

# The 2008 PIP Statute

Revisions to Florida Statute §627.736  
Effective January 1, 2008



DAVID S. GED, P.A.  
Your PIP Claims Professionals

# What HAS Changed

- Reimbursements are based on the 2007 Medicare Part A and/or Medicare Part B Fee Schedule (depending on facility), and if such services are not covered under Medicare, then payments will be based on current Workers' Compensation Fee Schedule.
- Provisions designating what type of clinic may bill PIP and Limits on PIP claims by licensed clinics.
  - Health care clinic must have a Medical Directors
  - Chiropractors can not Serve as a Medical Director of a non physician owned clinic
  - Clinic must be continuously licensed for a period of three years, and provide at least 4 of the following 8 medical specialties per F.S. § 627.736 (1)(a)(5)(b).



# What HAS Changed

- Extension of time in which insurers must respond to demand letters – Demand Letters – NOW 30 DAYS per F.S. § 627.736 (10).
- Death benefits still available, but now \$5,000. (section 627.736(1)(c), payable death benefits are equal to the lesser of \$5,000 or the remainder of unused PIP benefits.)
- Podiatrist and Acupuncture can not bill PIP, however an MD (licensed under ch. 458) or Chiropractor (licensed under ch. 460) that can perform those services can bill PIP.
- A set aside of \$5,000 is available for EMERGENCY CARE which is defined under FL Stat. 395 et seq.



# What HAS Changed

- Attorney General authorization to investigate PIP insurers who constantly fail to pay valid claims. (s. 501.212)
- If insurer fails to pay valid PIP claims with such frequency so as to indicate a general business practice, then the insurer is engaging in a prohibited practice. “Unfair & Deceptive Trade Practices Act” (s. 626.9521)
- ALL CLAIMS BROUGHT IN A SINGLE ACTION. Per F.S. § 627.736 (11), in PIP suit filed by claimant (patient) against insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why claims should be separate.



# What Has NOT Changed

- Signed Acknowledgement and Disclosure Form
- Patient Treatment Logs
- Claim filing time limit (30 days from date of service)
- IME's
- 20% co-payments; Providers shall make a reasonable effort to collect co-payments, and can not make habit of waiving them, unless the patient is represented by counsel.
- Deductible amounts– Providers shall make reasonable attempts to collect deductible amounts from insured, if any.
- Procedure for filing PIP suits



# When to Litigate

Since provider reimbursements are now set by schedules, the issue of what constitutes a reasonable fee is no longer an issue for litigation.

- However, hospitals will still litigate what is usual and customary.



# What Remains to be Litigated

- Whether an injury is related to the accident
- Whether medical treatment is reasonable and necessary
- Whether the correct CPT code is used (down coding)
- Whether the claims are properly filed
- Coverage issues
- IME cut off dates
- EUO cut off dates
- Denials by the insurer
- Physicians office consultation coding



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# Who is Reimbursed

Medical benefits will be reimbursed for services that are lawfully provided, supervised, ordered, or prescribed by:

- Hospital or ambulatory surgical center licensed under Chapter 395
- Emergency transportation and/or treatment licensed under ss. 401.2101–401.45
- Physicians licensed by the Board of Medicine/Department of Health under Chapters 458 and 459
- Chiropractors licensed under Chapter 460
- Dentists licensed under Chapter 466
- Health Care Clinics licensed under ss. 400.990–400.995
  - Under this provision, massage therapists, physical therapists and pharmacists are also reimbursed if ordered by a covered healthcare provider under F.S. § 627.736 (1)(a)(5).

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# Who is Reimbursed

- Licensed Health Care Clinics must be:

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



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# Who is Reimbursed

- Clinic has a medical doctor who is a Florida licensed MD: Medical Practice (under ch. 458), Osteopathic Medicine (under ch. 459), or Chiropractic Medicine (under ch. 460);
- Have been continuously licensed for more than 3 years or Is a publicly traded corporation ; and
- Provides at least four of the following specialties:
  - Radiography- x ray
  - General medicine-Internist
  - Orthopedic medicine
  - Physical medicine-psychiatry, neurology, pain management, etc.
  - Physical therapy - massage therapists
  - Physical rehabilitation-PT, OT
  - Prescribing or dispensing outpatient prescription medicine-Pharmacy
  - Laboratory Services - blood work



# Who is Reimbursed

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and health care provider as specified in F.S. § 627.736 (1)(a)(3,4,5), to document that the health care provider meets the criteria of this paragraph “F.S. § 627.736 (1)(a)”, which rule must include a requirement for a **sworn statement or affidavit.** (form not yet adopted)



# Insurer Duties

- PIP benefits must be paid within 30 days after the insurer is furnished with written notice of the fact of a covered loss and of the amount of same. [F.S. § 627.736 (4)(a) & (b)]
- PIP benefits are overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same.
- If a claim is rejected or only a portion of the claim is paid, the insurer must provide an itemized specification of each item that was reduced or omitted, or declined.



# Insurer Duties

- Once the insurer receives notice of the accident, it must reserve \$5000 of PIP benefits for payment to physicians as follows:
  - Physicians (MD) licensed (under ch. 458), Osteopaths (under ch. 459), and dentists (under ch. 466) who provide emergency services and care as defined in 395.002 (9) or who provide hospital inpatient care.
- This amount will only be held in reserve for 30 days pending claims for emergency treatment.  
[Per F.S. § 627.736 (4)(c)]



# Insurer Duties

- After the 30 day period, any amount of the reserve for which the insurer has not received notice of a claim from a physician or dentist who provided emergency services and care or who provided inpatient care may then be used to pay other claims. treatment has tolled, the remaining reserve may be used to pay out the other claims. [Per F.S. § 627.736 (4)(c)]
- Emergency Service & Care is defined as medical screening, examination and evaluation by a physician to determine if emergency medical condition exists and, if so, the care, treatment or surgery by a physician necessary to relieve or eliminate the emergency medical condition must be within the service capability of the facility. [Per F.S. § 395.002 (9)]



# Insurer Duties

- No action may be brought against an insurer if, within 30 days after receipt of the demand letter, an overdue claim specified in the notice is paid by the insurer.
- The insurer must pay applicable interest (which rate is set by the CFO on December 1<sup>st</sup> of each year per FSS 55.03), and a penalty of 10% of the overdue amount, subject to a maximum penalty of \$250.



# Insurer Duties

- The Statute of Limitations for any action under this section is tolled for a period of 30 business days by the mailing of the demand letter notice.
- Previously the notice was 15 business days.



# Electronic Data Transfer

If all parties mutually and expressly agree, any communication between the parties may be transmitted electronically.

- Must be transmitted by a secure electronic data transfer that is consistent with state and federal privacy and security laws.



# Death Benefits

According to 627.736(1)(c), payable death benefits are equal to the lesser of \$5,000 or the remainder of unused PIP benefits.



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# Charges for Treatment

An insurer may limit reimbursement to 80% for:

- Emergency transport and treatment; 200% of Medicare
- Emergency services provided by a hospital; 75% of the hospital's usual and customary charges
- Emergency services rendered by a physician or dentist relating to hospital inpatient services; usual and customary charges in the community



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# Charges for Treatment

- Hospital inpatient services other than emergency services and care; 200% of Medicare Part A
- Hospital outpatient services; 200% of Medicare Part A
- For all other medical services, supplies and care 200% of the Medicare part B fee schedule.
- However, if such services, care, or supplies are not reimbursable under Medicare Part B, reimbursement may be limited to 80% of the maximum reimbursable allowance under Workers' Compensation.



# Medicare Fee Schedule

The applicable fee schedule or payment limitation under Medicare is the schedule which is in effect at the time the services were rendered.

- However, it cannot be any less than the applicable 2007 Medicare Part B fee schedule.



# Medicare Fee Schedule

- The schedule is only used for the values assigned to the respective reimbursement codes.
- The insurer may not apply any limitations on the number of treatments that may apply under Medicare or Workers' Comp.
  - This allows chiropractors to be reimbursed without the limitations imposed by Medicare regulations or Worker's Comp. Law



# Contact Information

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