

PIP TODAY:
WHAT WE KNOW FROM 2007 AND
WHAT WE HAVE TO LEARN ABOUT 2008

Classroom Outline / Syllabus
3 hours Advanced - CE 3-24a - Adjuster Law and Policy
Course ID # 65697

- I. **History of the PIP statutes: 1972-2008 (10 Minutes)**
 - a. Purpose / intent of PIP
 - b. Changes over time to PIP

- II. **PIP Sunset / Lapse: (20 Minutes)**
 - a. When did sunset happen
 - b. When did sunset end
 - c. What happened / happens as a result of sunset
 - i. Non mandatory PIP
 - ii. Med Pay
 - iii. Ongoing treatment from sunset period into 2008
 - 1. Affect of January 1, 2008 mandatory re-requirement of PIP
 - 2. Cannot create coverage
 - d. Detailed case examples, statutes and analysis
 - i. What are we seeing
 - 1. NADAL MEDICAL CENTER, INC. (as assignee of Marie Joseph), Plaintiff, v. DAIRYLAND INSURANCE COMPANY, 14 Fla. L. Weekly Supp. 895a
 - a. Who does your coding / bill review
 - 2. Florida Statute § 400.9935: Clinic responsibilities
 - a. Medical director
 - b. Records
 - c. Accreditation
 - 3. Staff Analysis HB 13C
 - a. What did they say
 - b. What did they mean
 - ii. What are you doing
 - iii. How do we defend

- III. **The 2008 PIP statute: how did it all come about (10 Minutes)**
 - a. Early bills / proposals
 - i. Protect the hospitals
 - ii. Limit attorneys fees
 - iii. Regulate charges
 - iv. Limit treatment
 - b. Compromise?
 - i. What did they give up

- ii. What did they get
- iii. Who won

- IV. **House Bill 13C gets approved:** (5 Minutes)
 - a. Florida Statute § 627.736 (“PIP”) revives from the sunset and goes back into affect on January 1, 2008
 - i. What do we do now

- V. **Who won, who lost:** (5 Minutes)
 - a. 2006 Bush veto
 - b. Attorneys fees
 - i. To cap or not to cap
 - c. Utilization ?
 - d. Hospitals
 - e. The 15th Statewide Grand Jury’s “Report on Insurance Fraud Related To Personal Injury Protection” dated August 17, 2000

- VI. **What changes under Bill CS/HB 13-C:** (5 Minutes)
 - a. The bill substantially amends the following sections of the Florida Statutes: 316.646, 320.02, 321.245, 324.022, 627.7275, 627.7295.
 - b. The bill creates the following sections of the Florida Statutes: 324.0221.
 - c. The bill revives and reenacts the following sections of the Florida Statutes: 627.730, 627.731, 627.732, 627.734, 627.737, 627.739, 627.7401, 627.7403, 627.7405.
 - d. The bill revises, reenacts, and amends the following sections of the Florida Statutes: 627.733, 627.736 and 627.739.

- VII. **Does the new law help or hurt:** (5 Minutes)
 - a. New bill, same idea
 - i. Does it prevent fraud
 - ii. Does it limit overbilling

- VIII. **Changes to the Statute:** (15 Minutes)
 - a. Demand letters – now subsection (10)
 - i. 30 day requirement
 - b. Unfair or Deceptive Practice – subsection (11)
 - i. Do you need a civil remedy notice
 - ii. Do you need a Judgment
 - iii. Bad faith discovery
 - iv. Attorney General’s authority
 - c. All Claims Brought in a Single Action – subsection (15)
 - i. Does it apply to demands
 - ii. What is “good cause”
 - d. Secure Electronic Data Transfer – subsection (16)
 - i. Who is a “party”

ii. HIPPA

IX. **Demand letters: (15 Minutes)**

- a. How do we respond
 - i. Cannot create non existent documents
 - ii. Cannot produce work product / attorney client documents
 - iii. Charge for copies
- b. Contents
 - i. How much do we owe
- c. Can we ever do enough

X. **6(b) Letters: (10 Minutes)**

- a. Tolls the time to consider a bill
- b. Quote the statute in your letter
 - i. Under Florida Statute § 627.736(6)(b) you are entitled to:
 - 1. a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief."
- c. 10 days after response to consider the bill
- d. Use it for the right reasons

XI. **Required Benefits – subsection (1): (20 Minutes)**

- a. Eighty percent of *all reasonable expenses* for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services
- b. Subsection (1)(a) specifically provides that medical benefits shall provide reimbursement only for such services and care that are "lawfully provided, supervised, ordered or prescribed" by:

- i. medical doctors, osteopathic and chiropractic physicians as well as dentists licensed pursuant to chapter 466, Fla. Stat. are reimbursable
- ii. Charges submitted by hospitals, surgical centers, emergency transportation personnel, hospitals and medical clinics wholly owned by one or more physicians as described above are also reimbursable
 - 1. Section 627.736 (1)(a)(3) provides that charges submitted by entities wholly owned by physicians (as described above) *and* that (or those) physicians' spouse(s), parent(s), child(ren) or sibling(s) are acceptable, so long as at least one physician is an owner at least in part.
- iii. subsection (1)(a) now requires non-health care provider owned clinics to be licensed by the Florida Agency for Health Care Administration and specifically provides that insurers are *not* required to reimburse charges submitted by these clinics unless the clinic is:
 - 1. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; **or**
 - 2. Has a medical director who is a Florida licensed allopath, osteopath or chiropractor; and
 - a. Has been continuously licensed for more than 3 years, or
 - b. Is a publicly traded corporation; and
 - c. Provides at least four of the following medical specialties:
 - i. General medicine;
 - ii. Radiography;
 - iii. Orthopedic medicine;
 - iv. Physical medicine;
 - v. Physical therapy;
 - vi. Physical rehabilitation;
 - vii. Prescribing or dispensing outpatient prescription medication and/or;
 - viii. Laboratory services

- XII. When Benefits are Due – subsection (4)(c): (20 Minutes)
- a. Subsection (4)(c) imposes a new obligation on P.I.P. insurers to set aside a \$5,000.00 reserve for physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466, who provide *emergency services and care*, or who provide hospital

inpatient care... until thirty (30) days after the insurer receives notice of an accident that is *potentially* covered under P.I.P.

- i. What is emergency services
- ii. What starts “thirty (30) days after the insurer receives notice of an accident that is *potentially* covered under P.I.P.”
- iii. Priority of bills v. emergency treatment
- iv. ER bills received after 30 days
- v. Subsequent “inpatient care”
- vi. Non ER care during the first 30 days
- vii. Hospital liens
- viii. Deductible

XIII. **Charges for Treatment of Injured Persons – subsection (5):** (30 Minutes)

- a. The P.I.P. statute now limits charges for medical services. Specifically, these subsections limit the reimbursement rates to usual and customary charges, Medicare Part B Fee Schedule, or Workers Compensation reimbursement rates
 - i. Reimbursement as to “bill”
 1. shifts the burden to Insurer
- b. Hospitals
 - i. Emergency transport
 1. 200% of Medicare
 - a. Part A or B
 - ii. Emergency services
 1. “usual and customary charges.”
 - iii. Inpatient
 1. 200 percent of the Medicare Part A prospective payment
 - iv. Outpatients
 1. 200% of Medicare Part A Ambulatory Payment Classification
- c. physicians, LMT’s & X-rays
 - i. 200 percent of the applicable Medicare Part B fee schedule
- d. MRI’s
 - i. 200 percent of the applicable Medicare Part B fee schedule
 - ii. No CPI adjustment
- e. Other treatment
 - i. or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers’ compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided.
- f. The rest

- i. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer
- g. The rules & limitations of payments
 - i. The applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered **AND**
 - ii. It may not be less than the applicable 2007 Medicare Part B fee schedule for medical services, supplies, and care subject to Medicare Part B.
 - iii. This does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.
 - iv. If an insurer limits payment the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.
- h. When do we not have to pay a bill
 - i. An insurer or insured is not required to pay a claim or charges:
 - 1. Made by a broker or by a person making a claim on behalf of a broker;

For any service or treatment that was not lawful at the time rendered;

To any person who knowingly submits a false or misleading statement relating to the claim or charges;

With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be

bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good faith effort to do so, as documented in the insurer's file; and

For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

XIV. **Attorneys fees:** (10 Minutes)

- a. Florida Statute 627.428
- b. Who is the prevailing party
- c. How do we limit exposure

XV. **Questions / Comments**