BENEFIT HANDBOOK

Approved August 24, 2023

NICA

SUPPORTIVE SERVICES FOR
FAMILIES & PHYSICIANS

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Florida Birth-Related Neurological Injury Compensation Plan (Approved August 25, 2022)

INTRODUCTION

Welcome to the Florida Birth-Related Neurological Injury Compensation Plan ("Plan"). Better known as NICA, the Plan is intended to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. To that end, the Plan provides a wide range of benefits.

We strongly urge every family to familiarize themselves with this Benefits Handbook, which offers clear guidance on potential benefits available under the NICA Plan. As a result of legislative changes made by the Florida Legislature in 2021, the NICA Plan offers several additional and enhanced benefits that all families should review and become familiar with.

The purpose of this Benefits Handbook is to provide simple and straightforward information about the benefits available from NICA and how families may request those benefits. However, this Benefits Handbook is a guide. Ultimately, NICA's activities are governed by Sections 766.301-766.316, Florida Statutes, sometimes referred to as the NICA Statute. It is essential to understand that the statute — not this handbook — controls any conflict between the information in this Benefits Handbook and the law itself.

Generally, according to Florida law, NICA pays for a participant's "medically necessary and reasonable" actual expenses, including but not limited to:

- Medical and hospital, habilitative care and training, residential or custodial care
- Professional residential and custodial care and service
- Medically necessary drugs
- Medically necessary special equipment and facilities; and related travel

(See: Section 766.31(1)(a), Florida Statutes)

Although this Handbook attempts to describe the range of benefits available to families, NICA may also pay for other medically necessary supplies, equipment, or expenses, associated with the participant's condition and medical needs. Families should submit medically necessary expenses not otherwise addressed in this Benefits Handbook for consideration to their participant's case manager.

One family may, or may not, be eligible for the same benefits as another family because of each participant's particular condition, medical necessity, or other available coverage. However, NICA strives to ensure that all families are treated similarly and that all medically necessary and reasonable expenses are covered, subject to the limitations set forth in section 766.31, Florida Statutes. NICA reserves the right to ask for a Letter of Medical Necessity for any requested benefit.

Please note that while, given recent legislative changes in Florida, NICA considers itself to be primary to Medicaid and a third party for NICA-covered services, we are still working with AHCA on a plan to coordinate services to ensure seamless service delivery to our participants. Until that plan is finalized, participant families should not change how they obtain services from their providers. Once the transition plan is complete, it will be communicated to families along with any new processes. However, if a family is experiencing any issues with obtaining Medicaid services, please contact your case manager so that NICA can go ahead and transition those services to NICA funding.

CLAIMS REQUEST FOR REIMBURSEMENT OR BENEFITS

In order to request a new benefit, the parent or guardian of a NICA participant may be asked to supply one or combination of the following:

- A letter of medical necessity from the prescribing physician or appropriate qualified and licensed health care provider and/or licensed therapist
- An Explanation of Benefits (EOB) or denial of coverage from your insurance carrier
- A receipt or other proof of purchase or direction to pay the reimbursement to you or to the provider directly
- A written explanation from the parent or guardian as to why the benefit is in the best interest of the participant and how it is related to their birth injury.

Please see the individual benefit descriptions to follow that detail the documentation needed for each type of benefit. If you need assistance with what should be included in the letter of medical necessity or guidance on what is needed, please contact your Nurse Case Manager.

Please keep in mind that NICA is subject to oversight and accountability of many government agencies and institutions. As such, NICA must be able to demonstrate the accuracy and legality of all payments to families through requested documents and associated payments.

NICA will honor reimbursement requests for expenses from medical providers and pharmacies submitted within four years (in accordance Section 95.11(3)(f), Florida Statutes) of the date the expense was incurred if the request is accompanied by documentation of medical necessity and provider invoice or receipts. This time limit does not apply to expenses incurred before the participant's acceptance into the NICA program. Reimbursement will be paid in a timely fashion, and you will be notified in writing if a benefit is denied, or NICA does not have sufficient information or documentation to pay the benefit.

INITIAL PARENTAL AWARD

Beginning January 1, 2021, parents or legal guardians of a NICA participant are entitled to an award not to exceed $250,000. Each year after 2021, the amount of the parental award for new families joining the program will increase by 3 percent annually.

NURSING CARE

Most NICA participants will need some level of professional nursing or attendant care during their lifetime. Many families opt to stay home and provide care for their participant, while other families prefer to engage professional nursing or attendant care services. Both options are available to eligible families at their discretion. The level of nursing care and amount paid for such care may vary from one family to another, as dictated by each participant's unique medical needs, and the skills of the caregiver.

In order for NICA to pay for nursing care for a participant, your case manager will send a Patient and Nursing Caregiver Form (PNCF) to a physician who provides care for the participant to complete. This form is what NICA will use to authorize the amount and type of care available. The form identifies the number of hours of care required and the level of care for those hours (i.e., CNA, LPN, or RN). NICA may periodically conduct a review with medical professionals to assess the ongoing and sometimes evolving needs of the participant over time.

If applicable, NICA may also request information from your insurance plan regarding the nursing care coverage they provide. Your Case Manager can help you with this process.

Nursing Care Provided in Home by Parent or Legal Guardian:

When professional nursing or attendant care is required, NICA may reimburse a parent or legal guardian for medically necessary and reasonable residential custodial care as documented on the PNCF. This would be as an alternative or in addition to paying for professional nursing care or other professional attendants.

For participants born since June 7, 2002:

Reimbursement is subject to the limitations specified in Sections 766.302(10) and 766.31, Florida Statutes. These sections specify that NICA may reimburse a parent or legal guardian for up to 10 hours of family residential or custodial care that they provide directly to the participant within a 24- hour period. If more than 10 hours are authorized, other caregivers can be reimbursed for care authorized and provided in excess of 10 hours. NICA does not reimburse for any hours when the participant is in school or PPEC.

If a participant requires more than 10 hours of care and if the parent is considered a medical professional (e.g., CNA, LPN, RN), the 10-hour limit is waived. A parent can be reimbursed at their level of licensure (at the Florida Medicaid rate) for the hours of care deemed medically necessary and provided by the parent. For example, if the parent is an LPN and the PNCF authorizes 12 hours of CNA care and 12 hours of LPN care, and the parent provides all 24 hours if care, that parent would be reimbursed for 12 hours at the CNA rate and 12 hours at the LPN rate.

For NICA participants born before June 7, 2002:

Reimbursement is subject to limitations specified in the Class Action Settlement Agreement and Final Judgment and Order Approving the Class Action Settlement Agreement (available at nica.com). For these families, NICA may reimburse a parent or legal guardian for up to 20 hours per day for their care directly to the participant. If other caregivers are involved in the care, the combined limit is 20 hours per day. School hours are also deducted. If a parent or guardian cares directly for the participant and is a licensed professional caregiver (e.g., Certified Nurse Assistant, Licensed Practical Nurse, or Registered Nurse), the caregiver can be paid for up to 24 hours per day. Payment rates are based on the parent or guardian's level of licensure, and the number of hours authorized by the physician.

Care while Hospitalized:

If a NICA participant is hospitalized and the parent or legal guardian must remain with them while in the hospital, NICA will reimburse the parent or legal guardian for up to 24 hours per day at their typical rate of pay, including day of admit and day of discharge. This change is effective January 1, 2021.

Professional Nursing or Attendant Care Provided in Home:

If recommended by a physician, NICA will reimburse families for medically necessary and reasonable professional nursing or attendant care provided for the participant. NICA will directly reimburse a provider agency or another qualified caregiver, as preferred by the parent or legal guardian. Parents can also be reimbursed when a third-party caregiver misses a shift and a parent must provide some of the care, subject to providing documentation to NICA of the missed shifts.

To request this benefit, a parent or legal guardian can contact their Nurse Case Manager. The Case Manager will request payment information for either the individual or nursing agency the parent wishes to care for the participant.

Nursing Care Provided Prior to NICA Program Entry:

Nursing care provided from date of discharge from the NICU up until the date of entry into the NICA program is reimbursable under the parameters above. The PNCF will be obtained upon entry into the program and applied retroactively.

Custodial Residential Care:

In the event a participant must be moved out of their home into a professional care facility, NICA will pay for the cost of the facility when no other payor is available.

MEDICAL TREATMENT

NICA will reimburse for physician visits related to care and treatment associated with the neurological birth injury, including co-pays and deductibles where applicable.

NICA will reimburse for hospital inpatient and outpatient care, including emergency care related to care and treatment associated with neurological birth injury and facilities charges.

DENTAL TREATMENT

Beginning January 1, 2022, dental services that are medically necessary and related to the birth injury are covered. The only items not covered are the cost of routine cleanings twice per year. Prior requests that have been denied within the last four years will be reconsidered on request.

PRESCRIPTION DRUGS

Prescription drugs will be reimbursed with a receipt and copy of the label. This reimbursement is exclusively for drugs related to care and treatment associated with the neurological birth injury.

INSURANCE POLICIES AND PREMIUMS

NICA encourages families to carry health insurance if the participant is not otherwise covered by the family's insurance plan, a state or federal program, or another type of health plan and will reimburse the costs of coverage if requested. If you are interested in obtaining health insurance, please inquire about this benefit with your Nurse Case Manager.

Insurance Premiums

NICA will reimburse families for the participant's portion of a health insurance premium starting from the date when the request is made in writing to NICA. For participants entering the program on or after January 1, 2022, NICA will reimburse families the participant's portion of the insurance premium from the date of birth of the participant.

NICA requires a copy of the coverage document and premium that identifies the participant's portion of the premium to pay for this expense. If documentation does not specifically identify the participant's portion, NICA reserves the right to calculate how much of the premium it will reimburse on a pro-rata basis.

THERAPY

NICA will reimburse families for therapies performed by a licensed therapist which are determined to be medically necessary and reasonable by a physician.

Some of the therapies covered include:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Aqua Therapy
- Intensive Therapy
- Music Therapy
- Equine therapy
- Massage Therapy
- Behavioral Therapy
- Vision Therapy

Annual therapy camp programs will be covered up to $2000. Therapy camp may be covered over $2000 if it meets the standards of an intensive therapy. Your Nurse Case Manager will evaluate the plan of care for the therapy camp program to determine if the therapy camp can be covered.

Additional therapies may also be eligible for coverage. Inquire with your Nurse Case Manager if a medical provider recommends a therapy not listed above.

NICA may consult periodically with appropriate medical professionals regarding the medical necessity for continuing various therapies.

To request therapy for the participant, NICA requires a plan of care written by the therapist and signed by the participant's physician, as well as information showing that the therapy was denied by all other payers, such as insurance, prepaid plans, HMO, or governmental assistance that may be available. If therapy is partially covered by an insurance plan or other entity, NICA will pay the copay or patient responsibility portion.

MENTAL HEALTH SERVICES

NICA believes in promoting the well-being of our participants and their families. Beginning June 21, 2021, NICA will provide immediate family members (or legal guardians who reside with the participant) with a total annual benefit of up to $10,000 to obtain mental health services from providers licensed under Chapter 490 and Chapter 491 Florida Statute (or similar statutes in other states). Providers under these Chapters include psychologists, marriage and family therapists, mental health counselors, and social workers. Mental health services provided by psychiatrists licensed under Chapter 458 Florida Statute (or similar statutes in other states) will also qualify for reimbursement. NICA will also pay for any co-payments or deductibles. In the event a participant passes away, families can receive the remainder of that calendar year's funds for mental health services (up to $10,000), plus an additional two years of funds (up to $20,000) for mental health services until the amount is exhausted.

For reimbursement, NICA must be provided with documentation that the provider is licensed in their home state to provide such services, an explanation of benefits (if applicable), proof of payment, and the dates of service.

Recommendations outside of the therapy made to family members by mental health providers (e.g., prescription medication, massage therapy, yoga, etc.) are not reimbursable under this benefit.

EQUIPMENT

NICA will purchase or reimburse actual expenses for equipment that is requested for a participant's care. Because the equipment needed by NICA participants varies widely, a list of equipment that has been covered to date has can be found in Appendix A.

To order or reimburse for equipment that is less than $3,000, NICA will require a written statement from the parent or legal guardian of the participant as to why the equipment is necessary (if not clearly related to the injury) and an insurance denial if the item is potentially covered by the participant's insurance plan.

To order or reimburse for equipment that is more than $3,000 NICA will require a letter of medical necessity OR a prescription, and an insurance denial if the item is potentially covered by the participant's insurance plan. In some cases, (such as a stander or a wheelchair) NICA will also need the order specifications if buying directly from a vendor.

There are specific pieces of equipment where NICA has a relationship with a vendor for a specialized type or brand of equipment and would like to order the equipment requested from these vendors directly. You can find a list of this equipment in Appendix A with a "*" beside the equipment name. In these cases, the documentation needed in the categories above would still apply.

Beginning 1/1/23, for those pieces of equipment that NICA purchases or reimburses for the participant, extended warranties and protective accessories can be reimbursed.

*NICA Nurse Case Managers can be contacted if there is an uncertainty about whether the equipment item requested may or may not need an insurance denial.

Electricity Stipend

Effective October 15, 2021, upon request, NICA may pay families a monthly stipend to offset the additional electricity costs associated with the use of medically necessary equipment related to the participant's neurological injury. The monthly stipend amount for 2021 is $100 and is indexed to the U.S. Bureau of Labor Statistics cost per Kilowatt hour for the South Atlantic region. The stipend will be adjusted each January 1st to reflect the percentage change in Kilowatt hour from November of the prior year (i.e. the annual change from the most recent November rate to the November rate prior to that). To qualify for the stipend families will need to fall under one of two categories.

Category 1:
Participant has additional electricity costs associated with the use of one of the following: an electric bed, oxygen concentrator, or a CPAP/BIPAP.

Category 2:
Participant has additional electricity costs associated with the use of a feeding pump, suction machine, and a third piece of medically necessary equipment.

Families should reach out to their Nurse Case Manager to request the stipend and inform their case manager of current necessary medical equipment being used in the home. This must be requested by the parent or guardian and can be paid starting on the 1st of the month following the participant's entry into the program.

Appendix A – Equipment

This list includes but is not limited to equipment that has been previously authorized.

Equipment < $3000			**Equipment >$3000**
Activity Seat/Chair			Bed
AFOs			Ceiling Lift (Mobility Works)*
Air Loss Mattress			Communication Device
Baby Monitor/Video			Compression Vest
Bath Chair			Electric Wheelchair
Car Seat			Firefly (Chairs)*
Changing Tables			Freedom Concept (Bikes)*
Computer			Gait Trainer
Feeding Chair			Hospital Bed
Feeding Pump			Permanent Ramp
Floor Ramps/ Thresholds			Portable 02 Concentrator
Glasses			Portable Pool Heater
Hitch for Van			Portable Ramp
Hoyer Lift			Ppod Chair
Hot Tub or Pool Heater ($2500 limit)			Scooter
Humidifier			Sleep Safe Bed*
Ipad***			Stander
Manual Transfer Wheelchair			Stim Designs (Galileo System)*
Mega Rubber Rolls			Stroller
Nebulizer			Tablet
O2 Concentrator			Tobii Dynavox*
Portable Ramp			Trexo*
Portable Suction Machine			Walker
Portable Generator ($3000 limit)			
Pulse Ox			
Replacement parts for Equipment			
Stethascope			
Suction Machine			
Therapy Bench			
Therapy Mat			
Toileting System			
Transfer Belt - with handles			
Urine Collection System			

*Items that NICA has a relationship with a specific vendor

** Beginning 1/1/2022 there is no longer a $500 limit for ipad purchase

SUPPLIES

NICA will purchase or reimburse actual expenses for supplies that are requested for a participant's care. Because the supplies needed by NICA participants vary widely, a list of supplies that has been covered to date has can be found in Appendix B.

To order or reimburse for supplies that are less than a onetime expense of $3000 or a recurring expense under $1000 monthly, NICA will require a written statement from the parent or legal guardian of the participant as to why the supply is necessary (if not clearly related to the injury) and an insurance denial if the item is potentially covered by the participant's insurance plan.

To order or reimburse for supplies that are more than a $3,000 onetime expense or an over $1000 monthly recurring expense, NICA will require a letter of medical necessity OR a prescription, and an insurance denial if the item is potentially covered by the participant's insurance plan.

*NICA Nurse Case Managers can be contacted if there is an uncertainty about whether the item requested may or may not need an insurance denial.

Appendix B – Supplies

This list includes but is not limited to supplies that have been previously authorized.

Adaptive Clothing
Alcohol
Baby Food
Backpack (for holding on-the-go emergency supplies)
Bibs
Booster Pads
Burp Cloth
Clorox Wipes
Diaper Rash Cream
Diapers (after age 3)
Feeding Bags - Pressure Relief System
Feeding Pump Kit
Feeding Spoons
Feeding tube cleaning supplies
Foam climbing blocks
Formula
Gauze
Gloves
G-tube accessories
Handgrips
Hippotherapy Helmet
Masks
Meal Replacement Powder
Mickey Buttons
Mouth swabs
Nasal Cannula
Oral Suction Toothbrushes
Oxygen

Pedialyte
Peroxide
Pullups
Saline
Sanitizer
Shoes for AFOs
Socks for AFOs
Specialized Feeding Cups
Suction Cathater
Suction Tray
Supplements
Syringes
Tape
Toothettes
Trach Supplies
Trachs
Trash Bags
Tubing
Underpads (with or without tape)
Urine Collection System Supplies
Emesis Bags
Washcloths
Water (for equipment or formula)
Weighted blanket
Wipes (after age 3)

Specialized Nutritional Products

For participants who are unable to eat a typical diet and require modified soft/puréed food due to a digestive system dysfunction related to the neurological injury, beginning at age 2, NICA will reimburse pre-packaged specialized nutritional products OR provide a monthly stipend for fresh foods to be prepared into purée at home. Families choosing either option may need to provide a letter of medical necessity.

Option 1: Reimbursement for Pre-Packages Specialized Nutritional Products:

NICA will reimburse for specialized nutritional products that provide needed nutritional value and are medically necessary. Puréed baby foods, enteral formulas, and other specialized nutritional products will be reimbursable for as long as they are medically necessary. Families must submit a receipt with any reimbursement request. .

Option 2: Monthly Fresh Food Stipend:

NICA encourages families to use fresh foods and beginning October 1, 2022, NICA will provide a monthly stipend for those fresh foods needed for families to process puréed food at home. The monthly stipend is based on the USDA's Thrifty Food Plan which estimates the monthly cost for a nutritious diet based on age. The monthly stipend effective October 1, 2022 will be based on the November 2022 USDA Thrifty Food Plan report. NICA will update the monthly stipend amount for families each January 1st based on the most recent USDA Thrifty Food Plan monthly average report available.

If families opt for the monthly fresh food stipend, there will be no reimbursement for specialized nutritional products.

Blender

In addition, NICA will reimburse families, whose participant requires a modified soft/puréed food diet, up to $500 for a blender every three years. Families must submit a receipt with any reimbursement request for a blender and a letter of medical necessity may be required.

ANNUAL SPECIAL BENEFIT

NICA will reimburse families up to $500 per calendar year for any items that are related to the participant's best interest. Examples may include adaptive toys, pool equipment, games, electronics, and other items that improve quality of life. Beginning with the 2021 benefit, any unused amounts can be rolled over indefinitely.

TRANSPORTATION AND TRAVEL

Reliable Transportation

When a participant needs a reliable mode of transportation, NICA coordinates the purchase of a reliable vehicle or an accessible van upon the parent's request. Current proof of vehicle insurance and valid driver license is required.

NICA is listed as a lienholder on the vehicle's title. However, the vehicle itself is titled in the name of the parents or legal guardians as custodians for the participant under the Florida Uniform Transfer to Minors Act.

As lienholder, NICA pays and/or reimburses the following expenses:

- Vehicle purchase price and associated acquisition costs
- License tag/registration and renewals
- Maintenance costs. Any expenses more than $500.00 require pre-approval or they may not be reimbursed.
- Basic insurance coverage, full collision coverage, and comprehensive coverage. NICA must be listed as lienholder on the policy.
- Mileage for medical appointments or pre-approved travel will be reimbursed at twice the GSA rate for a government furnished vehicle.

NICA replaces the vehicle every seven years or 150,000 miles, whichever comes first.

Families no longer needing a vehicle should return it to NICA in good working order within 60 days.

Travel Reimbursement

NICA will reimburse expenses incurred when a NICA participant travels to and from medically necessary appointments, such as physician visits, therapy, or other medically necessary travel. Additionally, NICA will reimburse mileage associated with trips to the pharmacy for prescriptions related to the participant's birth injury (requires dated receipt and label), and any non-routine supply/equipment related travel (For example, if a piece of equipment is broken and needs repair, with proper documentation, mileage may be reimbursed for the travel to and from taking the equipment to be repaired).

If the participant is driven, NICA will reimburse parking fees and tolls (upon submission of receipts), as well as doc-umented mileage at the following rates:

- When using reliable transportation:

  – Mileage for medical appointments or pre-approved travel will be reimbursed at twice the GSA rate for a government furnished vehicle.

- When using a personal vehicle:

  – Mileage for medical appointments or pre-approved travel will be reimbursed at the GSA rate for a privately owned vehicle.

To be reimbursed for mileage, NICA must have documentation of the reimbursable appointment the participant attended. Mileage reimbursement will be calculated by the participant's Nurse Case Manager using the addresses for the locations provided by the parent or legal guardian. If the parent or legal guardian wants a specific map route used for the reimbursement, they will need to provide the map used to arrive at the location to their Nurse Case Manager for reimbursement.

When a participant must travel, one-way either 30 miles or in excess of 45 minutes, from home for a medical, therapeutic, or otherwise reimbursable appointment, NICA will reimburse for meals and incidentals at the GSA day-of-travel rate (75% of the per diem) for up to two caregivers and the NICA participant, if applicable (i.e. partic-ipant can consume food orally, does not have a digestive system dysfunction which impedes the ability to con-sume food, and is not receiving reimbursement for pre-packaged specialized nutritional products or the monthly Fresh Food Stipend). No receipts are required. Note that the rate utilized is the rate effective in the destination city.

When the participant and one parent/guardian travel at least 50 miles from home and must stay overnight, NICA will reimburse accommodations of the actual expense up to 1.3 times GSA lodging rate (plus applicable sales taxes) for the destination city.

Meals and incidentals are also reimbursed for overnight travel in accordance with GSA policies for up to two care-givers and the NICA participant, if applicable.

Beginning January 1, 2022, if the participant is flown, NICA will reimburse airline coach travel fares for the partici-pant and two parents/guardians and will reimburse accommodations of the actual expense up to 1.3 times GSA lodging rate. Please note this GSA rate is intended to cover all travelers.

Upon submission of receipts, NICA can reimburse medically necessary transportation expenses not otherwise men-tioned above. Please contact your Nursing Case Manager if you have questions about reimbursement of other travel-related expenses.

Effective 9/1/23, when a participant is hospitalized, regardless of the hospital distance, medical mileage and per diem for up to two caregivers will be reimbursed. Mileage can only be reimbursed for one round-trip per day. For parents who choose to remain in the hospital overnight with the participant, the day-of-admission and the day-of-discharge per diem will be reimbursed at the GSA day-of-travel rate (75% of the per diem), the days in between admission and discharge will be reimbursed at the full per diem rate. If the parent does not stay overnight in the hospital with the participant, per diem will be reimbursed at the GSA day-of-travel rate (75% of the per diem) for each day the participant is hospitalized.

HOUSING ASSISTANCE

Participants are entitled to a housing assistance benefit of up to $100,000 during their lifetime. This benefit has been utilized by families in a variety of ways including (but not limited to) accessible renovations in a current home, new home construction, mortgage or rent monthly payments, moving expenses to a more accessible dwelling, whole house generators or a down payment on a new home. Please contact your case manager with any questions and for information on the documentation needed to utilize this particular benefit.

BEREAVEMENT SUPPORT FUND

It is NICA's utmost goal to support participants and families through every chapter of life. In the event that NICA is notified of the death of a participant, families will receive $50,000 in an effort to unburden them of the cost of services. A time of loss can be emotional and confusing, NICA desires to be a resource for healing for its families during these difficult times.

GUARDIANSHIP

When a participant turns 18, states typically require parents to become legal guardians to continue making medical decisions on their behalf. NICA will cover the costs for families to obtain guardianship of their NICA participant. Families may select their own attorney, or at request by the parent, NICA can provide a list of attorneys who specialize in guardianship. While there are no restrictions for the cost of obtaining guardianship, it is expected that the range of all costs will be $3,000-$7,500. NICA will also cover the costs for annual guardianship renewals.

EXPERIMENTAL PROGRAMS OR EQUIPMENT

When a parent or legal guardian requests that NICA pay for participation in an experimental program or to obtain experimental equipment, the Executive Director may approve the request based on the following criteria:

1. Overall cost associated with the program or equipment must not be excessive and must be submitted for preapproval. It may include the duration of the program; expected medical benefits; and availability of the program elsewhere in Florida if it is located outside the participant's home area.
2. A report must be received from the participant's primary care physician recommending the experimental program or equipment by detailing its medical necessity.
3. Proof must be provided that the experimental program or equipment has shown objective, observable, or demonstrable medical benefit, as well as evidence the participant has benefited or will benefit from the experimental program or equipment.
4. The Executive Director may approve the expected frequency and duration of the requested experimental program or equipment.
5. Continuation of the program or equipment may be authorized if periodic evaluation by a physician shows an objective, observable, or demonstrable medical benefit to the participant.

If the evaluation indicates consideration of other criteria, then additional information will be requested and should be submitted for review.

In an effort to provide clarity and transparency, the following have not been approved for reimbursement:

- Stem cell therapy
- Human Growth Hormone treatments
- Hyperbaric treatments
- Enbrel

BENEFITS NOT SPECIFICALLY ADDRESSED

The Board has authorized the Executive Director to approve the benefits described in this Benefits Handbook. The Board recognizes, however, that there may be types of equipment or other items that may be of value to a participant and their family but are not addressed in this Benefits Handbook. If there is an item or service you feel should be covered and is not mentioned please talk to your case manager.

AUTHORIZATION TO OBTAIN SERVICES OUTSIDE YOUR INSURANCE PLAN'S COVERED AREA OR OUT OF STATE

Parents or legal guardians must notify NICA before taking a participant outside their insurance plan's covered area or outside the State of Florida for evaluation, surgery, or other medically necessary treatment. NICA must pre-authorize out-of-state treatment. NICA can expedite payment for pre-authorized equipment and services and sometimes pre-pay for them. Without preauthorization, NICA will only pay for treatment outside the insurance plan's covered area or for out-of-state treatment and travel if an emergency existed at the time of treatment.

DISAGREEMENTS, DENIAL OF BENEFITS

If a disagreement arises on a claim for benefits, we invite you to discuss the issue with a Nurse Claim Supervisor. They will welcome the opportunity to work with you in hopes of resolving the disagreement. In some instances, NICA may ask for a more clearly written letter of medical necessity or additional documentation.

If a disagreement arises and the Nurse Claim Supervisor cannot resolve it, upon written request, the Executive Director may review the claim and attempt to resolve the disagreement with the parents or legal guardians.

If the Executive Director cannot resolve the disagreement and a benefit is denied, the parents or legal guardians have the right to file a petition with the Division of Administrative Hearings to dispute the amount of actual expenses reimbursed or the denial of benefits. See DOAH.fl.us for more details. Parents or legal guardians may contact the Insurance Consumer Advocate at the Florida Department of Financial Services for additional guidance on an informal basis.

The address to submit a letter or petition is:

Division of Administrative Hearings
1230 Apalachee Parkway
Tallahassee, FL 32399
Phone: (850) 488-9675
Fax: (850) 921-6847

The contact information for the Insurance Consumer Advocate is:

Office of the Insurance Consumer Advocate
Florida Department of Financial Services
Office: 850.413.2868
Fax: 850.487.0453

2021 FLORIDA STATUE CHAPTER 766

766.301 Legislative findings and intent.

(1) The Legislature makes the following findings:

(a) Physicians practicing obstetrics are high-risk medical specialists for whom malpractice insurance premiums are very costly, and recent increases in such premiums have been greater for such physicians than for other physicians.

(b) Any birth other than a normal birth frequently leads to a claim against the attending physician; consequently, such physicians are among the physicians most severely affected by current medical malpractice problems.

(c) Because obstetric services are essential, it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida.

(d) The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault. The issue of whether such claims are covered by this act must be determined exclusively in an administrative proceeding.

(2) It is the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. This plan shall apply only to birth-related neurological injuries.

History.—s. 60, ch. 88-1; s. 1, ch. 98-113.

766.302 Definitions; ss. 766.301-766.316.—As used in ss. 766.301-766.316, the term:

(1) "Association" means the Florida Birth-Related Neurological Injury Compensation Association established in s. 766.315 to administer the Florida Birth-Related Neurological Injury Compensation Plan and the plan of operation established in s. 766.314.

(2) "Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.

This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

(3) "Claimant" means any person who files a claim pursuant to s. 766.305 for compensation for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, personal representative, or other legal representative thereof.

(4) "Administrative law judge" means an administrative law judge appointed by the division.

(5) "Division" means the Division of Administrative Hearings of the Department of Management Services.

(6) "Hospital" means any hospital licensed in Florida.

(7) "Participating physician" means a physician licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part time and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth-related neurological injury compensation plan for the year in which the injury occurred. Such term shall not apply to any physician who practices medicine as an officer, employee, or agent of the Federal Government.

(8) “Plan” means the Florida Birth-Related Neurological Injury Compensation Plan established under s. 766.303.

(9) “Family member” means a father, mother, or legal guardian.

(10) “Family residential or custodial care” means care normally rendered by trained professional attendants which is beyond the scope of participant care duties, but which is provided by family members. Family members who provide nonprofessional residential or custodial care may not be compensated under this act for care that falls within the scope of participant care duties and other services normally and gratuitously provided by family members. Family residential or custodial care shall be performed only at the direction and control of a physician when such care is medically necessary. Reasonable charges for expenses for family residential or custodial care provided by a family member shall be determined as follows:

(a) If the family member is not employed, the per-hour value equals the federal minimum hourly wage.

(b) If the family member is employed and elects to leave that employment to provide such care, the per-hour value of that care shall equal the rates established by Medicaid for private duty services provided by a home health aide. A family member or a combination of family members providing care in accordance with this definition may not be compensated for more than a total of 10 hours per day. Family care is in lieu of professional residential or custodial care, and no professional residential or custodial care may be awarded for the period of time during the day that family care is being provided.

(c) The award of family residential or custodial care as defined in this section shall not be included in the current estimates for purposes of s. 766.314(9)(c).

History.—s. 61, ch. 88-1; s. 36, ch. 88-277; s. 16, ch. 91-46; s. 2, ch. 93-251; s. 307, ch. 96-410; s. 149, ch. 2001-277; s. 5, ch. 2002-401.766.303 Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy.

(1) There is established the Florida Birth-Related Neurological Injury Compensation Plan for the purpose of providing compensation, irrespective of fault, for birth-related neurological injury claims. Such plan shall apply to births occurring on or after January 1, 1989, and shall be administered by the Florida Birth-Related Neurological Injury Compensation Association.

(2) The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, her or his personal representative, parents, dependents, and next of kin, at common law or otherwise, against any person or entity directly involved with the labor, delivery, or immediate postdelivery resuscitation during which such injury occurs, arising out of or related to a medical negligence claim with respect to such injury; except that a civil action shall not be foreclosed where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under ss. 766.301-766.316. Such suit shall be filed before the award of the division becomes conclusive and binding as provided for in s. 766.311.

(3) Sovereign immunity is hereby waived on behalf of the Florida Birth-Related Neurological Injury Compensation Association solely to the extent necessary to assure payment of compensation as provided in s. 766.31.

(4) The association shall administer the plan in a manner that promotes and protects the health and best interests of children with birth-related neurological injuries.

History.—s. 62, ch. 88-1; s. 37, ch. 88-277; s. 1, ch. 89-186; s. 1154, ch. 97-102; s. 74, ch. 2003-416; s. 2, ch. 2021-134.

766.304 Administrative law judge to determine claims

The administrative law judge shall hear and determine all claims filed pursuant to ss. 766.301- 766.316 and shall exercise the full power and authority granted to her or him in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge has exclusive jurisdiction to determine whether a claim filed under this act is compensable. No civil action may be brought until the determinations under s. 766.309 have been made by the administrative law judge. If the administrative law judge determines that the claimant is entitled to compensation from the association, or if the claimant accepts an award issued under s. 766.31, no civil action may be brought or continued in violation of the exclusiveness of remedy provisions of s. 766.303. If it is determined that a claim filed under this act is not compensable, neither the doctrine of collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law. The findings of fact and conclusions of law of the administrative law judge shall not be admissible in any subsequent proceeding; however, the sworn testimony of any person and the exhibits introduced into evidence in the administrative case are admissible as impeachment in any subsequent civil action only against a party to the administrative proceeding, subject to the Rules of Evidence. An award may not be made or paid under ss. 766.301-766.316 if the claimant recovers under a settlement or a final judgment is entered in a civil action.

History.—s. 63, ch. 88-1; s. 17, ch. 91-46; s. 3, ch. 93-251; s. 308, ch. 96-410; s. 1803, ch. 97-102; s. 2, ch. 98-113; s. 90, ch. 99-3; s. 75, ch. 2003-416; s. 109, ch. 2013-18.

766.305 Filing of claims and responses; medical disciplinary review.

(1) All claims filed for compensation under the plan shall commence by the claimant filing with the division a petition seeking compensation. Such petition shall include the following information:

(a) The name and address of the legal representative and the basis for her or his representation of the injured infant.

(b) The name and address of the injured infant.

(c) The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred.

(d) A description of the disability for which the claim is made.

(e) The time and place the injury occurred.

(f) A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

(2) The claimant shall furnish the division with as many copies of the petition as required for service upon the association, any physician and hospital named in the petition, and the Division of Medical Quality Assurance, along with a $15 filing fee payable to the Division of Administrative Hearings. Upon receipt of the petition, the division shall immediately serve the association, by service upon the agent designated to accept service on behalf of the association, by registered or certified mail, and shall mail copies of the petition, by registered or certified mail, to any physician, health care provider, and hospital named in the petition, and shall furnish a copy by regular mail to the Division of Medical Quality Assurance and the Agency for Health Care Administration.

(3) The claimant shall furnish to the Florida Birth-Related Neurological Injury Compensation Association the following information, which must be filed with the association within 10 days after the filing of the petition as set forth in subsection (1):

(a) All available relevant medical records relating to the birth-related neurological injury and a list identifying any unavailable records known to the claimant and the reasons for the records' unavailability.

(b) Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of the birth-related neurological injury.

(c) Documentation of expenses and services incurred to date which identifies any payment made for such expenses and services and the payor.

(d) Documentation of any applicable private or governmental source of services or reimbursement relative to the impairments.

The information required by paragraphs (a)-(d) shall remain confidential and exempt under the provisions of s. 766.315(5)(b).

(4) The association shall have 45 days from the date of service of a complete claim, filed pursuant to subsections (1) and (2), in which to file a response to the petition and to submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury.

(5) Upon receipt of such petition, the Division of Medical Quality Assurance shall review the information therein and determine whether it involved conduct by a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(6) Upon receipt of such petition, the Agency for Health Care Administration shall investigate the claim, and if it determines that the injury resulted from, or was aggravated by, a breach of duty on the part of a hospital in violation of chapter 395, it shall take any such action consistent with its disciplinary authority as may be appropriate.

(7) Any claim which the association determines to be compensable may be accepted for compensation, provided that the acceptance is approved by the administrative law judge to whom the claim for compensation is assigned.

History.—s. 64, ch. 88-1; s. 2, ch. 89-186; s. 18, ch. 91-46; s. 4, ch. 93-251; s. 1, ch. 94-106; s. 309, ch. 96-410; s. 1804, ch. 97-102; s. 165, ch. 98-166; s. 287, ch. 99-8; s. 226, ch. 2000-160; s. 115, ch. 2002-1; s. 76, ch. 2003-416.

766.306 Tolling of statute of limitations.

The statute of limitations with respect to any civil action that may be brought by, or on behalf of, an injured infant allegedly arising out of, or related to, a birth-related neurological injury shall be tolled by the filing of a claim in accordance with ss. 766.301-766.316, and the time such claim is pending or is on appeal shall not be computed as part of the period within which such civil action may be brought.

History.—s. 65, ch. 88-1.

766.307 Hearing; parties; discovery.

(1) The administrative law judge shall set the date for a hearing no sooner than 60 days and no later than 120 days after the filing by a claimant of a petition in compliance with s. 766.305. The administrative law judge shall immediately notify the parties of the time and place of such hearing, which shall be held in the county where the injury occurred unless otherwise agreed to by the parties and authorized by the division.

(2) The parties to the hearing shall include the claimant and the association.

(3) Any party to a proceeding under ss. 766.301-766.316 may, upon application to the administrative law judge setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the state to be taken, the costs thereof to be taxed as expenses incurred in connection with the filing of a claim. Such depositions shall be taken after giving notice and in the manner prescribed for the taking of depositions in actions at law, except that they shall be directed to the administrative law judge before whom the proceedings may be pending.

History.—s. 66, ch. 88-1; s. 19, ch. 91-46; s. 2, ch. 94-106; s. 310, ch. 96-410.

766.309 Determination of claims; presumption; findings of administrative law judge binding on participants.

(1) The administrative law judge shall make the following determinations based upon all available evidence:

(a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.302(2).

(b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital.(c) How much compensation, if any, is awardable pursuant to s. 766.31.

(d) Whether, if raised by the claimant or other party, the factual determinations regarding the notice requirements in s. 766.316 are satisfied. The administrative law judge has the exclusive jurisdiction to make these factual determinations.

(2) If the administrative law judge determines that the injury alleged is not a birth-related neurological injury or that obstetrical services were not delivered by a participating physician at the birth, she or he shall enter an order and shall cause a copy of such order to be sent immediately to the parties by registered or certified mail.

(3) By becoming a participating physician, a physician shall be bound for all purposes by the finding of the administrative law judge or any appeal therefrom with respect to whether such injury is a birth-related neurological injury.

(4) If it is in the interest of judicial economy or if requested to by the claimant, the administrative law judge may bifurcate the proceeding addressing compensability and notice pursuant to s. 766.316 first, and addressing an award pursuant to s. 766.31, if any, in a separate proceeding. The administrative law judge may issue a final order on compensability and notice which is subject to appeal under s. 766.311, prior to issuance of an award pursuant to s. 766.31.

History.—s. 68, ch. 88-1; s. 4, ch. 89-186; s. 21, ch. 91-46; s. 3, ch. 94-106; s. 312, ch. 96-410; s. 1805, ch. 97-102; s. 77, ch. 2003-416; s. 1, ch. 2006-8.

766.31 Administrative law judge awards for birth-related neurological injuries; notice of award.

1) The administrative law judge shall make the following determinations based upon all available evidence:

(a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.302(2).

(b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital.

(c) How much compensation, if any, is awardable pursuant to s. 766.31.

(d) Whether, if raised by the claimant or other party, the factual determinations regarding the notice requirements in s. 766.316 are satisfied. The administrative law judge has the exclusive jurisdiction to make these factual determinations.

(2) If the administrative law judge determines that the injury alleged is not a birth-related neurological injury or that obstetrical services were not delivered by a participating physician at the birth, she or he shall enter an order and shall cause a copy of such order to be sent immediately to the parties by registered or certified mail.

(3) By becoming a participating physician, a physician shall be bound for all purposes by the finding of the administrative law judge or any appeal therefrom with respect to whether such injury is a birth-related neurological injury.(4) If it is in the interest of judicial economy or if requested to by the claimant, the administrative law judge may bifurcate the proceeding addressing compensability and notice pursuant to s. 766.316 first, and addressing an award pursuant to s. 766.31, if any, in a separate proceeding. The administrative law judge may issue a final order on compensability and notice which is subject to appeal under s. 766.311, prior to issuance of an award pursuant to s. 766.31.

History.—s. 68, ch. 88-1; s. 4, ch. 89-186; s. 21, ch. 91-46; s. 3, ch. 94-106; s. 312, ch. 96-410; s. 1805, ch. 97-102; s. 77, ch. 2003-416; s. 1, ch. 2006-8.

1766.31 Administrative law judge awards for birth-related neurological injuries; notice of award.

(1) Upon determining that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth, the administrative law judge shall make an award providing compensation for the following items relative to such injury:

(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel.

At a minimum, compensation must be provided for the following actual expenses:

1. A total annual benefit of up to $10,000 for immediate family members who reside with the infant for psychotherapeutic services obtained from providers licensed under chapter 490 or chapter 491.

2. For the life of the participant, providing parents or legal guardians with a reliable method of transportation for the care of the participant or reimbursing the cost of upgrading an existing vehicle to accommodate the participant's needs when it becomes medically necessary for wheelchair transportation. The mode of transportation must take into account the special accommodations required for the specific participant. The plan may not limit such transportation assistance based on the participant's age or weight. The plan must replace any vans purchased by the plan every 7 years or 150,000 miles, whichever comes first.

3. Housing assistance of up to $100,000 for the life of the participant, including home construction and modification costs.

(b) However, the following expenses are not subject to compensation:

1. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

2. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.

3. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

4. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

(c) Expenses included under paragraph (a) are limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person. The parents or legal guardians receiving benefits under the plan may file a petition with the Division of Administrative Hearings to dispute the amount of actual expenses reimbursed or a denial of reimbursement.(d)1.a. Periodic payments of an award to the parents or legal guardians of the infant found to have sustained a birth-related neurological injury, which award may not exceed $100,000. However, at the discretion of the administrative law judge, such award may be made in a lump sum. Beginning on January 1, 2021, the award may not exceed $250,000, and each January 1 thereafter, the maximum award authorized under this paragraph shall increase by 3 percent.

b. Parents or legal guardians who received an award pursuant to this section before January 1, 2021, and whose participant currently receives benefits under the plan must receive a retroactive payment in an amount sufficient to bring the total award paid to the parents or legal guardians pursuant to sub-subparagraph a. to $250,000. This additional payment may be made in a lump sum or in periodic payments as designated by the parents or legal guardians and must be paid by July 1, 2021.

2.a. Death benefit for the infant in an amount of $50,000.

b. Parents or legal guardians who received an award pursuant to this section, and whose participant died since the inception of the program, must receive a retroactive payment in an amount sufficient to bring the total award paid to the parents or legal guardians pursuant to subsubparagraph a. to $50,000. This additional payment may be made in a lump sum or in periodic payments as designated by the parents or legal guardians and must be paid by July 1, 2021.

(e) Reasonable expenses incurred in connection with the filing of a claim under ss. 766.301- 766.316, including reasonable attorney's fees, which shall be subject to the approval and award of the administrative law judge. In determining an award for attorney's fees, the administrative law judge shall consider the following factors:

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly.

2. The fee customarily charged in the locality for similar legal services.

3. The time limitations imposed by the claimant or the circumstances.

4. The nature and length of the professional relationship with the claimant.

5. The experience, reputation, and ability of the lawyer or lawyers performing services.

6. The contingency or certainty of a fee.

Should there be a final determination of compensability, and the claimants accept an award under this section, the claimants shall not be liable for any expenses, including attorney's fees, incurred in connection with the filing of a claim under ss. 766.301-766.316 other than those expenses awarded under this section.

(2) The award shall require the immediate payment of expenses previously incurred and shall require that future expenses be paid as incurred.

(3) A copy of the award shall be sent immediately by registered or certified mail to each person served with a copy of the petition under s. 766.305(2).

History.—s. 69, ch. 88-1; s. 5, ch. 89-186; s. 22, ch. 91-46; s. 4, ch. 94-106; s. 313, ch. 96-410; s. 150, ch. 2001-277; s. 6, ch. 2002-401; s. 78, ch. 2003-416; s. 3, ch. 2021-134.766.311 Conclusiveness of determination or award; appeal.

(1) A determination of the administrative law judge as to qualification of the claim for purposes of compensability under s. 766.309 or an award by the administrative law judge pursuant to s. 766.31 shall be conclusive and binding as to all questions of fact. Review of an order of an administrative law judge shall be by appeal to the District Court of Appeal. Appeals shall be filed in accordance with rules of procedure prescribed by the Supreme Court for review of such orders.

(2) In case of an appeal from an award of the administrative law judge, the appeal shall operate as a suspension of the award, and the association shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined.

History.—s. 70, ch. 88-1; s. 23, ch. 91-46; s. 6, ch. 93-251; s. 314, ch. 96-410.

766.312 Enforcement of awards.

(1) The administrative law judge shall have full authority to enforce her or his awards and to protect herself or himself from any deception or lack of cooperation in reaching her or his determination as to any award. Such authority shall include the power to petition the circuit court for an order of contempt.

(2) A party may, if the circumstances so warrant, petition the circuit court for enforcement of a final award by the administrative law judge.

History.—s. 71, ch. 88-1; s. 24, ch. 91-46; s. 5, ch. 94-106; s. 315, ch. 96-410; s. 1806, ch. 97-102.

766.313 Limitation on claim.

Any claim for compensation under ss. 766.301-766.316 that is filed more than 5 years after the birth of an infant alleged to have a birth-related neurological injury shall be barred.

History.—s. 72, ch. 88-1; s. 38, ch. 88-277; s. 1, ch. 93-251.

766.314 Assessments; plan of operation.

(1) The assessments established pursuant to this section shall be used to finance the Florida Birth-Related Neurological Injury Compensation Plan.

(2) The assessments and appropriations dedicated to the plan shall be administered by the Florida Birth-Related Neurological Injury Compensation Association established in s. 766.315, in accordance with the following requirements:

(a) On or before July 1, 1988, the directors of the association shall submit to the 1Department of Insurance for review a plan of operation which shall provide for the efficient administration of the plan and for prompt processing of claims against and awards made on behalf of the plan.

The plan of operation shall include provision for:

1. Establishment of necessary facilities;

2. Management of the funds collected on behalf of the plan;

3. Processing of claims against the plan;

4. Assessment of the persons and entities listed in subsections (4) and (5) to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in subsections (4) and (5); and

5. Any other matters necessary for the efficient operation of the birth-related neurological injury compensation plan.

(b) Amendments to the plan of operation may be made by the directors of the plan, subject to the approval of the Office of Insurance Regulation of the Financial Services Commission.

(3) All assessments shall be deposited with the Florida Birth-Related Neurological Injury Compensation Association. The funds collected by the association and any income therefrom shall be disbursed only for the payment of awards under ss. 766.301-766.316 and for the payment of the reasonable expenses of administering the plan.

(4) The following persons and entities shall pay into the association an initial assessment in accordance with the plan of operation:

(a) On or before October 1, 1988, each hospital licensed under chapter 395 shall pay an initial assessment of $50 per infant delivered in the hospital during the prior calendar year, as reported to the Agency for Health Care Administration; provided, however, that a hospital owned or operated by the state or a county, special taxing district, or other political subdivision of the state shall not be required to pay the initial assessment or any assessment required by subsection (5). The term “infant delivered” includes live births and not stillbirths, but the term does not include infants delivered by employees or agents of the board of trustees of a state university, those born in a teaching hospital as defined in s. 408.07, 2or those born in a teaching hospital as defined in s. 395.806 that have been deemed by the association as being exempt from assessments since fiscal year 1997 to fiscal year 2001. The initial assessment and any assessment imposed pursuant to subsection (5) may not include any infant born to a charity patient (as defined by rule of the Agency for Health Care Administration) or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus the annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital. The hospital is responsible for documenting, to the satisfaction of the association, the exclusion of any birth from the computation of the assessment. Upon demonstration of financial need by a hospital, the association may provide for installment payments of assessments.

(b)1. On or before October 15, 1988, all physicians licensed pursuant to chapter 458 or chapter 459 as of October 1, 1988, other than participating physicians, shall be assessed an initial assessment of $250, which must be paid no later than December 1, 1988.

2. Any such physician who becomes licensed after September 30, 1988, and before January 1, 1989, shall pay into the association an initial assessment of $250 upon licensure.

3. Any such physician who becomes licensed on or after January 1, 1989, shall pay an initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5) (a), or paragraph (7)(b).

4. However, if the physician is a physician specified in this subparagraph, the assessment is not applicable:

a. A resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule;

b. A retired physician who has withdrawn from the practice of medicine but who maintains an active license as evidenced by an affidavit filed with the Department of Health. Prior to reentering the practice of medicine in this state, a retired physician as herein defined must notify the Board of Medicine or the Board of Osteopathic Medicine and pay the appropriate assessments pursuant to this section;

c. A physician who holds a limited license pursuant to s. 458.317 and who is not being compensated for medical services;

d. A physician who is employed full time by the United States Department of Veterans Affairs and whose practice is confined to United States Department of Veterans Affairs hospitals; or e. A physician who is a member of the Armed Forces of the United States and who meets the requirements of s. 456.024.

f. A physician who is employed full time by the State of Florida and whose practice is confined to state-owned correctional institutions, a county health department, or state-owned mental health or developmental services facilities, or who is employed full time by the Department of Health.

(c) On or before December 1, 1988, each physician licensed pursuant to chapter 458 or chapter 459 who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an initial assessment of $5,000. However, if the physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule, and is supervised in accordance with program requirements established by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the board of trustees of a state university who has paid the assessment required by this paragraph and paragraph (5)(a), and any certified nurse midwife supervised by such employee. Participating physicians include any certified nurse midwife who has paid 50 percent of the physician assessment required by this paragraph and paragraph (5)(a) and who is supervised by a participating physician who has paid the assessment required by this paragraph and paragraph (5)(a). Supervision for nurse midwives shall require that the supervising physician will be easily available and have a prearranged plan of treatment for specified patient problems which the supervised certified nurse midwife may carry out in the absence of any complicating features. Any physician who elects to participate in such plan on or after January 1, 1989, who was not a participating physician at the time of such election to participate and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an additional initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

(d) Any hospital located in a county with a population in excess of 1.1 million as of January 1, 2003, as determined by the Agency for Health Care Administration under the Health Care Responsibility Act, may elect to pay the fee for the participating physician and the certified nurse midwife if the hospital first determines that the primary motivating purpose for making such payment is to ensure coverage for the hospital's patients under the provisions of ss. 766.301- 766.316; however, no hospital may restrict any participating physician or nurse midwife, directly or indirectly, from being on the staff of hospitals other than the staff of the hospital making the payment. Each hospital shall file with the association an affidavit setting forth specifically the reasons why the hospital elected to make the payment on behalf of each participating physician and certified nurse midwife. The payments authorized under this paragraph shall be in addition to the assessment set forth in paragraph (5)(a).

(5)(a) Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the plan of operation, taking into account persons licensed subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). If payment of the annual assessment by a physician is received by the association by January 31 of any calendar year, the physician shall qualify as a participating physician for that entire calendar year. If the payment is received after January 31 of any calendar year, the physician shall qualify as a participating physician for that calendar year only from the date the payment was received by the association.

On January 1, 1991, and on each January 1 thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the 3Office of Insurance Regulation pursuant to paragraph (7)(b). On July 1, 1991, and on each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a), including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.

(b) If the assessments collected pursuant to subsection (4) and the appropriation of funds provided by s. 76, chapter 88-1, Laws of Florida, as amended by s. 41, chapter 88-277, Laws of Florida, to the plan from the Insurance Regulatory Trust Fund are insufficient to maintain the plan on an actuarially sound basis, there is hereby appropriated for transfer to the association from the Insurance Regulatory Trust Fund an additional amount of up to $20 million.

(c)1. Taking into account the assessments collected pursuant to subsection (4) and appropriations from the Insurance Regulatory Trust Fund, if required to maintain the plan on an actuarially sound basis, the Office of Insurance Regulation shall require each entity licensed to issue casualty insurance as defined in s. 624.605(1)(b), (k), and (q) to pay into the association an annual assessment in an amount determined by the office pursuant to paragraph (7)(a), in the manner required by the plan of operation.

2. All annual assessments shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to the Office of Insurance Regulation, and shall be in the proportion that the net direct premiums written by each carrier on account of the business activity forming the basis for its inclusion in the plan bears to the aggregate net direct premiums for all such business activity written in this state by all such entities.

3. No entity listed in this paragraph shall be individually liable for an annual assessment in excess of 0.25 percent of that entity's net direct premiums written.

4. Casualty insurance carriers shall be entitled to recover their initial and annual assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.

(6)(a) The association shall make all assessments required by this section, except initial assessments of physicians licensed on or after October 1, 1988, which assessments will be made by the Department of Business and Professional Regulation, and except assessments of casualty insurers pursuant to subparagraph (5)(c)1., which assessments will be made by the Office of Insurance Regulation. Beginning October 1, 1989, for any physician licensed between October 1 and December 31 of any year, the Department of Business and Professional Regulation shall make the initial assessment plus the assessment for the following calendar year. The Department of Business and Professional Regulation shall provide the association, with such frequency as determined to be necessary, a listing, in a computer-readable form, of the names and addresses of all physicians licensed under chapter 458 or chapter 459.

(b)1. The association may enforce collection of assessments required to be paid pursuant to ss. 766.301-766.316 by suit filed in county court. The association shall be entitled to an award of attorney's fees, costs, and interest upon the entry of a judgment against a physician for failure to pay such assessment, with such interest accruing until paid. Notwithstanding the provisions of chapters 47 and 48, the association may file such suit in either Leon County or the county of the residence of the defendant.

2. The Department of Business and Professional Regulation, upon notification by the association that an assessment has not been paid and that there is an unsatisfied judgment against a physician, shall not renew any license to practice for such physician issued pursuant to chapter 458 or chapter 459 until such time as the judgment is satisfied in full.

(c) The Agency for Health Care Administration shall, upon notification by the association that an assessment has not been timely paid, enforce collection of such assessments required to be paid by hospitals pursuant to ss. 766.301-766.316. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to s. 395.1065 notwithstanding any provision of law to the contrary.

(7)(a) The Office of Insurance Regulation shall undertake an actuarial investigation of the requirements of the plan based on the plan's experience in the first year of operation and any additional relevant information, including without limitation the assets and liabilities of the plan.

Pursuant to such investigation, the Office of Insurance Regulation shall establish the rate of contribution of the entities listed in paragraph (5)(c) for the tax year beginning January 1, 1990. Following the initial valuation, the Office of Insurance Regulation shall cause an actuarial valuation to be made of the assets and liabilities of the plan no less frequently than biennially. Pursuant to the results of such valuations, the Office of Insurance Regulation shall prepare a statement as to the contribution rate applicable to the entities listed in paragraph (5)(c). However, at no time shall the rate be greater than 0.25 percent of net direct premiums written.

(b) If the Office of Insurance Regulation finds that the plan cannot be maintained on an actuarially sound basis based on the assessments and appropriations listed in subsections (4) and (5), the office shall increase the assessments specified in subsection (4) on a proportional basis as needed.

(8) The association shall report to the Legislature its determination as to the annual cost of maintaining the fund on an actuarially sound basis. In making its determination, the association shall consider the recommendations of all hospitals, physicians, casualty insurers, attorneys, consumers, and any associations representing any such person or entity. Notwithstanding the provisions of s. 395.3025, all hospitals, casualty insurers, departments, boards, commissions, and legislative committees shall provide the association with all relevant records and information upon request to assist the association in making its determination. All hospitals shall, upon request by the association, provide the association with information from their records regarding any live birth. Such information shall not include the name of any physician, the name of any hospital employee or agent, the name of the patient, or any other information which will identify the infant involved in the birth. Such information thereby obtained shall be utilized solely for the purpose of assisting the association and shall not subject the hospital to any civil or criminal liability for the release thereof. Such information shall otherwise be confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(9)(a) Within 60 days after a claim is filed, the association shall estimate the present value of the total cost of the claim, including the estimated amount to be paid to the claimant, the claimant's attorney, the attorney's fees of the association incident to the claim, and any other expenses that are reasonably anticipated to be incurred by the association in connection with the adjudication and payment of the claim. For purposes of this estimate, the association should include the maximum benefits for noneconomic damages.

(b) The association shall revise these estimates quarterly based upon the actual costs incurred and any additional information that becomes available to the association since the last review of this estimate. The estimate shall be reduced by any amounts paid by the association that were included in the current estimate.

(c) In the event the total of all current estimates equals 80 percent of the funds on hand and the funds that will become available to the association within the next 12 months from all sources described in subsections (4) and (5) and paragraph (7)(a), the association shall not accept any new claims without express authority from the Legislature. Nothing herein shall preclude the association from accepting any claim if the injury occurred 18 months or more prior to the effective date of this suspension. Within 30 days of the effective date of this suspension, the association shall notify the Governor, the Speaker of the House of Representatives, the President of the Senate, the Office of Insurance Regulation, the Agency for Health Care Administration, the Department of Health, and the Department of Business and Professional Regulation of this suspension.

(d) If any person is precluded from asserting a claim against the association because of paragraph

(c), the plan shall not constitute the exclusive remedy for such person, his or her personal representative, parents, dependents, or next of kin.

History.—s. 73, ch. 88-1; s. 39, ch. 88-277; s. 44, ch. 88-294; s. 6, ch. 89-186; s. 103, ch. 92-33; s. 122, ch. 92-149; s. 1, ch. 92-196; s. 94, ch. 92-289; s. 66, ch. 93-268; s. 1, ch. 94-85; s. 248, ch. 94- 218; s. 426, ch. 96-406; s. 1807, ch. 97-102; s. 81, ch. 97-237; s. 167, ch. 98-166; s. 288, ch. 99-8; s. 227, ch. 2000-160; s. 7, ch. 2002-401; s. 4, ch. 2003-258; s. 1901, ch. 2003-261; ss. 79, 84, ch. 2003-416.

1Note.—Duties of the Department of Insurance were transferred to the Department of Financial Services or the Financial Services Commission by ch. 2002-404, and s. 20.13, creating the Department of Insurance, was repealed by s. 3, ch. 2003-1.

2Note.—As amended by s. 4, ch. 2003-258, enacted at the 2003 Regular Session. Section 79, ch. 2003-416, enacted at Special Session D, 2003, failed to incorporate the amendment by s. 4, ch. 2003-258, adding the language "or those born in a teaching hospital as defined in s. 395.806 that have been deemed by the association as being exempt from assessments since fiscal year 1997 to fiscal year 2001."

3Note.—As amended by s. 1901, ch. 2003-261, enacted at the 2003 Regular Session. Section 79, ch. 2003-416, enacted at Special Session D, 2003, failed to incorporate the amendment by s. 1901, ch. 2003-261, which substituted a reference to the Office of Insurance Regulation for a reference to the Department of Insurance.

766.3145 Code of ethics.

(1) On or before July 1 of each year, employees of the association must sign and submit a statement attesting that they do not have a conflict of interest as defined in part III of chapter 112. As a condition of employment, all prospective employees must sign and submit to the association a conflict-of-interest statement.

(2) The executive director, senior managers, and members of the board of directors are subject to the code of ethics under part III of chapter 112. For purposes of applying part III of chapter 112 to activities of the executive director, senior managers, and members of the board of directors, those persons are considered public officers or employees and the association is considered their agency. A board member may not vote on any measure that would inure to his or her special private gain or loss and, notwithstanding s. 112.3143(2), may not vote on any measure that he or she knows would inure to the special private gain or loss of any principal by whom he or she

is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312; or that he or she knows would inure to the special private gain or loss of a relative or business associate of the public officer. Before the vote is taken, such member shall publicly state to the board the nature of his or her interest in the matter from which he or she is abstaining from voting and, within 15 days after the vote occurs, disclose the nature of his or her interest as a public record in a memorandum filed with the person responsible for recording the minutes of the meeting, who shall incorporate the memorandum in the minutes.

(3) Notwithstanding s. 112.3148, s. 112.3149, or any other law, an employee or board member may not knowingly accept, directly or indirectly, any gift or expenditure from a person or entity, or an employee or representative of such person or entity, which has a contractual relationship with the association or which is under consideration for a contract.

(4) An employee or board member who fails to comply with subsection (2) or subsection (3) is subject to penalties provided under ss. 112.317 and 112.3173.

(5) Any senior manager or executive director of the association who is employed on or after January 1, 2022, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from representing another person or entity before the association for 2 years after retirement or termination of employment from the association.

History.—s. 4, ch. 2021-134.

766.315 Florida Birth-Related Neurological Injury Compensation Association; board of directors.

(1)(a) The Florida Birth-Related Neurological Injury Compensation Plan shall be governed by a board of seven directors which shall be known as the Florida Birth-Related Neurological Injury Compensation Association. The association is not a state agency, board, or commission. Notwithstanding the provision of s. 15.03, the association is authorized to use the state seal.

(b) The directors shall be appointed for staggered terms of 3 years or until their successors are appointed and have qualified; however, a director may not serve for more than 6 consecutive years.

(c) The directors shall be appointed by the Chief Financial Officer as follows:

1. One citizen representative who is not affiliated with any of the groups identified in subparagraphs 2.-7.

2. One representative of participating physicians.

3. One representative of hospitals.

4. One representative of casualty insurers.

5. One representative of physicians other than participating physicians.

6. One parent or legal guardian representative of an injured infant under the plan.

7. One representative of an advocacy organization for children with disabilities.

(2)(a) The Chief Financial Officer may select the representative of the participating physicians from a list of at least three names recommended by the American Congress of Obstetricians and Gynecologists, District XII; the representative of hospitals from a list of at least three names recommended by the Florida Hospital Association; the representative of casualty insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one of which is recommended by the Florida Insurance Council, and one of which is recommended by the Property Casualty Insurers Association of America; and the representative of physicians, other than participating physicians, from a list of three names recommended by the Florida Medical Association

and a list of three names recommended by the Florida Osteopathic Medical Association. However, the Chief Financial Officer is not required to make an appointment from among the nominees of the respective associations. A participating physician who is named in a pending petition for a claim may not be appointed to the board. An appointed director who is a participating physician may not vote on any board matter relating to a claim accepted for an award for compensation if the physician is named in the petition for the claim.(b) If applicable, the Chief Financial Officer shall promptly notify the appropriate association or person identified in paragraph (a) to make recommendations upon the occurrence of any vacancy, and like nominations may be made for the filling of the vacancy.

(c) The Governor or the Chief Financial Officer may remove a director from office for misconduct, malfeasance, misfeasance, or neglect of duty in office. Any vacancy so created shall be filled as provided in paragraph (a).

(3) The directors may not transact any business or exercise any power of the plan except upon the affirmative vote of four directors. The directors shall serve without salary but are entitled to receive reimbursement for actual and necessary expenses incurred in the performance of his or her official duties as a director of the plan in accordance with s. 112.061. The directors are not subject to any liability with respect to the administration of the plan.

(4) The board of directors has the power to:

(a) Administer the plan.

(b) Administer the funds collected on behalf of the plan.

(c) Administer the payment of claims on behalf of the plan.

(d) Direct the investment and reinvestment of any surplus funds over losses and expenses, if any investment income generated thereby remains credited to the plan.

(e) Reinsure the risks of the plan in whole or in part.

(f) Sue and be sued, and appear and defend, in all actions and proceedings in its name to the same extent as a natural person.

(g) Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the plan is created.

(h) Enter into such contracts as are necessary or proper to administer the plan.

(i) Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the plan and to perform other necessary and proper functions not prohibited by law.

(j) Take such legal action as may be necessary to avoid payment of improper claims.

(k) Indemnify any employee, agent, member of the board of directors or alternate thereof, or person acting on behalf of the plan in an official capacity, for expenses, including attorney fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with any action, suit, or proceeding, including any appeal thereof, arising out of such person's capacity to act on behalf of the plan, if such person acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the plan and the health and best interest of the participant having birth-related neurological injuries, and if, with respect to any criminal action or proceeding, such person had reasonable cause to believe his or her conduct was lawful.

(5)(a) Money may be withdrawn on account of the plan only upon a voucher as authorized by the association.

(b) All meetings of the board of directors are subject to the requirements of s. 286.011, and all books, records, and audits of the plan are open to the public for reasonable inspection, except that a claim file in the possession

of the association or its representative is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until termination of litigation or settlement of the claim, although medical records and other portions of the claim file may remain confidential and exempt as otherwise provided by law. Any book, record, document, audit, or asset acquired by, prepared for, or paid for by the association is subject to the authority of the board of directors, which is responsible therefor.(c) Except in the case of emergency meetings, the association shall give notice of any board meeting by publication on the association's website not fewer than 7 days before the meeting. The association shall prepare an agenda in time to ensure that a copy of the agenda may be received at least 7 days before the meeting by any person who requests a copy and who pays the reasonable cost of the copy. The agenda, along with any meeting materials available in electronic form, excluding confidential and exempt information, shall be published on the association's website. The agenda shall contain the items to be considered in order of presentation and a telephone number for members of the public to participate telephonically at the board meeting. After the agenda has been made available, a change shall be made only for good cause, as determined by the person designated to preside, and must be stated in the record. Notification of such change shall be at the earliest practicable time.

(d) Each person authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any funds shall post a blanket fidelity bond in an amount reasonably sufficient to protect plan assets, as determined by the plan of operation. The cost of such bond will be paid from the assets of the plan.

(e) Annually, the association shall furnish audited financial reports to any plan participant upon request, to the Office of Insurance Regulation of the Financial Services Commission, and to the Joint Legislative Auditing Committee. The reports must be prepared in accordance with accepted accounting procedures and must include such information as may be required by the Office of Insurance Regulation or the Joint Legislative Auditing Committee. At any time determined to be necessary, the Office of Insurance Regulation or the Joint Legislative Auditing Committee may conduct an audit of the plan.

(f) Funds held on behalf of the plan are funds of the State of Florida. The association 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 will be credited to the plan. The State Board of Administration may invest and reinvest funds held on behalf of the plan in accordance with the trust agreement approved by the association and the State Board of Administration and within the provisions of ss. 215.44-215.53.

(6) The association shall furnish annually to each parent and legal guardian receiving benefits under the plan either by mail or electronically a list of expenses compensable under the plan.

(7) The association shall publish a report on its website by January 1, 2022, and every January 1 thereafter. The report shall include:

(a) The names and terms of each board member and executive staff member.

(b) The amount of compensation paid to each association employee.

(c) A summary of reimbursement disputes and resolutions.

(d) A list of expenditures for attorney fees and lobbying fees.

(e) Other expenses to oppose each plan claim. Any personal identifying information of the parent, legal guardian, or participant involved in the claim must be removed from this list.

(8) On or before November 1, 2021, and by each November 1 thereafter, the association shall submit a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer. The report must include:

(a) The number of petitions filed for compensation with the division, the number of claimants awarded compensation, the number of claimants denied compensation, and the reasons for the denial of compensation.

(b) The number and dollar amount of paid and denied compensation for expenses by category and the reasons for any denied compensation for expenses by category.(c) The average turnaround time for paying or denying compensation for expenses.

(d) Legislative recommendations to improve the program.

(e) A summary of any pending or resolved litigation during the year which affects the plan.

(f) The amount of compensation paid to each association employee or member of the board of directors.

(g) For the initial report due on or before November 1, 2021, an actuarial report conducted by an independent actuary which provides an analysis of the estimated costs of implementing the following changes to the plan:

1. Reducing the minimum birth weight eligibility for a participant in the plan from 2,500 grams to 2,000 grams.

2. Revising the eligibility for participation in the plan by providing that an infant must be permanently and substantially mentally or physically impaired, rather than permanently and substantially mentally and physically impaired.

3. Increasing the annual special benefit or quality of life benefit from $500 to $2,500 per calendar year.

History.—s. 74, ch. 88-1; s. 40, ch. 88-277; s. 7, ch. 89-186; s. 2, ch. 94-85; s. 427, ch. 96-406; s. 1808, ch. 97-102; s. 3, ch. 98-113; s. 2, ch. 98-409; s. 1902, ch. 2003-261; s. 3, ch. 2006-8; s. 11, ch. 2014-103; s. 5, ch. 2021-134.

766.316 Notice to obstetrical participants of participation in the plan.

Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not 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.

History.—s. 75, ch. 88-1; s. 8, ch. 89-186; s. 4, ch. 98-113; s. 91, ch. 99-3; s. 205, ch. 2007-230.

NICA SUPPORTIVE SERVICES FOR FAMILIES & PHYSICIANS

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BENEFIT HANDBOOK

Approved August 24, 2023

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