Understanding Florida’s PIP Laws

Bacen & Jordan, P.A.
Renee Jordan, Esq.
4801 South University Drive
Suite 3100
Davie, FL 33328
(954) 961-5511
rjordan@bacenjordan.com

PIP = No Fault !!

No Fault are first party benefits that pay regardless of fault. No Fault claims are paid quicker than Fault claims which must apportion fault. There are 12 States that have No Fault insurance.

- Florida, Michigan, New Jersey*, New York, Pennsylvania*, Hawaii, Kansas, Kentucky*, Massachusetts, Minnesota, North Dakota, Utah.
- * Choice No Fault

PIP Coverage

- No fault benefits (PIP) covers the following persons:
  - Named Insured or any relative living with them while operating or occupying a motor vehicle or as a pedestrian. (*Relative residing in the same household means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere).*
  - Any other person while operating the insured's vehicle or as a passenger, or as a pedestrian struck by the insured's vehicle.

PIP Coverage

- PIP benefits will not cover:
  - The named insured or any relative while occupying an uninsured vehicle owned by the insured.
  - Any person while operating the insured vehicle without the consent of the insured.
  - Any person causing bodily injury to oneself intentionally or while committing a felony.
  - Any person other than the insured if he owns a vehicle which is required to be insured under Florida's No Fault Law

PIP Coverage

Non-covered vehicles:

- Motorcycles, Mopeds, Golf Carts, Go Carts, Dune Buggies, Farm Tractors, Off Road Construction Equipment, Vehicles on tracks, Taxicabs and Limousines, riding lawnmower tractor
- *Exception = School Bus

PIP Coverage

- 80% of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devises, and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care within 14 days after the motor vehicle accident.

PIP vs. W/C

- Benefits; when due.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405.

Death Benefits

- Adds $5,000 in death benefits in addition to and separate from the $10,000 medical and disability benefits.

Timely Billing

- With respect to any treatment or service, **other than medical services billed by a hospital** or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement,

Prompt Payment

- Personal injury protection insurance benefits paid pursuant to this section 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.
- For the purpose of calculating the extent to which benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.
- All overdue payments bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the quarter in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest is due at the time payment of the overdue claim is made.

Physician Reserve

- Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims may be used by the insurer to pay other claims. The time periods specified in paragraph (b) for payment of personal injury protection benefits are tolled for the period of time that an insurer is required to hold payment of a claim that is not from such physician or dentist to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim.

Revised Claims

- 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. The person making the claim may submit a revised claim within 15 days of receipt of the explanation.

Fraud Investigation

- If an insurer has a reasonable belief that a fraudulent insurance act has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its investigation and no later than 90 days after the submission of the claim, the insurer must deny or pay the claim with simple interest.

EMC

- Reimbursement for services and care up to $10,000 if the provider has determined that the injured person had an emergency medical condition.
- Limited to $2,500 if the provider determines that the injured person did not have an emergency medical condition.

EMC Case Law

Two United States District Courts for the Southern District have ruled on the EMC issue:

The statute does not contain a default provision establishing the coverage limit when a qualified medical professional "makes no determination that the patient did not have an emergency medical condition." (*See* ECF No. 14, ¶ 19.) After reviewing the broad structure of this provision, however, the Court concludes that PIP medical benefits are limited to $2,500 unless a physician, osteopathic physician, dentist, physician's assistant, or advanced registered nurse practitioner has determined that the injured person has an emergency medical condition.

EMC Definition

- 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.
- Courts have been liberal in interpreting the meaning of an emergency medical condition and numerous cases have taken into account the perception of a prudent layperson person.
- 42 U.S.C. § 1396u-2(b)(2)(C) defines an "Emergency medical condition" as: "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a **prudent layperson**, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."

PIP Deductible

- Florida Statute 627.739(2) states: The deductible must be applied to 100 percent of the expenses and losses described in 627.736.
- According to the Senate Staff Analysis, section 627.739 F.S. was amended from its earlier version relating to PIP deductibles to change the calculation of the PIP deductible to require that it must be applied to 100 percent of medical expenses, rather than to the current 80 percent of expenses that PIP pays. That analysis goes on to provide this example of the changes and states:
- This provision has the effect of requiring PIP to pay more in benefits than it does now if a deductible is elected. For example, under current law: $5,000.00 medical bill, PIP pays 80 percent, or $4,000.00, minus $2,000.00 deductible = $2,000.00. Under this provision: $5,000.00 medical bill, minus $2,000.00 deductible, is $3,000.00. PIP pays 80 percent x $3,000.00 = $2,400.00.

Exhaustion of Benefit Defense

- Fourth District Court of Appeals ruled that once PIP insurance benefits are exhausted through payment of valid claims, an insurer no longer holds any liability on unresolved pending claims absent bad faith in the handling of the claim by the insurer.
- * This applies to denied and underpaid claims as the compensability under PIP is not established until the insurer accepts compensability or by resolution of disputed charges by the court.

PIP Balance billing

- 627.736 (5) If an insurer limits payment as authorized, the provider 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 PIP coverage due to the coinsurance amount or maximum policy limits.

PIP Balance Billing

- Example:
- Inpatient Services = $100k
- Paid at 200% of Medicare or $40,000.
- PIP pays $5,000 max benefits.
- Bill Secondary or File Lien for $95,000
- Bill the Pt $95,000 because benefits were maxed.

Med Pay Benefits

- Optional
- Similar to PIP benefits
- Contractual not statutory

Statutory Demand Letter

- Demand letter is prerequisite to filing suit
- Must mail to PIP address on file with the State
- PIP carrier has 30 days to respond
- Payment must include interest, penalty and postage

January 5, 2015 PIP Insurance Data Call Report

- The findings show a general decrease in the per claim costs and the overall number of claims (frequency and severity) for PIP since the implementation of HB 119 on January 1, 2013. The regional analysis concludes that South Florida and the Tampa/St. Petersburg regions experienced the most significant decreases in Florida. However, the data also exposed that other coverages, such as Bodily Injury (BI) and Uninsured Motorists (UM), experienced increases in both frequency and severity when some benefits covered under PIP moved to these coverages. These trends are expected to continue over the next year.

Shands vs State Farm June 2015 DCA Opinion

- F.S. 627.736(6)(b) Requires a healthcare provider to provide certain information and documents related to the treatment and associated costs upon request.
- F.S. 627.736(6)(c) In the event of a dispute regarding an insurer's right to discovery under this section, the insurer may petition the court to enter an order permitting such discovery.
- State Farm requested Shands contracts with health insurance entities and a deposition of a corporate representative.
- First DCA held that (6)(c) doesn't require the healthcare provider to produce evidence regarding the reasonableness of charges nor does it allow for a deposition. However, the court held that said discover may occur under (5)(a).