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; creating s. 766.404, F.S.; specifying that certain provisions are an exclusive remedy for personal injury or wrongful death; prohibiting compensation for certain wrongful deaths; creating s. 766.405, F.S.; creating the Patient Compensation System and the Patient Compensation Board; providing for board membership, terms, meetings, per diem and travel reimbursement, and powers and duties; providing for offices, staff, committees, and panels and the membership, terms, meetings, per diem and travel reimbursement, and powers and duties thereof; prohibiting certain conflicts of interest; authorizing rulemaking; creating s. 766.406, F.S.; providing a process for filing applications; providing for the release of

protected health information; providing procedures for incomplete applications; providing an application filing period; allowing applicants to provide supplemental information; permitting applicants to be represented by legal counsel; creating s. 766.407, F.S.; providing for review of applications; providing for award of compensation upon determination of medical injury; providing a limitation on compensation; providing for payment of compensation awards; providing for determinations of medical malpractice for purposes of a specified constitutional provision; requiring the system to notify the Board of Medicine regarding certain providers for purposes of professional discipline; creating s. 766.408, F.S.; providing for review of awards by an administrative law judge; providing for appellate review; authorizing an administrative law judge to grant time extensions; creating s. 766.409, F.S.; requiring annual contributions from specified providers for payment of awards and administrative expenses; providing maximum contribution amounts; specifying payment dates; providing for licensure nonrenewal for failure to pay; providing for deposit of funds; authorizing providers to opt out of participation in the system and providing requirements therefor; creating s. 766.410, F.S.; requiring notice to patients of provider

participation in the Patient Compensation System; providing exceptions; creating s. 766.411, F.S.; requiring an annual report to the Governor and the Legislature; providing for applicability; providing severability; providing effective dates.

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 Malpractice and Related Matters"; ss. 766.201-766.212, Florida Statutes, as part II of that chapter, entitled "Presuit Investigation and Voluntary Binding Arbitration"; ss. 766.301-766.316, Florida Statutes, as part III of that chapter, entitled "Birth-Related Neurological Injuries"; and ss. 766.401-766.411, Florida Statutes, as created by this act, as part IV of that chapter, entitled "Patient Compensation System."

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

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

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

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

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

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

(3) "Board" means the Patient Compensation Board as

established in s. 766.405.

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

(a) The federal Social Security Act; any federal, state, or local income disability act; or any other public program providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law.

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

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

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

(5) "Compensation schedule" means a schedule of compensation for medical injuries.

(6) "Department" means the Department of Health.

(7) "Independent medical review panel" or "panel" means a panel convened by the chief medical officer to review each application.

(8)(a) "Medical injury" means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, which could have been avoided by an experienced specialist provider practicing in the same field of care under the same or similar circumstances or, for a general practitioner provider, an experienced general practitioner provider practicing under the same or similar circumstances. Only information that would have been known to an experienced specialist at the time of the medical treatment may be considered when determining the existence of a medical injury.

(b) For purposes of this subsection, the term "medical injury" includes a personal injury or wrongful death for which all of the following criteria exist:

1. The participating provider performed a medical treatment on the applicant.

2. The applicant suffered medical harm.

3. The medical treatment was the proximate cause of the medical injury.

4. One or both of the following occurred:

a. An accepted method of medical treatment was not used.

b. An accepted method of medical treatment was used but was executed in a substandard fashion.

(c) For purposes of this subsection, the term "medical injury" does not include a personal injury or wrongful death if the independent medical review panel determines that the medical treatment performed conformed with national practice standards

for the care and treatment of patients with the underlying condition.

(9) "Panelist" means a person licensed under chapter 458 or chapter 459 and practicing in this state.

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

(11) "System" means the Patient Compensation System as established in s. 766.405.

(12) "Provider" means a person licensed under chapter 458 or chapter 459 and practicing in this state.

Section 5. Effective July 1, 2017, section 766.403, Florida Statutes, is created to read:

766.403 Legislative findings and intent.—

(1) LEGISLATIVE FINDINGS.—The Legislature finds that:

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

(b) Seeking compensation through medical malpractice litigation is a costly and protracted process, such that legal counsel cannot afford to finance more than a small number of legitimate claims.

(c) Even for patients who are able to obtain legal representation, the delay in obtaining compensation is an average of 5 years, creating a significant hardship for patients

and their caregivers who often need access to immediate care and compensation.

(d) Because of continued exposure to liability, an overwhelming majority of physicians practice defensive medicine by ordering unnecessary tests and procedures, increasing the cost of health care for individuals covered by a public or private health care or health insurance program and exposing patients to unnecessary clinical risks.

(e) A significant number of physicians, particularly obstetricians, intend to relocate out of state, retire, or change specialties as a result of the costs and risks of medical liability in this state, according to the Department of Health 2014 Physician Workforce Annual Report.

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

(2) LEGISLATIVE INTENT.—The Legislature intends:

(a) To supersede medical malpractice litigation by creating a new remedy whereby patients are fairly and expeditiously compensated for medical injuries. As provided in this part, this alternative is intended to significantly reduce the practice of defensive medicine, thereby reducing health care costs; increase patient safety; increase the number of physicians practicing in this state; and provide patients fair and timely compensation without the expense and delay of the court system.

(b) That an application filed under this part not constitute a claim for medical malpractice or a written demand for payment, any action on such application not constitute a judgment or adjudication for medical malpractice, and, therefore, professional liability carriers not be obligated to report such applications or actions on such applications to the National Practitioner Data Bank.

(c) That the definition of the term "medical injury" be construed to encompass a broader range of personal injuries as compared to a negligence standard, such that a greater number of applications qualify for compensation under this part as compared to the current system.

Section 6. Effective July 1, 2017, section 766.404, Florida Statutes, is created to read:

766.404 Exclusive remedy; wrongful death.—

(1) EXCLUSIVE REMEDY.—All statutes in conflict with this part shall stand repealed with respect to an applicant who has suffered a personal injury or wrongful death while in the care of a participating provider. Except as provided in part III, the rights and remedies granted by this part due to a personal injury or wrongful death exclude all other rights and remedies of the applicant and his or her personal representative, parents, dependents, and next of kin, at common law or as provided in general law, against any participating provider directly involved in providing the medical treatment resulting in such injury or death arising out of or related to a medical

negligence claim, whether in tort or in contract, with respect to such injury or death. Notwithstanding any other law, this part applies exclusively to applications submitted under this part.

(2) WRONGFUL DEATH.—Compensation may not be provided under this part for an application requesting an investigation of an alleged wrongful death due to medical treatment if such application is filed by an adult child on behalf of his or her parent or by a parent on behalf of his or her adult child.

Section 7. Section 766.405, Florida Statutes, is created to read:

766.405 Patient Compensation System; Patient Compensation Board; offices; staff; committees; independent medical review panels; conflicts of interest; rulemaking.—

(1) PATIENT COMPENSATION SYSTEM.—The Patient Compensation System is created and shall be governed by the Patient Compensation Board created in this section. The Patient Compensation System is not a state agency, board, or commission. Notwithstanding s. 15.03, the system is authorized to use the state seal.

(2) PATIENT COMPENSATION BOARD.—The Patient Compensation Board is a board of trustees, as defined in s. 20.03, established to govern the Patient Compensation System.

(a) Members.—The board shall be composed of 11 members who represent the medical, legal, patient, and business communities from diverse geographic areas throughout this state. Members of

the board shall serve at the pleasure of, and be appointed by, the Governor as follows:

1. Five members, two of whom shall be physicians licensed under chapter 458 or chapter 459 who actively practice in this state, one of whom shall be an executive in the business community who works in this state, one of whom shall be a certified public accountant who actively practices in this state, and one of whom shall be a member of The Florida Bar who actively practices in this state.

2. Three members from a list of persons recommended by the President of the Senate, one of whom shall be a physician licensed under chapter 458 or chapter 459 who actively practices in this state and one of whom shall be a patient advocate who resides in this state.

3. Three members from a list of persons recommended by the Speaker of the House of Representatives, one of whom shall be a physician licensed under chapter 458 or chapter 459 who actively practices in this state and one of whom shall be a patient advocate who resides in this state.

(b) Terms of appointment.—Each member shall be appointed for a 4-year term. For the purpose of providing staggered terms of the initial appointments, the five members appointed pursuant to subparagraph (a)1. shall be appointed to 2-year terms and the six members appointed pursuant to subparagraphs (a)2. and 3. shall be appointed to 3-year terms. If a vacancy occurs on the board before the expiration of a term, the Governor shall

appoint a successor to serve the remainder of the term.

(c) Chair and vice chair.—The board shall annually elect from its membership one member to serve as chair and one member to serve as vice chair.

(d) Meetings.—The first meeting of the board shall be held no later than August 1, 2016. Thereafter, the board shall meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, web conference, or other electronic means.

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

(f) Powers and duties.—The board shall:

1. Ensure the operation of the Patient Compensation System in accordance with applicable federal and state laws, rules, and regulations.

2. Enter into contracts as necessary to administer this part.

3. Employ an executive director and other staff as necessary to perform the functions of the Patient Compensation System. However, the Governor shall appoint the initial executive director.

4. Approve the hiring of a chief compensation officer and chief medical officer, as recommended by the executive director.

5. Approve a schedule of compensation for medical

injuries, as recommended by the Compensation Committee.

6. Approve medical review panelists, as recommended by the Medical Review Committee.

7. Approve an annual budget.

8. Annually approve provider contribution amounts.

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

(a) Office of Medical Review.—The Office of Medical Review shall evaluate and, as necessary, investigate all applications in accordance with this part. For the purpose of an investigation of an application, the office shall have the power to administer oaths; take depositions; issue subpoenas; compel the attendance of witnesses and the production of papers, documents, and other evidence; and obtain patient records pursuant to the applicant's release of protected health information.

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

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

have prevented the medical injury.

(4) STAFF.—The executive director shall oversee the operation of the Patient Compensation System in accordance with this part. The following staff shall report directly to and serve at the pleasure of the executive director:

(a) Advocacy director.—The advocacy director shall ensure that each applicant is provided high-quality individual assistance throughout the application process, from initial filing to disposition of the application. The advocacy director shall assist each applicant in determining whether to retain an attorney and explain possible fee arrangements and the advantages and disadvantages of retaining an attorney. If the applicant seeks to file an application without an attorney, the advocacy director shall assist the applicant in filing the application. In addition, the advocacy director shall regularly provide status reports to each applicant regarding his or her application.

(b) Chief compensation officer.—The chief compensation officer shall manage the Office of Compensation. The chief compensation officer shall recommend to the Compensation Committee a compensation schedule for each type of medical injury. The chief compensation officer may not be a licensed physician or an attorney.

(c) Chief financial officer.—The chief financial officer shall be responsible for overseeing the financial operations of the Patient Compensation System, including the annual

development of a budget.

(d) Chief legal officer.—The chief legal officer shall represent the Patient Compensation System in all contested applications, oversee the operation of the Patient Compensation System to ensure compliance with established procedures, and ensure adherence to all applicable federal and state laws, rules, and regulations.

(e) Chief medical officer.—The chief medical officer shall manage the Office of Medical Review. The chief medical officer shall recommend to the Medical Review Committee a qualified list of multidisciplinary panelists for independent medical review panels. In addition, the chief medical officer shall convene independent medical review panels as necessary to review applications. The chief medical officer must be a physician licensed under chapter 458 or chapter 459 who resides in this state.

(f) Chief quality officer.—The chief quality officer shall manage the Office of Quality Improvement.

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

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

1. The Medical Review Committee shall be composed of two physicians licensed in this state and a board member who is not

an attorney who resides in this state. The board shall designate a physician committee member to serve as chair of the committee.

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

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

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

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

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

(f) Powers and duties.—

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

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

a. A compensation schedule such that, in any fiscal year, the aggregate payments made by the system do not exceed the contributions received under this part.

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

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

(6) INDEPENDENT MEDICAL REVIEW PANELS.—The chief medical officer shall convene an independent medical review panel to evaluate each application to determine whether a medical injury occurred. Each panel shall be composed of an odd number of at least three panelists chosen from a list of panelists representing the same or similar specialty as the participating provider identified in the application and shall convene, either in person or by electronic means, upon the call of the chief medical officer. Each panelist shall be paid a stipend as determined by the board for his or her service on the panel. In order to expedite the review of applications, the chief medical officer may, whenever practicable, group related applications together for consideration by a single panel.

(7) CONFLICTS OF INTEREST.—A board member, panelist, or employee of the Patient Compensation System may not engage in

any conduct that constitutes a conflict of interest. For purposes of this subsection, the term "conflict of interest" means a situation in which the private interest of a board member, panelist, or employee could influence his or her judgment in the performance of his or her duties under this part. A board member, panelist, or employee shall immediately disclose in writing the presence of a conflict of interest when the board member, panelist, or employee knows or should reasonably have known that the factual circumstances surrounding a particular application constitute a conflict of interest. A board member, panelist, or employee who violates this subsection is subject to disciplinary action as determined by the board. A conflict of interest includes, but is not limited to:

(a) Conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a board member, panelist, or employee is biased against or in favor of an applicant.

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

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

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

(b) Disciplinary procedures for a board member, panelist,

or employee who violates subsection (7).

(c) Stipends paid to panelists for their service on an independent medical review panel, which may be adjusted in accordance with the relative scarcity of the panelist's specialty, if applicable.

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

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

Section 8. Effective July 1, 2017, section 766.406, Florida Statutes, is created to read:

766.406 Filing of applications.—

(1) CONTENT.—In order to obtain compensation for a medical injury, an applicant, or his or her legal representative, shall verbally submit an application with the Patient Compensation System through a toll-free telephone number established by the system. The application shall include:

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

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

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

(d) Any other information that the applicant believes will benefit the investigatory process, including the full names and addresses of potential witnesses.

(e) Documentation of any applicable private or governmental source of services or reimbursement relating to the medical injury.

(2) RELEASE OF PROTECTED HEALTH INFORMATION.—An applicant must submit, in writing, to the Office of Medical Review an authorization for release of all protected health information that is potentially relevant to the application as required by federal law.

(3) INCOMPLETE APPLICATIONS.—If an application is incomplete, the Patient Compensation System shall, within 30 days after the receipt of the initial application, notify the applicant in writing of any errors or omissions. An applicant shall have 30 days after receipt of the notice in which to correct the errors or omissions in the initial application through the toll-free telephone number established by the system.

(4) TIME LIMITATION ON APPLICATIONS.—An application shall be filed within the time periods specified in s. 95.11(4) for medical malpractice actions. The applicable time period shall be tolled from the date the application is filed until the date the applicant receives the results of the initial medical review under s. 766.407.

(5) SUPPLEMENTAL INFORMATION.—After filing an application,

the applicant may supplement the initial application with additional information that he or she believes may be beneficial in the resolution of the application.

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

Section 9. Effective July 1, 2017, section 766.407, Florida Statutes, is created to read:

766.407 Disposition of applications; scope of compensation; determination of medical malpractice; notice.—

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

(a) If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury, the office shall immediately notify, by registered or certified mail, each participating provider named in the application. The notification shall inform the participating provider that he or she may support the application to expedite the processing of the application. A participating provider shall have 15 days after the receipt of notification of an application to support the application. If the participating provider supports the application, the Office of Medical Review shall review the

application in accordance with subsection (2).

(b) If the Office of Medical Review determines that the application does not, prima facie, constitute a medical injury, the office shall send a rejection letter to the applicant by registered or certified mail informing the applicant of his or her right to appeal. The applicant shall have 15 days after receipt of the rejection letter to appeal, through the toll-free telephone number established by the Patient Compensation System, the office's determination pursuant to s. 766.408.

(2) EXPEDITED MEDICAL REVIEW.—An application that is supported by a participating provider in accordance with subsection (1) shall be reviewed by individuals with relevant clinical expertise in the Office of Medical Review within 30 days after notification of the participating provider's support of the application to determine the validity of the application. If the Office of Medical Review finds that the application is valid, the Office of Compensation shall determine an award of compensation in accordance with subsection (4). If the Office of Medical Review finds that the application is invalid, the office shall immediately notify the applicant of the rejection of the application and, in the case of fraud, shall immediately notify relevant law enforcement authorities.

(3) FORMAL MEDICAL REVIEW.—If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury and the participating provider does not elect to support the application, the office shall complete a thorough

investigation of the application within 60 days after the office's determination. The investigation shall be conducted by a multidisciplinary team with relevant clinical expertise and shall include a thorough investigation of all available documentation, witnesses, and other information. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the participating provider to access records, statements, and other information obtained in the course of its investigation, in accordance with relevant state and federal laws.

(a) Within 30 days after the completion of the investigation, the chief medical officer shall convene an independent medical review panel to determine whether the application constitutes a medical injury. The independent medical review panel shall have access to all redacted information obtained by the office in the course of its investigation of the application and shall make a written determination within 10 days after the convening of the panel, which shall be immediately provided to the applicant and the participating provider.

(b) If the panel determines that the application constitutes a medical injury, the Office of Medical Review shall immediately notify the participating provider by registered or certified mail of the participating provider's right to appeal the panel's determination. The participating provider shall have 15 days after receipt of the letter to appeal the panel's

determination pursuant to s. 766.408.

(c) If the panel determines that the application does not constitute a medical injury, the Office of Medical Review shall immediately notify the applicant by registered or certified mail of his or her right to appeal the panel's determination. The applicant shall have 15 days after receipt of the letter to appeal the panel's determination pursuant to s. 766.408.

(4) COMPENSATION REVIEW.—If an independent medical review panel determines that an application constitutes a medical injury under subsection (3) and all appeals of that finding have been exhausted by the participating provider pursuant to s. 766.408, the Office of Compensation shall, within 30 days after the determination of the panel or the exhaustion of all appeals of that finding, whichever occurs later, make a written determination of an award of compensation in accordance with the compensation schedule and the findings of the panel. The office shall notify the applicant and the participating provider by registered or certified mail of the amount of compensation and shall also explain to the applicant the process for appealing the determination of the office. The applicant shall have 15 days after the receipt of the letter to appeal the determination of the office pursuant to s. 766.408.

(5) LIMITATION ON COMPENSATION.—Compensation for each application shall be offset by any past and future collateral source payments. In addition, compensation may be paid by periodic payments as determined by the Office of Compensation in

accordance with rules adopted by the board.

(6) PAYMENT OF COMPENSATION.—Within 14 days after the earlier of the acceptance of compensation by the applicant or the conclusion of all appeals pursuant to s. 766.408, the Patient Compensation System shall immediately provide compensation to the applicant in accordance with the compensation award.

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

(8) PROFESSIONAL BOARD NOTICE.—If the independent medical review panel determines that care and treatment of patients by a provider represents an imminent risk of harm to the public, the chief medical officer of the Patient Compensation System shall notify the Board of Medicine of the independent medical review panel's determination of imminent risk and provide the Board of Medicine with electronic access to all appropriate and relevant information concerning the medical injury. The Board of Medicine may review such information and conduct an investigation to determine whether any of the incidents that resulted in the application may have involved conduct by the person who is subject to disciplinary action.

Section 10. Effective July 1, 2017, section 766.408,

Florida Statutes, is created to read:

766.408 Review by administrative law judge; appellate review; extensions of time.—

(1) REVIEW BY ADMINISTRATIVE LAW JUDGE.—An administrative law judge shall hear and determine appeals filed pursuant to s. 766.407 and exercise the full power and authority granted to him or her in chapter 120, as necessary, to carry out the purposes of that section. The administrative law judge shall be limited in his or her review to determining whether the Office of Medical Review, the independent medical review panel, or the Office of Compensation, as appropriate, has faithfully followed the requirements of this part and rules adopted thereunder in reviewing applications. If the administrative law judge determines that such requirements were not followed in reviewing an application, he or she shall require the chief medical officer to reconvene the original independent medical review panel or convene a new panel, or require the Office of Compensation to redetermine the compensation amount, in accordance with the determination of the judge.

(2) APPELLATE REVIEW.—A determination by an administrative law judge under this section regarding the award or denial of compensation under this part shall be conclusive and binding as to all questions of fact and shall be provided to the applicant and the participating provider. An applicant may appeal the award or denial of compensation to the district court of appeal. Appeals shall be filed in accordance with rules of procedure

adopted by the Supreme Court for review of such orders.

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

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

766.409 Contributions by participating providers; opt out option; administration of funds collected.—

(1) The board shall annually determine a contribution that shall be paid by each participating provider for the payment of awards under this part and for administrative expenses, unless the provider opts out of participation in the Patient Compensation System pursuant to subsection (5). The contribution amount shall be based on the provider's specialty and may not exceed the following amounts:

(a) Administrative Medicine: $2,100.

(b) Allergy/Immunology: $1,800.

(c) Anesthesiology: $4,300.

(d) Anesthesiology-Pain Management: $4,600.

(e) Cardiology (Invasive): $6,100.

(f) Cardiology (Non-invasive): $5,300.

(g) Colon & Rectal Surgery (Minor Surgery Limited to Anal Ring): $6,100.

(h) Dermatology: $1,800.

(i) Dermatology (With Liposuction): $4,800.

(j) Diagnostic Radiology (interventional): $8,400.

(k) Diagnostic Radiology (Non-interventional): $8,400.

(l) Emergency Medicine: $8,400.

(m) Endocrinology: $2,700.

(n) Family General Practice (Minor Surgery-No Obstetrics): $5,300.

(o) Family General Practice (Restricted Major Surgery-No Obstetrics): $9,100.

(p) Gastroenterology: $6,100.

(q) General Surgery (All Other): $17,600.

(r) General Surgery (Bariatric): $17,600.

(s) Gynecology (Major Surgery): $5,300.

(t) Hematology: $5,300.

(u) Hospitalist (General Surgery): $17,600.

(v) Infectious Disease: $5,300.

(w) Internal Medicine: $4,400.

(x) Nephrology: $2,700.

(y) Neurology: $5,300.

(z) Neurosurgery: $21,900.

(aa) Nuclear Medicine: $3,000.

(bb) Obstetrics & Gynecology (All Other): $17,600.

(cc) Occupational Medicine: $3,000.

(dd) Oncology: $5,300.

(ee) Ophthalmology (Minor Surgery): $4,000.

(ff) Orthopedic Surgery (No Spinal): $10,600.

(gg) Orthopedic Surgery (With Spinal): $12,900.

(hh) Otolaryngology (Major With No Facial Plastic): $5,300.

(ii) Pathology: $4,000.

(jj) Pediatrics: $2,700.

(kk) Physical Medicine & Rehabilitation: $2,100.

(ll) Physical Medicine & Rehabilitation-Pain Management (Minor Procedures): $5,300.

(mm) Physical Medicine & Rehabilitation-Pain Management (Major Procedures): $5,300.

(nn) Plastic Surgery: $8,400.

(oo) Psychiatry: $2,100.

(pp) Pulmonary Medicine: $6,100.

(qq) Rheumatology: $3,000.

(rr) Thoracic/Cardiovascular Surgery: $15,200.

(ss) Urology: $5,300.

(2) The contribution determined under this section shall be payable by each participating provider upon notice delivered on or after July 1 of the following state fiscal year. Each participating provider shall pay the contribution amount within 30 days after the date the notice is delivered to the provider. If the provider fails to pay the contribution determined under this section within 30 days after such notice, the board shall notify the provider by certified or registered mail that the provider's license will not be renewed if the contribution is

not paid within 60 days after the date of the original notice, unless the provider opts out of participation in the system.

(3) Upon notification by the system that a provider that has not opted out of participation pursuant to subsection (5) and has failed to pay the contribution amount determined under this section within 60 days after receipt of the original notice, the department shall not renew the provider's license until the contribution is paid in full.

(4) All amounts collected under this section shall be deposited with the Patient Compensation System. The funds collected by the system and any income therefrom shall be disbursed only for the payment of awards under this part and for the payment of the reasonable expenses of administering the system. Funds held on behalf of the plan are funds of the State of Florida. The system may only invest plan funds in the investments and securities described in s. 215.47, and shall be subject to the limitations on investments contained in that section. All income derived from such investments shall be credited to the system. The State Board of Administration may invest and reinvest funds held on behalf of the system in accordance with the trust agreement approved by the system and the State Board of Administration and within the provisions of ss. 215.44-215.53.

(5) A provider may elect to opt out of participation in the Patient Compensation System. The election to opt out must be made in writing no later than 15 days before the due date of the

contribution required under this section. A provider who opts out may subsequently elect to participate in the system by paying the appropriate contribution amount for the current fiscal year. However, any medical malpractice claim filed while the provider was not participating in the system shall be adjudicated pursuant to parts I through III of this chapter.

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

766.410 Notice to patients of participation in the Patient Compensation System; exception.—

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

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

Section 13. Section 766.411, Florida Statutes, is created to read:

766.411 Annual report.—The board shall annually, beginning October 1, 2018, submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that describes the filing and disposition of applications in the preceding fiscal year. The report shall include, in the

aggregate, the number of applications, the disposition of such applications, and the compensation awarded.

Section 14. Sections 766.401-766.411, Florida Statutes, as created by this act, apply to medical incidents that occur on or after July 1, 2017.

Section 15. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which may be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 16. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.