

By the Committee on Banking and Insurance; and Senator Bogdanoff

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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;

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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," "entity wholly owned,"
35 and "no-fault law"; amending s. 627.736, F.S.;
36 conforming a cross-reference; adding licensed
37 acupuncturists to the list of practitioners authorized
38 to provide, supervise, order, or prescribe services;
39 requiring certain entities providing medical services
40 to document that they meet required criteria; revising
41 requirements relating to the form that must be
42 submitted by providers; requiring an entity or clinic
43 to file a new form within a specified period after the
44 date of a change of ownership; revising provisions
45 relating to when payment for a benefit is due;
46 providing that an insurer's failure to send certain
47 specification or explanation does not waive other
48 grounds for rejecting an invalid claim; authorizing an
49 insurer to obtain evidence and assert any ground for
50 adjusting or rejecting a claim; providing that the
51 time period for paying a claim is tolled during the
52 investigation of a fraudulent insurance act;
53 specifying when benefits are not payable; preempting
54 local lien laws with respect to payment of benefits to
55 medical providers; providing that a claimant that
56 violates certain provisions is not entitled to any
57 payment, regardless of whether a portion of the claim
58 may be legitimate; authorizing an insurer to recover

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59 payments and bring a cause of action to recover
60 payments; providing that an insurer may deny any claim
61 based on other evidence of fraud; forbidding a
62 physician, hospital, clinic, or other medical
63 institution that fails to comply with certain
64 provisions from billing the injured person or the
65 insured; providing that an insurer has a right to
66 conduct reasonable investigations of claims;
67 authorizing an insurer to require a claimant to
68 provide certain records; requiring a records review to
69 be conducted by the same type of practitioner as the
70 medical provider whose records are being reviewed;
71 specifying when the period for payment is tolled;
72 authorizing an insurer to deny benefits if an insured,
73 claimant, or medical provider fails to comply with
74 certain provisions; revising the insurer's
75 reimbursement limitation; providing a limit on the
76 amount of reimbursement if the insurance policy
77 includes a schedule of charges; creating a rebuttable
78 presumption that the insured did not receive the
79 alleged treatment if the insured does not countersign
80 the patient log; authorizing the insurer to deny a
81 claim if the provider does not submit a properly
82 completed statement or bill within a certain time;
83 specifying requirements for furnishing the insured
84 with notice of the amount of covered loss; deleting an
85 obsolete provision; requiring the provider to provide
86 copies of the patient log within a certain time if
87 requested by the insurer; providing that failure to

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88 maintain a patient log renders the treatment unlawful
89 and noncompensable; revising requirements relating to
90 discovery; authorizing the insurer to conduct a
91 physical review of the treatment location; requiring
92 the insured and assignee to comply with certain
93 provisions to recover benefits; requiring the provider
94 to produce persons having the most knowledge in
95 specified circumstances; requiring the insurer to pay
96 reasonable compensation to the provider for attending
97 the examination; requiring the insurer to request
98 certain information before requesting an assignee to
99 participate in an examination under oath; providing
100 that an insurer that requests an examination under
101 oath without a reasonable basis is engaging in an
102 unfair and deceptive trade practice; providing that
103 failure to appear for scheduled examinations
104 establishes a rebuttable presumption that such failure
105 was unreasonable; authorizing an insurer to contract
106 with a preferred provider network; authorizing an
107 insurer to provide a premium discount to an insured
108 who selects a preferred provider; authorizing an
109 insurance policy to not pay for nonemergency services
110 performed by a nonpreferred provider in specified
111 circumstances; authorizing an insurer to use a
112 preferred provider network; revising requirements
113 relating to demand letters in an action for benefits;
114 specifying when a demand letter is defective;
115 requiring a second demand letter under certain
116 circumstances; deleting obsolete provisions; providing

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117 that a demand letter may not be used to request the
118 production of claim documents or records from the
119 insurer; amending s. 817.234, F.S.; providing that
120 persons and business entities found guilty of
121 insurance fraud lose their occupational and
122 practitioner licenses for a certain period; providing
123 civil penalties for fraudulent insurance claims;
124 amending ss. 324.021, 456.057, and 627.7401, F.S.;
125 conforming cross-references; providing an effective
126 date.

127

128 Be It Enacted by the Legislature of the State of Florida:

129

130 Section 1. Subsection (1) of section 316.066, Florida
131 Statutes, is amended to read:

132 316.066 Written reports of crashes.—

133 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~
134 ~~required to~~ be completed and submitted to the department within
135 10 days after ~~completing~~ an investigation is completed by the
136 ~~every~~ law enforcement officer who in the regular course of duty
137 investigates a motor vehicle crash:

138 1. That resulted in death, or personal injury, or any
139 indication of complaints of pain or discomfort by any of the
140 parties or passengers involved in the crash;

141 2. That involved one or more passengers, other than the
142 drivers of the vehicles, in any of the vehicles involved in the
143 crash;

144 ~~3.2.~~ That involved a violation of s. 316.061(1) or s.
145 316.193; ~~or.~~

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146 ~~4.3.~~ In which a vehicle was rendered inoperative to a
147 degree that required a wrecker to remove it from traffic, if
148 such action is appropriate, in the officer's discretion.

149 (b) In every crash for which a Florida Traffic Crash
150 Report, Long Form, is not required by this section, the law
151 enforcement officer may complete a short-form crash report or
152 provide a short-form crash report to be completed by each party
153 involved in the crash. Short-form crash reports prepared by the
154 law enforcement officer shall be maintained by the officer's
155 agency.

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

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

158 2. A description of the vehicles involved.

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

160 4. The names and addresses of all passengers in all
161 vehicles involved in the crash, each clearly identified as being
162 a passenger and the identification of the vehicle in which they
163 were a passenger.

164 ~~5.4.~~ The names and addresses of witnesses.

165 ~~6.5.~~ The name, badge number, and law enforcement agency of
166 the officer investigating the crash.

167 ~~7.6.~~ The names of the insurance companies for the
168 respective parties involved in the crash.

169 (d) ~~(e)~~ Each party to the crash must ~~shall~~ provide the law
170 enforcement officer with proof of insurance, which must ~~to~~ be
171 included in the crash report. If a law enforcement officer
172 submits a report on the accident, proof of insurance must be
173 provided to the officer by each party involved in the crash. Any
174 party who fails to provide the required information commits a

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175 noncriminal traffic infraction, punishable as a nonmoving
176 violation as provided in chapter 318, unless the officer
177 determines that due to injuries or other special circumstances
178 such insurance information cannot be provided immediately. If
179 the person provides the law enforcement agency, within 24 hours
180 after the crash, proof of insurance that was valid at the time
181 of the crash, the law enforcement agency may void the citation.

182 (e) ~~(d)~~ The driver of a vehicle that was in any manner
183 involved in a crash resulting in damage to any vehicle or other
184 property in an amount of \$500 or more, which ~~crash~~ was not
185 investigated by a law enforcement agency, shall, within 10 days
186 after the crash, submit a written report of the crash to the
187 department or traffic records center. The entity receiving the
188 report may require witnesses of the crash ~~crashes~~ to render
189 reports and may require any driver of a vehicle involved in a
190 crash of which a written report must be made ~~as provided in this~~
191 ~~section~~ to file supplemental written reports if ~~whenever~~ the
192 original report is deemed insufficient by the receiving entity.

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

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

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

200 400.991 License requirements; background screenings;
201 prohibitions.-

202 (6) All forms that constitute part of the application for
203 licensure or exemption from licensure under this part must

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204 contain the following statement:

205
206 INSURANCE FRAUD NOTICE.—Submitting a false,
207 misleading, or fraudulent application or other
208 document when applying for licensure as a health care
209 clinic, when seeking an exemption from licensure as a
210 health care clinic, or when demonstrating compliance
211 with part X of chapter 400, Florida Statutes, is a
212 fraudulent insurance act, as defined in s. 626.989 or
213 s. 817.234, Florida Statutes, subject to investigation
214 by the Division of Insurance Fraud, and is grounds for
215 discipline by the appropriate licensing board of the
216 Florida Department of Health.

217 Section 3. Section 626.9894, Florida Statutes, is created
218 to read:

219 626.9894 Motor vehicle insurance fraud direct-support
220 organization.—

221 (1) DEFINITIONS.—As used in this section, the term:

222 (a) "Division" means the Division of Insurance Fraud of the
223 Department of Financial Services.

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

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

230 (2) ORGANIZATION ESTABLISHED.—The division may establish a
231 direct-support organization, to be known as the "Automobile
232 Insurance Fraud Strike Force," whose sole purpose is to support

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233 the prosecution, investigation, and prevention of motor vehicle
234 insurance fraud. The organization shall:

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

237 (b) Be organized and operated to conduct programs and
238 activities; to raise funds; to request and receive grants,
239 gifts, and bequests of money; to acquire, receive, hold, invest,
240 and administer, in its own name, securities, funds, objects of
241 value, or other property, real or personal; and to make grants
242 and expenditures to or for the direct or indirect benefit of the
243 division, state attorneys' offices, the statewide prosecutor,
244 the Agency for Health Care Administration, and the Department of
245 Health to the extent that such grants and expenditures are to be
246 used exclusively to advance the purpose of prosecuting,
247 investigating, or preventing motor vehicle insurance fraud.
248 Grants and expenditures may include the cost of salaries or
249 benefits of dedicated motor vehicle insurance fraud
250 investigators, prosecutors, or support personnel if such grants
251 and expenditures do not interfere with prosecutorial
252 independence or otherwise create conflicts of interest which
253 threaten the success of prosecutions.

254 (c) Be determined by the division to operate in a manner
255 that promotes the goals of laws relating to motor vehicle
256 insurance fraud, that is in the best interest of the state, and
257 that is in accordance with the adopted goals and mission of the
258 division.

259 (d) Use all of its grants and expenditures solely for the
260 purpose of preventing and decreasing motor vehicle insurance
261 fraud, and not for the purpose of lobbying as defined in s.

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262 11.045.

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

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

267 (a) Approval of the articles of incorporation and bylaws of
268 the organization by the division.

269 (b) Submission of an annual budget for the approval of the
270 division. The budget must require the organization to minimize
271 costs to the division and its members at all times by using
272 existing personnel and property and allowing for telephonic
273 meetings when appropriate.

274 (c) Certification by the division that the direct-support
275 organization is complying with the terms of the contract and in
276 a manner consistent with the goals and purposes of the
277 department and in the best interest of the state. Such
278 certification must be made annually and reported in the official
279 minutes of a meeting of the organization.

280 (d) Allocation of funds to address motor vehicle insurance
281 fraud.

282 (e) Reversion of moneys and property held in trust by the
283 organization for motor vehicle insurance fraud prosecution,
284 investigation, and prevention to the division if the
285 organization is no longer approved to operate for the department
286 or if the organization ceases to exist, or to the state if the
287 division ceases to exist.

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

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291 (g) The fiscal year of the organization, which begins July
292 1 of each year and ends June 30 of the following year.

293 (h) Disclosure of the material provisions of the contract,
294 and distinguishing between the department and the organization
295 to donors of gifts, contributions, or bequests, including
296 providing such disclosure on all promotional and fundraising
297 publications.

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

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

302 (b) Two state attorneys, one of whom shall be appointed by
303 the Chief Financial Officer and one of whom shall be appointed
304 by the Attorney General.

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

307 (d) Two representatives of local law enforcement agencies,
308 both of whom shall be appointed by the Chief Financial Officer.

309
310 The officer who appointed a member of the board may remove that
311 member for cause. The term of office of an appointed member
312 expires at the same time as the term of the officer who
313 appointed him or her or at such earlier time as the person
314 ceases to be qualified.

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

318 (a) The department may prescribe any condition with which
319 the organization must comply in order to use the division's

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320 property or facilities.

321 (b) The department may not authorize the use of the
322 division's property or facilities if the organization does not
323 provide equal membership and employment opportunities to all
324 persons regardless of race, religion, sex, age, or national
325 origin.

326 (c) The department shall adopt rules prescribing the
327 procedures by which the organization is governed and any
328 conditions with which the organization must comply to use the
329 division's property or facilities.

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

333 (7) DEPOSITORY.—Any moneys received by the organization may
334 be held in a separate depository account in the name of the
335 organization and subject to the provisions of the contract with
336 the division.

337 (8) DIVISION'S RECEIPT OF PROCEEDS.—If the division
338 receives proceeds from the organization, those proceeds shall be
339 deposited into the Insurance Regulatory Trust Fund.

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

342 627.4137 Disclosure of certain information required.—

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

346 Section 5. Section 627.730, Florida Statutes, is amended to
347 read:

348 627.730 Florida Motor Vehicle No-Fault Law.—Sections

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349 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the
350 "Florida Motor Vehicle No-Fault Law."

351 Section 6. Section 627.731, Florida Statutes, is amended to
352 read:

353 627.731 Purpose; legislative intent.—The purpose of the no-
354 fault law ss. ~~627.730-627.7405~~ is to provide for medical,
355 surgical, funeral, and disability insurance benefits without
356 regard to fault, and to require motor vehicle insurance securing
357 such benefits, for motor vehicles required to be registered in
358 this state and, with respect to motor vehicle accidents, a
359 limitation on the right to claim damages for pain, suffering,
360 mental anguish, and inconvenience.

361 (1) The Legislature finds that automobile insurance fraud
362 remains a major problem for state consumers and insurers.
363 According to the National Insurance Crime Bureau, in recent
364 years this state has been among those states that have the
365 highest number of fraudulent and questionable claims.

366 (2) The Legislature intends to balance the insured's
367 interest in prompt payment of valid claims for insurance
368 benefits under the no-fault law with the public's interest in
369 reducing fraud, abuse, and overuse of the no-fault system. To
370 that end, the Legislature intends that the investigation and
371 prevention of fraudulent insurance acts in this state be
372 enhanced, that additional sanctions for such acts be imposed,
373 and that the no-fault law be revised to remove incentives for
374 fraudulent insurance acts. The Legislature intends that the no-
375 fault law be construed according to the plain language of the
376 statutory provisions, which are designed to meet these goals.

377 (3) The Legislature intends that:

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378 (a) Insurers properly investigate claims, and as such, be
379 allowed to obtain examinations under oath and sworn statements
380 from any claimant seeking no-fault insurance benefits, and to
381 request mental and physical examinations of persons seeking
382 personal injury protection coverage or benefits.

383 (b) Any false, misleading, or otherwise fraudulent activity
384 associated with a claim renders any claim brought by a claimant
385 engaging in such activity invalid. An insurer must be able to
386 raise fraud as a defense to a claim for no-fault insurance
387 benefits irrespective of any prior adjudication of guilt or
388 determination of fraud by the Department of Financial Services.

389 (c) Insurers toll the payment or denial of a claim, with
390 respect to any portion of a claim for which the insurer has a
391 reasonable belief that a fraudulent insurance act, as defined in
392 s. 626.989, has been committed.

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

399 (e) The insured's interest in obtaining competent counsel
400 must be balanced with the public's interest in preventing a no-
401 fault system that encourages litigation by allowing for
402 exorbitant attorney's fees. Courts should limit attorney fee
403 awards so as to eliminate the incentive for attorneys to
404 manufacture unnecessary litigation.

405 Section 7. Section 627.732, Florida Statutes, is reordered
406 and amended to read:

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407 627.732 Definitions.—As used in the no-fault law ~~ss.~~
408 ~~627.730-627.7405~~, the term:

409 (1) "Broker" means any person not possessing a license
410 under chapter 395, chapter 400, chapter 429, chapter 458,
411 chapter 459, chapter 460, chapter 461, or chapter 641 who
412 charges or receives compensation for any use of medical
413 equipment and is not the 100-percent owner or the 100-percent
414 lessee of such equipment. For purposes of this section, such
415 owner or lessee may be an individual, a corporation, a
416 partnership, or any other entity and any of its 100-percent-
417 owned affiliates and subsidiaries. For purposes of this
418 subsection, the term "lessee" means a long-term lessee under a
419 capital or operating lease, but does not include a part-time
420 lessee. The term "broker" does not include a hospital or
421 physician management company whose medical equipment is
422 ancillary to the practices managed, a debt collection agency, or
423 an entity that has contracted with the insurer to obtain a
424 discounted rate for such services; or ~~nor does the term include~~
425 a management company that has contracted to provide general
426 management services for a licensed physician or health care
427 facility and whose compensation is not materially affected by
428 the usage or frequency of usage of medical equipment or an
429 entity that is 100-percent owned by one or more hospitals or
430 physicians. The term "broker" does not include a person or
431 entity that certifies, upon request of an insurer, that:
432 (a) It is a clinic licensed under ss. 400.990-400.995;
433 (b) It is a 100-percent owner of medical equipment; and
434 (c) The owner's only part-time lease of medical equipment
435 for personal injury protection patients is on a temporary basis,

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436 not to exceed 30 days in a 12-month period, and such lease is
437 solely for the purposes of necessary repair or maintenance of
438 the 100-percent-owned medical equipment or pending the arrival
439 and installation of the newly purchased or a replacement for the
440 100-percent-owned medical equipment, or for patients for whom,
441 because of physical size or claustrophobia, it is determined by
442 the medical director or clinical director to be medically
443 necessary that the test be performed in medical equipment that
444 is open-style. The leased medical equipment may not ~~cannot~~ be
445 used by patients who are not patients of the registered clinic
446 ~~for medical treatment of services~~. Any person or entity making a
447 false certification under this subsection commits insurance
448 fraud as defined in s. 817.234. However, the 30-day period
449 ~~provided in this paragraph~~ may be extended for an additional 60
450 days as applicable to magnetic resonance imaging equipment if
451 the owner certifies that the extension otherwise complies with
452 this paragraph.

453 (10) ~~(2)~~ "Medically necessary" refers to a medical service
454 or supply that a prudent physician would provide for the purpose
455 of preventing, diagnosing, or treating an illness, injury,
456 disease, or symptom in a manner that is:

457 (a) In accordance with generally accepted standards of
458 medical practice;

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

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

463 (11) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
464 with four or more wheels which is of a type both designed and

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465 required to be licensed for use on the highways of this state,
466 and any trailer or semitrailer designed for use with such
467 vehicle, and includes:

468 (a) A "private passenger motor vehicle," which is any motor
469 vehicle that ~~which~~ is a sedan, station wagon, or jeep-type
470 vehicle and, if not used primarily for occupational,
471 professional, or business purposes, a motor vehicle of the
472 pickup, panel, van, camper, or motor home type.

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

475

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

482 (12)~~(4)~~ "Named insured" means a person, usually the owner
483 of a vehicle, identified in a policy by name as the insured
484 under the policy.

485 (13) "No-fault law" means the Florida Motor Vehicle No-
486 Fault Law codified at ss. 627.730-627.7407.

487 (14)~~(5)~~ "Owner" means a person who holds the legal title to
488 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
489 subject of a security agreement or lease with an option to
490 purchase with the debtor or lessee having the right to
491 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
492 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405.~~

493 (16)~~(6)~~ "Relative residing in the same household" means a

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494 relative of any degree by blood or by marriage who usually makes
495 her or his home in the same family unit, whether or not
496 temporarily living elsewhere.

497 (2)~~(7)~~ "Certify" means to swear or attest to being true or
498 represented in writing.

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

501 (4) "Entity wholly owned" means a proprietorship, group
502 practice, partnership, or corporation that provides health care
503 services rendered by licensed health care practitioners. In
504 order to be wholly owned, licensed health care practitioners
505 must be the business owners of all aspects of the business
506 entity, including, but not limited to, being reflected as the
507 business owners on the title or lease of the physical facility,
508 filing taxes as the business owners, being account holders on
509 the entity's bank account, being listed as the principals on all
510 incorporation documents required by this state, and having
511 ultimate authority over all personnel and compensation decisions
512 relating to the entity.

513 (6)~~(8)~~ "Immediate personal supervision," as it relates to
514 the performance of medical services by nonphysicians not in a
515 hospital, means that an individual licensed to perform the
516 medical service or provide the medical supplies must be present
517 within the confines of the physical structure where the medical
518 services are performed or where the medical supplies are
519 provided such that the licensed individual can respond
520 immediately to any emergencies if needed.

521 (7)~~(9)~~ "Incident," with respect to services considered as
522 incident to a physician's professional service, for a physician

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523 licensed under chapter 458, chapter 459, chapter 460, or chapter
524 461, if not furnished in a hospital, means ~~such~~ services that
525 are must be an integral, even if incidental, part of a covered
526 physician's service.

527 (8)~~(10)~~ "Knowingly" means that a person, with respect to
528 information, has actual knowledge of the information,+ acts in
529 deliberate ignorance of the truth or falsity of the
530 information,+ or acts in reckless disregard of the information.+
531 ~~and~~ Proof of specific intent to defraud is not required.

532 (9)~~(11)~~ "Lawful" or "lawfully" means in substantial
533 compliance with all relevant applicable criminal, civil, and
534 administrative requirements of state and federal law related to
535 the provision of medical services or treatment.

536 (5)~~(12)~~ "Hospital" means a facility that, at the time
537 services or treatment were rendered, was licensed under chapter
538 395.

539 (15)~~(13)~~ "Properly completed" means providing truthful,
540 substantially complete, and substantially accurate responses ~~as~~
541 to all material elements of ~~to~~ each applicable request for
542 information or statement by a means that may lawfully be
543 provided and that complies with this section, or as agreed by
544 the parties.

545 (18)~~(14)~~ "Upcoding" means submitting ~~an action that submits~~
546 a billing code that would result in payment greater in amount
547 than would be paid using a billing code that accurately
548 describes the services performed. The term does not include an
549 otherwise lawful bill by a magnetic resonance imaging facility,
550 which globally combines both technical and professional
551 components, if the amount of the global bill is not more than

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552 the components if billed separately; however, payment of such a
553 bill constitutes payment in full for all components of such
554 service.

555 ~~(17)-(15)~~ "Unbundling" means submitting an action that
556 ~~submits~~ a billing code that is properly billed under one billing
557 code, but that has been separated into two or more billing
558 codes, and would result in payment greater than the in amount
559 that than would be paid using one billing code.

560 Section 8. Subsections (1) and (4) of section 627.736,
561 Florida Statutes, are amended, subsections (5) through (16) of
562 that section are redesignated as subsections (6) through (17),
563 respectively, a new subsection (5) is added to that section,
564 present subsection (5), paragraph (b) of present subsection (6),
565 paragraph (b) of present subsection (7), and present subsections
566 (8), (9), and (10) of that section are amended, to read:

567 627.736 Required personal injury protection benefits;
568 exclusions; priority; claims.—

569 (1) REQUIRED BENEFITS.—Every insurance policy complying
570 with the security requirements of s. 627.733 must ~~shall~~ provide
571 personal injury protection to the named insured, relatives
572 residing in the same household, persons operating the insured
573 motor vehicle, passengers in such motor vehicle, and other
574 persons struck by such motor vehicle and suffering bodily injury
575 while not an occupant of a self-propelled vehicle, subject to
576 ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(e)~~, to
577 a limit of \$10,000 for loss sustained by ~~any~~ such person as a
578 result of bodily injury, sickness, disease, or death arising out
579 of the ownership, maintenance, or use of a motor vehicle as
580 follows:

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581 (a) *Medical benefits.*—Eighty percent of all reasonable
582 expenses, charged pursuant to subsection (6), for medically
583 necessary medical, surgical, X-ray, dental, and rehabilitative
584 services, including prosthetic devices, and for medically
585 necessary ambulance, hospital, and nursing services. However,
586 the medical benefits ~~shall~~ provide reimbursement only for such
587 services and care that are lawfully provided, supervised,
588 ordered, or prescribed by a physician licensed under chapter 458
589 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a
590 chiropractic physician licensed under chapter 460, or an
591 acupuncturist licensed under chapter 457 exclusively to provide
592 oriental medicine as defined in s. 457.102, or that are provided
593 by any of the following ~~persons or entities~~:

594 1. A hospital or ambulatory surgical center licensed under
595 chapter 395.

596 2. A person or entity licensed under part III of chapter
597 401 which ss. 401.2101-401.45 that provides emergency
598 transportation and treatment.

599 3. An entity wholly owned by one or more physicians
600 licensed under chapter 458 or chapter 459, chiropractic
601 physicians licensed under chapter 460, or dentists licensed
602 under chapter 466 or by such ~~practitioner or~~ practitioners and
603 the spouse, parent, child, or sibling of such ~~that practitioner~~
604 ~~or those~~ practitioners.

605 4. An entity wholly owned, directly or indirectly, by a
606 hospital or hospitals.

607 5. A health care clinic licensed under part X of chapter
608 400 which ss. 400.990-400.995 that is:

609 a. Accredited by the Joint Commission on Accreditation of

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610 Healthcare Organizations, the American Osteopathic Association,
611 the Commission on Accreditation of Rehabilitation Facilities, or
612 the Accreditation Association for Ambulatory Health Care, Inc.;

613 or

614 b. A health care clinic that:

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

617 (II) Has been continuously licensed for more than 3 years
618 or is a publicly traded corporation that issues securities
619 traded on an exchange registered with the United States
620 Securities and Exchange Commission as a national securities
621 exchange; and

622 (III) Provides at least four of the following medical
623 specialties:

624 (A) General medicine.

625 (B) Radiography.

626 (C) Orthopedic medicine.

627 (D) Physical medicine.

628 (E) Physical therapy.

629 (F) Physical rehabilitation.

630 (G) Prescribing or dispensing outpatient prescription
631 medication.

632 (H) Laboratory services.

633

634 If any services under this paragraph are provided by an entity
635 or clinic described in subparagraph 3., subparagraph 4., or
636 subparagraph 5., the entity or clinic must provide the insurer
637 at the initial submission of the claim with a form adopted by
638 the Department of Financial Services which documents that the

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639 entity or clinic meets applicable criteria for such entity or
640 clinic and includes a sworn statement or affidavit to that
641 effect. Any change in ownership requires the filing of a new
642 form within 10 days after the date of the change in ownership.
643 ~~The Financial Services Commission shall adopt by rule the form~~
644 ~~that must be used by an insurer and a health care provider~~
645 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
646 ~~5. to document that the health care provider meets the criteria~~
647 ~~of this paragraph, which rule must include a requirement for a~~
648 ~~sworn statement or affidavit.~~

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

658 (c) *Death benefits.*—Death benefits equal to the lesser of
659 \$5,000 or the remainder of unused personal injury protection
660 benefits per individual. The insurer may pay such benefits to
661 the executor or administrator of the deceased, to any of the
662 deceased's relatives by blood, ~~or~~ legal adoption, ~~or connection~~
663 ~~by~~ marriage, or to any person appearing to the insurer to be
664 equitably entitled thereto.

665
666 Only insurers writing motor vehicle liability insurance in this
667 state may provide the required benefits of this section, and ~~no~~

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668 such insurers may not ~~insurer shall~~ require the purchase of any
 669 other motor vehicle coverage other than the purchase of property
 670 damage liability coverage as required by s. 627.7275 as a
 671 condition for providing such ~~required~~ benefits. Insurers may not
 672 require that property damage liability insurance in an amount
 673 greater than \$10,000 be purchased in conjunction with personal
 674 injury protection. Such insurers shall make benefits and
 675 required property damage liability insurance coverage available
 676 through normal marketing channels. An ~~Any~~ insurer writing motor
 677 vehicle liability insurance in this state who fails to comply
 678 with such availability requirement as a general business
 679 practice violates ~~shall be deemed to have violated~~ part IX of
 680 chapter 626, and such violation constitutes ~~shall constitute~~ an
 681 unfair method of competition or an unfair or deceptive act or
 682 practice involving the business of insurance. An; ~~and any such~~
 683 insurer committing such violation is ~~shall be~~ subject to the
 684 penalties afforded in such part, as well as those that are ~~which~~
 685 ~~may be~~ afforded elsewhere in the insurance code.

686 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
 687 the no-fault law are ~~ss. 627.730-627.7405~~ shall be primary,
 688 except that benefits received under any workers' compensation
 689 law shall be credited against the benefits provided by
 690 subsection (1) and are ~~shall be~~ due and payable as loss accrues,
 691 upon the receipt of reasonable proof of such loss and the amount
 692 of expenses and loss incurred which are covered by the policy
 693 issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the
 694 Agency for Health Care Administration provides, pays, or becomes
 695 liable for medical assistance under the Medicaid program related
 696 to injury, sickness, disease, or death arising out of the

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697 ownership, maintenance, or use of a motor vehicle, the benefits
698 are under ss. ~~627.730-627.7405~~ shall be subject to the
699 provisions of the Medicaid program.

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

704 (b) Personal injury protection insurance benefits paid
705 pursuant to this section are ~~shall be~~ overdue if not paid within
706 30 days after the insurer is furnished written notice of the
707 fact of a covered loss and of the amount of same. If ~~such~~
708 written notice is not furnished to the insurer as to the entire
709 claim, any partial amount supported by written notice is overdue
710 if not paid within 30 days after the ~~such~~ written notice is
711 furnished to the insurer. Any part or all of the remainder of
712 the claim that is subsequently supported by written notice is
713 overdue if not paid within 30 days after ~~such~~ written notice is
714 furnished to the insurer. For the purpose of calculating the
715 extent to which benefits are overdue, payment shall be
716 considered made on the date a draft or other valid instrument
717 that is equivalent to payment is placed in the United States
718 mail in a properly addressed, postpaid envelope, or, if not so
719 posted, on the date of delivery.

720 (c) If ~~When~~ an insurer pays only a portion of a claim or
721 rejects a claim, the insurer shall provide at the time of the
722 partial payment or rejection an itemized specification of each
723 item that the insurer had reduced, omitted, or declined to pay
724 and any information that the insurer desires the claimant to
725 consider related to the medical necessity of the denied

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726 treatment or to explain the reasonableness of the reduced
727 charge, provided that this does ~~shall~~ not limit the introduction
728 of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the
729 name and address of the person to whom the claimant should
730 respond and a claim number to be referenced in future
731 correspondence. An insurer's failure to send an itemized
732 specification or explanation of benefits does not waive other
733 grounds for rejecting an invalid claim.

734 (d) A ~~However, notwithstanding the fact that written notice~~
735 ~~has been furnished to the insurer, Any payment is~~ shall not be
736 ~~deemed overdue if when~~ the insurer has reasonable proof ~~to~~
737 ~~establish~~ that the insurer is not responsible for the payment.
738 An insurer may obtain evidence and assert any ground for
739 adjustment or rejection of a ~~For the purpose of calculating the~~
740 ~~extent to which any benefits are overdue, payment shall be~~
741 ~~treated as being made on the date a draft or other valid~~
742 ~~instrument which is equivalent to payment was placed in the~~
743 ~~United States mail in a properly addressed, postpaid envelope~~
744 ~~or, if not so posted, on the date of delivery. This paragraph~~
745 ~~does not preclude or limit the ability of the insurer to assert~~
746 ~~that the claim that is~~ was unrelated, ~~was~~ not medically
747 necessary, ~~or was~~ unreasonable, or submitted ~~that the amount of~~
748 ~~the charge was in excess of that permitted under, or in~~
749 ~~violation of, subsection (6) (5). Such assertion by the insurer~~
750 ~~may be made at any time, including after payment of the claim,~~
751 ~~or~~ after the 30-day ~~time~~ period for payment set forth in ~~this~~
752 paragraph (b), or after the filing of a lawsuit.

753 (e) The 30-day period for payment is tolled while the
754 insurer investigates a fraudulent insurance act, as defined in

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755 s. 626.989, with respect to any portion of a claim for which the
756 insurer has a reasonable belief that a fraudulent insurance act
757 has been committed. The insurer must notify the claimant in
758 writing that it is investigating a fraudulent insurance act
759 within 30 days after the date it has a reasonable belief that
760 such act has been committed. The insurer must pay or deny the
761 claim, in full or in part, within 90 days after the date the
762 written notice of the fact of a covered loss and of the amount
763 of the loss was provided to the insurer. However, no payment is
764 due to a claimant that has violated paragraph (k).

765 (f)(e) Notwithstanding any local lien law, upon receiving
766 notice of an accident that is potentially covered by personal
767 injury protection benefits, the insurer must reserve \$5,000 of
768 personal injury protection benefits for payment to physicians
769 licensed under chapter 458 or chapter 459 or dentists licensed
770 under chapter 466 who provide emergency services and care, as
771 defined in s. 395.002~~(9)~~, or who provide hospital inpatient
772 care. The amount required to be held in reserve may be used only
773 to pay claims from such physicians or dentists until 30 days
774 after the date the insurer receives notice of the accident.
775 After the 30-day period, any amount of the reserve for which the
776 insurer has not received notice of such a claim from a physician
777 ~~or dentist who provided emergency services and care or who~~
778 ~~provided hospital inpatient care~~ may then be used by the insurer
779 to pay other claims. The time periods specified in paragraph (b)
780 for ~~required~~ payment of personal injury protection benefits are
781 ~~shall be~~ tolled for the period of time that an insurer is
782 required ~~by this paragraph~~ to hold payment of a claim that is
783 not from a physician or dentist who provided emergency services

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784 and care or who provided hospital inpatient care to the extent
785 that the personal injury protection benefits not held in reserve
786 are insufficient to pay the claim. This paragraph does not
787 require an insurer to establish a claim reserve for insurance
788 accounting purposes.

789 (g) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
790 the rate established under s. 55.03 or the rate established in
791 the insurance contract, whichever is greater, for the year in
792 which the payment became overdue, calculated from the date the
793 insurer was furnished with written notice of the amount of
794 covered loss. Interest is ~~shall be~~ due at the time payment of
795 the overdue claim is made. However, interest on a payment that
796 is overdue pursuant to paragraph (e) shall be calculated from
797 the date the payment is due pursuant to paragraph (b).

798 (h) ~~(e)~~ The insurer of the owner of a motor vehicle shall
799 pay personal injury protection benefits for:

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

804 2. Accidental bodily injury sustained outside this state,
805 but within the United States of America or its territories or
806 possessions or Canada, by the owner while occupying the owner's
807 motor vehicle.

808 3. Accidental bodily injury sustained by a relative of the
809 owner residing in the same household, under the circumstances
810 described in subparagraph 1. or subparagraph 2. if, provided the
811 relative at the time of the accident is domiciled in the owner's
812 household and is not ~~himself or herself~~ the owner of a motor

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813 vehicle with respect to which security is required under the no-
814 fault law ss. ~~627.730-627.7405~~.

815 4. Accidental bodily injury sustained in this state by any
816 other person while occupying the owner's motor vehicle or, if a
817 resident of this state, while not an occupant of a self-
818 propelled vehicle, if the injury is caused by physical contact
819 with such motor vehicle if, ~~provided~~ the injured person is not
820 ~~himself or herself~~:

821 a. The owner of a motor vehicle with respect to which
822 security is required under the no-fault law ss. ~~627.730-~~
823 ~~627.7405~~; or

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

826 (i) ~~(f)~~ If two or more insurers are liable to pay personal
827 injury protection benefits for the same injury to any one
828 person, the maximum payable is ~~shall be~~ as specified in
829 subsection (1), and any insurer paying the benefits is ~~shall be~~
830 entitled to recover from each of the other insurers an equitable
831 pro rata share of the benefits paid and expenses incurred in
832 processing the claim.

833 (j) ~~(g)~~ It is a violation of the insurance code for an
834 insurer to fail to timely provide benefits as required by this
835 section with such frequency as to constitute a general business
836 practice.

837 (k) ~~(h)~~ Benefits are ~~shall not be~~ due or payable to a
838 claimant who knowingly: ~~or on the behalf of an insured person if~~
839 ~~that person has~~

840 1. Submits a false or misleading statement, document,
841 record, or bill;

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842 2. Submits false or misleading information; or

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

845

846 A claimant that violates this paragraph is not entitled to any
847 personal injury protection benefits or payment for any bills and
848 services, regardless of whether a portion of the claim may be
849 legitimate. However, a claimant that does not violate this
850 paragraph may not be denied benefits solely due to a violation
851 by another claimant.

852 (1) Notwithstanding any remedies afforded by law, the
853 insurer may recover from a claimant who violates paragraph (k)
854 any sums previously paid to that claimant and may bring any
855 available common law and statutory causes of action. A claimant
856 has violated paragraph (k) ~~committed, by a material act or~~
857 ~~emission, any insurance fraud relating to personal injury~~
858 ~~protection coverage under his or her policy, if the fraud is~~
859 ~~admitted to in a sworn statement by the insured or if it is~~
860 established in a court of competent jurisdiction. Any insurance
861 fraud voids ~~shall void~~ all coverage arising from the claim
862 related to ~~such fraud under the personal injury protection~~
863 ~~coverage of the claimant insured person~~ who committed the fraud,
864 irrespective of whether a portion of the insured person's claim
865 may be legitimate, and any benefits paid before ~~prior to~~ the
866 discovery of the ~~insured person's insurance fraud is~~ shall be
867 recoverable by the insurer from the claimant ~~person~~ who
868 committed insurance fraud in their entirety. The prevailing
869 party is entitled to its costs and attorney's fees in any action
870 in which it prevails in an insurer's action to enforce its right

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871 of recovery under this paragraph. This paragraph does not
872 preclude or limit an insurer's right to deny a claim based on
873 other evidence of fraud or affect an insurer's right to plead
874 and prove a claim or defense of fraud under common law. If a
875 physician, hospital, clinic, or other medical institution
876 violates paragraph (k), the injured party is not liable for, and
877 the physician, hospital, clinic, or other medical institution
878 may not bill the insured for, charges that are unpaid because of
879 failure to comply with paragraph (k). Any agreement requiring
880 the injured person or insured to pay for such charges is
881 unenforceable.

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

885 (a) The insurer may require the insured, claimant, or
886 medical provider to provide copies of the treatment and
887 examination records. Any records review need not be based on a
888 physical examination and may be obtained at any time, including
889 after reduction or denial of the claim.

890 1. The records review must be conducted by a practitioner
891 within the same licensing chapter as the medical provider whose
892 records are being reviewed.

893 2. The 30-day period for payment under paragraph (4) (b) is
894 tolled from the date the insurer sends its request for treatment
895 records to the date that the insurer receives the treatment
896 records.

897 3. A medical provider may impose a reasonable, cost-based
898 fee that includes only the cost of copying and postage, but does
899 not include the cost of labor for copying. The cost of copying

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900 may not exceed \$1 per page for the first 25 pages and 25 cents
901 per page for each page in excess of 25 pages. However, a medical
902 provider may impose the reasonable costs of reproducing X rays
903 and other special kinds of records, including the actual cost of
904 the material and supplies used to duplicate the record, as well
905 as the labor costs and overhead costs associated with such
906 duplication.

907 (b) In all circumstances, an insured seeking benefits under
908 the no-fault law must comply with the terms of the policy, which
909 includes, but is not limited to, submitting to examinations
910 under oath. Compliance with this paragraph is a condition
911 precedent to receiving benefits.

912 (c) An insurer may deny benefits if the insured, claimant,
913 or medical provider fails to:

- 914 1. Cooperate in the insurer's investigation;
- 915 2. Commits a fraud or material misrepresentation; or
- 916 3. Comply with this subsection.

917 (6) ~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.-

918 (a) ~~4~~. Any physician, hospital, clinic, or other person or
919 institution lawfully rendering treatment to an injured person
920 for a bodily injury covered by personal injury protection
921 insurance may charge the insurer and injured party only a
922 reasonable amount pursuant to this section for the services and
923 supplies rendered, and the insurer providing ~~such~~ coverage may
924 pay for such charges directly to the ~~such~~ person or institution
925 lawfully rendering such treatment, ~~7~~ if the insured receiving such
926 treatment or his or her guardian has countersigned the properly
927 completed invoice, bill, or claim form approved by the office
928 upon which such charges are to be paid for as having actually

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929 been rendered, to the best knowledge of the insured or his or
930 her guardian. ~~In no event,~~ However, ~~may~~ such charges may not
931 exceed a charge be in excess of the amount the person or
932 institution customarily charges for like services or supplies.
933 In determining ~~With respect to a determination of~~ whether a
934 charge for a particular service, treatment, or otherwise is
935 reasonable, consideration may be given to evidence of usual and
936 customary charges and payments accepted by the provider involved
937 in the dispute, ~~and~~ reimbursement levels in the community, ~~and~~
938 various federal and state medical fee schedules applicable to
939 automobile and other insurance coverages, and other information
940 relevant to the reasonableness of the reimbursement for the
941 service, treatment, or supply.

942 1.2. The insurer may limit reimbursement to no more than 80
943 percent of the following schedule of maximum charges:

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

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

949 c. For emergency services and care as defined by s.
950 395.002(9) provided in a facility licensed under chapter 395
951 rendered by a physician or dentist, and related hospital
952 inpatient services rendered by a physician or dentist, the usual
953 and customary charges in the community.

954 d. For hospital inpatient services, other than emergency
955 services and care, 200 percent of the Medicare Part A
956 prospective payment applicable to the specific hospital
957 providing the inpatient services.

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958 e. For hospital outpatient services, other than emergency
959 services and care, 200 percent of the Medicare Part A Ambulatory
960 Payment Classification for the specific hospital providing the
961 outpatient services.

962 f. For all other medical services, ~~supplies, and care,~~ 200
963 percent of the allowable amount under the participating
964 physicians schedule of Medicare Part B. For all other supplies
965 and care, including durable medical equipment and care and
966 services rendered by ambulatory surgical centers and clinical
967 laboratories, 200 percent of the allowable amount under Medicare
968 Part B. However, if such services, supplies, or care is not
969 reimbursable under Medicare Part B, the insurer may limit
970 reimbursement to 80 percent of the maximum reimbursable
971 allowance under workers' compensation, as determined under s.
972 440.13 and rules adopted thereunder which are in effect at the
973 time such services, supplies, or care is provided. Services,
974 supplies, or care that is not reimbursable under Medicare or
975 workers' compensation is not required to be reimbursed by the
976 insurer.

977 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable fee
978 schedule or payment limitation under Medicare is the fee
979 schedule or payment limitation in effect on January 1 of the
980 year in which ~~at the time~~ the services, supplies, or care was
981 rendered and for the area in which such services were rendered,
982 which shall apply throughout the remainder of the year
983 notwithstanding any subsequent changes made to the fee schedule
984 or payment limitation, except that it may not be less than the
985 allowable amount under the participating physicians schedule of
986 Medicare Part B for 2007 for medical services, supplies, and

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987 care subject to Medicare Part B.

988 ~~3.4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply
989 any limitation on the number of treatments or other utilization
990 limits that apply under Medicare or workers' compensation. An
991 insurer that applies the allowable payment limitations of
992 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully
993 provided care or treatment under the scope of his or her
994 license, regardless of whether such provider is ~~would be~~
995 entitled to reimbursement under Medicare due to restrictions or
996 limitations on the types or discipline of health care providers
997 who may be reimbursed for particular procedures or procedure
998 codes.

999 ~~4.5.~~ If an insurer limits payment as authorized by
1000 subparagraph 1. ~~2.~~, the person providing such services,
1001 supplies, or care may not bill or attempt to collect from the
1002 insured any amount in excess of such limits, except for amounts
1003 that are not covered by the insured's personal injury protection
1004 coverage due to the coinsurance amount or maximum policy limits.

1005 5. Effective January 1, 2012, an insurer may limit
1006 reimbursement pursuant to this paragraph only if the insurance
1007 policy includes the schedule of charges specified in this
1008 paragraph.

1009 (b)1. An insurer or insured is not required to pay a claim
1010 or charges:

1011 a. Made by a broker or by a person making a claim on behalf
1012 of a broker;

1013 b. For any service or treatment that was not lawful at the
1014 time rendered;

1015 c. To any person who knowingly submits a false or

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1016 misleading statement relating to the claim or charges;

1017 d. With respect to a bill or statement that does not
1018 ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs
1019 (c), ~~paragraph~~ (d), and (e);

1020 e. Except for emergency treatment and care, if the insured
1021 failed to countersign a billing form or patient log related to
1022 such claim or charges. Failure to submit a countersigned billing
1023 form or patient log creates a rebuttable presumption that the
1024 insured did not receive the alleged treatment. The insurer is
1025 not considered to have been furnished with notice of the subject
1026 treatment and loss until the insurer is able to verify that the
1027 insured received the alleged treatment. As used in this sub-
1028 paragraph, the term "countersigned" means a second or
1029 verifying signature, as on a previously signed document, and is
1030 not satisfied by the statement "signature on file" or any
1031 similar statement;

1032 ~~f.e.~~ For any treatment or service that is upcoded, or that
1033 is unbundled if ~~when~~ such treatment or services should be
1034 bundled, in accordance with paragraph (d). To facilitate prompt
1035 payment of lawful services, an insurer may change codes that it
1036 determines to have been improperly or incorrectly upcoded or
1037 unbundled, and may make payment based on the changed codes,
1038 without affecting the right of the provider to dispute the
1039 change by the insurer if, ~~provided that~~ before doing so, the
1040 insurer contacts ~~must contact~~ the health care provider and
1041 discusses ~~discuss~~ the reasons for the insurer's change and the
1042 health care provider's reason for the coding, or makes ~~make~~ a
1043 reasonable good faith effort to do so, as documented in the
1044 insurer's file; and

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1045 ~~g.f.~~ For medical services or treatment billed by a
1046 physician and not provided in a hospital unless such services
1047 are rendered by the physician or are incident to his or her
1048 professional services and are included on the physician's bill,
1049 including documentation verifying that the physician is
1050 responsible for the medical services that were rendered and
1051 billed.

1052 2. The Department of Health, in consultation with the
1053 appropriate professional licensing boards, shall adopt, by rule,
1054 a list of diagnostic tests deemed not to be medically necessary
1055 for use in the treatment of persons sustaining bodily injury
1056 covered by personal injury protection benefits under this
1057 section. The ~~initial list shall be adopted by January 1, 2004,~~
1058 ~~and~~ shall be revised from time to time as determined by the
1059 Department of Health, in consultation with the respective
1060 professional licensing boards. Inclusion of a test on the list
1061 ~~must of invalid diagnostic tests shall~~ be based on lack of
1062 demonstrated medical value and a level of general acceptance by
1063 the relevant provider community and may ~~shall~~ not be dependent
1064 for results entirely upon subjective patient response.
1065 Notwithstanding its inclusion on a fee schedule in this
1066 subsection, an insurer or insured is not required to pay any
1067 charges or reimburse claims for any invalid diagnostic test as
1068 determined by the Department of Health.

1069 (c)~~1.~~ With respect to any treatment or service, other than
1070 medical services billed by a hospital or other provider for
1071 emergency services as defined in s. 395.002 or inpatient
1072 services rendered at a hospital-owned facility, the statement of
1073 charges must be furnished to the insurer by the provider and may

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1074 not include, and the insurer is not required to pay, charges for
1075 treatment or services rendered more than 35 days before the
1076 postmark date or electronic transmission date of the statement,
1077 except for past due amounts previously billed on a timely basis
1078 under this paragraph, and except that, if the provider submits
1079 to the insurer a notice of initiation of treatment within 21
1080 days after its first examination or treatment of the claimant,
1081 the statement may include charges for treatment or services
1082 rendered up to, but not more than, 75 days before the postmark
1083 date of the statement. The injured party is not liable for, and
1084 the provider may ~~shall~~ not bill the injured party for, charges
1085 that are unpaid because of the provider's failure to comply with
1086 this paragraph. Any agreement requiring the injured person or
1087 insured to pay for such charges is unenforceable.

1088 1.2. ~~If, however,~~ the insured fails to furnish the provider
1089 with the correct name and address of the insured's personal
1090 injury protection insurer, the provider has 35 days from the
1091 date the provider obtains the correct information to furnish the
1092 insurer with a statement of the charges. The insurer is not
1093 required to pay for such charges unless the provider includes
1094 with the statement documentary evidence that was provided by the
1095 insured during the 35-day period demonstrating that the provider
1096 reasonably relied on erroneous information from the insured and
1097 either:

- 1098 a. A denial letter from the incorrect insurer; or
1099 b. Proof of mailing, which may include an affidavit under
1100 penalty of perjury, reflecting timely mailing to the incorrect
1101 address or insurer.

1102 2.3. For emergency services and care as defined in s.

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1103 395.002 rendered in a hospital emergency department or for
1104 transport and treatment rendered by an ambulance provider
1105 licensed pursuant to part III of chapter 401, the provider is
1106 not required to furnish the statement of charges within the time
1107 periods established by this paragraph, ~~and the insurer is shall~~
1108 not ~~be~~ considered to have been furnished with notice of the
1109 amount of covered loss for purposes of paragraph (4) (b) until it
1110 receives a statement complying with paragraph (d), or copy
1111 thereof, which specifically identifies the place of service to
1112 be a hospital emergency department or an ambulance in accordance
1113 with billing standards recognized by the Centers for Medicare
1114 and Medicaid Services ~~Health Care Finance Administration.~~

1115 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
1116 must include the following statement in type no smaller than 12
1117 points:

1118
1119 BILLING REQUIREMENTS.—Florida Statutes provide that
1120 with respect to any treatment or services, other than
1121 certain hospital and emergency services, the statement
1122 of charges furnished to the insurer by the provider
1123 may not include, and the insurer and the injured party
1124 are not required to pay, charges for treatment or
1125 services rendered more than 35 days before the
1126 postmark date of the statement, except for past due
1127 amounts previously billed on a timely basis, and
1128 except that, if the provider submits to the insurer a
1129 notice of initiation of treatment within 21 days after
1130 its first examination or treatment of the claimant,
1131 the first billing cycle statement may include charges

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1132 for treatment or services rendered up to, but not more
1133 than, 75 days before the postmark date of the
1134 statement.

1135
1136 (d) All statements and bills for medical services rendered
1137 by any physician, hospital, clinic, or other person or
1138 institution shall be submitted to the insurer on a properly
1139 completed Centers for Medicare and Medicaid Services (CMS) 1500
1140 form, UB 92 forms, or any other standard form approved by the
1141 office or adopted by the commission for purposes of this
1142 paragraph. All billings for such services rendered by providers
1143 must ~~shall~~, to the extent applicable, follow the Physicians'
1144 Current Procedural Terminology (CPT) or Healthcare Correct
1145 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1146 year in which services are rendered and comply with the ~~Centers~~
1147 ~~for Medicare and Medicaid Services~~ (CMS) 1500 form instructions
1148 and the American Medical Association Current Procedural
1149 Terminology (CPT) Editorial Panel and Healthcare Correct
1150 Procedural Coding System (HCPCS). All providers other than
1151 hospitals shall include on the applicable claim form the
1152 professional license number of the provider in the line or space
1153 provided for "Signature of Physician or Supplier, Including
1154 Degrees or Credentials." In determining compliance with
1155 applicable CPT and HCPCS coding, guidance shall be provided by
1156 the Physicians' Current Procedural Terminology (CPT) or the
1157 Healthcare Correct Procedural Coding System (HCPCS) in effect
1158 for the year in which services were rendered, the Office of the
1159 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1160 other authoritative treatises designated by rule by the Agency

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1161 for Health Care Administration. A ~~Ne~~ statement of medical
1162 services may not include charges for medical services of a
1163 person or entity that performed such services without possessing
1164 the valid licenses required to perform such services. For
1165 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
1166 considered to have been furnished with notice of the amount of
1167 covered loss or medical bills due unless the statements or bills
1168 comply with this paragraph, and unless the statements or bills
1169 are ~~comply with this paragraph, and unless the statements or~~
1170 ~~bills are~~ properly completed in their entirety as to all
1171 material provisions, with all relevant information being
1172 provided therein. If an insurer denies a claim due to a
1173 provider's failure to submit a properly completed statement or
1174 bill, the insurer shall notify the provider as to the provisions
1175 that were improperly completed, and the provider shall have 15
1176 days after the receipt of such notice to submit a properly
1177 completed statement or bill. If the provider fails to comply
1178 with this requirement, the insurer is not required to pay for
1179 improperly billed services.

1180 (e)1. At the initial treatment or service provided, each
1181 physician, other licensed professional, clinic, or other medical
1182 institution providing medical services upon which a claim for
1183 personal injury protection benefits is based shall require an
1184 insured person, or his or her guardian, to execute a disclosure
1185 and acknowledgment form, which reflects at a minimum that:

1186 a. The insured, or his or her guardian, must countersign
1187 the form attesting to the fact that the services set forth
1188 therein were actually rendered. Listing CPT codes or other
1189 coding on the disclosure and acknowledgment form does not

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1190 satisfy this requirement;

1191 b. The insured, or his or her guardian, has both the right
1192 and affirmative duty to confirm that the services were actually
1193 rendered;

1194 c. The insured, or his or her guardian, was not solicited
1195 by any person to seek any services from the medical provider;

1196 d. The physician, other licensed professional, clinic, or
1197 other medical institution rendering services for which payment
1198 is being claimed explained the services to the insured or his or
1199 her guardian; and

1200 e. If the insured notifies the insurer in writing of a
1201 billing error, the insured may be entitled to a certain
1202 percentage of a reduction in the amounts paid by the insured's
1203 motor vehicle insurer.

1204 2. The physician, other licensed professional, clinic, or
1205 other medical institution rendering services for which payment
1206 is being claimed has the affirmative duty to explain the
1207 services rendered to the insured, or his or her guardian, so
1208 that the insured, or his or her guardian, countersigns the form
1209 with informed consent.

1210 3. Countersignature by the insured, or his or her guardian,
1211 is not required for the reading of diagnostic tests or other
1212 services that are of such a nature that they are not required to
1213 be performed in the presence of the insured.

1214 4. The licensed medical professional rendering treatment
1215 for which payment is being claimed must sign, by his or her own
1216 hand, the form complying with this paragraph.

1217 5. An insurer is not considered to have been furnished with
1218 notice of the amount of a covered loss or medical bills unless

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1219 the original completed disclosure and acknowledgment form is
1220 ~~shall be~~ furnished to the insurer pursuant to paragraph (4) (b)
1221 and sub-subparagraph 1.a. The disclosure and acknowledgement
1222 form may not be electronically furnished. A disclosure and
1223 acknowledgement form that does not meet the minimum requirements
1224 of sub-subparagraph 1.a. does not provide an insurer with notice
1225 of the amount of a covered loss or medical bills due.

1226 6. This disclosure and acknowledgment form is not required
1227 for services billed by a provider for emergency services as
1228 defined in s. 395.002, for emergency services and care as
1229 defined in s. 395.002 rendered in a hospital emergency
1230 department, or for transport and treatment rendered by an
1231 ambulance provider licensed pursuant to part III of chapter 401.

1232 7. The Financial Services Commission shall adopt~~7~~ by rule~~7~~
1233 a standard disclosure and acknowledgment form to that shall be
1234 used to fulfill the requirements of this paragraph~~7~~, ~~effective 90~~
1235 ~~days after such form is adopted and becomes final. The~~
1236 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1237 ~~the rule is final, the provider may use a form of its own which~~
1238 ~~otherwise complies with the requirements of this paragraph.~~

1239 8. As used in this paragraph, the term "countersigned" or
1240 "countersignature" means a second or verifying signature, as on
1241 a previously signed document, and is not satisfied by the
1242 statement "signature on file" or any similar statement.

1243 9. The requirements of this paragraph apply only with
1244 respect to the initial treatment or service of the insured by a
1245 provider. For subsequent treatments or service, the provider
1246 must maintain a patient log signed by the patient, in
1247 chronological order by date of service, that is consistent with

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1248 the services being rendered to the patient as claimed. Listing
1249 CPT codes or other coding on the patient log does not satisfy
1250 this requirement. The provider must provide copies of the
1251 patient log to the insurer within 30 days after receiving a
1252 written request from the insurer. Failure to maintain a patient
1253 log renders the treatment unlawful and noncompensable. The
1254 requirements ~~of this subparagraph~~ for maintaining a patient log
1255 signed by the patient may be met by a hospital that maintains
1256 medical records as required by s. 395.3025 and applicable rules
1257 and makes such records available to the insurer upon request.

1258 (f) Upon written notification by any person, an insurer
1259 shall investigate any claim of improper billing by a physician
1260 or other medical provider. The insurer shall determine if the
1261 insured was properly billed for only those services and
1262 treatments that the insured actually received. If the insurer
1263 determines that the insured has been improperly billed, the
1264 insurer shall notify the insured, the person making the written
1265 notification, and the provider of its findings and ~~shall~~ reduce
1266 the amount of payment to the provider by the amount determined
1267 to be improperly billed. If a reduction is made due to such
1268 written notification by any person, the insurer shall pay to the
1269 person 20 percent of the amount of the reduction, up to \$500. If
1270 the provider is arrested due to the improper billing, ~~then~~ the
1271 insurer shall pay to the person 40 percent of the amount of the
1272 reduction, up to \$500.

1273 (g) An insurer may not systematically downcode with the
1274 intent to deny reimbursement otherwise due. Such action
1275 constitutes a material misrepresentation under s.
1276 626.9541(1)(i)2.

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1277 (7)~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1278 DISPUTES.—

1279 (b) Every physician, hospital, clinic, or other medical
1280 institution providing, before or after bodily injury upon which
1281 a claim for personal injury protection insurance benefits is
1282 based, any products, services, or accommodations in relation to
1283 that or any other injury, or in relation to a condition claimed
1284 to be connected with that or any other injury, shall, if
1285 requested to do so by the insurer against whom the claim has
1286 been made, permit the insurer or the insurer's representative to
1287 conduct an onsite physical review and examination of the
1288 treatment location, treatment apparatuses, diagnostic devices,
1289 and any other medical equipment used for the services rendered
1290 within 10 days after the insurer's request, and furnish
1291 ~~forthwith~~ a written report of the history, condition, treatment,
1292 dates, and costs of such treatment of the injured person and why
1293 the items identified by the insurer were reasonable in amount
1294 and medically necessary, together with a sworn statement that
1295 the treatment or services rendered were reasonable and necessary
1296 with respect to the bodily injury sustained and identifying
1297 which portion of the expenses for such treatment or services was
1298 incurred as a result of such bodily injury, and produce
1299 forthwith, and permit the inspection and copying of, his or her
1300 or its records regarding such history, condition, treatment,
1301 dates, and costs of treatment ~~if, provided that~~ this does shall
1302 not limit the introduction of evidence at trial. Such sworn
1303 statement must shall read as follows: "Under penalty of perjury,
1304 I declare that I have read the foregoing, and the facts alleged
1305 are true, to the best of my knowledge and belief." A ~~No~~ cause of

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1306 action for violation of the physician-patient privilege or
1307 invasion of the right of privacy may not be brought ~~shall be~~
1308 ~~permitted~~ against any physician, hospital, clinic, or other
1309 medical institution complying with ~~the provisions of~~ this
1310 section. The person requesting such records and such sworn
1311 statement shall pay all reasonable costs connected therewith.

1312 1. If an insurer makes a written request for documentation
1313 or information under this paragraph within 30 days after having
1314 received notice of the amount of a covered loss under paragraph
1315 (4) (a), the amount or the partial amount that ~~which~~ is the
1316 subject of the insurer's inquiry is ~~shall become~~ overdue if the
1317 insurer does not pay in accordance with paragraph (4) (b) or
1318 within 10 days after the insurer's receipt of the requested
1319 documentation or information, whichever occurs later. For
1320 purposes of this subparagraph ~~paragraph~~, the term "receipt"
1321 includes, but is not limited to, inspection and copying pursuant
1322 to this paragraph. An ~~Any~~ insurer that requests documentation or
1323 information pertaining to reasonableness of charges or medical
1324 necessity under this paragraph without a reasonable basis for
1325 such requests as a general business practice is engaging in an
1326 unfair trade practice under the insurance code.

1327 2. If an insured seeking to recover benefits pursuant to
1328 the no-fault law assigns the contractual right to those benefits
1329 or payment of those benefits to any person or entity, the
1330 assignee must comply with the terms of the policy. In all
1331 circumstances, the assignee is obligated to cooperate under the
1332 policy, which includes, but is not limited to, participating in
1333 an examination under oath. Examinations under oath may be
1334 recorded by audio, video, court reporter, or any combination

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1335 thereof. Compliance with this paragraph is a condition precedent
1336 to recovery of benefits pursuant to the no-fault law.

1337 a. If an insurer requests an examination under oath of a
1338 medical provider, the provider must produce the persons having
1339 the most knowledge of the issues identified by the insurer in
1340 the request for examination under oath. All claimants must
1341 produce and allow for the inspection all documents requested by
1342 the insurer which are relevant to the services rendered and
1343 reasonably obtainable by the claimant. The insurer must pay the
1344 medical provider reasonable compensation for attending the
1345 examination under oath; however, expert witness fees are not
1346 reasonable compensation. The medical provider may have an
1347 attorney present at the examination under oath at the provider's
1348 own expense.

1349 b. Before requesting that an assignee participate in an
1350 examination under oath, the insurer must send a written request
1351 to the assignee requesting all information that the insurer
1352 believes is necessary to process the claim and relevant to the
1353 services rendered, including the information contemplated under
1354 this subparagraph.

1355 c. An insurer that, as a general practice, requests
1356 examinations under oath of an assignee without a reasonable
1357 basis is engaging in an unfair and deceptive trade practice.

1358 (8) ~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1359 REPORTS.-

1360 (b) If requested by the person examined, a party causing an
1361 examination to be made shall deliver to him or her a copy of
1362 every written report concerning the examination rendered by an
1363 examining physician, at least one of which reports must set out

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1364 the examining physician's findings and conclusions in detail.
 1365 After such request and delivery, the party causing the
 1366 examination to be made is entitled, upon request, to receive
 1367 from the person examined every written report available to him
 1368 or her or his or her representative concerning any examination,
 1369 previously or thereafter made, of the same mental or physical
 1370 condition. By requesting and obtaining a report of the
 1371 examination so ordered, or by taking the deposition of the
 1372 examiner, the person examined waives any privilege he or she may
 1373 have, in relation to the claim for benefits, regarding the
 1374 testimony of every other person who has examined, or may
 1375 thereafter examine, him or her in respect to the same mental or
 1376 physical condition. If a person fails to appear for ~~unreasonably~~
 1377 ~~refuses to submit to~~ an examination, the personal injury
 1378 protection carrier is not required to pay ~~no longer liable~~ for
 1379 ~~subsequent~~ personal injury protection benefits incurred after
 1380 the date of the first requested examination until the insured
 1381 appears for the examination. Failure to appear for two scheduled
 1382 examinations raises a rebuttable presumption that such failure
 1383 was unreasonable. Submission to an examination is a condition
 1384 precedent to the recovery of benefits.

1385 (9) ~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 1386 FEES.—With respect to any dispute ~~under the provisions of ss.~~
 1387 ~~627.730-627.7405~~ between the insured and the insurer under the
 1388 no-fault law, or between an assignee of an insured's rights and
 1389 the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as
 1390 provided in subsections (11) and (16) ~~(10) and (15)~~.

1391 (10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and
 1392 enter into contracts with preferred ~~licensed health care~~

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1393 providers for the benefits described in this section, ~~referred~~
1394 ~~to in this section as "preferred providers,"~~ which include shall
1395 ~~include~~ health care providers licensed under chapter 457,
1396 chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or
1397 chapter ~~and~~ 463.

1398 (a) The insurer may provide an option to an insured to use
1399 a preferred provider at the time of purchase of the policy for
1400 personal injury protection benefits, ~~if the requirements of this~~
1401 subsection are met. However, if the insurer offers a preferred
1402 provider option, it must also offer a nonpreferred provider
1403 policy. If the insured elects to use a provider who is not a
1404 preferred provider, whether the insured purchased a preferred
1405 provider policy or a nonpreferred provider policy, the medical
1406 benefits provided by the insurer must ~~shall~~ be as required by
1407 this section.

1408 (b) If the insured elects the ~~to use a provider who is a~~
1409 preferred provider option, the insurer may pay medical benefits
1410 in excess of the benefits required by this section and may waive
1411 or lower the amount of any deductible that applies to such
1412 medical benefits. As an alternative, or in addition to such
1413 benefits, waiver, or reduction, the insurer may provide an
1414 actuarially appropriate premium discount as specified in an
1415 approved rate filing to an insured who selects the preferred
1416 provider option. If the preferred provider option provides a
1417 premium discount, the insured forfeits the premium discount
1418 effective on the date that the insured elects to use a provider
1419 who is not a preferred provider and who renders nonemergency
1420 services, unless there is no member of the preferred provider
1421 network located within 15 miles of the insured's place of

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1422 residence whose scope of practice includes the required
 1423 services, or unless the nonemergency services are rendered in
 1424 the emergency room of a hospital licensed under chapter 395. ~~If~~
 1425 ~~the insurer offers a preferred provider policy to a policyholder~~
 1426 ~~or applicant, it must also offer a nonpreferred provider policy.~~

1427 (c) The insurer shall provide each insured ~~policyholder~~
 1428 with a current roster of preferred providers in the county in
 1429 which the insured resides at the time of purchasing ~~purchase of~~
 1430 such policy, and ~~shall~~ make such list available for public
 1431 inspection during regular business hours at the insurer's
 1432 principal office ~~of the insurer~~ within the state. The insurer
 1433 may contract with a health insurer to use an existing preferred
 1434 provider network to implement the preferred provider option. All
 1435 providers and entities that are eligible to receive
 1436 reimbursement pursuant to paragraph (1)(a) may provide services
 1437 through a preferred provider network. Any other arrangement is
 1438 subject to the approval of the Office of Insurance Regulation.

1439 ~~(11)-(10)~~ DEMAND LETTER.-

1440 (a) As a condition precedent to filing any action for
 1441 benefits under this section, the claimant filing suit must
 1442 provide the insurer ~~must be provided~~ with written notice of an
 1443 intent to initiate litigation. Such notice may not be sent until
 1444 the claim is overdue, including any additional time the insurer
 1445 has to pay the claim pursuant to paragraph (4)(b). A premature
 1446 demand letter is defective and cannot be cured unless the court
 1447 first abates the action or the claimant first voluntarily
 1448 dismisses the action.

1449 (b) The ~~notice~~ required notice must ~~shall~~ state that it is
 1450 a "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with

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1451 specificity:

1452 1. The name of the insured upon which such benefits are
1453 being sought, including a copy of the assignment giving rights
1454 to the claimant if the claimant is not the insured.

1455 2. The claim number or policy number upon which such claim
1456 was originally submitted to the insurer.

1457 3. To the extent applicable, the name of any medical
1458 provider who rendered to an insured the treatment, services,
1459 accommodations, or supplies that form the basis of such claim;
1460 and an itemized statement specifying each exact amount, the date
1461 of treatment, service, or accommodation, and the type of benefit
1462 claimed to be due. A completed form satisfying the requirements
1463 of paragraph (6) ~~(5)~~ (d) or the lost-wage statement previously
1464 submitted may be used as the itemized statement. ~~To the extent~~
1465 ~~that the demand involves an insurer's withdrawal of payment~~
1466 ~~under paragraph (7) (a) for future treatment not yet rendered,~~
1467 ~~the claimant shall attach a copy of the insurer's notice~~
1468 ~~withdrawing such payment and an itemized statement of the type,~~
1469 ~~frequency, and duration of future treatment claimed to be~~
1470 ~~reasonable and medically necessary.~~

1471 (c) Each notice required by this subsection must be
1472 delivered to the insurer by United States certified or
1473 registered mail, return receipt requested. Such postal costs
1474 shall be reimbursed by the insurer if ~~so~~ requested by the
1475 claimant in the notice, when the insurer pays the claim. Such
1476 notice must be sent to the person and address specified by the
1477 insurer for the purposes of receiving notices under this
1478 subsection. Each licensed insurer, whether domestic, foreign, or
1479 alien, shall file with the office designation of the name and

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1480 address of the person to whom notices must ~~pursuant to this~~
1481 ~~subsection shall~~ be sent which the office shall make available
1482 on its Internet website. The name and address on file with the
1483 office pursuant to s. 624.422 shall be deemed the authorized
1484 representative to accept notice pursuant to this subsection if
1485 ~~in the event~~ no other designation has been made.

1486 (d) If, within 30 days after receipt of notice by the
1487 insurer, the overdue claim specified in the notice is paid by
1488 the insurer together with applicable interest and a penalty of
1489 10 percent of the overdue amount paid by the insurer, subject to
1490 a maximum penalty of \$250, no action may be brought against the
1491 insurer. ~~If the demand involves an insurer's withdrawal of~~
1492 ~~payment under paragraph (7)(a) for future treatment not yet~~
1493 ~~rendered, no action may be brought against the insurer if,~~
1494 ~~within 30 days after its receipt of the notice, the insurer~~
1495 ~~mails to the person filing the notice a written statement of the~~
1496 ~~insurer's agreement to pay for such treatment in accordance with~~
1497 ~~the notice and to pay a penalty of 10 percent, subject to a~~
1498 ~~maximum penalty of \$250, when it pays for such future treatment~~
1499 ~~in accordance with the requirements of this section. To the~~
1500 ~~extent~~ the insurer determines not to pay any amount demanded,
1501 the penalty is ~~shall not be~~ payable in any subsequent action.
1502 For purposes of this subsection, payment or the insurer's
1503 agreement is ~~shall be~~ treated as being made on the date a draft
1504 or other valid instrument that is equivalent to payment, or the
1505 insurer's written statement of agreement, is placed in the
1506 United States mail in a properly addressed, postpaid envelope,
1507 or if not so posted, on the date of delivery. The insurer is not
1508 obligated to pay any attorney's fees if the insurer pays the

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1509 claim or mails its agreement to pay for future treatment within
1510 the time prescribed by this subsection.

1511 (e) The applicable statute of limitation for an action
1512 under this section shall be tolled for ~~a period of~~ 30 business
1513 days by the mailing of the notice required by this subsection.

1514 (f) A demand letter that does not meet the minimum
1515 requirements set forth in this subsection or that is sent during
1516 the pendency of the lawsuit is defective. A defective demand
1517 letter cannot be cured unless the court first abates the action
1518 or the claimant first voluntarily dismisses the action.

1519 (g) ~~(f)~~ An Any insurer making a general business practice of
1520 not paying valid claims until receipt of the notice required by
1521 this subsection is engaging in an unfair trade practice under
1522 the insurance code.

1523 (h) If the insurer pays in response to a demand letter and
1524 the claimant disputes the amount paid, the claimant must send a
1525 second demand letter by certified or registered mail stating the
1526 exact amount that the claimant believes the insurer owes and why
1527 the claimant believes the amount paid is incorrect. The insurer
1528 has an additional 10 days after receipt of the second letter to
1529 issue any additional payment that is owed. The purpose of this
1530 provision is to avoid unnecessary litigation over miscalculated
1531 payments.

1532 (i) Demand letters may not be used to request the
1533 production of claim documents or other records from the insurer.

1534 Section 9. Subsection (10) of section 817.234, Florida
1535 Statutes, is amended, present subsection (12) of that section is
1536 renumbered as subsection (13) and amended, and a new subsection
1537 (12) is added to that section, to read:

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1538 817.234 False and fraudulent insurance claims.—

1539 (10) (a) Any person who owns an business entity eligible for
1540 reimbursement under s. 627.736(1) and who is found guilty of
1541 insurance fraud under this section shall lose his or her
1542 occupational license for such entity for 5 years and may not
1543 receive reimbursement for personal injury protection benefits
1544 for 10 years.

1545 (b) Any licensed health care practitioner found guilty of
1546 insurance fraud under this section shall lose his or her license
1547 to practice for 5 years and may not receive reimbursement for
1548 personal injury protection benefits for 10 years. As used in
1549 this section, the term "insurer" means any insurer, health
1550 maintenance organization, self-insurer, self-insurance fund, or
1551 other similar entity or person regulated under chapter 440 or
1552 chapter 641 or by the Office of Insurance Regulation under the
1553 Florida Insurance Code.

1554 (12) In addition to any criminal liability, a person
1555 convicted of violating any provision of this section for the
1556 purpose of receiving insurance proceeds from a motor vehicle
1557 insurance contract is subject to a civil penalty.

1558 (a) Except for a violation of subsection (9), the civil
1559 penalty shall be:

1560 1. A fine up to \$5,000 for a first offense.

1561 2. A fine greater than \$5,000, but not to exceed \$10,000,
1562 for a second offense.

1563 3. A fine greater than \$10,000, but not to exceed \$15,000,
1564 for a third or subsequent offense.

1565 (b) The civil penalty for a violation of subsection (9)
1566 must be at least \$15,000, but may not exceed \$50,000.

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1567 (c) The civil penalty shall be paid to the Insurance
1568 Regulatory Trust Fund within the Department of Financial
1569 Services and used by the department for the investigation and
1570 prosecution of insurance fraud.

1571 (d) This subsection does not prohibit a state attorney from
1572 entering into a written agreement in which the person charged
1573 with the violation does not admit to or deny the charges but
1574 consents to payment of the civil penalty.

1575 (13)~~(12)~~ As used in this section, the term:

1576 (a) "Insurer" means any insurer, health maintenance
1577 organization, self-insurer, self-insurance fund, or similar
1578 entity or person regulated under chapter 440 or chapter 641 or
1579 by the Office of Insurance Regulation under the Florida
1580 Insurance Code.

1581 (b)~~(a)~~ "Property" means property as defined in s. 812.012.

1582 (c)~~(b)~~ "Value" has the same meaning ~~means value~~ as provided
1583 defined in s. 812.012.

1584 Section 10. Subsection (1) of section 324.021, Florida
1585 Statutes, is amended to read:

1586 324.021 Definitions; minimum insurance required.—The
1587 following words and phrases when used in this chapter shall, for
1588 the purpose of this chapter, have the meanings respectively
1589 ascribed to them in this section, except in those instances
1590 where the context clearly indicates a different meaning:

1591 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
1592 is designed and required to be licensed for use upon a highway,
1593 including trailers and semitrailers designed for use with such
1594 vehicles, except traction engines, road rollers, farm tractors,
1595 power shovels, and well drillers, and every vehicle that ~~which~~

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1596 is propelled by electric power obtained from overhead wires but
1597 not operated upon rails, but not including any bicycle or moped.
1598 However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~
1599 motor vehicle as defined in s. 627.732(3) if ~~when~~ the owner of
1600 such vehicle has complied with the no-fault law requirements of
1601 ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s.
1602 324.051 apply; and, in such case, the applicable proof of
1603 insurance provisions of s. 320.02 apply.

1604 Section 11. Paragraph (k) of subsection (2) of section
1605 456.057, Florida Statutes, is amended to read:

1606 456.057 Ownership and control of patient records; report or
1607 copies of records to be furnished.—

1608 (2) As used in this section, the terms "records owner,"
1609 "health care practitioner," and "health care practitioner's
1610 employer" do not include any of the following persons or
1611 entities; furthermore, the following persons or entities are not
1612 authorized to acquire or own medical records, but are authorized
1613 under the confidentiality and disclosure requirements of this
1614 section to maintain those documents required by the part or
1615 chapter under which they are licensed or regulated:

1616 (k) Persons or entities practicing under s. 627.736(8)
1617 ~~627.736(7)~~.

1618 Section 12. Paragraph (b) of subsection (1) of section
1619 627.7401, Florida Statutes, is amended to read:

1620 627.7401 Notification of insured's rights.—

1621 (1) The commission, by rule, shall adopt a form for the
1622 notification of insureds of their right to receive personal
1623 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1624 fault law. Such notice shall include:

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1625 (b) An advisory informing insureds that:

1626 1. Pursuant to s. 626.9892, the Department of Financial
1627 Services may pay rewards of up to \$25,000 to persons providing
1628 information leading to the arrest and conviction of persons
1629 committing crimes investigated by the Division of Insurance
1630 Fraud arising from violations of s. 440.105, s. 624.15, s.
1631 626.9541, s. 626.989, or s. 817.234.

1632 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
1633 insured notifies the insurer of a billing error, the insured may
1634 be entitled to a certain percentage of a reduction in the amount
1635 paid by the insured's motor vehicle insurer.

1636 Section 13. This act shall take effect July 1, 2011.