HIGHLIGHTS OF THE NEW PERSONAL INJURY PROTECTION ("PIP") STATUTE SIGNED INTO LAW ON MAY 04, 2012

By Travis L. Stock, Esq. | May 14, 2012

On May 04, 2012, Governor Rick Scott signed legislation that purportedly aims to reduce auto accident fraud, lower the cost of auto insurance premiums, and reduce the litigation costs associated with the current Personal Injury Protection ("PIP") insurance statute. A portion of the revised statute goes into effect on July 01, 2012, with the remainder going into effect on January 01, 2013.

Despite the major impact that this revised statute can potentially have on an insured's or medical provider's ability to recover benefits under the PIP statute, in most cases an insurance company is NOT required to amend its policy or notify its insured before this new law applies (i.e., it will automatically apply). For this reason, we felt that it was imperative to, at a minimum, set forth the most significant changes that may impact insureds' and/or medical providers' rights when involved in an auto accident or when treating an auto accident victim. Below are some answers to FAQs that will help you understand the changes of the revised law and how it might impact your case. If your question is not answered below or you would like more information about your specific situation, please call the Weinstein Law Firm at (954) 757-7500.

FREQUENTLY ASKED QUESTIONS:

Will the revised PIP statute impact my case if my accident occurred before July 01, 2012?

No. Newly enacted statutes generally do not apply retroactively. In the PIP context, courts have held that the statute in effect at the time an insurance contract is executed governs substantive issues arising in connection with that contract.

NOTE: The revised PIP statute, as written, seems to contradict this precedent since it appears that the new statute applies automatically. This also contradicts Fla. Stat. § 627.43141 which would most likely make the revised PIP statute effective upon either a proper renewal of an existing policy (including proper notice of the changes) or the effective date of replacement coverage obtained by the named insured. In addition, an automatic application of the revised PIP statute may be susceptible to a constitutional challenge since it could be argued that such a statute substantially impairs the contractual rights of the insured with the insurance company thereby violating Article 1, Section 10 of the Florida Constitution.

How much does PIP cover under the revised statute?

PIP covers ***up to*** $10,000 in medical and disability benefits and up to $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle (i.e., it's related to the accident).

NOTE: The $5,000 in death benefits is now in addition to the $10,000 policy limits.

When can I potentially recover the full $10,000 under PIP?

Fla. Stat. § 627.736(1)(a)(3) essentially states that PIP will cover ***up to*** $10,000 if a medical doctor, osteopathic doctor, dentist, physician assistant, or an advanced registered nurse practitioner has determined that the injured person had an "emergency medical condition". A chiropractor cannot make this determination under the revised PIP statute.

§ 627.732(16) – Definitions *(effective January 1, 2013)*

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity,

which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health; OR
2. Serious impairment to bodily functions; OR
3. Serious dysfunction of any bodily organ or part.

When may my PIP benefits be limited to $2,500?

Fla. Stat. § 627.736(1)(a)(4) essentially states that PIP will be limited to a maximum of $2,500 if any medical doctor, osteopathic physician, dentist, or chiropractor determines that the injured person did not have an emergency medical condition as defined above.

What medical benefits does PIP cover?

If the individual receives initial services and care[1] **within 14 days** after the motor vehicle accident then generally PIP will cover 80% of all reasonable expenses[2] for medically necessary[3] medical, surgical, X-ray, dental, and rehabilitative services[4], including prosthetic devises, and medically necessary ambulance, hospital, and nursing services.

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[1] The initial services and care must be lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 (i.e., medical practice) or chapter 459 (i.e., osteopathic medicine), a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

[2] In deciding whether the amount of a charge is reasonable, the Court and/or Jury may consider evidence of: (1) usual and customary charges and payments accepted by the provider involved in the dispute; (2) reimbursement levels in the community; (3) reimbursements levels in various federal and state medical fee schedules applicable to automobile coverages; and (4) any other evidence relevant to the reasonableness of the charges. A medical provider, however, may not be awarded an amount that exceeds the amount the provider customarily charges for like services or supplies.

[3] "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner than is: (1) In accordance with generally accepted standards of medical practice; (2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) Not primarily for the convenience of the patient, physician, or other health care provider.

[4] According to the Florida Civil Jury Instructions, services include, but are not limited to, treatment, diagnostic studies, and supplies provided by the medical provider to the insured.

What happens if I wait more than 14 days after my auto accident to seek initial treatment?

You will not be able to recover PIP benefits. To preserve your potential eligibility for PIP benefits, it is **extremely important** that you seek treatment within 14 days of your auto accident, regardless of your condition.

What medical benefits does the revised PIP statute expressly exclude?

Medical benefits do not include massage[5] or acupuncture, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

Will PIP cover treatment other than initial services and care?

Possibly. Fla. Stat. § 627.736(1)(a)(2) states that upon referral by a medical doctor, osteopathic doctor, dentist, or chiropractor, followup services and care consistent with the underlying medical diagnosis rendered may be provided. Among the providers listed in the current PIP statute, a physical therapist licensed under chapter 486 is also included.

Once a medical provider submits the appropriate paperwork requesting payment from an insurer, how long does the insurer have before the PIP benefits are overdue?

Generally, PIP insurance 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. However, under the revised statute, an insurer may have an additional 60 days to investigate if the insurer has a reasonable belief that a fraudulent insurance act has been committed.

Is the insurance company allowed to reduce a medical provider's bill based on a fee schedule?

Possibly. Fla. Stat. § 627.736(5)(a)(1)(f) states that the insurer **may** limit reimbursement to 80% of 200% of the allowable amount under:

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[5] "Massage" means the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation.

(I) the participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80% of the maximum reimbursable allowance under workers' compensation. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

Is the insurer required to do anything before reducing a medical provider's bill based on a fee schedule?

Fla. Stat. § 627.736(5)(a)(5) goes into effect on July 01, 2012, and states that an insurer may limit payment based on the fee schedules listed in the statute only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment based on the fee schedules listed.

How long does a medical provider have to submit a bill to an insurer for PIP benefits before it is considered untimely?

As a general rule, Fla. Stat. § 627.736(c) states that with respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services, the statement of charges must be postmarked or electronically transmitted within 35 days after the date of service.

Are there any circumstances where a medical provider can submit a bill after the 35-day deadline?

Yes, under the following circumstances a medical provider may submit a bill after the 35-day deadline:

1. If the medical provider is submitting a bill for past due amounts that were previously billed on a timely basis.

2. If the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment

of the claimant then the time period to submit the bill is extended from 35 days to 75 days.

3. If the insured fails to give the provider the correct name and address of the PIP insurer, then the provider has 35 days from the date that the provider obtains the correct information to submit the statement of the charges to the correct PIP insurer.

4. A provider for emergency services and care rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider are not required to submit a bill within 35 days from the date of treatment.

5. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

What is the consequence of untimely submitting a bill to an insurer?

The insurer is not required to pay the bill and the medical provider may not bill the injured party for the charges that were not paid based on the untimely submission.

Are there any requirements pertaining to the form and content of a bill?

Yes. Fla. Stat. § 627.736(d) states that all statements and bills for medical services rendered must be submitted to the insurer using one of the following:

1. Centers for Medicare and Medicaid Services (CMS) 1500 form; OR

2. UB 92 form; OR

3. Any other standard form approved by the office or adopted by the commission.

All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space

provided for "Signature of Physician or Supplier, Including Degrees or Credentials."

An insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided.

What information is a medical provider required to provide to an insurer upon request?

Fla. Stat. § 627.736(6)(b) requires a medical provider, upon request of an insurer, to provide the insurer at the insurers own expense with the following:

- A written report of the history, condition, treatment, dates, and costs of such treatment of the injured person;

- Why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement[6] 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;

- Produce and allow the inspection and copying of the medical provider's records regarding such history, condition, treatment, dates, and costs of treatment if this does not limit the introduction of evidence at trial.

Is an insurance company required to notify me when benefits are exhausted?

Upon request, the revised PIP statute now requires that, in a dispute, the insurer must notify the claimant or the assignee that benefits are exhausted within 15 days after the benefits have exhausted. In addition, an insurance company is now required to maintain a log of PIP benefits paid by the insurer on behalf of the insured.

NOTE: We strongly recommend that all assignments of benefits contain such request. For a copy of our most updated assignment of benefits that we recommend, please visit our website at http://www.weinstein-law.com. Once on the website, click on

[6] The sworn statement must 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."

"Client Login" in the upper left-hand corner and create a new-user account.

Is a disclosure and acknowledgement form required for every date of service?

No. Fla. Stat. § 627.736(e)(1) requires that a disclosure and acknowledgement form must be executed by the insured person or his or her guardian at the **initial** treatment or service provided. The most up to date standard disclosure and acknowledgment form can be retrieved from the website of the Florida Office of Insurance Regulation at **http://www.floir.com/** or by visiting our website at http://www.weinstein-law.com. Once on the website, click on "Client Login" in the upper left-hand corner and create a new-user account.

For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which is consistent with the services being rendered to the patient as claimed.

Is the failure to attend an examination under oath (EUO) grounds for denial of PIP benefits?

Possibly. Fla. Stat. § 627.736(6)(g) states that an insured, including an omnibus insured, seeking PIP benefits must comply with the terms of the policy, including submitting to an EUO, which is now a condition precedent to receiving benefits (effectively overruling the Florida Supreme Court's decision in Custer Medical). This means that benefits can be denied, in there entirety, if the insured refuses to be examined under oath.

NOTE: There doesn't appear to be anything in the revised statute that would alter the reasoning of *Shaw v. State Farm Fire and Casualty Company*, which stated that assignee medical providers are not required to attend EUOs.

Is the failure to attend a compulsory medical examination (aka independent medical examination) grounds for denial of PIP benefits?

Possibly. Fla. Stat. § 627.736(7)(b) states that "if a person unreasonably refuses to submit to or fails to appear at an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable."

Will my insurance premiums go down as a result of the revised PIP statute?

Time will tell. According to Governor Rick Scott, "By helping reduce fraudulent auto accident claims, this legislation will benefit the pocketbooks of every Florida family who drives an automobile." In addition, the revised statute mandates that insurers must submit, by October 01, 2012, a rate filing to the Office of Insurance Regulation with at least a 10 percent rate reduction unless insurance companies explain in detail why they cannot cut rates. A 25 percent reduction is provided for through a second rate filing due Jan. 1, 2014, but insurance companies again can avoid it with an explanation.
