

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1317 Medical Services and Insurance
SPONSOR(S): Health & Human Services Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Grabowski	Calamas

SUMMARY ANALYSIS

Florida's Motor Vehicle No-Fault Law (No-Fault Law) requires motorists to carry no-fault insurance known as personal injury protection (PIP) coverage. The purpose of PIP coverage under the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to who is responsible for a motor vehicle accident.

PIP medical benefits are subject to parameters set in statute. Initial services and care are only reimbursable if lawfully provided, supervised, ordered or prescribed by a licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. Follow-up services and care require a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care. Reimbursement rates for the majority of medical services paid for by PIP are limited in statute and linked either to Medicare reimbursement rates or usual and customary charges paid to providers.

HB 1317 amends the PIP fee schedules by limiting reimbursement for benefits payable under PIP coverage to 80 percent of 200 percent of the relevant Medicare payment rates for emergency services. This change brings the fee schedules for emergency services into alignment with the other, non-emergency service fee schedules provided in the PIP statute.

The bill extends the time period in which initial treatment services are subject to reimbursement under PIP coverage from 14 days following a motor vehicle accident to 30 days following such an accident. This change provides insureds with greater flexibility in obtaining medical services under PIP coverage.

The bill also establishes new standards of care that must be met in order for medical services to be reimbursed by PIP. The standards involve the development of a treatment plan by a practitioner providing initial medical services, which must be regularly updated as an individual receives care. If a practitioner fails to maintain and update the treatment, he or she may forfeit PIP reimbursement for services provided and could be subject to disciplinary actions established under current law.

The bill has no fiscal impact on state or local governments.

The bill has an effective date of July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Financial Responsibility Law

Florida's Financial Responsibility Law requires proof of ability to pay monetary damages for bodily injury (BI) and property damage (PD) liability arising out of a motor vehicle accident or serious traffic violation.¹ The owner or operator of a motor vehicle is not required to provide proof of BI coverage at the time of vehicle registration. Motorcycle owners also are not required to provide proof of BI coverage at the time of registration. Proof of such coverage is only required after an accident.² At that time, a driver proves financial responsibility by furnishing an active motor vehicle liability policy, a certificate showing a qualifying security deposit with the Department of Highway Safety and Motor Vehicles (DHSMV), or proof of qualifying self-insurance.³

The required minimum amounts of BI insurance coverages are \$10,000, in the event of bodily injury to, or death of, one person, and \$20,000, in the event of bodily injury to, or death of, two or more persons. The required minimum amount of PD insurance coverage is \$10,000, in the event of damage to property of others, or \$30,000 combined for both BI and PD coverage.⁴ Some refer to these coverage amounts in a summary manner, i.e., \$10,000/\$20,000/\$10,000 or 10/20/10.

A driver's license and vehicle registration are subject to suspension for failure to comply with the PD coverage requirement.⁵ One may obtain driver's license and registration reinstatement by obtaining a liability policy and by paying a fee to DHSMV.⁶

Financial responsibility requirements are common. All states have financial responsibility laws that require persons involved in auto accidents (or serious traffic infractions) to furnish proof of BI and PD liability insurance. The minimum coverage amounts vary among the states.

Florida Motor Vehicle No-Fault Law

Florida's Motor Vehicle No-Fault Law (No-Fault Law)⁷ requires motorists to carry no-fault insurance known as personal injury protection (PIP) coverage. The purpose of PIP coverage under the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to who is responsible for a motor vehicle accident. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida

¹ Ch. 324, F.S.

² Ss. 320.02 and 324.011, F.S.

³ Ss. 324.031, 324.061, 324.161, and 324.171, F.S. Businesses that choose to self-insure the financial responsibility requirements must deposit \$30,000 per vehicle, up to a maximum of \$120,000, with the DHSMV and maintain excess insurance with limits of \$125,000/\$250,000/\$300,000. Individuals that choose to self-insure must deposit \$30,000 with the DHSMV. Individuals and businesses can also obtain a certificate of self-insurance to satisfy the financial responsibility requirements. Individuals must have an unencumbered net worth of \$40,000 and businesses must have either an unencumbered net worth of \$40,000 for the first vehicle and \$20,000 for each additional vehicle or a sufficient net worth determined by the DHSMV by rule. Currently, the applicable rule provides that \$40,000 for the first vehicle and an amount less than \$20,000 for each additional vehicle is sufficient if the applicant carries excess insurance in the amounts of \$25,000/\$50,000/\$100,000. The amount applicable to each additional vehicle is determined annually under a "Manual of Financial Responsibility Rates" (Revised 05-89) adopted by rule by the Office of Insurance Regulation. Rule 15A-3.011, F.A.C.

⁴ S. 324.022, F.S.

⁵ S. 324.0221(2), F.S. Failure to maintain PIP coverage will also result in suspension of the driver's license and vehicle registration.

⁶ S. 324.0221(3), F.S.

⁷ Ss. 627.730-627.7405, F.S.

motorists are required to carry \$10,000 of PIP coverage.⁸ However, motorcycles are excluded from this requirement.

PIP General Provisions

Required Coverage	All owners or registrants of motor vehicles with four or more wheels, except school buses, limos, and taxicabs, are required to carry PIP. ⁹
Individuals Covered	The named insured, relatives living in the same household, persons operating the vehicle, passengers in the vehicle, and persons struck and injured while not occupying the vehicle.
Tort Limitation	Limited exemption from tort liability; injured persons may pursue certain tort claims as specified by the PIP law.
Benefits	\$10,000 in emergency medical and disability benefits (limited to \$2,500 in medical benefits for non-emergency medical conditions) and \$5,000 in death benefits. Coverage of 60 percent of lost income due to disability.
Timely Treatment	Medical benefits are paid only if initial treatment is received within 14 days of the accident.
Timely Payment	Payments are overdue if not paid within 30 days of insurer receipt of written notice.
Medical Reimbursement	80 percent of reasonable medical expenses paid to eligible medical providers. ¹⁰
Excluded Treatment	Massage and acupuncture are not PIP medical benefits. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.
Attorney Fees	Prevailing insureds and beneficiaries may receive a reasonable attorney fees award.

PIP Medical Benefits

To receive PIP medical benefits, insureds must receive initial services and care within 14 days after the motor vehicle accident.¹¹ Initial services and care are only reimbursable if lawfully provided, supervised, ordered or prescribed by a licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider.¹² Follow-up services and care

⁸ S. 627.7275, F.S. Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for Bodily Injury and Property Damage liability at the time of motor vehicle accidents or when serious traffic violations occur. The Financial Responsibility Law requires \$10,000, per person, and \$20,000, per incident, of Bodily Injury coverage, and \$10,000 of Property Damage liability coverage.

⁹ This includes non-resident owners who keep a vehicle in Florida for more than 90 days during the previous 365 days. s. 627.733(2), F.S.

¹⁰ Insurers may limit reimbursements to a fee schedule tied to the Medicare allowed amount. s. 627.736(5)(a)1., F.S. For many services, 80 percent of 200 percent of the Medicare allowed amount is the standard reimbursement under this fee schedule.

¹¹ S. 627.736(1)(a), F.S.

¹² S. 627.736(1)(a)1., F.S.

require a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.¹³

PIP medical benefits have two different coverage limits, based upon the severity of the medical condition of the individual. An insured may receive up to \$10,000 in medical benefits for services and care if a physician, osteopathic physician, dentist, physician's assistant or advanced registered nurse practitioner has determined that the injured person had an emergency medical condition.¹⁴ An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.¹⁵ If a provider who rendered treatment or services does not determine that the insured had an emergency medical condition, the PIP medical benefit limit is \$2,500.¹⁶

Medicare Fee Schedules

Medicare is the federal health insurance program that provides benefits to people over the age of 65, certain younger people with disabilities, and people with end-stage renal disease.¹⁷ Health care providers who participate in the program are reimbursed based on fee schedules, which are periodically updated by the federal Centers for Medicare and Medicaid Services (CMS). A fee schedule is a complete listing of fees used by Medicare to pay doctors, hospitals, and other providers. This comprehensive listing of fee maximums is used to reimburse providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.¹⁸

The Medicare Part A fee schedule sets reimbursement rates for inpatient hospitalizations, as well as services provided in nursing home facilities and hospice care facilities.¹⁹

The Medicare Part B fee schedule sets reimbursement rates for physicians, hospital clinics, and other providers for outpatient services.²⁰

PIP Medical Fee Schedules

Section 627.736, F.S., sets parameters on the payment of medical expenses by PIP coverage. Section 627.736(5), F.S., authorizes insurers to limit reimbursement for benefits payable under PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;

¹³ S. 627.736(1)(a)2., F.S.

¹⁴ S. 627.736(1)(a)3., F.S.

¹⁵ S. 627.732(16), F.S.

¹⁶ S. 627.736(1)(a)4., F.S.

¹⁷ U.S. Department of Health and Human Services, *What's Medicare?*, available at <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> (last accessed April 4, 2019).

¹⁸ Centers for Medicare and Medicaid Services, *Fee Schedules – General Information*, available at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo/index.html> (last accessed March 30, 2019).

¹⁹ Henry J. Kaiser Family Foundation, *A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, March 2015. Available at <http://files.kff.org/attachment/report-a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers> (last accessed April 4, 2019).

²⁰ "Medicare Part B," Health Affairs Health Policy Brief, August 10, 2017. Available at <https://www.healthaffairs.org/doi/10.1377/hpb20171008.000171/full/> (last accessed April 4, 2019).

- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For services supplies and care provided by ambulatory surgical centers and clinical laboratories, 200 percent of Medicare Part B;
- For durable medical equipment, 200 percent of the Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B;
- For all other medical services, supplies, and care, 200 percent of the participating physicians fee schedule of Medicare Part B; and
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation.²¹ In addition, the insurer must reimburse a health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent copayment) or for amounts that exceed maximum policy limits.²²

Medical Billing and Coding

Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes.²³ These codes allow for the standardization of billing across services, providers, and patients.

Section 627.736, F.S., requires PIP medical providers to bill their services and code their diagnoses using the *Physicians' Current Procedural Terminology (CPT)*, the *Healthcare Correct Procedural Coding System (HCPCS)*,²⁴ or the *International Classification of Diseases, 10th Revision (ICD-10)*,²⁵ in effect for the year that the medical service is rendered and to comply with the CMS-1500 medical billing form instructions of the Centers for Medicare & Medicaid Services (CMS), the American Medical Services CPT Editorial Panel, and the HCPCS.

Effect of the Bill

The PCS for HB 1317 revises PIP medical fee schedules by linking allowable charges for emergency services to the Medicare fee schedules. The bill also revises the timely treatment standard and establishes new standards of care for medical services reimbursed under PIP coverage.

PIP Medical Fee Schedules

The bill amends the fee schedules under s. 627.736 (5), F.S., by limiting reimbursement for benefits payable under PIP coverage to 80 percent of the following Medicare payment rates:

- For emergency services and care provided by a hospital, 200 percent of the Medicare Part A payment applicable to the hospital providing the services;

²¹ S. 627.736(5)(a)3., F.S.

²² S. 627.736(5)(a)4., F.S.

²³ AAPC, "What is Medical Coding?," available at <https://www.aapc.com/medical-coding/medical-coding.aspx> (last accessed April 4, 2019).

²⁴ The CPT and the HCPCS are produced by the American Medical Association. They are available at <https://commerce.ama-assn.org/store/> under the Coding & Reimbursement section (last accessed April 4, 2019).

²⁵ The International Classification of Diseases (ICD) manuals are developed by the World Health Organization. Information about the ICD manuals can be obtained at <https://www.who.int/classifications/icd/icdonlineversions/en/> (last accessed April 4, 2019).

- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, 200 percent of the Medicare Part B payment applicable to the physician providing the services.

This change brings the fee schedules for emergency services into alignment with the other, non-emergency service fee schedules provided in the PIP statute.

Timely Treatment

The bill extends the time period in which initial treatment services are subject to reimbursement under PIP coverage from 14 days following a motor vehicle accident to 30 days following such an accident. This change provides insureds with greater flexibility in obtaining medical services under PIP coverage.

Standards of Care

The bill establishes new and expanded standards of care that must be met by health care practitioners in order to receive reimbursement under PIP coverage. The bill defines health care practitioners as any of the following:

- A physician licensed under ch. 458, F.S.
- An osteopathic physician licensed under ch. 459, F.S.
- A chiropractic physician licensed under ch. 460, F.S.
- A physician assistant licensed under either ch. 458 or 459, F.S.
- An advanced practice registered nurse licensed under ch. 464, F.S.
- A dentist licensed under ch. 466, F.S.

A licensed medical practitioner who provides treatment to a patient in anticipation of PIP reimbursement must develop a treatment plan for that patient. The treatment plan must:

- Be based on a patient's medical history and an examination or diagnostic study of the patient;
- Be supported by a written clinical rationale which indicates that treatment is reasonable and necessary;
- Document the clinical rationale for any diagnostic tests and provide the results of those tests; and,
- Include diagnostic codes from the most recent ICD revision.

The initial treatment plan may not exceed 6 weeks in duration. Subsequent treatment plans may be developed as necessary, but may not exceed 8 weeks without being updated, revised, or extended using appropriate diagnosis coding. The bill requires that a practitioner have an interaction with the patient at least every 2 weeks or every fourth visit, whichever occurs first, between treatment plans. For each interaction, the patient's medical record must show that medical professional's presence was necessary during the interaction or that the interaction was translated into an appropriate CPT code for billing purposes. In addition, a medical practitioner ordering a course of treatment that extends to more than three patient interactions is required to submit to the PIP insurer the medical record of the interaction at which the treatment plan was developed.

The bill specifies that intentionally submitting a claim, statement, or bill for payment which violates the new standard of care requirements constitutes grounds for discipline under the practitioner licensure statutes. In other words, if a practitioner intentionally submits a claim for PIP reimbursement that is not in compliance with the treatment plan guidelines, he or she is subject to disciplinary actions by either the relevant licensing board or the Department of Health.

PIP Reimbursement

The bill conditions reimbursement by a PIP insurer upon development of the treatment plan described above. After the provision of initial health care services, and upon referral to a health care practitioner, the treatment plan and any associated medical documentation must be submitted to the insurer within 30 days of the start date of the treatment plan. The treatment plan must be updated regularly and in accordance with the standard of care requirements.

Rulemaking Authority

Lastly, the bill provides the Financial Services Commission with rulemaking authority to implement and administer the new standards of care requirements.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.072, F.S., relating to grounds for discipline; penalties; enforcement.

Section 2: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.

Section 3: Creates s. 627.7361, F.S., relating to standards of care for personal injury protection medical services.

Section 4: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The OIR may incur indeterminate costs associated with rulemaking and enforcement of the revised reimbursement guidelines.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have an indeterminate negative impact on health care providers. Providers whose current practices do not meet the new standards of care will be required to update and revise their record-keeping, billing systems, and procedures.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides OIR with sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES