment.—Members of each committee shall
 425 serve 2-year terms concurrent with their respective terms as
 426 board members. If a vacancy occurs on a committee, the board
 427 shall appoint a successor to serve the remainder of the term. A
 428 committee member who is removed or resigns from the board shall
 429 be removed from the committee.

430 (c) Chair and vice chair.—The board shall annually
 431 designate a chair and vice chair of each committee.

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

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

439 (f) Powers and duties.—

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

443 2. The Compensation Committee shall, in consultation with
 444 the chief compensation officer, recommend to the board:

445 a. A compensation schedule, formulated such that the
 446 aggregate cost of medical malpractice and the aggregate of
 447 provider contributions are equal to or less than the prior
 448 fiscal year's aggregate cost of medical malpractice. In
 449 addition, damage payments for each injury shall be no less than
 450 the average indemnity payment reported by the Physician Insurers
 451 Association of America or its successor organization for similar
 452 medical injuries with similar severity. Thereafter, the
 453 committee shall annually review the compensation schedule and,
 454 if necessary, recommend a revised schedule, such that a
 455 projected increase in the upcoming fiscal year's aggregate cost
 456 of medical malpractice, including insured and self-insured
 457 providers, does not exceed the percentage change from the prior
 458 year in the medical care component of the Consumer Price Index
 459 for All Urban Consumers.

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

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

466 (5) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical
 467 officer shall convene an independent medical review panel to
 468 evaluate each application to determine whether a medical injury

469 occurred. Each panel shall be composed of an odd number of at
 470 least three panelists chosen from a list of panelists
 471 representing the same or similar specialty as the provider and
 472 shall convene, either in person or by teleconference, upon the
 473 call of the chief medical officer. Each panelist shall be paid a
 474 stipend as determined by the board for his or her service on the
 475 panel. In order to expedite the review of applications, the
 476 chief medical officer may, whenever practicable, group related
 477 applications together for consideration by a single panel.

478 (6) CONFLICTS OF INTEREST.—A board member, panelist, or
 479 employee of the Patient Compensation System may not engage in
 480 any conduct that constitutes a conflict of interest. For
 481 purposes of this subsection, the term "conflict of interest"
 482 means a situation in which the private interest of a board
 483 member, panelist, or employee could influence his or her
 484 judgment in the performance of his or her duties under this
 485 part. A board member, panelist, or employee shall immediately
 486 disclose in writing the presence of a conflict of interest when
 487 the board member, panelist, or employee knows or should
 488 reasonably have known that the factual circumstances surrounding
 489 a particular application constitute or constituted a conflict of
 490 interest. A board member, panelist, or employee who violates
 491 this subsection is subject to disciplinary action as determined
 492 by the board. A conflict of interest includes, but is not
 493 limited to:

494 (a) Conduct that would lead a reasonable person having

495 knowledge of all of the circumstances to conclude that a board
 496 member, panelist, or employee is biased against or in favor of
 497 an applicant.

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

502 (7) RULEMAKING.—The board shall adopt rules to implement
 503 and administer this part, including rules addressing:

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

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

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

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

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

518 Section 7. Effective July 1, 2015, section 766.405,
 519 Florida Statutes, is created to read:

520 766.405 Filing of applications.—

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

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

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

530 (c) A brief statement of the facts and circumstances
 531 surrounding the medical injury that gave rise to the
 532 application.

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

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

539 (f) Documentation of any applicable private or
 540 governmental source of services or reimbursement relative to the
 541 medical injury.

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

547 correct the errors or omissions in the initial application.

548 (3) TIME LIMITATION ON APPLICATIONS.—An application shall
 549 be filed within the time periods specified in s. 95.11(4) for
 550 medical malpractice actions. The applicable time period shall be
 551 tolled from the date of the filing of an application until the
 552 date of the receipt by the applicant of the results of the
 553 initial medical review under s. 766.406.

554 (4) SUPPLEMENTAL INFORMATION.—After the filing of an
 555 application, the applicant may supplement the initial
 556 application with additional information that the applicant
 557 believes may be beneficial in the resolution of the application.

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

562 Section 8. Effective July 1, 2015, section 766.406,
 563 Florida Statutes, is created to read:

564 766.406 Disposition of applications.—

565 (1) INITIAL MEDICAL REVIEW.—Individuals with relevant
 566 clinical expertise in the Office of Medical Review shall, within
 567 10 days after the receipt of a completed application, determine
 568 whether the application, prima facie, constitutes a medical
 569 injury.

570 (a) If the Office of Medical Review determines that the
 571 application, prima facie, constitutes a medical injury, the
 572 office shall immediately notify, by registered or certified

573 mail, each participating provider named in the application and,
 574 for participating providers that are not self-insured, the
 575 insurer that provides coverage for the provider. The
 576 notification shall inform the participating provider that he or
 577 she may support the application to expedite the processing of
 578 the application. A participating provider shall have 15 days
 579 after the receipt of notification of an application to support
 580 the application. If the participating provider supports the
 581 application, the Office of Medical Review shall review the
 582 application in accordance with subsection (2).

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

590 (2) EXPEDITED MEDICAL REVIEW.—An application that is
 591 supported by a participating provider in accordance with
 592 subsection (1) shall be reviewed by individuals with relevant
 593 clinical expertise in the Office of Medical Review within 30
 594 days after notification of the participating provider's support
 595 of the application to determine the validity of the application.
 596 If the Office of Medical Review finds that the application is
 597 valid, the Office of Compensation shall determine an award of
 598 compensation in accordance with subsection (4). If the Office of

599 Medical Review finds that the application is not valid, the
 600 office shall immediately notify the applicant of the rejection
 601 of the application and, in the case of fraud, shall immediately
 602 notify relevant law enforcement authorities.

603 (3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review
 604 determines that the application, prima facie, constitutes a
 605 medical injury and the participating provider does not elect to
 606 support the application, the office shall complete a thorough
 607 investigation of the application within 60 days after the
 608 determination by the office. The investigation shall be
 609 conducted by a multidisciplinary team with relevant clinical
 610 expertise and shall include a thorough investigation of all
 611 available documentation, witnesses, and other information.
 612 Within 15 days after the completion of the investigation, the
 613 chief medical officer shall allow the applicant and the
 614 participating provider to access records, statements, and other
 615 information obtained in the course of its investigation, in
 616 accordance with relevant state and federal laws.

617 (a) Within 30 days after the completion of the
 618 investigation, the chief medical officer shall convene an
 619 independent medical review panel to determine whether the
 620 application constitutes a medical injury. The independent
 621 medical review panel shall have access to all redacted
 622 information obtained by the office in the course of its
 623 investigation of the application and shall make a written
 624 determination within 10 days after the convening of the panel,

625 which written determination shall be immediately provided to the
 626 applicant and the participating provider.

627 (b)1. If the panel determines that the medical service
 628 conformed to national practice standards for the care and
 629 treatment of patients, the application shall be dismissed and
 630 the provider shall not be held responsible for the patient's
 631 medical injury.

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

635 a. The provider performed a medical service on the
 636 applicant.

637 b. The applicant suffered damages.

638 c. The medical service was the proximate cause of the
 639 damages.

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

642 (I) An accepted method of medical services was not used
 643 for treatment;

644 (II) An accepted method of medical services was used for
 645 treatment but executed in a substandard fashion; or

646 (III) An accepted method was used, but a prospective
 647 analysis concludes that damages could have been avoided by using
 648 a less hazardous but equally effective treatment.

649 (c)1. If the independent medical review panel determines
 650 that the application constitutes a medical injury, the Office of

651 Medical Review shall immediately notify the participating
 652 provider by registered or certified mail of the right to appeal
 653 the determination of the panel. The participating provider shall
 654 have 15 days after the receipt of the letter in which to appeal
 655 the determination of the panel pursuant to s. 766.407.

656 2. If the independent medical review panel determines that
 657 the application does not constitute a medical injury, the Office
 658 of Medical Review shall immediately notify the applicant by
 659 registered or certified mail of the right to appeal the
 660 determination of the panel. The applicant shall have 15 days
 661 from the receipt of the letter to appeal the determination of
 662 the panel pursuant to s. 766.407.

663 (4) COMPENSATION REVIEW.—If an independent medical review
 664 panel finds that an application constitutes a medical injury
 665 under subsection (3) and all appeals of that finding have been
 666 exhausted by the participating provider pursuant to s. 766.407,
 667 the Office of Compensation shall, within 30 days after either
 668 the finding of the panel or the exhaustion of all appeals of
 669 that finding, whichever occurs later, make a written
 670 determination of an award of compensation in accordance with the
 671 compensation schedule and the findings of the panel. The office
 672 shall notify the applicant and the participating provider by
 673 registered or certified mail of the amount of compensation and
 674 shall also explain to the applicant the process to appeal the
 675 determination of the office. The applicant shall have 15 days
 676 from the receipt of the letter to appeal the determination of

677 | the office pursuant to s. 766.407.

678 | (5) LIMITATION ON COMPENSATION.—Compensation for each
 679 | application shall be offset by any past and future collateral
 680 | source payments. In addition, compensation may be paid by
 681 | periodic payments as determined by the Office of Compensation in
 682 | accordance with rules adopted by the board.

683 | (6) PAYMENT OF COMPENSATION.—Within 14 days after either
 684 | the acceptance of compensation by the applicant or the
 685 | conclusion of all appeals pursuant to s. 766.407, the
 686 | participating provider, or the insurer for a participating
 687 | provider who has insurance coverage, shall remit the
 688 | compensation award to the Patient Compensation System, which
 689 | shall immediately provide compensation to the applicant in
 690 | accordance with the final compensation award. Beginning 45 days
 691 | after the acceptance of compensation by the applicant or the
 692 | conclusion of all appeals pursuant to s. 766.407, whichever
 693 | occurs later, an unpaid award shall begin to accrue interest at
 694 | the rate of 18 percent per year.

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

701 | (8) PROFESSIONAL BOARD NOTICE.—The Patient Compensation
 702 | System shall provide the department with electronic access to

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

711 Section 9. Effective July 1, 2015, section 766.407,
 712 Florida Statutes, is created to read:

713 766.407 Review by administrative law judge; appellate
 714 review; extensions of time.—

715 (1) REVIEW BY ADMINISTRATIVE LAW JUDGE.—An administrative
 716 law judge shall hear and determine appeals filed pursuant to s.
 717 766.406 and shall exercise the full power and authority granted
 718 to him or her in chapter 120, as necessary, to carry out the
 719 purposes of that section. The administrative law judge shall be
 720 limited in his or her review to determining whether the Office
 721 of Medical Review, the independent medical review panel, or the
 722 Office of Compensation, as appropriate, has faithfully followed
 723 the requirements of this part and rules adopted thereunder in
 724 reviewing applications. If the administrative law judge
 725 determines that such requirements were not followed in reviewing
 726 an application, he or she shall require the chief medical
 727 officer to either reconvene the original panel or convene a new
 728 panel, or require the Office of Compensation to redetermine the

729 compensation amount, in accordance with the determination of the
 730 judge.

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

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

745 Section 10. Effective July 1, 2015, section 766.408,
 746 Florida Statutes, is created to read:

747 766.408 Expenses of administration; opt out.—

748 (1) The board shall annually determine a contribution that
 749 shall be paid by each provider, unless the provider opts out of
 750 participation in the Patient Compensation System pursuant to
 751 subsection (6). The contribution amount shall be determined by
 752 January 1 of each year and shall be based on the anticipated
 753 expenses of the administration of this part for the next state
 754 fiscal year.

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

757 (a) For an individual licensed under section 401.27, a
 758 chiropractic assistant licensed under chapter 460, or an
 759 individual licensed under chapter 461, chapter 462, chapter 463,
 760 chapter 464 with the exception of a certified registered nurse
 761 anesthetist, chapter 465, chapter 466, chapter 467, part I, part
 762 II, part III, part IV, part V, part X, part XIII, or part XIV of
 763 chapter 468, chapter 478, part III of chapter 483, or chapter
 764 486, \$100 per licensee.

765 (b) For an anesthesiology assistant or physician assistant
 766 licensed under chapter 458 or chapter 459 or a certified
 767 registered nurse anesthetist certified under part I of chapter
 768 464, \$250 per licensee.

769 (c) For a physician licensed under chapter 458, chapter
 770 459, or chapter 460, \$600 per licensee. The contribution for the
 771 initial fiscal year shall be \$500 per licensee.

772 (d) For a facility licensed under part II of chapter 400,
 773 \$100 per bed.

774 (e) For a facility licensed under chapter 395, \$200 per
 775 bed, except that the contribution for the initial fiscal year
 776 shall be \$100 per bed.

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

779 (3) The contribution determined under this section shall
 780 be payable by each participating provider upon notice delivered

781 on or after July 1 of the next state fiscal year. Each
 782 participating provider shall pay the contribution amount within
 783 30 days after the date the notice is delivered to the provider.
 784 If a provider fails to pay the contribution determined under
 785 this section within 30 days after such notice, the board shall
 786 notify the provider by certified or registered mail that the
 787 provider's license shall be subject to revocation if the
 788 contribution is not paid within 60 days from the date of the
 789 original notice.

790 (4) A provider who has not opted out of participation
 791 pursuant to subsection (6) who fails to pay the contribution
 792 amount determined under this section within 60 days after
 793 receipt of the original notice shall be subject to a licensure
 794 revocation action by the department, the Agency for Health Care
 795 Administration, or the relevant regulatory board, as applicable.

796 (5) All amounts collected under this section shall be paid
 797 into the Patient Compensation Trust Fund established in s.
 798 766.4105.

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

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

807 766.409 Notice to patients of participation in the Patient
 808 Compensation System.—

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

815 (2) Notice is not required to be given to a patient when
 816 the patient has an emergency medical condition as defined in s.
 817 395.002(8)(b) or when notice is not practicable.

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

820 766.410 Annual report.—The board shall annually, beginning
 821 October 1, 2015, submit to the Governor, the President of the
 822 Senate, and the Speaker of the House of Representatives a report
 823 that describes the filing and disposition of applications in the
 824 preceding fiscal year. The report shall include, in the
 825 aggregate, the number of applications, the disposition of such
 826 applications, and the compensation awarded.

827 Section 13. This act applies to medical incidents for
 828 which a notice of intent to initiate litigation has not been
 829 mailed before July 1, 2015.

830 Section 14. If any provision of this act or its
 831 application to any person or circumstance is held invalid, the
 832 invalidity does not affect other provisions or applications of

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833 | the act which may be given effect without the invalid provision
834 | or application, and to this end the provisions of this act are
835 | severable.

836 | Section 15. Except as otherwise expressly provided in this
837 | act, this act shall take effect July 1, 2014.