

By Senator Bogdanoff

25-01013C-11

20111930__

1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; amending s. 316.066, F.S.;
4 revising provisions relating to the contents of
5 written reports of motor vehicle crashes; requiring
6 short-form crash reports by a law enforcement officer
7 to be maintained by the officer's agency; authorizing
8 the investigation officer to testify at trial or
9 provide an affidavit concerning the content of the
10 reports; amending s. 400.991, F.S.; requiring that an
11 application for licensure as a mobile clinic include a
12 statement regarding insurance fraud; creating s.
13 626.9894, F.S.; providing definitions; authorizing the
14 Division of Insurance Fraud to establish a direct-
15 support organization for the purpose of prosecuting,
16 investigating, and preventing motor vehicle insurance
17 fraud; providing requirements for the organization and
18 the organization's contract with the division;
19 providing for a board of directors; authorizing the
20 organization to use the division's property and
21 facilities subject to certain requirements;
22 authorizing contributions from insurers; providing
23 that any moneys received by the organization may be
24 held in a separate depository account in the name of
25 the organization; requiring the division to deposit
26 certain proceeds into the Insurance Regulatory Trust
27 Fund; amending s. 627.4137, F.S.; requiring a
28 claimant's request about insurance coverage to be
29 appropriately served upon the disclosing entity;

25-01013C-11

20111930__

30 amending s. 627.730, F.S.; conforming a cross-
31 reference; amending s. 627.731, F.S.; providing
32 legislative intent with respect to the Florida Motor
33 Vehicle No-Fault Law; amending s. 627.732, F.S.;
34 defining the terms "claimant" and "no-fault law";
35 amending s. 627.736, F.S.; conforming a cross-
36 reference; requiring certain entities providing
37 medical services to document that they meet required
38 criteria; revising requirements relating to the form
39 that must be submitted by providers; requiring an
40 entity or clinic to file a new form within a specified
41 period after the date of a change of ownership;
42 revising provisions relating to when payment for a
43 benefit is due; providing that an insurer's failure to
44 send certain specification or explanation does not
45 waive any ground for rejecting an invalid claim;
46 authorizing an insurer to define "reasonable proof" in
47 its policy and to request information for its
48 investigation; providing that the time period for
49 paying a claim is tolled during the investigation of a
50 fraudulent insurance act; specifying when benefits are
51 not payable; providing that a claimant that violates
52 certain provisions is not entitled to any payment,
53 regardless of whether a portion of the claim may be
54 legitimate; authorizing an insurer to recover payments
55 and bring a cause of action to recover payments;
56 providing that an insurer may deny any claim based on
57 other evidence of fraud; forbidding a physician,
58 hospital, clinic, or other medical institution that

25-01013C-11

20111930__

59 fails to comply with certain provisions from billing
60 the injured person or the insured; providing that an
61 insurer has a right to conduct reasonable
62 investigations of claims; authorizing an insurer to
63 require a claimant to provide certain records;
64 authorizing an insurer to deny or reduce a claim if a
65 medical provider fails to keep adequate records;
66 providing that an insurer's choice of physician is not
67 limited by the physician's area of practice or
68 licensing chapter; authorizing an insurer to deny
69 benefits if an insured, claimant, or medical provider
70 fails to comply with certain provisions; forbidding
71 the claimant from filing suit unless the claimant
72 complies with the act; revising the insurer's
73 reimbursement limitation; providing that an insurer is
74 not required to pay a claim that the insured did not
75 countersign; requiring the provider to submit the
76 statements or bills on an approved form; requiring the
77 provider to ensure that the insured understands the
78 services being provided; specifying requirements for
79 furnishing the insured with notice of the amount of
80 covered loss; deleting an obsolete provision;
81 requiring the provider to provide copies of the
82 patient log within a certain time if requested by the
83 insurer; providing that failure to maintain a patient
84 log renders the treatment unlawful and noncompensable;
85 revising requirements relating to discovery;
86 authorizing the insurer to conduct a physical review
87 of the treatment location; requiring the insured and

25-01013C-11

20111930__

88 assignee to comply with certain provisions to recover
89 benefits; requiring the provider to produce persons
90 having the most knowledge in specified circumstances;
91 providing that an insurer that requests an examination
92 under oath without a reasonable basis is engaging in
93 an unfair and deceptive trade practice; providing that
94 failure to appear for an examination establishes a
95 rebuttable presumption that such failure was
96 unreasonable; authorizing an insurer to contract with
97 a preferred provider network; authorizing an insurer
98 to provide a premium discount to an insured who
99 selects a preferred provider; authorizing an insurance
100 policy to not pay for nonemergency services performed
101 by a nonpreferred provider in specified circumstances;
102 authorizing an insurer to contract with a health
103 insurer in specified circumstances; revising
104 requirements relating to demand letters in an action
105 for benefits; specifying when a demand letter is
106 defective; requiring a second demand letter under
107 certain circumstances; deleting obsolete provisions;
108 providing that a demand letter may not be used to
109 request the production of claim documents or records
110 from the insurer; amending ss. 324.021, 456.057,
111 627.7401, and 817.234, F.S.; conforming cross-
112 references; providing an effective date.

113
114 Be It Enacted by the Legislature of the State of Florida:

115
116 Section 1. Subsection (1) of section 316.066, Florida

25-01013C-11

20111930__

117 Statutes, is amended to read:

118 316.066 Written reports of crashes.—

119 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~
120 ~~required to~~ be completed and submitted to the department within
121 10 days after ~~completing~~ an investigation is completed by the
122 ~~every~~ law enforcement officer who in the regular course of duty
123 investigates a motor vehicle crash:

124 1. That resulted in death, ~~or~~ personal injury, or any
125 indication of complaints of pain or discomfort by any of the
126 parties or passengers involved in the crash;

127 2. That involved one or more passengers, other than the
128 drivers of the vehicles, in any of the vehicles involved in the
129 crash;

130 ~~3.2.~~ That involved a violation of s. 316.061(1) or s.
131 316.193; ~~or.~~

132 ~~4.3.~~ In which a vehicle was rendered inoperative to a
133 degree that required a wrecker to remove it from traffic, if
134 such action is appropriate, in the officer's discretion.

135 (b) In every crash for which a Florida Traffic Crash
136 Report, Long Form, is not required by this section, the law
137 enforcement officer may complete a short-form crash report or
138 provide a short-form crash report to be completed by each party
139 involved in the crash. Short-form crash reports prepared by the
140 law enforcement officer shall be maintained by the officer's
141 agency.

142 (c) The long-form and the short-form report must include:

143 1. The date, time, and location of the crash.

144 2. A description of the vehicles involved.

145 3. The names and addresses of the parties involved.

25-01013C-11

20111930__

146 4. The names and addresses of all passengers in all
147 vehicles involved in the crash, each clearly identified as being
148 a passenger and the identification of the vehicle in which they
149 were a passenger.

150 ~~5.4.~~ The names and addresses of witnesses.

151 ~~6.5.~~ The name, badge number, and law enforcement agency of
152 the officer investigating the crash.

153 ~~7.6.~~ The names of the insurance companies for the
154 respective parties involved in the crash.

155 (d) (e) Each party to the crash must ~~shall~~ provide the law
156 enforcement officer with proof of insurance, which must ~~to~~ be
157 included in the crash report. If a law enforcement officer
158 submits a report on the accident, proof of insurance must be
159 provided to the officer by each party involved in the crash. Any
160 party who fails to provide the required information commits a
161 noncriminal traffic infraction, punishable as a nonmoving
162 violation as provided in chapter 318, unless the officer
163 determines that due to injuries or other special circumstances
164 such insurance information cannot be provided immediately. If
165 the person provides the law enforcement agency, within 24 hours
166 after the crash, proof of insurance that was valid at the time
167 of the crash, the law enforcement agency may void the citation.

168 (e) (d) The driver of a vehicle that was in any manner
169 involved in a crash resulting in damage to any vehicle or other
170 property in an amount of \$500 or more, ~~which crash~~ was not
171 investigated by a law enforcement agency, shall, within 10 days
172 after the crash, submit a written report of the crash to the
173 department or traffic records center. The entity receiving the
174 report may require witnesses of the crash ~~crashes~~ to render

25-01013C-11

20111930__

175 reports and may require any driver of a vehicle involved in a
176 crash of which a written report must be made ~~as provided in this~~
177 ~~section~~ to file supplemental written reports if whenever the
178 original report is deemed insufficient by the receiving entity.

179 (f) The investigating law enforcement officer may testify
180 at trial or provide a signed affidavit to confirm or supplement
181 the information included on the long-form or short-form report.

182 ~~(e) Short form crash reports prepared by law enforcement~~
183 ~~shall be maintained by the law enforcement officer's agency.~~

184 Section 2. Subsection (6) is added to section 400.991,
185 Florida Statutes, to read:

186 400.991 License requirements; background screenings;
187 prohibitions.-

188 (6) All forms that constitute part of the application for
189 licensure or exemption from licensure under this part must
190 contain the following statement:

191
192 INSURANCE FRAUD NOTICE.-Submitting a false,
193 misleading, or fraudulent application or other
194 document when applying for licensure as a health care
195 clinic, when seeking an exemption from licensure as a
196 health care clinic, or when demonstrating compliance
197 with part X of chapter 400, Florida Statutes, is a
198 fraudulent insurance act, as defined in s. 626.989,
199 Florida Statutes, subject to investigation by the
200 Division of Insurance Fraud, and is grounds for
201 discipline by the appropriate licensing board of the
202 Florida Department of Health.

203 Section 3. Section 626.9894, Florida Statutes, is created

25-01013C-11

20111930__

204 to read:

205 626.9894 Motor vehicle insurance fraud direct-support
206 organization.-

207 (1) DEFINITIONS.-As used in this section, the term:

208 (a) "Division" means the Division of Insurance Fraud of the
209 Department of Financial Services.

210 (b) "Motor vehicle insurance fraud" means any act defined
211 as a "fraudulent insurance act" under s. 626.989, which relates
212 to the coverage of motor vehicle insurance as described in part
213 XI of chapter 627.

214 (c) "Organization" means the direct-support organization
215 established under this section.

216 (2) ORGANIZATION ESTABLISHED.-The division may establish a
217 direct-support organization, to be known as the "Fight Auto
218 Fraud Fund," whose sole purpose is to support the prosecution,
219 investigation, and prevention of motor vehicle insurance fraud.
220 The organization shall:

221 (a) Be a not-for-profit corporation incorporated under
222 chapter 617 and approved by the Department of State.

223 (b) Be organized and operated to conduct programs and
224 activities; to raise funds; to request and receive grants,
225 gifts, and bequests of money; to acquire, receive, hold, invest,
226 and administer, in its own name, securities, funds, objects of
227 value, or other property, real or personal; and to make grants
228 and expenditures to or for the direct or indirect benefit of the
229 division, state attorneys' offices, the statewide prosecutor,
230 the Agency for Health Care Administration, and the Department of
231 Health to the extent that such grants and expenditures are to be
232 used exclusively to advance the purpose of prosecuting,

25-01013C-11

20111930__

233 investigating, or preventing motor vehicle insurance fraud.
234 Grants and expenditures may include the cost of salaries or
235 benefits of dedicated motor vehicle insurance fraud
236 investigators, prosecutors, or support personnel if such grants
237 and expenditures do not interfere with prosecutorial
238 independence or otherwise create conflicts of interest which
239 threaten the success of prosecutions.

240 (c) Be determined by the division to operate in a manner
241 that promotes the goals of laws relating to motor vehicle
242 insurance fraud, that is in the best interest of the state, and
243 that is in accordance with the adopted goals and mission of the
244 division.

245 (d) Use all of its grants and expenditures solely for the
246 purpose of preventing and decreasing motor vehicle insurance
247 fraud, and not for the purpose of lobbying as defined in s.
248 11.045.

249 (e) Be subject to an annual financial audit in accordance
250 with s. 215.981.

251 (3) CONTRACT.—The organization shall operate under written
252 contract with the division. The contract must provide for:

253 (a) Approval of the articles of incorporation and bylaws of
254 the organization by the division.

255 (b) Submission of an annual budget for the approval of the
256 division.

257 (c) Certification by the division that the direct-support
258 organization is complying with the terms of the contract and in
259 a manner consistent with the goals and purposes of the
260 department and in the best interest of the state. Such
261 certification must be made annually and reported in the official

25-01013C-11

20111930__

262 minutes of a meeting of the organization.

263 (d) Allocation of funds to address motor vehicle insurance
264 fraud.

265 (e) Reversion of moneys and property held in trust by the
266 organization for motor vehicle insurance fraud prosecution,
267 investigation, and prevention to the division if the
268 organization is no longer approved to operate for the department
269 or if the organization ceases to exist, or to the state if the
270 division ceases to exist.

271 (f) Specific criteria to be used by the organization's
272 board of directors to evaluate the effectiveness of funding used
273 to combat motor vehicle insurance fraud.

274 (g) The fiscal year of the organization, which begins July
275 1 of each year and ends June 30 of the following year.

276 (h) Disclosure of the material provisions of the contract,
277 and distinguishing between the department and the organization
278 to donors of gifts, contributions, or bequests, including
279 providing such disclosure on all promotional and fundraising
280 publications.

281 (4) BOARD OF DIRECTORS.—The board of directors of the
282 organization shall consist of the following seven members:

283 (a) The Chief Financial Officer, or designee, who shall
284 serve as chair.

285 (b) Two state attorneys appointed by the Attorney General.

286 (c) Two representatives of motor vehicle insurers appointed
287 by the Chief Financial Officer.

288 (d) Two representatives of local law enforcement agencies,
289 one of whom shall be appointed by the Chief Financial Officer,
290 and one of whom shall be appointed by the Attorney General.

25-01013C-11

20111930

291
292 The officer who appointed a member of the board may remove that
293 member for cause. The term of office of an appointed member may
294 not exceed 4 years and expires at the same time as the term of
295 the officer who appointed him or her or at such earlier time as
296 the person ceases to be qualified.

297 (5) USE OF PROPERTY.—The department may authorize, without
298 charge, appropriate use of fixed property and facilities of the
299 division by the organization, subject to this subsection.

300 (a) The department may prescribe any condition with which
301 the organization must comply in order to use the division's
302 property or facilities.

303 (b) The department may not authorize the use of the
304 division's property or facilities if the organization does not
305 provide equal membership and employment opportunities to all
306 persons regardless of race, religion, sex, age, or national
307 origin.

308 (c) The department shall adopt rules prescribing the
309 procedures by which the organization is governed and any
310 conditions with which the organization must comply to use the
311 division's property or facilities.

312 (6) CONTRIBUTIONS.—Any contributions made by an insurer to
313 the organization shall be allowed as appropriate business
314 expenses for all regulatory purposes.

315 (7) DEPOSITORY.—Any moneys received by the organization may
316 be held in a separate depository account in the name of the
317 organization and subject to the provisions of the contract with
318 the division.

319 (8) DIVISION'S RECEIPT OF PROCEEDS.—If the division

25-01013C-11

20111930__

320 receives proceeds from the organization, those proceeds shall be
321 deposited into the Insurance Regulatory Trust Fund.

322 Section 4. Subsection (3) is added to section 627.4137,
323 Florida Statutes, to read:

324 627.4137 Disclosure of certain information required.—

325 (3) Any request made to a self-insured corporation pursuant
326 to this section shall be sent by certified mail to the
327 registered agent of the disclosing entity.

328 Section 5. Section 627.730, Florida Statutes, is amended to
329 read:

330 627.730 Florida Motor Vehicle No-Fault Law.—Sections
331 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the
332 "Florida Motor Vehicle No-Fault Law."

333 Section 6. Section 627.731, Florida Statutes, is amended to
334 read:

335 627.731 Purpose; legislative intent.—The purpose of the no-
336 fault law ss. 627.730-627.7405 is to provide for medical,
337 surgical, funeral, and disability insurance benefits without
338 regard to fault, and to require motor vehicle insurance securing
339 such benefits, for motor vehicles required to be registered in
340 this state and, with respect to motor vehicle accidents, a
341 limitation on the right to claim damages for pain, suffering,
342 mental anguish, and inconvenience.

343 (1) The Legislature intends to balance the insured's
344 interest in prompt payment of valid claims for insurance
345 benefits under the no-fault law with the public's interest in
346 reducing fraud, abuse, and overuse of the no-fault system. To
347 that end, the Legislature intends that the investigation and
348 prevention of fraudulent insurance acts in this state be

25-01013C-11

20111930

349 enhanced, that additional sanctions for such acts be imposed,
350 and that the no-fault law be revised to remove incentives for
351 fraudulent insurance acts. The Legislature intends that the no-
352 fault law be construed according to the plain language of the
353 statutory provisions, which are designed to meet these goals.

354 (2) The Legislature finds that:

355 (a) Automobile insurance fraud remains a major problem for
356 state consumers and insurers. According to the National
357 Insurance Crime Bureau, in recent years this state has been
358 among those states that have the highest number of fraudulent
359 and questionable claims.

360 (b) The current regulatory process for health care clinics
361 under part X of chapter 400, which was originally enacted to
362 reduce automobile insurance fraud, is not adequately preventing
363 fraudulent insurance acts with respect to licensure exemptions
364 and compliance with that part.

365 (3) The Legislature intends that:

366 (a) The provisions, schedules, and procedures authorized
367 under the no-fault law be implemented by the insurers offering
368 policies pursuant to the no-fault law. These provisions,
369 schedules, and procedures have full force and effect regardless
370 of their express inclusion in an insurance policy, and an
371 insurer is not required to amend its policy to implement and
372 apply such provisions, schedules, or procedures.

373 (b) Insurers properly investigate claims, and as such, be
374 allowed to obtain examinations under oath and sworn statements
375 from any claimant seeking no-fault insurance benefits, and to
376 request mental and physical examinations of persons seeking
377 personal injury protection coverage or benefits.

25-01013C-11

20111930__

378 (c) Any false, misleading, or otherwise fraudulent activity
379 associated with a claim render the entire claim invalid. An
380 insurer must be able to raise fraud as a defense to a claim for
381 no-fault insurance benefits irrespective of any prior
382 adjudication of guilt or determination of fraud by the
383 Department of Financial Services.

384 (d) Insurers toll the payment or denial of a claim, with
385 respect to any portion of a claim for which the insurer has a
386 reasonable belief that a fraudulent insurance act, as defined in
387 s. 626.989, has been committed.

388 (e) Insurers discover the names of all passengers involved
389 in an automobile accident before paying claims or benefits
390 pursuant to an insurance policy governed by the no-fault law. A
391 rebuttable presumption must be established that a person was not
392 involved in the event giving rise to the claim if that person's
393 name does not appear on the police report.

394 (f) The insured's interest in obtaining competent counsel
395 must be balanced with the public's interest in preventing a no-
396 fault system that encourages litigation by allowing for
397 exorbitant attorney's fees. Courts should limit attorney fee
398 awards so as to eliminate the incentive for attorneys to
399 manufacture unnecessary litigation.

400 Section 7. Section 627.732, Florida Statutes, is reordered
401 and amended to read:

402 627.732 Definitions.—As used in the no-fault law ~~ss.~~
403 ~~627.730-627.7405~~, the term:

404 (1) "Broker" means any person not possessing a license
405 under chapter 395, chapter 400, chapter 429, chapter 458,
406 chapter 459, chapter 460, chapter 461, or chapter 641 who

25-01013C-11

20111930__

407 charges or receives compensation for any use of medical
408 equipment and is not the 100-percent owner or the 100-percent
409 lessee of such equipment. For purposes of this section, such
410 owner or lessee may be an individual, a corporation, a
411 partnership, or any other entity and any of its 100-percent-
412 owned affiliates and subsidiaries. For purposes of this
413 subsection, the term "lessee" means a long-term lessee under a
414 capital or operating lease, but does not include a part-time
415 lessee. The term "broker" does not include a hospital or
416 physician management company whose medical equipment is
417 ancillary to the practices managed, a debt collection agency, or
418 an entity that has contracted with the insurer to obtain a
419 discounted rate for such services; or ~~nor does the term include~~
420 a management company that has contracted to provide general
421 management services for a licensed physician or health care
422 facility and whose compensation is not materially affected by
423 the usage or frequency of usage of medical equipment or an
424 entity that is 100-percent owned by one or more hospitals or
425 physicians. The term "broker" does not include a person or
426 entity that certifies, upon request of an insurer, that:

- 427 (a) It is a clinic licensed under ss. 400.990-400.995;
428 (b) It is a 100-percent owner of medical equipment; and
429 (c) The owner's only part-time lease of medical equipment
430 for personal injury protection patients is on a temporary basis,
431 not to exceed 30 days in a 12-month period, and such lease is
432 solely for the purposes of necessary repair or maintenance of
433 the 100-percent-owned medical equipment or pending the arrival
434 and installation of the newly purchased or a replacement for the
435 100-percent-owned medical equipment, or for patients for whom,

25-01013C-11

20111930__

436 because of physical size or claustrophobia, it is determined by
437 the medical director or clinical director to be medically
438 necessary that the test be performed in medical equipment that
439 is open-style. The leased medical equipment may not ~~cannot~~ be
440 used by patients who are not patients of the registered clinic
441 ~~for medical treatment of services~~. Any person or entity making a
442 false certification under this subsection commits insurance
443 fraud as defined in s. 817.234. However, the 30-day period
444 ~~provided in this paragraph~~ may be extended for an additional 60
445 days as applicable to magnetic resonance imaging equipment if
446 the owner certifies that the extension otherwise complies with
447 this paragraph.

448 (9) ~~(2)~~ "Medically necessary" refers to a medical service or
449 supply that a prudent physician would provide for the purpose of
450 preventing, diagnosing, or treating an illness, injury, disease,
451 or symptom in a manner that is:

452 (a) In accordance with generally accepted standards of
453 medical practice;

454 (b) Clinically appropriate in terms of type, frequency,
455 extent, site, and duration; and

456 (c) Not primarily for the convenience of the patient,
457 physician, or other health care provider.

458 (10) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
459 with four or more wheels which is of a type both designed and
460 required to be licensed for use on the highways of this state,
461 and any trailer or semitrailer designed for use with such
462 vehicle, and includes:

463 (a) A "private passenger motor vehicle," which is any motor
464 vehicle that ~~which~~ is a sedan, station wagon, or jeep-type

25-01013C-11

20111930__

465 vehicle and, if not used primarily for occupational,
466 professional, or business purposes, a motor vehicle of the
467 pickup, panel, van, camper, or motor home type.

468 (b) A "commercial motor vehicle," which is any motor
469 vehicle that ~~which~~ is not a private passenger motor vehicle.

470

471 The term "~~motor vehicle~~" does not include a mobile home or any
472 motor vehicle that ~~which~~ is used in mass transit, other than
473 public school transportation, and designed to transport more
474 than five passengers exclusive of the operator of the motor
475 vehicle and that ~~which~~ is owned by a municipality, a transit
476 authority, or a political subdivision of the state.

477 (11)~~(4)~~ "Named insured" means a person, usually the owner
478 of a vehicle, identified in a policy by name as the insured
479 under the policy.

480 (12) "No-fault law" means the Florida Motor Vehicle No-
481 Fault Law codified at ss. 627.730-627.7407.

482 (13)~~(5)~~ "Owner" means a person who holds the legal title to
483 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
484 subject of a security agreement or lease with an option to
485 purchase with the debtor or lessee having the right to
486 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
487 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.

488 (15)~~(6)~~ "Relative residing in the same household" means a
489 relative of any degree by blood or by marriage who usually makes
490 her or his home in the same family unit, whether or not
491 temporarily living elsewhere.

492 (2)~~(7)~~ "Certify" means to swear or attest to being true or
493 represented in writing.

25-01013C-11

20111930__

494 (3) "Claimant" means the person, organization, or entity
495 seeking benefits, including all assignees.

496 (5)~~(8)~~ "Immediate personal supervision," as it relates to
497 the performance of medical services by nonphysicians not in a
498 hospital, means that an individual licensed to perform the
499 medical service or provide the medical supplies must be present
500 within the confines of the physical structure where the medical
501 services are performed or where the medical supplies are
502 provided such that the licensed individual can respond
503 immediately to any emergencies if needed.

504 (6)~~(9)~~ "Incident," with respect to services considered as
505 incident to a physician's professional service, for a physician
506 licensed under chapter 458, chapter 459, chapter 460, or chapter
507 461, if not furnished in a hospital, means ~~such~~ services that
508 are must be an integral, even if incidental, part of a covered
509 physician's service.

510 (7)~~(10)~~ "Knowingly" means that a person, with respect to
511 information, has actual knowledge of the information,+ acts in
512 deliberate ignorance of the truth or falsity of the
513 information,+ or acts in reckless disregard of the information.+
514 ~~and~~ Proof of specific intent to defraud is not required.

515 (8)~~(11)~~ "Lawful" or "lawfully" means in substantial
516 compliance with all relevant applicable criminal, civil, and
517 administrative requirements of state and federal law related to
518 the provision of medical services or treatment.

519 (4)~~(12)~~ "Hospital" means a facility that, at the time
520 services or treatment were rendered, was licensed under chapter
521 395.

522 (14)~~(13)~~ "Properly completed" means providing truthful,

25-01013C-11

20111930__

523 substantially complete, and substantially accurate responses ~~as~~
 524 to all material elements of ~~to~~ each applicable request for
 525 information or statement by a means that may lawfully be
 526 provided and that complies with this section, or as agreed by
 527 the parties.

528 (17)~~(14)~~ "Upcoding" means submitting ~~an action that submits~~
 529 a billing code that would result in payment greater in amount
 530 than would be paid using a billing code that accurately
 531 describes the services performed. The term does not include an
 532 otherwise lawful bill by a magnetic resonance imaging facility,
 533 which globally combines both technical and professional
 534 components, if the amount of the global bill is not more than
 535 the components if billed separately; however, payment of such a
 536 bill constitutes payment in full for all components of such
 537 service.

538 (16)~~(15)~~ "Unbundling" means submitting ~~an action that~~
 539 ~~submits~~ a billing code that is properly billed under one billing
 540 code, but that has been separated into two or more billing
 541 codes, ~~and~~ would result in payment greater than the ~~in~~ amount
 542 that ~~than~~ would be paid using one billing code.

543 Section 8. Subsections (1) and (4) of section 627.736,
 544 Florida Statutes, are amended, subsections (5) through (16) of
 545 that section are redesignated as subsections (6) through (17),
 546 respectively, a new subsection (5) is added to that section,
 547 present subsection (5), paragraph (b) of present subsection (6),
 548 paragraph (b) of present subsection (7), and present subsections
 549 (8), (9), and (10) of that section are amended, to read:

550 627.736 Required personal injury protection benefits;
 551 exclusions; priority; claims.-

25-01013C-11

20111930__

552 (1) REQUIRED BENEFITS.—Every insurance policy complying
553 with the security requirements of s. 627.733 must ~~shall~~ provide
554 personal injury protection to the named insured, relatives
555 residing in the same household, persons operating the insured
556 motor vehicle, passengers in such motor vehicle, and other
557 persons struck by such motor vehicle and suffering bodily injury
558 while not an occupant of a self-propelled vehicle, subject to
559 ~~the provisions of~~ subsection (2) and paragraph (4)(g) ~~(4)(e)~~, to
560 a limit of \$10,000 for loss sustained by ~~any~~ such person as a
561 result of bodily injury, sickness, disease, or death arising out
562 of the ownership, maintenance, or use of a motor vehicle as
563 follows:

564 (a) *Medical benefits.*—Eighty percent of all reasonable
565 expenses, charged pursuant to subsection (6), for medically
566 necessary medical, surgical, X-ray, dental, and rehabilitative
567 services, including prosthetic devices, and for medically
568 necessary ambulance, hospital, and nursing services. However,
569 the medical benefits ~~shall~~ provide reimbursement only for such
570 services and care that are lawfully provided, supervised,
571 ordered, or prescribed by a physician licensed under chapter 458
572 or chapter 459, a dentist licensed under chapter 466, or a
573 chiropractic physician licensed under chapter 460 or that are
574 provided by any of the following ~~persons or entities~~:

575 1. A hospital or ambulatory surgical center licensed under
576 chapter 395.

577 2. A person or entity licensed under part III of chapter
578 401 which ss. 401.2101-401.45 ~~that~~ provides emergency
579 transportation and treatment.

580 3. An entity wholly owned by one or more physicians

25-01013C-11

20111930__

581 licensed under chapter 458 or chapter 459, chiropractic
582 physicians licensed under chapter 460, or dentists licensed
583 under chapter 466 or by such ~~practitioner or~~ practitioners and
584 the spouse, parent, child, or sibling of such ~~that practitioner~~
585 ~~or these~~ practitioners.

586 4. An entity wholly owned, directly or indirectly, by a
587 hospital or hospitals.

588 5. A health care clinic licensed under part X of chapter
589 400 which ~~ss. 400.990-400.995 that~~ is:

590 a. Accredited by the Joint Commission on Accreditation of
591 Healthcare Organizations, the American Osteopathic Association,
592 the Commission on Accreditation of Rehabilitation Facilities, or
593 the Accreditation Association for Ambulatory Health Care, Inc.;

594 or

595 b. A health care clinic that:

596 (I) Has a medical director licensed under chapter 458,
597 chapter 459, or chapter 460;

598 (II) Has been continuously licensed for more than 3 years
599 or is a publicly traded corporation that issues securities
600 traded on an exchange registered with the United States
601 Securities and Exchange Commission as a national securities
602 exchange; and

603 (III) Provides at least four of the following medical
604 specialties:

605 (A) General medicine.

606 (B) Radiography.

607 (C) Orthopedic medicine.

608 (D) Physical medicine.

609 (E) Physical therapy.

25-01013C-11

20111930__

610 (F) Physical rehabilitation.

611 (G) Prescribing or dispensing outpatient prescription
612 medication.

613 (H) Laboratory services.

614

615 If any services under this paragraph are provided by an entity
616 or clinic described in subparagraph 3., subparagraph 4., or
617 subparagraph 5., the entity or clinic must provide the insurer
618 at the initial submission of the claim with a form adopted by
619 the Department of Financial Services which documents that the
620 entity or clinic meets applicable criteria for such entity or
621 clinic and includes a sworn statement or affidavit to that
622 effect. Any change in ownership requires the filing of a new
623 form within 10 days after the date of the change in ownership.

624 ~~The Financial Services Commission shall adopt by rule the form~~
625 ~~that must be used by an insurer and a health care provider~~
626 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
627 ~~5. to document that the health care provider meets the criteria~~
628 ~~of this paragraph, which rule must include a requirement for a~~
629 ~~sworn statement or affidavit.~~

630 (b) *Disability benefits.*—Sixty percent of any loss of gross
631 income and loss of earning capacity per individual from
632 inability to work proximately caused by the injury sustained by
633 the injured person, plus all expenses reasonably incurred in
634 obtaining from others ordinary and necessary services in lieu of
635 those that, but for the injury, the injured person would have
636 performed without income for the benefit of his or her
637 household. All disability benefits payable under this provision
638 must shall be paid at least not less than every 2 weeks.

25-01013C-11

20111930__

639 (c) *Death benefits.*—Death benefits equal to the lesser of
 640 \$5,000 or the remainder of unused personal injury protection
 641 benefits per individual. The insurer may pay such benefits to
 642 the executor or administrator of the deceased, to any of the
 643 deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection~~
 644 ~~by~~ marriage, or to any person appearing to the insurer to be
 645 equitably entitled thereto.

646
 647 Only insurers writing motor vehicle liability insurance in this
 648 state may provide the required benefits of this section, and ~~no~~
 649 such insurers may not ~~insurer shall~~ require the purchase of any
 650 other motor vehicle coverage other than the purchase of property
 651 damage liability coverage as required by s. 627.7275 as a
 652 condition for providing such ~~required~~ benefits. Insurers may not
 653 require that property damage liability insurance in an amount
 654 greater than \$10,000 be purchased in conjunction with personal
 655 injury protection. Such insurers shall make benefits and
 656 required property damage liability insurance coverage available
 657 through normal marketing channels. An ~~Any~~ insurer writing motor
 658 vehicle liability insurance in this state who fails to comply
 659 with such availability requirement as a general business
 660 practice violates ~~shall be deemed to have violated~~ part IX of
 661 chapter 626, and such violation constitutes ~~shall constitute~~ an
 662 unfair method of competition or an unfair or deceptive act or
 663 practice involving the business of insurance. An ~~and any such~~
 664 insurer committing such violation is ~~shall be~~ subject to the
 665 penalties afforded in such part, as well as those that are ~~which~~
 666 ~~may be~~ afforded elsewhere in the insurance code.

667 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under

25-01013C-11

20111930__

668 the no-fault law are ~~ss. 627.730-627.7405~~ shall be primary,
669 except that benefits received under any workers' compensation
670 law shall be credited against the benefits provided by
671 subsection (1) and are ~~shall be~~ due and payable as loss accrues,
672 upon the receipt of reasonable proof of such loss and the amount
673 of expenses and loss incurred which are covered by the policy
674 issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the
675 Agency for Health Care Administration provides, pays, or becomes
676 liable for medical assistance under the Medicaid program related
677 to injury, sickness, disease, or death arising out of the
678 ownership, maintenance, or use of a motor vehicle, the benefits
679 are ~~under ss. 627.730-627.7405~~ shall be subject to the
680 provisions of the Medicaid program.

681 (a) An insurer may require written notice to be given as
682 soon as practicable after an accident involving a motor vehicle
683 with respect to which the policy affords the security required
684 by the no-fault law ~~ss. 627.730-627.7405~~.

685 (b) Personal injury protection insurance benefits paid
686 pursuant to this section are ~~shall be~~ overdue if not paid within
687 30 days after the insurer is furnished written notice of the
688 fact of a covered loss and of the amount of same. If such
689 written notice is not furnished to the insurer as to the entire
690 claim, any partial amount supported by written notice is overdue
691 if not paid within 30 days after such written notice is
692 furnished to the insurer. Any part or all of the remainder of
693 the claim that is subsequently supported by written notice is
694 overdue if not paid within 30 days after such written notice is
695 furnished to the insurer.

696 (c) ~~If~~ ~~When~~ an insurer pays only a portion of a claim or

25-01013C-11

20111930__

697 rejects a claim, the insurer shall provide at the time of the
698 partial payment or rejection an itemized specification of each
699 item that the insurer had reduced, omitted, or declined to pay
700 and any information that the insurer desires the claimant to
701 consider related to the medical necessity of the denied
702 treatment or to explain the reasonableness of the reduced
703 charge, provided that this does ~~shall~~ not limit the introduction
704 of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the
705 name and address of the person to whom the claimant should
706 respond and a claim number to be referenced in future
707 correspondence. An insurer's failure to send an itemized
708 specification or explanation of benefits does not waive any
709 ground for rejecting an invalid claim.

710 (d) A ~~However, notwithstanding the fact that written notice~~
711 ~~has been furnished to the insurer, Any payment is shall not be~~
712 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~
713 ~~establish~~ that the insurer is not responsible for the payment.
714 An insurer may define "reasonable proof" in its policy and may
715 request information that will aid it in its investigation of a
716 claim. An insurer may obtain evidence and assert any ground for
717 adjustment or rejection of a ~~For the purpose of calculating the~~
718 ~~extent to which any benefits are overdue, payment shall be~~
719 ~~treated as being made on the date a draft or other valid~~
720 ~~instrument which is equivalent to payment was placed in the~~
721 ~~United States mail in a properly addressed, postpaid envelope~~
722 ~~or, if not so posted, on the date of delivery. This paragraph~~
723 ~~does not preclude or limit the ability of the insurer to assert~~
724 ~~that the claim~~ that is ~~was~~ unrelated, ~~was~~ not medically
725 necessary, ~~or was unreasonable, or submitted that the amount of~~

25-01013C-11

20111930__

726 ~~the charge was in excess of that permitted under, or in~~
727 ~~violation of, subsection (6) (5). Such assertion by the insurer~~
728 ~~may be made~~ at any time, including after payment of the claim,
729 ~~or~~ after the 30-day ~~time~~ period for payment set forth in ~~this~~
730 paragraph (b), or after the filing of a lawsuit. The 30-day
731 period for payment is tolled while the insurer investigates a
732 fraudulent insurance act, as defined in s. 626.989, with respect
733 to any portion of a claim for which the insurer has a reasonable
734 belief that a fraudulent insurance act has been committed. The
735 insurer must notify the claimant in writing that it is
736 investigating a fraudulent insurance act within 30 days after
737 the date it has a reasonable belief that such act has been
738 committed. The insurer must pay or deny the claim, in full or in
739 part, within 120 days after the date the written notice of the
740 fact of a covered loss and of the amount of the loss was
741 provided to the insurer.

742 (e) ~~(e)~~ Upon receiving notice of an accident that is
743 potentially covered by personal injury protection benefits, the
744 insurer must reserve \$5,000 of personal injury protection
745 benefits for payment to physicians licensed under chapter 458 or
746 chapter 459 or dentists licensed under chapter 466 who provide
747 emergency services and care, as defined in s. 395.002~~(9)~~, or who
748 provide hospital inpatient care. The amount required to be held
749 in reserve may be used only to pay claims from such physicians
750 or dentists until 30 days after the date the insurer receives
751 notice of the accident. After the 30-day period, any amount of
752 the reserve for which the insurer has not received notice of
753 such a claim from a physician or dentist who provided emergency
754 services and care or who provided hospital inpatient care may

25-01013C-11

20111930__

755 ~~then~~ be used by the insurer to pay other claims. The time
756 periods specified in paragraph (b) for ~~required~~ payment of
757 personal injury protection benefits are ~~shall be~~ tolled for the
758 period of time that an insurer is required ~~by this paragraph~~ to
759 hold payment of a claim that is not from a physician or dentist
760 who provided emergency services and care or who provided
761 hospital inpatient care to the extent that the personal injury
762 protection benefits not held in reserve are insufficient to pay
763 the claim. This paragraph does not require an insurer to
764 establish a claim reserve for insurance accounting purposes.

765 (f) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
766 the rate established under s. 55.03 or the rate established in
767 the insurance contract, whichever is greater, for the year in
768 which the payment became overdue, calculated from the date the
769 insurer was furnished with written notice of the amount of
770 covered loss. Interest is ~~shall be~~ due at the time payment of
771 the overdue claim is made.

772 (g) ~~(e)~~ The insurer of the owner of a motor vehicle shall
773 pay personal injury protection benefits for:

774 1. Accidental bodily injury sustained in this state by the
775 owner while occupying a motor vehicle, or while not an occupant
776 of a self-propelled vehicle if the injury is caused by physical
777 contact with a motor vehicle.

778 2. Accidental bodily injury sustained outside this state,
779 but within the United States of America or its territories or
780 possessions or Canada, by the owner while occupying the owner's
781 motor vehicle.

782 3. Accidental bodily injury sustained by a relative of the
783 owner residing in the same household, under the circumstances

25-01013C-11

20111930__

784 described in subparagraph 1. or subparagraph 2. if, ~~provided~~ the
785 relative at the time of the accident is domiciled in the owner's
786 household and is not ~~himself or herself~~ the owner of a motor
787 vehicle with respect to which security is required under the no-
788 fault law ss. ~~627.730-627.7405.~~

789 4. Accidental bodily injury sustained in this state by any
790 other person while occupying the owner's motor vehicle or, if a
791 resident of this state, while not an occupant of a self-
792 propelled vehicle, if the injury is caused by physical contact
793 with such motor vehicle if, ~~provided~~ the injured person is not
794 ~~himself or herself~~:

795 a. The owner of a motor vehicle with respect to which
796 security is required under the no-fault law ss. ~~627.730-~~
797 ~~627.7405;~~ or

798 b. Entitled to personal injury benefits from the insurer of
799 the owner ~~or owners~~ of such a motor vehicle.

800 (h)~~(f)~~ If two or more insurers are liable to pay personal
801 injury protection benefits for the same injury to any one
802 person, the maximum payable is ~~shall be~~ as specified in
803 subsection (1), and any insurer paying the benefits is ~~shall be~~
804 entitled to recover from each of the other insurers an equitable
805 pro rata share of the benefits paid and expenses incurred in
806 processing the claim.

807 (i)~~(g)~~ It is a violation of the insurance code for an
808 insurer to fail to timely provide benefits as required by this
809 section with such frequency as to constitute a general business
810 practice.

811 (j)~~(h)~~ Benefits are ~~shall~~ not be due or payable to or on
812 the behalf of an insured, claimant, medical provider, or

25-01013C-11

20111930__

813 attorney who: ~~person if that person has~~

814 1. Submits a false or misleading statement, document,
815 record, or bill;

816 2. Submits false or misleading information; or

817 3. Has otherwise committed or attempted to commit a
818 fraudulent insurance act as defined in s. 626.989.

819

820 A claimant that violates this paragraph is not entitled to any
821 personal injury protection benefits or payment for any bills and
822 services, regardless of whether a portion of the claim may be
823 legitimate.

824 (k) Notwithstanding any remedies afforded by law, the
825 insurer may recover from a claimant that has violated paragraph
826 (j) any sums previously paid to the claimant and may bring any
827 available common law and statutory causes of action. An insured,
828 claimant, medical provider, or attorney has committed, by a
829 material act or omission, ~~any~~ insurance fraud relating to
830 personal injury protection coverage under his or her policy or a
831 claim for attorney's fees, if the fraud is admitted to in a
832 sworn statement ~~by the insured or if it is~~ established in a
833 court of competent jurisdiction. Any insurance fraud voids ~~shall~~
834 ~~void~~ all coverage arising from the claim and all claims for
835 attorney's fees ~~related to such fraud under the personal injury~~
836 ~~protection coverage of the insured person who committed the~~
837 ~~fraud~~, irrespective of whether a portion of the insured person's
838 claim may be legitimate, and any benefits or attorney's fees
839 paid before ~~prior to~~ the discovery of the ~~insured person's~~
840 ~~insurance~~ fraud is ~~shall be~~ recoverable by the insurer from the
841 person who committed insurance fraud in their entirety. The

25-01013C-11

20111930__

842 prevailing party is entitled to its costs and attorney's fees in
843 any action in which it prevails in an insurer's action to
844 enforce its right of recovery under this paragraph. This
845 paragraph does not preclude or limit an insurer's right to deny
846 a claim based on other evidence of fraud or affect an insurer's
847 right to plead and prove a claim or defense of fraud under
848 common law. If a physician, hospital, clinic, or other medical
849 institution violates paragraph (j), the injured party is not
850 liable for, and the physician, hospital, clinic, or other
851 medical institution may not bill the insured for, charges that
852 are unpaid because of failure to comply with paragraph (j). Any
853 agreement requiring the injured person or insured to pay for
854 such charges is unenforceable.

855 (5) INSURER INVESTIGATIONS.—An insurer has the right and
856 duty to conduct a reasonable investigation of a claim. In the
857 course of the insurer's investigation of a claim:

858 (a) The insurer may require the insured, claimant, or
859 medical provider to provide copies of the treatment and
860 examination records so that the insurer can provide such records
861 to a physician for a records review. A records review need not
862 be based on a physical examination and may be obtained at any
863 time, including after reduction or denial of the claim. The 30-
864 day period for payment under paragraph (4) (b) is tolled from the
865 date the insurer sends its request for treatment records to the
866 date that the insurer receives the treatment records. The claim
867 may be denied or reduced if the medical provider fails to keep
868 adequate records such that the insurer is unable to obtain a
869 records review.

870 (b) An insurer's choice of physician is not limited by the

25-01013C-11

20111930

871 physician's area of practice or licensing chapter.

872 (c) An insurer may deny benefits if the insured, claimant,
873 or medical provider fails to comply with this subsection.

874 (d) An insurer may deny benefits if the insured, claimant,
875 or medical provider fails to cooperate in the insurer's
876 investigation.

877 (e) An insurer may deny benefits if the insured, claimant,
878 or medical provider commits a fraud or material
879 misrepresentation.

880 (f) The claimant may not file suit unless and until it
881 complies with this subsection.

882 (6) ~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.-

883 (a) ~~1-~~ Any physician, hospital, clinic, or other person or
884 institution lawfully rendering treatment to an injured person
885 for a bodily injury covered by personal injury protection
886 insurance may charge the insurer and injured party only a
887 reasonable amount pursuant to this section for the services and
888 supplies rendered, and the insurer providing such coverage may
889 pay for such charges directly to such person or institution
890 lawfully rendering such treatment, if the insured receiving such
891 treatment or his or her guardian has countersigned the properly
892 completed invoice, bill, or claim form approved by the office
893 upon which such charges are to be paid for as having actually
894 been rendered, to the best knowledge of the insured or his or
895 her guardian. ~~In no event,~~ However, may such a charge may not
896 exceed ~~be in excess of~~ the amount the person or institution
897 customarily charges for like services or supplies. When
898 determining ~~With respect to a determination of~~ whether a charge
899 for a particular service, treatment, or otherwise is reasonable,

25-01013C-11

20111930__

900 consideration may be given to evidence of usual and customary
901 charges and payments accepted by the provider involved in the
902 dispute, ~~and~~ reimbursement levels in the community and various
903 federal and state medical fee schedules applicable to automobile
904 and other insurance coverages, and other information relevant to
905 the reasonableness of the reimbursement for the service,
906 treatment, or supply.

907 1.2- The insurer may limit reimbursement to 80 percent of
908 the following schedule of maximum charges:

909 a. For emergency transport and treatment by providers
910 licensed under chapter 401, 200 percent of Medicare.

911 b. For emergency services and care provided by a hospital
912 licensed under chapter 395, 75 percent of the hospital's usual
913 and customary charges.

914 c. For emergency services and care as defined by s.
915 395.002(9) provided in a facility licensed under chapter 395
916 rendered by a physician or dentist, and related hospital
917 inpatient services rendered by a physician or dentist, the usual
918 and customary charges in the community.

919 d. For hospital inpatient services, other than emergency
920 services and care, 200 percent of the Medicare Part A
921 prospective payment applicable to the specific hospital
922 providing the inpatient services.

923 e. For hospital outpatient services, other than emergency
924 services and care, 200 percent of the Medicare Part A Ambulatory
925 Payment Classification for the specific hospital providing the
926 outpatient services.

927 f. For all other medical services, supplies, and care, 200
928 percent of the allowable amount under the participating

25-01013C-11

20111930__

929 physicians schedule of Medicare Part B. However, if such
930 services, supplies, or care is not reimbursable under Medicare
931 Part B, the insurer may limit reimbursement to 80 percent of the
932 maximum reimbursable allowance under workers' compensation, as
933 determined under s. 440.13 and rules adopted thereunder which
934 are in effect at the time such services, supplies, or care is
935 provided. Services, supplies, or care that is not reimbursable
936 under Medicare or workers' compensation is not required to be
937 reimbursed by the insurer.

938 2.3. For purposes of subparagraph 1. 2., the applicable fee
939 schedule or payment limitation under Medicare is the fee
940 schedule or payment limitation in effect on January 1 of the
941 year in which ~~at the time~~ the services, supplies, or care was
942 rendered and for the area in which such services were rendered,
943 notwithstanding any subsequent changes made to such fee schedule
944 or payment limitation, except that it may not be less than the
945 allowable amount under the participating physicians schedule of
946 Medicare Part B for 2007 for medical services, supplies, and
947 care subject to Medicare Part B.

948 3.4. Subparagraph 1. 2. does not allow the insurer to apply
949 any limitation on the number of treatments or other utilization
950 limits that apply under Medicare or workers' compensation. An
951 insurer that applies the allowable payment limitations of
952 subparagraph 1. 2. must reimburse a provider who lawfully
953 provided care or treatment under the scope of his or her
954 license, ~~regardless of whether such provider is~~ would be
955 entitled to reimbursement under Medicare due to restrictions or
956 limitations on the types or discipline of health care providers
957 who may be reimbursed for particular procedures or procedure

25-01013C-11

20111930__

958 codes.

959 ~~4.5.~~ If an insurer limits payment as authorized by
960 subparagraph 1. 2., the person providing such services,
961 supplies, or care may not bill or attempt to collect from the
962 insured any amount in excess of such limits, except for amounts
963 that are not covered by the insured's personal injury protection
964 coverage due to the coinsurance amount or maximum policy limits.

965 (b)1. An insurer or insured is not required to pay a claim
966 or charges:

967 a. Made by a broker or by a person making a claim on behalf
968 of a broker;

969 b. For any service or treatment that was not lawful at the
970 time rendered;

971 c. To any person who knowingly submits a false or
972 misleading statement relating to the claim or charges;

973 d. With respect to a bill or statement that does not
974 ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs
975 (c), paragraph (d), and (e);

976 e. If the insured has not countersigned the billing forms
977 and patient logs. As used in this sub-subparagraph, the term
978 "countersigned" means a second or verifying signature, as on a
979 previously signed document, and is not satisfied by the
980 statement "signature on file" or any similar statement;

981 ~~f.e.~~ For any treatment or service that is upcoded, or that
982 is unbundled if when such treatment or services should be
983 bundled, in accordance with paragraph (d). To facilitate prompt
984 payment of lawful services, an insurer may change codes that it
985 determines to have been improperly or incorrectly upcoded or
986 unbundled, and may make payment based on the changed codes,

25-01013C-11

20111930__

987 without affecting the right of the provider to dispute the
 988 change by the insurer ~~if, provided that~~ before doing so, the
 989 insurer contacts ~~must contact~~ the health care provider and
 990 discusses ~~discuss~~ the reasons for the insurer's change and the
 991 health care provider's reason for the coding, or makes ~~make~~ a
 992 reasonable good faith effort to do so, as documented in the
 993 insurer's file; and

994 g.f. For medical services or treatment billed by a
 995 physician and not provided in a hospital unless such services
 996 are rendered by the physician or are incident to his or her
 997 professional services and are included on the physician's bill,
 998 including documentation verifying that the physician is
 999 responsible for the medical services that were rendered and
 1000 billed.

1001 2. The Department of Health, in consultation with the
 1002 appropriate professional licensing boards, shall adopt, by rule,
 1003 a list of diagnostic tests deemed not to be medically necessary
 1004 for use in the treatment of persons sustaining bodily injury
 1005 covered by personal injury protection benefits under this
 1006 section. The ~~initial list shall be adopted by January 1, 2004,~~
 1007 ~~and~~ shall be revised from time to time as determined by the
 1008 Department of Health, in consultation with the respective
 1009 professional licensing boards. Inclusion of a test on the list
 1010 must ~~of invalid diagnostic tests shall~~ be based on lack of
 1011 demonstrated medical value and a level of general acceptance by
 1012 the relevant provider community and may ~~shall~~ not be dependent
 1013 for results entirely upon subjective patient response.
 1014 Notwithstanding its inclusion on a fee schedule in this
 1015 subsection, an insurer or insured is not required to pay any

25-01013C-11

20111930__

1016 charges or reimburse claims for any invalid diagnostic test as
 1017 determined by the Department of Health.

1018 (c)~~1.~~ With respect to any treatment or service, other than
 1019 medical services billed by a hospital or other provider for
 1020 emergency services as defined in s. 395.002 or inpatient
 1021 services rendered at a hospital-owned facility, the statement of
 1022 charges must be furnished to the insurer by the provider and may
 1023 not include, and the insurer is not required to pay, charges for
 1024 treatment or services rendered more than 35 days before the
 1025 postmark date or electronic transmission date of the statement,
 1026 except for past due amounts previously billed on a timely basis
 1027 under this paragraph, and except that, if the provider submits
 1028 to the insurer a notice of initiation of treatment within 21
 1029 days after its first examination or treatment of the claimant,
 1030 the statement may include charges for treatment or services
 1031 rendered up to, but not more than, 75 days before the postmark
 1032 date of the statement. The injured party is not liable for, and
 1033 the provider may ~~shall~~ not bill the injured party for, charges
 1034 that are unpaid because of the provider's failure to comply with
 1035 this paragraph. Any agreement requiring the injured person or
 1036 insured to pay for such charges is unenforceable.

1037 1.2. ~~If, however,~~ the insured fails to furnish the provider
 1038 with the correct name and address of the insured's personal
 1039 injury protection insurer, the provider has 35 days from the
 1040 date the provider obtains the correct information to furnish the
 1041 insurer with a statement of the charges. The insurer is not
 1042 required to pay for such charges unless the provider includes
 1043 with the statement documentary evidence that was provided by the
 1044 insured during the 35-day period demonstrating that the provider

25-01013C-11

20111930__

1045 reasonably relied on erroneous information from the insured and
1046 either:

1047 a. A denial letter from the incorrect insurer; or

1048 b. Proof of mailing, which may include an affidavit under
1049 penalty of perjury, reflecting timely mailing to the incorrect
1050 address or insurer.

1051 ~~2.3.~~ For emergency services and care as defined in s.
1052 395.002 rendered in a hospital emergency department or for
1053 transport and treatment rendered by an ambulance provider
1054 licensed pursuant to part III of chapter 401, the provider is
1055 not required to furnish the statement of charges within the time
1056 periods established by this paragraph,~~+~~ and the insurer is ~~shall~~
1057 not ~~be~~ considered to have been furnished with notice of the
1058 amount of covered loss for purposes of paragraph (4) (b) until it
1059 receives a statement complying with paragraph (d), or copy
1060 thereof, which specifically identifies the place of service to
1061 be a hospital emergency department or an ambulance in accordance
1062 with billing standards recognized by the Centers for Medicare
1063 and Medicaid Services Health Care Finance Administration.

1064 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
1065 must include the following statement in type no smaller than 12
1066 points:

1067
1068 BILLING REQUIREMENTS.—Florida Statutes provide that
1069 with respect to any treatment or services, other than
1070 certain hospital and emergency services, the statement
1071 of charges furnished to the insurer by the provider
1072 may not include, and the insurer and the injured party
1073 are not required to pay, charges for treatment or

25-01013C-11

20111930__

1074 services rendered more than 35 days before the
1075 postmark date of the statement, except for past due
1076 amounts previously billed on a timely basis, and
1077 except that, if the provider submits to the insurer a
1078 notice of initiation of treatment within 21 days after
1079 its first examination or treatment of the claimant,
1080 the first billing cycle statement may include charges
1081 for treatment or services rendered up to, but not more
1082 than, 75 days before the postmark date of the
1083 statement.

1084
1085 (d) All statements and bills for medical services rendered
1086 by any physician, hospital, clinic, or other person or
1087 institution shall be submitted to the insurer on a properly
1088 completed Centers for Medicare and Medicaid Services (CMS) 1500
1089 form, UB 92 forms, or any other standard form approved by the
1090 office or adopted by the commission for purposes of this
1091 paragraph. All billings for such services rendered by providers
1092 must ~~shall~~, to the extent applicable, follow the Physicians'
1093 Current Procedural Terminology (CPT) or Healthcare Correct
1094 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1095 year in which services are rendered and comply with the ~~Centers~~
1096 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
1097 and the American Medical Association Current Procedural
1098 Terminology (CPT) Editorial Panel and Healthcare Correct
1099 Procedural Coding System (HCPCS). All providers other than
1100 hospitals shall include on the applicable claim form the
1101 professional license number of the provider in the line or space
1102 provided for "Signature of Physician or Supplier, Including

25-01013C-11

20111930__

1103 Degrees or Credentials." In determining compliance with
1104 applicable CPT and HCPCS coding, guidance shall be provided by
1105 the Physicians' Current Procedural Terminology (CPT) or the
1106 Healthcare Correct Procedural Coding System (HCPCS) in effect
1107 for the year in which services were rendered, the Office of the
1108 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1109 other authoritative treatises designated by rule by the Agency
1110 for Health Care Administration. A ~~Ne~~ statement of medical
1111 services may not include charges for medical services of a
1112 person or entity that performed such services without possessing
1113 the valid licenses required to perform such services. For
1114 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
1115 considered to have been furnished with notice of the amount of
1116 covered loss or medical bills due unless the statements or bills
1117 are submitted on an approved form, follow the foregoing coding
1118 requirements, and contain the professional license number of the
1119 provider. The remaining portions of the statements and bills
1120 must be ~~comply with this paragraph, and unless the statements or~~
1121 ~~bills are properly completed in their entirety as to all~~
1122 ~~material provisions, with all relevant information being~~
1123 ~~provided therein.~~

1124 (e)1. At the initial treatment or service provided, each
1125 physician, other licensed professional, clinic, or other medical
1126 institution providing medical services upon which a claim for
1127 personal injury protection benefits is based shall require an
1128 insured person, or his or her guardian, to execute a disclosure
1129 and acknowledgment form, which reflects at a minimum that:

1130 a. The insured, or his or her guardian, must countersign
1131 the form attesting to the fact that the services set forth

25-01013C-11

20111930

1132 therein were actually rendered. The services shall be described
1133 and listed on the disclosure and acknowledgement form in words
1134 readable by the insured. If the insured cannot read, the
1135 provider should verify, under penalty of perjury, that the
1136 services listed on the form were verbally explained to the
1137 insured before the insured signs the form. Listing CPT codes or
1138 other coding on the disclosure and acknowledgment form does not
1139 satisfy this requirement;

1140 b. The insured, or his or her guardian, has both the right
1141 and affirmative duty to confirm that the services were actually
1142 rendered;

1143 c. The insured, or his or her guardian, was not solicited
1144 by any person to seek any services from the medical provider;

1145 d. The physician, other licensed professional, clinic, or
1146 other medical institution rendering services for which payment
1147 is being claimed explained the services to the insured or his or
1148 her guardian; and

1149 e. If the insured notifies the insurer in writing of a
1150 billing error, the insured may be entitled to a certain
1151 percentage of a reduction in the amounts paid by the insured's
1152 motor vehicle insurer.

1153 2. The physician, other licensed professional, clinic, or
1154 other medical institution rendering services for which payment
1155 is being claimed has the affirmative duty to explain the
1156 services rendered to the insured, or his or her guardian, so
1157 that the insured, or his or her guardian, countersigns the form
1158 with informed consent.

1159 3. Countersignature by the insured, or his or her guardian,
1160 is not required for the reading of diagnostic tests or other

25-01013C-11

20111930__

1161 services that are of such a nature that they are not required to
1162 be performed in the presence of the insured.

1163 4. The licensed medical professional rendering treatment
1164 for which payment is being claimed must sign, by his or her own
1165 hand, the form complying with this paragraph.

1166 5. An insurer is not considered to have been furnished with
1167 notice of the amount of a covered loss or medical bills unless
1168 the original completed disclosure and acknowledgment form is
1169 ~~shall be~~ furnished to the insurer pursuant to paragraph (4) (b)
1170 and sub-subparagraph 1.e. The disclosure and acknowledgement
1171 form may not be electronically furnished. A disclosure and
1172 acknowledgement form that does not meet the minimum requirements
1173 of sub-subparagraph 1.a. does not provide an insurer with notice
1174 of the amount of a covered loss or medical bills due.

1175 6. This disclosure and acknowledgment form is not required
1176 for services billed by a provider for emergency services as
1177 defined in s. 395.002, for emergency services and care as
1178 defined in s. 395.002 rendered in a hospital emergency
1179 department, or for transport and treatment rendered by an
1180 ambulance provider licensed pursuant to part III of chapter 401.

1181 7. The Financial Services Commission shall adopt~~7~~ by rule~~7~~
1182 a standard disclosure and acknowledgment form to that shall be
1183 used to fulfill the requirements of this paragraph~~, effective 90~~
1184 ~~days after such form is adopted and becomes final. The~~
1185 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1186 ~~the rule is final, the provider may use a form of its own which~~
1187 ~~otherwise complies with the requirements of this paragraph.~~

1188 8. As used in this paragraph, the term "countersigned" or
1189 "countersignature" means a second or verifying signature, as on

25-01013C-11

20111930__

1190 a previously signed document, and is not satisfied by the
1191 statement "signature on file" or any similar statement.

1192 9. The requirements of this paragraph apply only with
1193 respect to the initial treatment or service of the insured by a
1194 provider. For subsequent treatments or service, the provider
1195 must maintain a patient log signed by the patient, in
1196 chronological order by date of service, which describes the
1197 treatment rendered in a language readable by the insured ~~that is~~
1198 ~~consistent with the services being rendered to the patient as~~
1199 ~~claimed.~~ Listing CPT codes or other coding on the patient log
1200 does not satisfy this requirement. The provider must provide
1201 copies of the patient log to the insurer within 30 days after
1202 receiving a written request from the insurer. Failure to
1203 maintain a patient log renders the treatment unlawful and
1204 noncompensable. The requirements ~~of this subparagraph~~ for
1205 maintaining a patient log signed by the patient may be met by a
1206 hospital that maintains medical records as required by s.
1207 395.3025 and applicable rules and makes such records available
1208 to the insurer upon request.

1209 (f) Upon written notification by any person, an insurer
1210 shall investigate any claim of improper billing by a physician
1211 or other medical provider. The insurer shall determine if the
1212 insured was properly billed for only those services and
1213 treatments that the insured actually received. If the insurer
1214 determines that the insured has been improperly billed, the
1215 insurer shall notify the insured, the person making the written
1216 notification, and the provider of its findings and ~~shall~~ reduce
1217 the amount of payment to the provider by the amount determined
1218 to be improperly billed. If a reduction is made due to such

25-01013C-11

20111930__

1219 written notification by any person, the insurer shall pay to the
 1220 person 20 percent of the amount of the reduction, up to \$500. If
 1221 the provider is arrested due to the improper billing, ~~then~~ the
 1222 insurer shall pay to the person 40 percent of the amount of the
 1223 reduction, up to \$500.

1224 (g) An insurer may not systematically downcode with the
 1225 intent to deny reimbursement otherwise due. Such action
 1226 constitutes a material misrepresentation under s.
 1227 626.9541(1)(i)2.

1228 (7)~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
 1229 DISPUTES.—

1230 (b) Every physician, hospital, clinic, or other medical
 1231 institution providing, before or after bodily injury upon which
 1232 a claim for personal injury protection insurance benefits is
 1233 based, any products, services, or accommodations in relation to
 1234 that or any other injury, or in relation to a condition claimed
 1235 to be connected with that or any other injury, shall, if
 1236 requested to do so by the insurer against whom the claim has
 1237 been made, permit the insurer or the insurer's representative to
 1238 conduct an onsite physical review and examination of the
 1239 treatment location, treatment apparatuses, diagnostic devices,
 1240 and any other medical equipment used for the services rendered
 1241 within 10 days after the insurer's request, and furnish
 1242 ~~forthwith~~ a written report of the history, condition, treatment,
 1243 dates, and costs of such treatment of the injured person and why
 1244 the items identified by the insurer were reasonable in amount
 1245 and medically necessary, together with a sworn statement that
 1246 the treatment or services rendered were reasonable and necessary
 1247 with respect to the bodily injury sustained and identifying

25-01013C-11

20111930__

1248 which portion of the expenses for such treatment or services was
1249 incurred as a result of such bodily injury, and produce
1250 forthwith, and permit the inspection and copying of, his or her
1251 or its records regarding such history, condition, treatment,
1252 dates, and costs of treatment if, ~~provided that this does shall~~
1253 not limit the introduction of evidence at trial. Such sworn
1254 statement must ~~shall~~ read as follows: "Under penalty of perjury,
1255 I declare that I have read the foregoing, and the facts alleged
1256 are true, to the best of my knowledge and belief." A ~~No~~ cause of
1257 action for violation of the physician-patient privilege or
1258 invasion of the right of privacy may not be brought ~~shall be~~
1259 ~~permitted~~ against any physician, hospital, clinic, or other
1260 medical institution complying with ~~the provisions of this~~
1261 section. The person requesting such records and such sworn
1262 statement shall pay all reasonable costs connected therewith. If
1263 an insurer makes a written request for documentation or
1264 information under this paragraph within 30 days after having
1265 received notice of the amount of a covered loss under paragraph
1266 (4) (a), the amount or the partial amount that ~~which~~ is the
1267 subject of the insurer's inquiry is ~~shall become~~ overdue if the
1268 insurer does not pay in accordance with paragraph (4) (b) or
1269 within 10 days after the insurer's receipt of the requested
1270 documentation or information, whichever occurs later. For
1271 purposes of this paragraph, the term "receipt" includes, but is
1272 not limited to, inspection and copying pursuant to this
1273 paragraph. An ~~Any~~ insurer that requests documentation or
1274 information pertaining to reasonableness of charges or medical
1275 necessity under this paragraph without a reasonable basis for
1276 such requests as a general business practice is engaging in an

25-01013C-11

20111930__

1277 unfair trade practice under the insurance code. If an insured
1278 seeking to recover benefits pursuant to the no-fault law assigns
1279 the contractual right to those benefits or payment to any person
1280 or entity, the assignee must comply with the terms of the
1281 policy, and both the insured and the assignee are obligated to
1282 cooperate under the policy, including, but not limited to,
1283 submitting to examinations under oath. Compliance with this
1284 paragraph is a condition precedent to recovery of benefits
1285 pursuant to the no-fault law. If an insurer requests an
1286 examination under oath of a medical provider, the provider must
1287 produce the persons having the most knowledge of the issues
1288 identified by the insurer in the request for examination. All
1289 claimants must produce and provide for inspection all documents
1290 requested by the insurer which are reasonably obtainable by the
1291 claimants. Examinations under oath may be recorded by audio,
1292 video, court reporter, or any combination thereof. An insurer
1293 that, as a general practice, requests examinations under oath
1294 without a reasonable basis is engaging in an unfair and
1295 deceptive trade practice.

1296 (8)~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1297 REPORTS.—

1298 (b) If requested by the person examined, a party causing an
1299 examination to be made shall deliver to him or her a copy of
1300 every written report concerning the examination rendered by an
1301 examining physician, at least one of which reports must set out
1302 the examining physician's findings and conclusions in detail.
1303 After such request and delivery, the party causing the
1304 examination to be made is entitled, upon request, to receive
1305 from the person examined every written report available to him

25-01013C-11

20111930__

1306 or her or his or her representative concerning any examination,
 1307 previously or thereafter made, of the same mental or physical
 1308 condition. By requesting and obtaining a report of the
 1309 examination so ordered, or by taking the deposition of the
 1310 examiner, the person examined waives any privilege he or she may
 1311 have, in relation to the claim for benefits, regarding the
 1312 testimony of every other person who has examined, or may
 1313 thereafter examine, him or her in respect to the same mental or
 1314 physical condition. If a person unreasonably refuses to submit
 1315 to an examination, the personal injury protection carrier is no
 1316 longer liable for ~~subsequent~~ personal injury protection benefits
 1317 incurred after the date of the first request for examination.
 1318 Failure to appear for an examination raises a rebuttable
 1319 presumption that such failure was unreasonable. Submission to an
 1320 examination is a condition precedent to the recovery of
 1321 benefits.

1322 (9) ~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 1323 FEES.—With respect to any dispute ~~under the provisions of ss.~~
 1324 ~~627.730-627.7405~~ between the insured and the insurer under the
 1325 no-fault law, or between an assignee of an insured's rights and
 1326 the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as
 1327 provided in subsections (11) and (16) ~~(10) and (15)~~.

1328 (10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and
 1329 enter into contracts with preferred ~~licensed health care~~
 1330 providers for the benefits described in this section, ~~referred~~
 1331 ~~to in this section as "preferred providers,"~~ which include ~~shall~~
 1332 ~~include~~ health care providers licensed under chapter ~~chapters~~
 1333 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

1334 (a) The insurer may provide an option to an insured to use

25-01013C-11

20111930__

1335 a preferred provider at the time of purchase of the policy for
1336 personal injury protection benefits, if the requirements of this
1337 subsection are met. However, if the insurer offers a preferred
1338 provider option, it must also offer a nonpreferred provider
1339 policy. If the insured elects to use a provider who is not a
1340 preferred provider, whether the insured purchased a preferred
1341 provider policy or a nonpreferred provider policy, the medical
1342 benefits provided by the insurer shall be as required by this
1343 section.

1344 (b) If the insured elects the ~~to use a provider who is a~~
1345 preferred provider option, the insurer may pay medical benefits
1346 in excess of the benefits required by this section and may waive
1347 or lower the amount of any deductible that applies to such
1348 medical benefits. As an alternative, or in addition to such
1349 benefits, waiver, or reduction, the insurer may provide an
1350 actuarially appropriate premium discount as specified in an
1351 approved rate filing to an insured who selects the preferred
1352 provider option. If the preferred provider option provides a
1353 premium discount, the policy may provide that charges for
1354 nonemergency services provided within this state are payable
1355 only if performed by members of the preferred provider network
1356 unless there is no member of the preferred provider network
1357 located within 15 miles of the insured's place of residence
1358 whose scope of practice includes the required services. If the
1359 insurer offers a preferred provider policy to a policyholder or
1360 applicant, it must also offer a nonpreferred provider policy.

1361 (c) The insurer shall provide each insured ~~policyholder~~
1362 with a current roster of preferred providers in the county in
1363 which the insured resides at the time of purchasing ~~purchase of~~

25-01013C-11

20111930__

1364 such policy, and ~~shall~~ make such list available for public
1365 inspection during regular business hours at the insurer's
1366 principal office ~~of the insurer~~ within the state. The insurer
1367 may contract with a health insurer for the right to use an
1368 existing preferred provider network to implement the preferred
1369 provider option. Any other arrangement is subject to the
1370 approval of the Office of Insurance Regulation.

1371 (11)-(10) DEMAND LETTER.-

1372 (a) As a condition precedent to filing any action for
1373 benefits under this section, the claimant filing suit must
1374 provide the insurer ~~must be provided~~ with written notice of an
1375 intent to initiate litigation. Such notice may not be sent until
1376 the claim is overdue, including any additional time the insurer
1377 has to pay the claim pursuant to paragraph (4)(b). A premature
1378 demand letter is defective and cannot be cured unless the court
1379 first abates the action or the claimant first voluntarily
1380 dismisses the action.

1381 (b) The ~~notice~~ required notice must ~~shall~~ state that it is
1382 a "demand letter under s. 627.736(10)" and ~~shall~~ state with
1383 specificity:

1384 1. The name of the insured upon which such benefits are
1385 being sought, including a copy of the assignment giving rights
1386 to the claimant if the claimant is not the insured.

1387 2. The claim number or policy number upon which such claim
1388 was originally submitted to the insurer.

1389 3. To the extent applicable, the name of any medical
1390 provider who rendered to an insured the treatment, services,
1391 accommodations, or supplies that form the basis of such claim;
1392 and an itemized statement specifying each exact amount, the date

25-01013C-11

20111930__

1393 of treatment, service, or accommodation, and the type of benefit
1394 claimed to be due. A completed form satisfying the requirements
1395 of paragraph (6) ~~(5)~~ (d) or the lost-wage statement previously
1396 submitted may be used as the itemized statement. ~~To the extent~~
1397 ~~that the demand involves an insurer's withdrawal of payment~~
1398 ~~under paragraph (7) (a) for future treatment not yet rendered,~~
1399 ~~the claimant shall attach a copy of the insurer's notice~~
1400 ~~withdrawing such payment and an itemized statement of the type,~~
1401 ~~frequency, and duration of future treatment claimed to be~~
1402 ~~reasonable and medically necessary.~~

1403 (c) Each notice required by this subsection must be
1404 delivered to the insurer by United States certified or
1405 registered mail, return receipt requested. Such postal costs
1406 shall be reimbursed by the insurer if ~~so~~ requested by the
1407 claimant in the notice, when the insurer pays the claim. Such
1408 notice must be sent to the person and address specified by the
1409 insurer for the purposes of receiving notices under this
1410 subsection. Each licensed insurer, whether domestic, foreign, or
1411 alien, shall file with the office designation of the name and
1412 address of the person to whom notices must ~~pursuant to this~~
1413 ~~subsection shall~~ be sent which the office shall make available
1414 on its Internet website. The name and address on file with the
1415 office pursuant to s. 624.422 shall be deemed the authorized
1416 representative to accept notice pursuant to this subsection if
1417 ~~in the event~~ no other designation has been made.

1418 (d) If, within 30 days after receipt of notice by the
1419 insurer, the overdue claim specified in the notice is paid by
1420 the insurer together with applicable interest and a penalty of
1421 10 percent of the overdue amount paid by the insurer, subject to

25-01013C-11

20111930__

1422 a maximum penalty of \$250, no action may be brought against the
1423 insurer. ~~If the demand involves an insurer's withdrawal of~~
1424 ~~payment under paragraph (7) (a) for future treatment not yet~~
1425 ~~rendered, no action may be brought against the insurer if,~~
1426 ~~within 30 days after its receipt of the notice, the insurer~~
1427 ~~mails to the person filing the notice a written statement of the~~
1428 ~~insurer's agreement to pay for such treatment in accordance with~~
1429 ~~the notice and to pay a penalty of 10 percent, subject to a~~
1430 ~~maximum penalty of \$250, when it pays for such future treatment~~
1431 ~~in accordance with the requirements of this section. To the~~
1432 ~~extent~~ the insurer determines not to pay any amount demanded,
1433 the penalty is ~~shall not be~~ payable in any subsequent action.
1434 For purposes of this subsection, payment or the insurer's
1435 agreement is ~~shall be~~ treated as being made on the date a draft
1436 or other valid instrument that is equivalent to payment, or the
1437 insurer's written statement of agreement, is placed in the
1438 United States mail in a properly addressed, postpaid envelope,
1439 or if not so posted, on the date of delivery. The insurer is not
1440 obligated to pay any attorney's fees if the insurer pays the
1441 claim or mails its agreement to pay for future treatment within
1442 the time prescribed by this subsection.

1443 (e) The applicable statute of limitation for an action
1444 under this section shall be tolled for ~~a period of~~ 30 business
1445 days by the mailing of the notice required by this subsection.

1446 (f) A demand letter that does not meet the minimum
1447 requirements set forth in this subsection or that is sent during
1448 the pendency of the lawsuit is defective. A defective demand
1449 letter cannot be cured unless the court first abates the action
1450 or the claimant first voluntarily dismisses the action. If the

25-01013C-11

20111930__

1451 insurer pays the benefits during abatement or dismissal, the
 1452 insurer is not liable for attorney's fees.

1453 (g) ~~(f)~~ An ~~Any~~ insurer making a general business practice of
 1454 not paying valid claims until receipt of the notice required by
 1455 this subsection is engaging in an unfair trade practice under
 1456 the insurance code.

1457 (h) If the insurer pays in response to a demand letter and
 1458 the claimant disputes the amount paid, the claimant must send a
 1459 second demand letter by certified or registered mail stating the
 1460 exact amount that the claimant believes the insurer owes and why
 1461 the claimant believes the amount paid is incorrect. The insurer
 1462 has an additional 10 days after receipt of the second letter to
 1463 issue any additional payment that is owed. The purpose of this
 1464 provision is to avoid unnecessary litigation over miscalculated
 1465 payments.

1466 (i) Demand letters may not be used to request the
 1467 production of claim documents or other records from the insurer.

1468 Section 9. Subsection (1) of section 324.021, Florida
 1469 Statutes, is amended to read:

1470 324.021 Definitions; minimum insurance required.—The
 1471 following words and phrases when used in this chapter shall, for
 1472 the purpose of this chapter, have the meanings respectively
 1473 ascribed to them in this section, except in those instances
 1474 where the context clearly indicates a different meaning:

1475 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
 1476 is designed and required to be licensed for use upon a highway,
 1477 including trailers and semitrailers designed for use with such
 1478 vehicles, except traction engines, road rollers, farm tractors,
 1479 power shovels, and well drillers, and every vehicle that ~~which~~

25-01013C-11

20111930__

1480 is propelled by electric power obtained from overhead wires but
1481 not operated upon rails, but not including any bicycle or moped.
1482 However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~
1483 motor vehicle as defined in s. 627.732(3) if ~~when~~ the owner of
1484 such vehicle has complied with the no-fault law requirements ~~of~~
1485 ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s.
1486 324.051 apply; and, in such case, the applicable proof of
1487 insurance provisions of s. 320.02 apply.

1488 Section 10. Paragraph (k) of subsection (2) of section
1489 456.057, Florida Statutes, is amended to read:

1490 456.057 Ownership and control of patient records; report or
1491 copies of records to be furnished.—

1492 (2) As used in this section, the terms "records owner,"
1493 "health care practitioner," and "health care practitioner's
1494 employer" do not include any of the following persons or
1495 entities; furthermore, the following persons or entities are not
1496 authorized to acquire or own medical records, but are authorized
1497 under the confidentiality and disclosure requirements of this
1498 section to maintain those documents required by the part or
1499 chapter under which they are licensed or regulated:

1500 (k) Persons or entities practicing under s. 627.736(8)
1501 ~~627.736(7)~~.

1502 Section 11. Paragraph (b) of subsection (1) of section
1503 627.7401, Florida Statutes, is amended to read:

1504 627.7401 Notification of insured's rights.—

1505 (1) The commission, by rule, shall adopt a form for the
1506 notification of insureds of their right to receive personal
1507 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1508 fault law. Such notice shall include:

25-01013C-11

20111930__

1509 (b) An advisory informing insureds that:

1510 1. Pursuant to s. 626.9892, the Department of Financial
1511 Services may pay rewards of up to \$25,000 to persons providing
1512 information leading to the arrest and conviction of persons
1513 committing crimes investigated by the Division of Insurance
1514 Fraud arising from violations of s. 440.105, s. 624.15, s.
1515 626.9541, s. 626.989, or s. 817.234.

1516 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
1517 insured notifies the insurer of a billing error, the insured may
1518 be entitled to a certain percentage of a reduction in the amount
1519 paid by the insured's motor vehicle insurer.

1520 Section 12. Paragraph (c) of subsection (7) of section
1521 817.234, Florida Statutes, is amended to read:

1522 817.234 False and fraudulent insurance claims.-

1523 (7)

1524 (c) An insurer, or any person acting at the direction of or
1525 on behalf of an insurer, may not change an opinion in a mental
1526 or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or
1527 direct the physician preparing the report to change such
1528 opinion; however, this provision does not preclude the insurer
1529 from calling to the attention of the physician errors of fact in
1530 the report based upon information in the claim file. Any person
1531 who violates this paragraph commits a felony of the third
1532 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1533 775.084.

1534 Section 13. This act shall take effect July 1, 2011.