

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE

Senator Richter, Chair
Senator Smith, Vice Chair

MEETING DATE: Tuesday, April 12, 2011

TIME: 9:15 a.m.—12:15 p.m.

PLACE: Pat Thomas Committee Room, 412 Knott Building

MEMBERS: Senator Richter, Chair; Senator Smith, Vice Chair; Senators Alexander, Bennett, Bogdanoff, Fasano, Hays, Margolis, Negron, Oelrich, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 1930 Bogdanoff (Compare CS/CS/H 967, CS/H 1411, S 1694)	Motor Vehicle Personal Injury Protection Insurance; Revises provisions relating to the contents of written reports of motor vehicle crashes. Requires that an application for licensure as a mobile clinic include a statement regarding insurance fraud. Authorizes the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity, etc.	
		BI 03/29/2011 Temporarily Postponed BI 04/05/2011 Temporarily Postponed BI 04/12/2011 CJ BC	
2	SB 1694 Richter (Compare CS/CS/H 967, CS/H 1411, S 1930)	Motor Vehicle Personal Injury Protection Insurance; Provides that the circuit court has exclusive jurisdiction in actions involving challenges to arbitration decisions under the Florida Motor Vehicle No-Fault Law. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity. Provides that an insurer that requests an examination under oath in a manner that is inconsistent with the policy is engaging in an unfair and deceptive trade practice, etc.	
		BI 03/29/2011 Not Considered BI 04/05/2011 Not Considered BI 04/12/2011 JU BC	

COMMITTEE MEETING EXPANDED AGENDA

Banking and Insurance

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TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	CS/SB 1522 Health Regulation / Gaetz (Compare CS/H 119, CS/CS/H 445, CS/S 1736, CS/CS/S 1972)	Wellness or Health Improvement Programs; Authorizes insurers to offer a voluntary wellness or health improvement program and to encourage or reward participation in the program by offering rewards or incentives to health benefit plan members. Authorizes insurers to require plan members not participating in the wellness or health improvement programs to provide verification that their medical condition warrants nonparticipation in order for the nonparticipants to receive rewards or incentives. Requires that the reward or incentive be disclosed in the policy or certificate, etc. HR 03/22/2011 Fav/CS BI 04/12/2011 RC	
4	SB 1500 Latvala (Identical H 1019, Compare CS/CS/S 1972)	Foster Care Providers; Decreases the limits of liability and requisite insurance coverage for lead community-based providers and subcontractors. Provides immunity from liability for the Department of Children and Family Services for acts or omissions of a community-based provider or subcontractor, or the officers, agents, or employees thereof. BI 03/29/2011 Not Considered BI 04/05/2011 Not Considered BI 04/12/2011 CF JU BC	
5	SB 1590 Hays (Compare CS/CS/H 479, S 1892, CS/CS/S 1972)	Medical Malpractice Actions; Requires the Board of Medicine and the Board of Osteopathic Medicine to issue expert witness certificates to physicians licensed outside the state. Provides application and certification requirements. Revises the length of devoted, professional time required in order for a health care provider to qualify to give expert testimony regarding the prevailing professional standard of care. Requires that presuit notice for medical negligence claims be accompanied by an authorization for release of protected health information, etc. HR 03/30/2011 Not Considered HR 04/04/2011 Favorable BI 04/12/2011 BC	



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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/11/2011	.	
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The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

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

316.066 Written reports of crashes.—

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



552780

13 1. That resulted in death, ~~or~~ personal injury, or any
14 indication of complaints of pain or discomfort by any of the
15 parties or passengers involved in the crash;~~—~~

16 2. That involved one or more passengers, other than the
17 drivers of the vehicles, in any of the vehicles involved in the
18 crash;

19 ~~3.2.~~ That involved a violation of s. 316.061(1) or s.
20 316.193; ~~or~~—

21 ~~4.3.~~ In which a vehicle was rendered inoperative to a
22 degree that required a wrecker to remove it from traffic, if
23 such action is appropriate, in the officer's discretion.

24 (b) In every crash for which a Florida Traffic Crash
25 Report, Long Form, is not required by this section, the law
26 enforcement officer may complete a short-form crash report or
27 provide a short-form crash report to be completed by each party
28 involved in the crash. Short-form crash reports prepared by the
29 law enforcement officer shall be maintained by the officer's
30 agency.

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

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

33 2. A description of the vehicles involved.

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

35 4. The names and addresses of all passengers in all
36 vehicles involved in the crash, each clearly identified as being
37 a passenger and the identification of the vehicle in which they
38 were a passenger.

39 ~~5.4.~~ The names and addresses of witnesses.

40 ~~6.5.~~ The name, badge number, and law enforcement agency of
41 the officer investigating the crash.



552780

42 7.6. The names of the insurance companies for the
43 respective parties involved in the crash.

44 (d)~~(c)~~ Each party to the crash must ~~shall~~ provide the law
45 enforcement officer with proof of insurance, which must ~~to~~ be
46 included in the crash report. If a law enforcement officer
47 submits a report on the accident, proof of insurance must be
48 provided to the officer by each party involved in the crash. Any
49 party who fails to provide the required information commits a
50 noncriminal traffic infraction, punishable as a nonmoving
51 violation as provided in chapter 318, unless the officer
52 determines that due to injuries or other special circumstances
53 such insurance information cannot be provided immediately. If
54 the person provides the law enforcement agency, within 24 hours
55 after the crash, proof of insurance that was valid at the time
56 of the crash, the law enforcement agency may void the citation.

57 (e)~~(d)~~ The driver of a vehicle that was in any manner
58 involved in a crash resulting in damage to any vehicle or other
59 property in an amount of \$500 or more, ~~which crash~~ was not
60 investigated by a law enforcement agency, shall, within 10 days
61 after the crash, submit a written report of the crash to the
62 department or traffic records center. The entity receiving the
63 report may require witnesses of the crash ~~crashes~~ to render
64 reports and may require any driver of a vehicle involved in a
65 crash of which a written report must be made ~~as provided in this~~
66 ~~section~~ to file supplemental written reports if ~~whenever~~ the
67 original report is deemed insufficient by the receiving entity.

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



552780

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

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

400.991 License requirements; background screenings; prohibitions.—

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

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

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

626.9894 Motor vehicle insurance fraud direct-support organization.—

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

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

(b) "Motor vehicle insurance fraud" means any act defined



552780

as a "fraudulent insurance act" under s. 626.989, which relates to the coverage of motor vehicle insurance as described in part XI of chapter 627.

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

(2) ORGANIZATION ESTABLISHED.—The division may establish a direct-support organization, to be known as the "Automobile Insurance Fraud Strike Force," whose sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The organization shall:

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

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



552780

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

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

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

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

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

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

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

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

(e) Reversion of moneys and property held in trust by the



552780

organization for motor vehicle insurance fraud prosecution,
investigation, and prevention to the division if the
organization is no longer approved to operate for the department
or if the organization ceases to exist, or to the state if the
division ceases to exist.

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

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

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

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

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

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

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

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

The officer who appointed a member of the board may remove that
member for cause. The term of office of an appointed member
expires at the same time as the term of the officer who



552780

187 appointed him or her or at such earlier time as the person
188 ceases to be qualified.

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

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

195 (b) The department may not authorize the use of the
196 division's property or facilities if the organization does not
197 provide equal membership and employment opportunities to all
198 persons regardless of race, religion, sex, age, or national
199 origin.

200 (c) The department shall adopt rules prescribing the
201 procedures by which the organization is governed and any
202 conditions with which the organization must comply to use the
203 division's property or facilities.

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

207 (7) DEPOSITORY.—Any moneys received by the organization may
208 be held in a separate depository account in the name of the
209 organization and subject to the provisions of the contract with
210 the division.

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

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



552780

216 627.4137 Disclosure of certain information required.-

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

220 Section 5. Section 627.730, Florida Statutes, is amended to
221 read:

222 627.730 Florida Motor Vehicle No-Fault Law.-Sections
223 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the
224 "Florida Motor Vehicle No-Fault Law."

225 Section 6. Section 627.731, Florida Statutes, is amended to
226 read:

227 627.731 Purpose; legislative intent.-The purpose of the no-
228 fault law ss. 627.730-627.7405 is to provide for medical,
229 surgical, funeral, and disability insurance benefits without
230 regard to fault, and to require motor vehicle insurance securing
231 such benefits, for motor vehicles required to be registered in
232 this state and, with respect to motor vehicle accidents, a
233 limitation on the right to claim damages for pain, suffering,
234 mental anguish, and inconvenience.

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

240 (2) The Legislature intends to balance the insured's
241 interest in prompt payment of valid claims for insurance
242 benefits under the no-fault law with the public's interest in
243 reducing fraud, abuse, and overuse of the no-fault system. To
244 that end, the Legislature intends that the investigation and



552780

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

(3) The Legislature intends that:

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

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

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

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

(e) The insured's interest in obtaining competent counsel



552780

274 must be balanced with the public's interest in preventing a no-
275 fault system that encourages litigation by allowing for
276 exorbitant attorney's fees. Courts should limit attorney fee
277 awards so as to eliminate the incentive for attorneys to
278 manufacture unnecessary litigation.

279 Section 7. Section 627.7311, Florida Statutes, is created
280 to read:

281 627.7311 Implementation of no-fault law.—The provisions,
282 schedules, and procedures authorized under the no-fault law
283 shall be implemented by insurers and have full force and effect
284 regardless of their express inclusion in an insurance policy,
285 and an insurer is not required to amend its policy to implement
286 such provisions, schedules, or procedures.

287 Section 8. Section 627.732, Florida Statutes, is reordered
288 and amended to read:

289 627.732 Definitions.—As used in the no-fault law ~~ss.~~
290 ~~627.730–627.7405~~, the term:

291 (1) "Broker" means any person not possessing a license
292 under chapter 395, chapter 400, chapter 429, chapter 458,
293 chapter 459, chapter 460, chapter 461, or chapter 641 who
294 charges or receives compensation for any use of medical
295 equipment and is not the 100-percent owner or the 100-percent
296 lessee of such equipment. For purposes of this section, such
297 owner or lessee may be an individual, a corporation, a
298 partnership, or any other entity and any of its 100-percent-
299 owned affiliates and subsidiaries. For purposes of this
300 subsection, the term "lessee" means a long-term lessee under a
301 capital or operating lease, but does not include a part-time
302 lessee. The term "broker" does not include a hospital or



552780

physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; or ~~nor does the term include~~ a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment may not ~~cannot~~ be used by patients who are not patients of the registered clinic ~~for medical treatment of services~~. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period ~~provided in this paragraph~~ may be extended for an additional 60



552780

days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

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

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

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

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

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

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

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

The term ~~"motor vehicle"~~ does not include a mobile home or any motor vehicle that ~~which~~ is used in mass transit, other than public school transportation, and designed to transport more



552780

than five passengers exclusive of the operator of the motor vehicle and that ~~which~~ is owned by a municipality, a transit authority, or a political subdivision of the state.

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

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

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

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

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

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

(5)~~(8)~~ "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can respond



552780

immediately to any emergencies if needed.

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

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

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

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

~~(14)-(13)~~ "Properly completed" means providing truthful, substantially complete, and substantially accurate responses ~~as~~ to all material elements of ~~to~~ each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as agreed by the parties.

~~(17)-(14)~~ "Upcoding" means submitting ~~an action that submits~~ a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. The term does not include an



552780

otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

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

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

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

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 must ~~shall~~ provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to ~~the provisions of~~ subsection (2) and paragraph (4) (h) ~~(4) (e)~~, to a limit of \$10,000 for loss sustained by ~~any~~ such person as a



552780

result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

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

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

2. A person or entity licensed under part III of chapter 401 which ss. 401.21-401.45 ~~that~~ provides emergency transportation and treatment.

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

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

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



552780

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

b. A health care clinic that:

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

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

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

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

6. An acupuncturist licensed under chapter 457.

If any services under this paragraph are provided by an entity or clinic described in subparagraph 3., subparagraph 4., or subparagraph 5., the entity or clinic must provide the insurer



552780

at the initial submission of the claim with a form adopted by the Department of Financial Services which documents that the entity or clinic meets applicable criteria for such entity or clinic and includes a sworn statement or affidavit to that effect. Any change in ownership requires the filing of a new form within 10 days after the date of the change in ownership. ~~The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.~~

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

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



552780

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

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under the no-fault law ~~are ss. 627.730-627.7405~~ shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues, upon the receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the Agency for Health Care Administration provides, pays, or becomes



552780

liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits are ~~under ss. 627.730-627.7405~~ shall be subject to the provisions of the Medicaid program.

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

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

(c) If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this does ~~shall~~ not limit the introduction of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the



552780

name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. An insurer's failure to send an itemized specification or explanation of benefits does not waive other grounds for rejecting an invalid claim.

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

(e) The 30-day period for payment is tolled while the insurer investigates a fraudulent insurance act, as defined in s. 626.989, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify the claimant in



552780

622 writing that it is investigating a fraudulent insurance act
623 within 30 days after the date it has a reasonable belief that
624 such act has been committed. The insurer must pay or deny the
625 claim, in full or in part, within 90 days after the date the
626 written notice of the fact of a covered loss and of the amount
627 of the loss was provided to the insurer. However, no payment is
628 due to a claimant that has violated paragraph (k).

629 (f)(e) Notwithstanding any local lien law, upon receiving
630 notice of an accident that is potentially covered by personal
631 injury protection benefits, the insurer must reserve \$5,000 of
632 personal injury protection benefits for payment to physicians
633 licensed under chapter 458 or chapter 459 or dentists licensed
634 under chapter 466 who provide emergency services and care, as
635 defined in s. 395.002(9), or who provide hospital inpatient
636 care. The amount required to be held in reserve may be used only
637 to pay claims from such physicians or dentists until 30 days
638 after the date the insurer receives notice of the accident.
639 After the 30-day period, any amount of the reserve for which the
640 insurer has not received notice of such a claim ~~from a physician~~
641 ~~or dentist who provided emergency services and care or who~~
642 ~~provided hospital inpatient care~~ may then be used by the insurer
643 to pay other claims. The time periods specified in paragraph (b)
644 for ~~required~~ payment of personal injury protection benefits are
645 ~~shall be~~ tolled for the period of time that an insurer is
646 ~~required by this paragraph~~ to hold payment of a claim that is
647 not from a physician or dentist who provided emergency services
648 and care or who provided hospital inpatient care to the extent
649 that the personal injury protection benefits not held in reserve
650 are insufficient to pay the claim. This paragraph does not



552780

require an insurer to establish a claim reserve for insurance accounting purposes.

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

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

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

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

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2. if, provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under the no-fault law ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any



552780

other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle ~~if, provided~~ the injured person is not ~~himself or herself~~:

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

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

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

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

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

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

2. Submits false or misleading information; or

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



552780

709
710 A claimant that violates this paragraph is not entitled to any
711 personal injury protection benefits or payment for any bills and
712 services, regardless of whether a portion of the claim may be
713 legitimate. However, a claimant that does not violate this
714 paragraph may not be denied benefits solely due to a violation
715 by another claimant.

716 (1) Notwithstanding any remedies afforded by law, the
717 insurer may recover from a claimant who violates paragraph (k)
718 any sums previously paid to a claimant and may bring any
719 available common law and statutory causes of action. A claimant
720 has violated paragraph (k) committed, by a material act or
721 omission, any insurance fraud relating to personal injury
722 protection coverage under his or her policy, if the fraud is
723 admitted to in a sworn statement by the insured or if it is
724 established in a court of competent jurisdiction. Any insurance
725 fraud voids shall void all coverage arising from the claim
726 related to such fraud under the personal injury protection
727 coverage of the claimant insured person who committed the fraud,
728 irrespective of whether a portion of the insured person's claim
729 may be legitimate, and any benefits paid before prior to the
730 discovery of the insured person's insurance fraud is shall be
731 recoverable by the insurer from the claimant person who
732 committed insurance fraud in their entirety. The prevailing
733 party is entitled to its costs and attorney's fees in any action
734 in which it prevails in an insurer's action to enforce its right
735 of recovery under this paragraph. This paragraph does not
736 preclude or limit an insurer's right to deny a claim based on
737 other evidence of fraud or affect an insurer's right to plead



552780

and prove a claim or defense of fraud under common law. If a physician, hospital, clinic, or other medical institution violates paragraph (k), the injured party is not liable for, and the physician, hospital, clinic, or other medical institution may not bill the insured for, charges that are unpaid because of failure to comply with paragraph (k). Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

(a) Any records review need not be based on a physical examination and may be obtained at any time, including after reduction or denial of the claim.

1. The records review must be conducted by a practitioner within the same licensing chapter as the medical provider whose records are being reviewed unless the records review is performed by a physician licensed under chapter 458 or chapter 459.

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

3. The insured, claimant, or medical provider may impose a reasonable, cost-based fee that includes only the cost of copying and postage and not the cost of labor for copying.

(b) In all circumstances, an insured seeking benefits under the no-fault law must comply with the terms of the policy, which includes, but is not limited to, submitting to examinations



552780

under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

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

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

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

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

(a) ~~1.~~ Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, However, may such charges may not exceed the reimbursement schedule under this paragraph a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments



552780

accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

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

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

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

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

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

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

f. For all other medical services, ~~supplies, and care,~~ 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For all other supplies



552780

and care, including durable medical equipment and care and services rendered by ambulatory surgical centers and clinical laboratories, 200 percent of the allowable amount under Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

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

~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her



552780

license, regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

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

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

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

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

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

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

e. Except for emergency treatment and care, if the insured failed to countersign a billing form or patient log related to such claim or charges. Failure to submit a countersigned billing form or patient log creates a rebuttable presumption that the insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the subject treatment and loss until the insurer is able to verify that the



552780

insured received the alleged treatment. As used in this sub-
subparagraph, the term "countersigned" means a second or
verifying signature, as on a previously signed document, and is
not satisfied by the statement "signature on file" or any
similar statement;

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

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

2. The Department of Health, in consultation with the
appropriate professional licensing boards, shall adopt, by rule,
a list of diagnostic tests deemed not to be medically necessary
for use in the treatment of persons sustaining bodily injury



552780

covered by personal injury protection benefits under this section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~ and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list ~~must of invalid diagnostic tests shall~~ be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and ~~may shall~~ not be dependent for results entirely upon subjective patient response.

Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.

(c)~~1.~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider ~~may shall~~ not bill the injured party for, charges



552780

that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

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

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



552780

and Medicaid Services ~~Health Care Finance Administration.~~

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

BILLING REQUIREMENTS.—Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the first billing cycle statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers



552780

999 ~~must shall~~, to the extent applicable, follow the Physicians'
1000 Current Procedural Terminology (CPT) or Healthcare Correct
1001 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1002 year in which services are rendered and comply with the ~~Centers~~
1003 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
1004 and the American Medical Association Current Procedural
1005 Terminology (CPT) Editorial Panel and Healthcare Correct
1006 Procedural Coding System (HCPCS). All providers other than
1007 hospitals shall include on the applicable claim form the
1008 professional license number of the provider in the line or space
1009 provided for "Signature of Physician or Supplier, Including
1010 Degrees or Credentials." In determining compliance with
1011 applicable CPT and HCPCS coding, guidance shall be provided by
1012 the Physicians' Current Procedural Terminology (CPT) or the
1013 Healthcare Correct Procedural Coding System (HCPCS) in effect
1014 for the year in which services were rendered, the Office of the
1015 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1016 other authoritative treatises designated by rule by the Agency
1017 for Health Care Administration. A ~~No~~ statement of medical
1018 services may not include charges for medical services of a
1019 person or entity that performed such services without possessing
1020 the valid licenses required to perform such services. For
1021 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
1022 considered to have been furnished with notice of the amount of
1023 covered loss or medical bills due unless the statements or bills
1024 comply with this paragraph, and unless the statements or bills
1025 ~~are comply with this paragraph, and unless the statements or~~
1026 ~~bills are~~ properly completed in their entirety as to all
1027 material provisions, with all relevant information being



552780

provided therein. If an insurer denies a claim due to a provider's failure to submit a properly completed form, the insurer shall notify the provider as to the provisions that were improperly completed, and the provider shall have 15 days after the receipt of such notice to submit a properly completed form. If the provider fails to comply with this requirement, the insurer is not required to pay for the services that were billed on the improperly completed form.

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

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered. The services shall be described and listed on the disclosure and acknowledgement form in words readable by the insured. If the insured cannot read, the provider should verify, under penalty of perjury, that the services listed on the form were verbally explained to the insured before the insured signs the form. Listing CPT codes or other coding on the disclosure and acknowledgment form does not satisfy this requirement;

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

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



552780

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

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

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

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

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

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



552780

1086 of the amount of a covered loss or medical bills due.

1087 6. This disclosure and acknowledgment form is not required
1088 for services billed by a provider for emergency services as
1089 defined in s. 395.002, for emergency services and care as
1090 defined in s. 395.002 rendered in a hospital emergency
1091 department, or for transport and treatment rendered by an
1092 ambulance provider licensed pursuant to part III of chapter 401.

1093 7. The Financial Services Commission shall adopt, by rule,
1094 a standard disclosure and acknowledgment form to that shall be
1095 used to fulfill the requirements of this paragraph, ~~effective 90~~
1096 ~~days after such form is adopted and becomes final. The~~
1097 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1098 ~~the rule is final, the provider may use a form of its own which~~
1099 ~~otherwise complies with the requirements of this paragraph.~~

1100 8. As used in this paragraph, the term "countersigned" or
1101 "countersignature" means a second or verifying signature, as on
1102 a previously signed document, and is not satisfied by the
1103 statement "signature on file" or any similar statement.

1104 9. The requirements of this paragraph apply only with
1105 respect to the initial treatment or service of the insured by a
1106 provider. For subsequent treatments or service, the provider
1107 must maintain a patient log signed by the patient, in
1108 chronological order by date of service, which describes the
1109 treatment rendered in a language readable by the insured ~~that is~~
1110 ~~consistent with the services being rendered to the patient as~~
1111 ~~claimed. Listing CPT codes or other coding on the patient log~~
1112 does not satisfy this requirement. The provider must provide
1113 copies of the patient log to the insurer within 30 days after
1114 receiving a written request from the insurer. Failure to



552780

maintain a patient log renders the treatment unlawful and noncompensable. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

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

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

(7)-(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
DISPUTES.—

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which



552780

a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request, and furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment ~~if, provided that this does shall~~ not limit the introduction of evidence at trial. Such sworn statement ~~must shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." ~~A No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of this~~



552780

section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith.

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

2. If an insured seeking to recover benefits pursuant to the no-fault law assigns the contractual right to those benefits or payment of those benefits to any person or entity, the assignee must comply with the terms of the policy. In all circumstances, the assignee is obligated to cooperate under the policy, which includes, but is not limited to, participating in an examination under oath. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof. Compliance with this paragraph is a condition precedent to recovery of benefits pursuant to the no-fault law.

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having



552780

the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer which are reasonably obtainable by the claimant.

b. Before requesting that an assignee participate in an examination under oath, the insurer must send a written request to the assignee requesting all information that the insurer believes is necessary to process the claim, including the information contemplated under this subparagraph.

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

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

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may



552780

thereafter examine, him or her in respect to the same mental or physical condition. If a person fails to appear for ~~unreasonably refuses to submit to~~ an examination, the personal injury protection carrier is not required to pay ~~no longer liable for subsequent~~ personal injury protection benefits incurred after the date of the first requested examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to the recovery of benefits.

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

(10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which include ~~shall include~~ health care providers licensed under chapter 457, ~~chapter~~ chapters 458, chapter 459, chapter 460, chapter 461, or chapter ~~and 463.~~

(a) The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy. ~~If the insured elects to use a provider who is not a~~



552780

~~preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section.~~

(b) If the insured elects the to use a provider who is a preferred provider option, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the policy may provide that charges for nonemergency services provided within this state are payable only if performed by members of the preferred provider network unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services, or unless the nonemergency services are rendered in the emergency room of a hospital licensed under chapter 395. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.

(c) The insurer shall provide each insured policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchasing ~~purchase of~~ such policy, and ~~shall~~ make such list available for public inspection during regular business hours at the insurer's principal office ~~of the insurer~~ within the state. The insurer



552780

may contract with a health insurer for the right to use an existing preferred provider network to implement the preferred provider option. Any other arrangement is subject to the approval of the Office of Insurance Regulation.

~~(11)-(10)~~ DEMAND LETTER.—

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

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

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

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

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (6)-(5)(d) or the lost-wage statement previously



552780

submitted may be used as the itemized statement. ~~To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.~~

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

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of \$250, no action may be brought against the insurer. ~~If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet~~



552780

rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of \$250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty is ~~shall~~ not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement is ~~shall be~~ treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

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

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

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



552780

the insurance code.

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

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

Section 10. Paragraph (c) of subsection (7), and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(7)

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

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-~~



552780

~~insurance fund, or other similar entity or person regulated
under chapter 440 or chapter 641 or by the Office of Insurance
Regulation under the Florida Insurance Code.~~

~~(10)~~ (11) If the value of any property involved in a
violation of this section:

(a) Is less than \$20,000, the offender commits a felony of
the third degree, punishable as provided in s. 775.082, s.
775.083, or s. 775.084.

(b) Is \$20,000 or more, but less than \$100,000, the
offender commits a felony of the second degree, punishable as
provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is \$100,000 or more, the offender commits a felony of
the first degree, punishable as provided in s. 775.082, s.
775.083, or s. 775.084.

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

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

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

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

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

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

(c) The civil penalty shall be paid to the Insurance
Regulatory Trust Fund within the Department of Financial



552780

Services and used by the department for the investigation and prosecution of insurance fraud.

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

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

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

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

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

Section 11. Subsection (1) of section 324.021, Florida Statutes, is amended to read:

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

(1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~ is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use with such vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped.



552780

However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~ motor vehicle as defined in s. 627.732(3) if ~~when~~ the owner of such vehicle has complied with the no-fault law requirements of ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

Section 12. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

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

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

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

Section 13. Paragraph (b) of subsection (1) of section 627.7401, Florida Statutes, is amended to read:

627.7401 Notification of insured's rights.—

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

(b) An advisory informing insureds that:

1. Pursuant to s. 626.9892, the Department of Financial



552780

Services may pay rewards of up to \$25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

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

Section 14. This act shall take effect July 1, 2011.

===== T I T L E A M E N D M E N T =====
And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled
An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; requiring short-form crash reports by a law enforcement officer to be maintained by the officer's agency; authorizing the investigation officer to testify at trial or provide an affidavit concerning the content of the reports; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; creating s. 626.9894, F.S.; providing definitions; authorizing the Division of Insurance Fraud to establish a direct-



552780

support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for the organization and the organization's contract with the division; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; authorizing contributions from insurers; providing that any moneys received by the organization may be held in a separate depository account in the name of the organization; requiring the division to deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.4137, F.S.; requiring a claimant's request about insurance coverage to be appropriately served upon the disclosing entity; amending s. 627.730, F.S.; conforming a cross-reference; amending s. 627.731, F.S.; providing legislative intent with respect to the Florida Motor Vehicle No-Fault Law; creating s. 627.7311, F.S.; requiring the provisions, schedules, and procedures of the no-fault law to be implemented by insurers regardless of whether they are expressly stated in the policy; amending s. 627.732, F.S.; defining the terms "claimant" and "no-fault law"; amending s. 627.736, F.S.; conforming a cross-reference; adding acupuncturists to the list of authorized practitioners; requiring certain entities providing medical services to document that they meet required criteria; revising requirements relating to the form



552780

that must be submitted by providers; requiring an entity or clinic to file a new form within a specified period after the date of a change of ownership; revising provisions relating to when payment for a benefit is due; providing that an insurer's failure to send certain specification or explanation does not waive other grounds for rejecting an invalid claim; authorizing an insurer to obtain evidence and assert any ground for adjusting or rejecting a claim; providing that the time period for paying a claim is tolled during the investigation of a fraudulent insurance act; specifying when benefits are not payable; preempting local lien laws with respect to payment of benefits to medical providers; providing that a claimant that violates certain provisions is not entitled to any payment, regardless of whether a portion of the claim may be legitimate; authorizing an insurer to recover payments and bring a cause of action to recover payments; providing that an insurer may deny any claim based on other evidence of fraud; forbidding a physician, hospital, clinic, or other medical institution that fails to comply with certain provisions from billing the injured person or the insured; providing that an insurer has a right to conduct reasonable investigations of claims; authorizing an insurer to require a claimant to provide certain records; requiring a records review to be conducted by the same type of practitioner as the medical provider whose records are being reviewed or



552780

by a physician; specifying when the period for payment is tolled; authorizing an insurer to deny benefits if an insured, claimant, or medical provider fails to comply with certain provisions; forbidding the claimant from filing suit unless the claimant complies with the act; revising the insurer's reimbursement limitation; providing a limit on the amount of reimbursement; creating a rebuttable presumption that the insured did not receive the alleged treatment if the insured does not countersign the patient log; authorizing the insurer to deny a claim if the provider does not properly complete the required form within a certain time; requiring the provider to ensure that the insured understands the services being provided; specifying requirements for furnishing the insured with notice of the amount of covered loss; deleting an obsolete provision; requiring the provider to provide copies of the patient log within a certain time if requested by the insurer; providing that failure to maintain a patient log renders the treatment unlawful and noncompensable; revising requirements relating to discovery; authorizing the insurer to conduct a physical review of the treatment location; requiring the insured and assignee to comply with certain provisions to recover benefits; requiring the provider to produce persons having the most knowledge in specified circumstances; requiring the insurer to request certain information before requesting an assignee to participate in an



552780

examination under oath; providing that an insurer that requests an examination under oath without a reasonable basis is engaging in an unfair and deceptive trade practice; providing that failure to appear for scheduled examinations establishes a rebuttable presumption that such failure was unreasonable; authorizing an insurer to contract with a preferred provider network; authorizing an insurer to provide a premium discount to an insured who selects a preferred provider; authorizing an insurance policy to not pay for nonemergency services performed by a nonpreferred provider in specified circumstances; authorizing an insurer to contract with a health insurer in specified circumstances; revising requirements relating to demand letters in an action for benefits; specifying when a demand letter is defective; requiring a second demand letter under certain circumstances; deleting obsolete provisions; providing that a demand letter may not be used to request the production of claim documents or records from the insurer; amending s. 817.234, F.S.; conforming a cross-reference; providing civil penalties for fraudulent insurance claims; amending ss. 324.021, 456.057, and 627.7401, F.S.; conforming cross-references; providing an effective date.



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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/11/2011	.	
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The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment to Amendment (552780)

Delete lines 177 - 182
and insert:

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

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

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



100124

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

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

316.066 Written reports of crashes.—

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



100124

13 1. That resulted in death, ~~or~~ personal injury, or any
14 indication of complaints of pain or discomfort by any of the
15 parties or passengers involved in the crash;~~—~~

16 2. That involved one or more passengers, other than the
17 drivers of the vehicles, in any of the vehicles involved in the
18 crash;

19 ~~3.2.~~ That involved a violation of s. 316.061(1) or s.
20 316.193; ~~or~~—

21 ~~4.3.~~ In which a vehicle was rendered inoperative to a
22 degree that required a wrecker to remove it from traffic, if
23 such action is appropriate, in the officer's discretion.

24 (b) In every crash for which a Florida Traffic Crash
25 Report, Long Form, is not required by this section, the law
26 enforcement officer may complete a short-form crash report or
27 provide a short-form crash report to be completed by each party
28 involved in the crash. Short-form crash reports prepared by the
29 law enforcement officer shall be maintained by the officer's
30 agency.

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

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

33 2. A description of the vehicles involved.

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

35 4. The names and addresses of all passengers in all
36 vehicles involved in the crash, each clearly identified as being
37 a passenger and the identification of the vehicle in which they
38 were a passenger.

39 ~~5.4.~~ The names and addresses of witnesses.

40 ~~6.5.~~ The name, badge number, and law enforcement agency of
41 the officer investigating the crash.



100124

42 7.6. The names of the insurance companies for the
43 respective parties involved in the crash.

44 (d)~~(c)~~ Each party to the crash must ~~shall~~ provide the law
45 enforcement officer with proof of insurance, which must ~~to~~ be
46 included in the crash report. If a law enforcement officer
47 submits a report on the accident, proof of insurance must be
48 provided to the officer by each party involved in the crash. Any
49 party who fails to provide the required information commits a
50 noncriminal traffic infraction, punishable as a nonmoving
51 violation as provided in chapter 318, unless the officer
52 determines that due to injuries or other special circumstances
53 such insurance information cannot be provided immediately. If
54 the person provides the law enforcement agency, within 24 hours
55 after the crash, proof of insurance that was valid at the time
56 of the crash, the law enforcement agency may void the citation.

57 (e)~~(d)~~ The driver of a vehicle that was in any manner
58 involved in a crash resulting in damage to any vehicle or other
59 property in an amount of \$500 or more, ~~which crash~~ was not
60 investigated by a law enforcement agency, shall, within 10 days
61 after the crash, submit a written report of the crash to the
62 department or traffic records center. The entity receiving the
63 report may require witnesses of the crash ~~crashes~~ to render
64 reports and may require any driver of a vehicle involved in a
65 crash of which a written report must be made ~~as provided in this~~
66 ~~section~~ to file supplemental written reports if ~~whenever~~ the
67 original report is deemed insufficient by the receiving entity.

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



100124

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

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

400.991 License requirements; background screenings; prohibitions.—

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

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

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

626.9894 Motor vehicle insurance fraud direct-support organization.—

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

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

(b) "Motor vehicle insurance fraud" means any act defined



100124

as a "fraudulent insurance act" under s. 626.989, which relates to the coverage of motor vehicle insurance as described in part XI of chapter 627.

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

(2) ORGANIZATION ESTABLISHED.—The division may establish a direct-support organization, to be known as the "Automobile Insurance Fraud Strike Force," whose sole purpose is to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The organization shall:

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

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



100124

129 (c) Be determined by the division to operate in a manner
130 that promotes the goals of laws relating to motor vehicle
131 insurance fraud, that is in the best interest of the state, and
132 that is in accordance with the adopted goals and mission of the
133 division.

134 (d) Use all of its grants and expenditures solely for the
135 purpose of preventing and decreasing motor vehicle insurance
136 fraud, and not for the purpose of lobbying as defined in s.
137 11.045.

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

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

142 (a) Approval of the articles of incorporation and bylaws of
143 the organization by the division.

144 (b) Submission of an annual budget for the approval of the
145 division. The budget must require the organization to minimize
146 costs to the division and its members at all times by using
147 existing personnel and property and allowing for telephonic
148 meetings when appropriate.

149 (c) Certification by the division that the direct-support
150 organization is complying with the terms of the contract and in
151 a manner consistent with the goals and purposes of the
152 department and in the best interest of the state. Such
153 certification must be made annually and reported in the official
154 minutes of a meeting of the organization.

155 (d) Allocation of funds to address motor vehicle insurance
156 fraud.

157 (e) Reversion of moneys and property held in trust by the



100124

organization for motor vehicle insurance fraud prosecution,
investigation, and prevention to the division if the
organization is no longer approved to operate for the department
or if the organization ceases to exist, or to the state if the
division ceases to exist.

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

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

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

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

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

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

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

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

The officer who appointed a member of the board may remove that
member for cause. The term of office of an appointed member



100124

expires at the same time as the term of the officer who
appointed him or her or at such earlier time as the person
ceases to be qualified.

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

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

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

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

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

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

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

Section 4. Subsection (3) is added to section 627.4137,



100124

Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

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

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

627.730 Florida Motor Vehicle No-Fault Law.—Sections 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the “Florida Motor Vehicle No-Fault Law.”

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

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

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

(2) The Legislature intends to balance the insured’s interest in prompt payment of valid claims for insurance benefits under the no-fault law with the public’s interest in reducing fraud, abuse, and overuse of the no-fault system. To



100124

that end, the Legislature intends that the investigation and prevention of fraudulent insurance acts in this state be enhanced, that additional sanctions for such acts be imposed, and that the no-fault law be revised to remove incentives for fraudulent insurance acts. The Legislature intends that the no-fault law be construed according to the plain language of the statutory provisions, which are designed to meet these goals.

(3) The Legislature intends that:

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

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

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

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



100124

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

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

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

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; or ~~nor does the term include~~ a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by



100124

the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment may not ~~cannot~~ be used by patients who are not patients of the registered clinic ~~for medical treatment of services~~. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period ~~provided in this paragraph~~ may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

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



100124

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

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

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

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

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

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

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

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

(12) "No-fault law" means the Florida Motor Vehicle No-



100124

Fault Law codified at ss. 627.730-627.7407.

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

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

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

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

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

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



100124

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

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

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

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

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

(16)~~(15)~~ "Unbundling" means submitting ~~an action that~~



100124

419 ~~submits~~ a billing code that is properly billed under one billing
420 code, but that has been separated into two or more billing
421 codes, and would result in payment greater than the ~~in~~ amount
422 that ~~than~~ would be paid using one billing code.

423 Section 8. Subsections (1) and (4) of section 627.736,
424 Florida Statutes, are amended, subsections (5) through (16) of
425 that section are redesignated as subsections (6) through (17),
426 respectively, a new subsection (5) is added to that section,
427 present subsection (5), paragraph (b) of present subsection (6),
428 paragraph (b) of present subsection (7), and present subsections
429 (8), (9), and (10) of that section are amended, to read:

430 627.736 Required personal injury protection benefits;
431 exclusions; priority; claims.—

432 (1) REQUIRED BENEFITS.—Every insurance policy complying
433 with the security requirements of s. 627.733 must ~~shall~~ provide
434 personal injury protection to the named insured, relatives
435 residing in the same household, persons operating the insured
436 motor vehicle, passengers in such motor vehicle, and other
437 persons struck by such motor vehicle and suffering bodily injury
438 while not an occupant of a self-propelled vehicle, subject to
439 ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(e)~~, to
440 a limit of \$10,000 for loss sustained by ~~any~~ such person as a
441 result of bodily injury, sickness, disease, or death arising out
442 of the ownership, maintenance, or use of a motor vehicle as
443 follows:

444 (a) *Medical benefits*.—Eighty percent of all reasonable
445 expenses, charged pursuant to subsection (6), for medically
446 necessary medical, surgical, X-ray, dental, and rehabilitative
447 services, including prosthetic devices, and for medically



100124

necessary ambulance, hospital, and nursing services. However, the medical benefits ~~shall~~ provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, ~~or a~~ chiropractic physician licensed under chapter 460, or an acupuncturist licensed under chapter 457 exclusively to provide oriental medicine as defined in s. 457.102, or that are provided by any of the following ~~persons or entities~~:

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

2. A person or entity licensed under part III of chapter 401 which ~~ss. 401.21-401.45 that~~ provides emergency transportation and treatment.

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

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

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

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



100124

b. A health care clinic that:

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

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

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

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

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



100124

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

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

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

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurers may not ~~insurer shall~~ require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such ~~required~~ benefits. Insurers may not



100124

require that property damage liability insurance in an amount greater than \$10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An ~~Any~~ insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates ~~shall be deemed to have violated~~ part IX of chapter 626, and such violation constitutes ~~shall constitute~~ an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An ~~and any such~~ insurer committing such violation is ~~shall be~~ subject to the penalties afforded in such part, as well as those that are ~~which may be~~ afforded elsewhere in the insurance code.

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

(a) An insurer may require written notice to be given as



100124

soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by the no-fault law ss. 627.730-627.7405.

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

(c) If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this does ~~shall~~ not limit the introduction of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the name and address of the person to whom the claimant should



100124

respond and a claim number to be referenced in future correspondence. An insurer's failure to send an itemized specification or explanation of benefits does not waive other grounds for rejecting an invalid claim.

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

(e) The 30-day period for payment is tolled while the insurer investigates a fraudulent insurance act, as defined in s. 626.989, with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify the claimant in writing that it is investigating a fraudulent insurance act



100124

within 30 days after the date it has a reasonable belief that such act has been committed. The insurer must pay or deny the claim, in full or in part, within 90 days after the date the written notice of the fact of a covered loss and of the amount of the loss was provided to the insurer. However, no payment is due to a claimant that has violated paragraph (k).

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



100124

accounting purposes.

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

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

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

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

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2. if, provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under the no-fault law ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a



100124

resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle if, ~~provided~~ the injured person is not ~~himself or herself~~:

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

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

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

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

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

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

2. Submits false or misleading information; or

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



100124

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

(1) Notwithstanding any remedies afforded by law, the insurer may recover from a claimant who violates paragraph (k) any sums previously paid to that claimant and may bring any available common law and statutory causes of action. A claimant has violated paragraph (k) ~~committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy,~~ if the fraud is admitted to in a sworn statement ~~by the insured or if it is~~ established in a court of competent jurisdiction. Any insurance fraud voids ~~shall void~~ all coverage arising from the claim related to ~~such fraud under the personal injury protection coverage of the claimant insured person~~ who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before ~~prior to~~ the discovery of the ~~insured person's insurance fraud is~~ shall be recoverable by the insurer from the claimant ~~person~~ who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph. This paragraph does not preclude or limit an insurer's right to deny a claim based on other evidence of fraud or affect an insurer's right to plead and prove a claim or defense of fraud under common law. If a



100124

physician, hospital, clinic, or other medical institution
violates paragraph (k), the injured party is not liable for, and
the physician, hospital, clinic, or other medical institution
may not bill the insured for, charges that are unpaid because of
failure to comply with paragraph (k). Any agreement requiring
the injured person or insured to pay for such charges is
unenforceable.

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

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

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

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

3. The insured, claimant, or medical provider may impose a
reasonable, cost-based fee that includes only the cost of
copying and postage. The cost of copying may not exceed 15 cents
per one-sided copy or 20 cents per two-sided copy and may not
include the cost of labor for copying.

(b) In all circumstances, an insured seeking benefits under
the no-fault law must comply with the terms of the policy, which



100124

includes, but is not limited to, submitting to examinations
under oath. Compliance with this paragraph is a condition
precedent to receiving benefits.

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

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

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

(a) ~~4~~. Any physician, hospital, clinic, or other person or
institution lawfully rendering treatment to an injured person
for a bodily injury covered by personal injury protection
insurance may charge the insurer and injured party only a
reasonable amount pursuant to this section for the services and
supplies rendered, and the insurer providing ~~such~~ coverage may
pay for such charges directly to the ~~such~~ person or institution
lawfully rendering such treatment, if the insured receiving such
treatment or his or her guardian has countersigned the properly
completed invoice, bill, or claim form approved by the office
upon which such charges are to be paid for as having actually
been rendered, to the best knowledge of the insured or his or
her guardian. ~~In no event,~~ However, ~~may~~ such charges may not
~~exceed a charge be in excess of~~ the amount the person or
institution customarily charges for like services or supplies.
In determining ~~With respect to a determination of~~ whether a
charge for a particular service, treatment, or otherwise is
reasonable, consideration may be given to evidence of usual and
customary charges and payments accepted by the provider involved
in the dispute, ~~and~~ reimbursement levels in the community, ~~and~~



100124

various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply. However, such charges may not exceed the reimbursement schedule under this paragraph.

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

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

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

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

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

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

f. For all other medical services, ~~supplies, and care,~~ 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. For all other supplies and care, including durable medical equipment and care and



100124

services rendered by ambulatory surgical centers and clinical laboratories, 200 percent of the allowable amount under Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

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

~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is ~~would be~~



100124

entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

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

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

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

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

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

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

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

e. Except for emergency treatment and care, if the insured failed to countersign a billing form or patient log related to such claim or charges. Failure to submit a countersigned billing form or patient log creates a rebuttable presumption that the



100124

insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the subject treatment and loss until the insurer is able to verify that the insured received the alleged treatment. As used in this subparagraph, the term "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement;

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

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

2. The Department of Health, in consultation with the



100124

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

(c)~~1~~. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services



100124

rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may ~~shall~~ not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

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

2.3. ~~For~~ emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, ~~and~~ and the insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy



100124

thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Centers for Medicare and Medicaid Services ~~Health Care Finance Administration~~.

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

BILLING REQUIREMENTS.—Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the first billing cycle statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500



100124

999 form, UB 92 forms, or any other standard form approved by the
1000 office or adopted by the commission for purposes of this
1001 paragraph. All billings for such services rendered by providers
1002 must ~~shall~~, to the extent applicable, follow the Physicians'
1003 Current Procedural Terminology (CPT) or Healthcare Correct
1004 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1005 year in which services are rendered and comply with the ~~Centers~~
1006 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
1007 and the American Medical Association Current Procedural
1008 Terminology (CPT) Editorial Panel and Healthcare Correct
1009 Procedural Coding System (HCPCS). All providers other than
1010 hospitals shall include on the applicable claim form the
1011 professional license number of the provider in the line or space
1012 provided for "Signature of Physician or Supplier, Including
1013 Degrees or Credentials." In determining compliance with
1014 applicable CPT and HCPCS coding, guidance shall be provided by
1015 the Physicians' Current Procedural Terminology (CPT) or the
1016 Healthcare Correct Procedural Coding System (HCPCS) in effect
1017 for the year in which services were rendered, the Office of the
1018 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1019 other authoritative treatises designated by rule by the Agency
1020 for Health Care Administration. A ~~No~~ statement of medical
1021 services may not include charges for medical services of a
1022 person or entity that performed such services without possessing
1023 the valid licenses required to perform such services. For
1024 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
1025 considered to have been furnished with notice of the amount of
1026 covered loss or medical bills due unless the statements or bills
1027 comply with this paragraph, and unless the statements or bills



100124

~~are~~ ~~comply with this paragraph, and unless the statements or~~
~~bills are~~ properly completed in their entirety as to all
material provisions, with all relevant information being
provided therein. If an insurer denies a claim due to a
provider's failure to submit a properly completed statement or
bill, the insurer shall notify the provider as to the provisions
that were improperly completed, and the provider shall have 15
days after the receipt of such notice to submit a properly
completed statement or bill. If the provider fails to comply
with this requirement, the insurer is not required to pay for
improperly billed services.

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

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

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

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

d. The physician, other licensed professional, clinic, or
other medical institution rendering services for which payment



100124

is being claimed explained the services to the insured or his or her guardian; and

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

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

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

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

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

6. This disclosure and acknowledgment form is not required



100124

for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

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

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

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. Listing CPT codes or other coding on the patient log does not satisfy this requirement. The provider must provide copies of the patient log to the insurer within 30 days after receiving a written request from the insurer. Failure to maintain a patient log renders the treatment unlawful and noncompensable. The requirements ~~of this subparagraph~~ for maintaining a patient log signed by the patient may be met by a hospital that maintains



100124

medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

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

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

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if



100124

requested to do so by the insurer against whom the claim has been made, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request, and furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment ~~if, provided that~~ this does shall not limit the introduction of evidence at trial. Such sworn statement ~~must shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A No cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith.

1. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having



100124

received notice of the amount of a covered loss under paragraph (4) (a), the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~ overdue if the insurer does not pay in accordance with paragraph (4) (b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this subparagraph ~~paragraph~~, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

2. If an insured seeking to recover benefits pursuant to the no-fault law assigns the contractual right to those benefits or payment of those benefits to any person or entity, the assignee must comply with the terms of the policy. In all circumstances, the assignee is obligated to cooperate under the policy, which includes, but is not limited to, participating in an examination under oath. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof. Compliance with this paragraph is a condition precedent to recovery of benefits pursuant to the no-fault law.

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and allow for the inspection all documents requested by the insurer which are relevant to the services rendered and



100124

reasonably obtainable by the claimant. The insurer must pay the medical provider reasonable compensation for attending the examination under oath; however, expert witness fees are not reasonable compensation. The medical provider may have an attorney present at the examination under oath at the provider's own expense.

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

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

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

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the



100124

examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person fails to appear for ~~unreasonably refuses to submit to~~ an examination, the personal injury protection carrier is not required to pay ~~no longer liable for subsequent~~ personal injury protection benefits incurred after the date of the first requested examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to the recovery of benefits.

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

(10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which include ~~shall include~~ health care providers licensed under chapter 457, ~~chapter~~ chapters 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

(a) The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this



100124

subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer must ~~shall~~ be as required by this section.

(b) If the insured elects the to use a provider who is a preferred provider option, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the insured forfeits the premium discount effective on the date that the insured elects to use a provider who is not a preferred provider and who renders nonemergency services, unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services, or unless the nonemergency services are rendered in the emergency room of a hospital licensed under chapter 395. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.

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



100124

such policy, and ~~shall~~ make such list available for public inspection during regular business hours at the insurer's principal office of the insurer within the state. The insurer may contract with a health insurer to use an existing preferred provider network to implement the preferred provider option. All providers and entities that are eligible to receive reimbursement pursuant to paragraph (1)(a) may provide services through a preferred provider network. Any other arrangement is subject to the approval of the Office of Insurance Regulation.

(11)-(10) DEMAND LETTER.-

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

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

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

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

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services,



100124

accommodations, or supplies that form the basis of such claim;
and an itemized statement specifying each exact amount, the date
of treatment, service, or accommodation, and the type of benefit
claimed to be due. A completed form satisfying the requirements
of paragraph ~~(6)(5)~~(d) or the lost-wage statement previously
submitted may be used as the itemized statement. ~~To the extent
that the demand involves an insurer's withdrawal of payment
under paragraph (7)(a) for future treatment not yet rendered,
the claimant shall attach a copy of the insurer's notice
withdrawing such payment and an itemized statement of the type,
frequency, and duration of future treatment claimed to be
reasonable and medically necessary.~~

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

(d) If, within 30 days after receipt of notice by the
insurer, the overdue claim specified in the notice is paid by



100124

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

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

(f) A demand letter that does not meet the minimum requirements set forth in this subsection or that is sent during the pendency of the lawsuit is defective. A defective demand



100124

letter cannot be cured unless the court first abates the action or the claimant first voluntarily dismisses the action.

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

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

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

Section 9. Paragraph (c) of subsection (7), and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person



100124

who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

~~(10)~~ ~~(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than \$20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is \$20,000 or more, but less than \$100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is \$100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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

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

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

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

3. A fine greater than \$10,000, but not to exceed \$15,000,



100124

for a third or subsequent offense.

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

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

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

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

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

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

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

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

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

(1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~ is designed and required to be licensed for use upon a highway,



100124

including trailers and semitrailers designed for use with such vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped. However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~ motor vehicle as defined in s. 627.732(3) ~~if when~~ the owner of such vehicle has complied with the no-fault law ~~requirements of ss. 627.730-627.7405, inclusive,~~ unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

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

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

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

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

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

627.7401 Notification of insured's rights.—

(1) The commission, by rule, shall adopt a form for the



100124

notification of insureds of their right to receive personal injury protection benefits under the ~~Florida Motor Vehicle~~ no-fault law. Such notice shall include:

(b) An advisory informing insureds that:

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

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

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

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; requiring short-form crash reports by a law enforcement officer to be maintained by the officer's agency; authorizing the investigation officer to testify at trial or provide an affidavit concerning the content of the



100124

reports; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; creating s. 626.9894, F.S.; providing definitions; authorizing the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for the organization and the organization's contract with the division; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; authorizing contributions from insurers; providing that any moneys received by the organization may be held in a separate depository account in the name of the organization; requiring the division to deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.4137, F.S.; requiring a claimant's request about insurance coverage to be appropriately served upon the disclosing entity; amending s. 627.730, F.S.; conforming a cross-reference; amending s. 627.731, F.S.; providing legislative intent with respect to the Florida Motor Vehicle No-Fault Law; amending s. 627.732, F.S.; defining the terms "claimant" and "no-fault law"; amending s. 627.736, F.S.; conforming a cross-reference; adding licensed acupuncturists to the list of practitioners authorized to provide, supervise, order, or prescribe services; requiring certain



100124

entities providing medical services to document that they meet required criteria; revising requirements relating to the form that must be submitted by providers; requiring an entity or clinic to file a new form within a specified period after the date of a change of ownership; revising provisions relating to when payment for a benefit is due; providing that an insurer's failure to send certain specification or explanation does not waive other grounds for rejecting an invalid claim; authorizing an insurer to obtain evidence and assert any ground for adjusting or rejecting a claim; providing that the time period for paying a claim is tolled during the investigation of a fraudulent insurance act; specifying when benefits are not payable; preempting local lien laws with respect to payment of benefits to medical providers; providing that a claimant that violates certain provisions is not entitled to any payment, regardless of whether a portion of the claim may be legitimate; authorizing an insurer to recover payments and bring a cause of action to recover payments; providing that an insurer may deny any claim based on other evidence of fraud; forbidding a physician, hospital, clinic, or other medical institution that fails to comply with certain provisions from billing the injured person or the insured; providing that an insurer has a right to conduct reasonable investigations of claims; authorizing an insurer to require a claimant to provide certain records; requiring a records review to



100124

be conducted by the same type of practitioner as the medical provider whose records are being reviewed; specifying when the period for payment is tolled; authorizing an insurer to deny benefits if an insured, claimant, or medical provider fails to comply with certain provisions; revising the insurer's reimbursement limitation; providing a limit on the amount of reimbursement if the insurance policy includes a schedule of charges; creating a rebuttable presumption that the insured did not receive the alleged treatment if the insured does not countersign the patient log; authorizing the insurer to deny a claim if the provider does not submit a properly completed statement or bill within a certain time; specifying requirements for furnishing the insured with notice of the amount of covered loss; deleting an obsolete provision; requiring the provider to provide copies of the patient log within a certain time if requested by the insurer; providing that failure to maintain a patient log renders the treatment unlawful and noncompensable; revising requirements relating to discovery; authorizing the insurer to conduct a physical review of the treatment location; requiring the insured and assignee to comply with certain provisions to recover benefits; requiring the provider to produce persons having the most knowledge in specified circumstances; requiring the insurer to pay reasonable compensation to the provider for attending the examination; requiring the insurer to request



100124

1608 certain information before requesting an assignee to
1609 participate in an examination under oath; providing
1610 that an insurer that requests an examination under
1611 oath without a reasonable basis is engaging in an
1612 unfair and deceptive trade practice; providing that
1613 failure to appear for scheduled examinations
1614 establishes a rebuttable presumption that such failure
1615 was unreasonable; authorizing an insurer to contract
1616 with a preferred provider network; authorizing an
1617 insurer to provide a premium discount to an insured
1618 who selects a preferred provider; authorizing an
1619 insurance policy to not pay for nonemergency services
1620 performed by a nonpreferred provider in specified
1621 circumstances; authorizing an insurer to use a
1622 preferred provider network; revising requirements
1623 relating to demand letters in an action for benefits;
1624 specifying when a demand letter is defective;
1625 requiring a second demand letter under certain
1626 circumstances; deleting obsolete provisions; providing
1627 that a demand letter may not be used to request the
1628 production of claim documents or records from the
1629 insurer; amending s. 817.234, F.S.; conforming a
1630 cross-reference; providing civil penalties for
1631 fraudulent insurance claims; amending ss. 324.021,
1632 456.057, and 627.7401, F.S.; conforming cross-
1633 references; providing an effective date.



507024

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment to Amendment (100124) (with title amendment)

Delete lines 328 - 418

and insert:

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

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

(b) Clinically appropriate in terms of type, frequency,



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13 extent, site, and duration; and

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

16 ~~(11)-(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
17 with four or more wheels which is of a type both designed and
18 required to be licensed for use on the highways of this state,
19 and any trailer or semitrailer designed for use with such
20 vehicle, and includes:

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

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

28
29 The term ~~"motor vehicle"~~ does not include a mobile home or any
30 motor vehicle that ~~which~~ is used in mass transit, other than
31 public school transportation, and designed to transport more
32 than five passengers exclusive of the operator of the motor
33 vehicle and that ~~which~~ is owned by a municipality, a transit
34 authority, or a political subdivision of the state.

35 ~~(12)-(4)~~ "Named insured" means a person, usually the owner
36 of a vehicle, identified in a policy by name as the insured
37 under the policy.

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

40 ~~(14)-(5)~~ "Owner" means a person who holds the legal title to
41 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the



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subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, ~~then~~ the debtor or lessee ~~is shall be~~ deemed the owner for the purposes of the no-fault law ss. 627.730-627.7405.

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

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

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

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

(6)-(8) "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the medical service or provide the medical supplies must be present within the confines of the physical structure where the medical



507024

services are performed or where the medical supplies are provided such that the licensed individual can respond immediately to any emergencies if needed.

~~(7)(9)~~ "Incident," with respect to services considered as incident to a physician's professional service, for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means ~~such~~ services that are ~~must be~~ an integral, even if incidental, part of a covered physician's service.

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

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

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

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

~~(18)(14)~~ "Upcoding" means submitting ~~an action that submits~~ a billing code that would result in payment greater in amount



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than would be paid using a billing code that accurately describes the services performed. The term does not include an otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

~~(17)(15)~~ "Unbundling" means submitting ~~an action that~~

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 1545

and insert:

defining the terms "claimant," "entity wholly owned,"
and "no-fault law";



182886

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment to Amendment (100124)

Delete lines 760 - 764
and insert:

3. A medical provider may impose a reasonable, cost-based fee that includes only the cost of copying and postage, but does not include the cost of labor for copying. The cost of copying may not exceed \$1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages. However, a medical provider may impose the reasonable costs of reproducing X rays and other special kinds of records, including the actual cost of the material and supplies used to duplicate the record, as well



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13 as the labor costs and overhead costs associated with such
14 duplication.



308938

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment to Amendment (100124)

Delete lines 799 - 800
and insert:
service, treatment, or supply.



495560

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment to Amendment (100124) (with title amendment)

Delete lines 92 - 1505

and insert:

Section 3. Subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance~~



495560

~~Regulation under the Florida Insurance Code.~~

~~(10)(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than \$20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is \$20,000 or more, but less than \$100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is \$100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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

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

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

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

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

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

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



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

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

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

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

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

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 1523 - 1633

and insert:

statement regarding insurance fraud; amending s.
817.234, F.S.; providing civil penalties for
fraudulent insurance claims involving motor vehicle
insurance; providing an effective date.



243424

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment (with title amendment)

Delete lines 203 - 1533
and insert:

Section 3. Present subsections (10), (11), and (12) of section 817.234, Florida Statutes, are renumbered as subsections (11), (12), and (13), respectively, and a new subsection (10) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle



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insurance contract is subject to a civil penalty.

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

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

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

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

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

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

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

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 12 - 112

and insert:

statement regarding insurance fraud; amending s.
817.234, F.S.; providing civil penalties for
fraudulent insurance claims involving motor vehicle
insurance; providing an effective date.



328022

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/11/2011	.	
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The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment to Amendment (243424) (with title amendment)

Delete lines 3 - 30

and insert:

Delete everything after the enacting clause

and insert:

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

316.066 Written reports of crashes.—

(1)(a) A Florida Traffic Crash Report, Long Form, must ~~is required to~~ be completed and submitted to the department within



328022

10 days after ~~completing~~ an investigation is completed by the
every law enforcement officer who in the regular course of duty
investigates a motor vehicle crash:

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

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

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

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

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

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

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

2. A description of the vehicles involved.

3. The names and addresses of the parties involved.

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



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42 ~~5.4.~~ The names and addresses of witnesses.

43 ~~6.5.~~ The name, badge number, and law enforcement agency of
44 the officer investigating the crash.

45 ~~7.6.~~ The names of the insurance companies for the
46 respective parties involved in the crash.

47 ~~(d)-(e)~~ Each party to the crash must ~~shall~~ provide the law
48 enforcement officer with proof of insurance, which must ~~to~~ be
49 included in the crash report. If a law enforcement officer
50 submits a report on the accident, proof of insurance must be
51 provided to the officer by each party involved in the crash. Any
52 party who fails to provide the required information commits a
53 noncriminal traffic infraction, punishable as a nonmoving
54 violation as provided in chapter 318, unless the officer
55 determines that due to injuries or other special circumstances
56 such insurance information cannot be provided immediately. If
57 the person provides the law enforcement agency, within 24 hours
58 after the crash, proof of insurance that was valid at the time
59 of the crash, the law enforcement agency may void the citation.

60 ~~(e)-(d)~~ The driver of a vehicle that was in any manner
61 involved in a crash resulting in damage to any vehicle or other
62 property in an amount of \$500 or more, ~~which crash~~ was not
63 investigated by a law enforcement agency, shall, within 10 days
64 after the crash, submit a written report of the crash to the
65 department or traffic records center. The entity receiving the
66 report may require witnesses of the crash ~~crashes~~ to render
67 reports and may require any driver of a vehicle involved in a
68 crash of which a written report must be made ~~as provided in this~~
69 ~~section~~ to file supplemental written reports if ~~whenever~~ the
70 original report is deemed insufficient by the receiving entity.



328022

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

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

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

78 400.991 License requirements; background screenings;
79 prohibitions.—

80 (6) All forms that constitute part of the application for
81 licensure or exemption from licensure under this part must
82 contain the following statement:

83
84 INSURANCE FRAUD NOTICE.—Submitting a false,
85 misleading, or fraudulent application or other
86 document when applying for licensure as a health care
87 clinic, when seeking an exemption from licensure as a
88 health care clinic, or when demonstrating compliance
89 with part X of chapter 400, Florida Statutes, is a
90 fraudulent insurance act, as defined in s. 626.989 or
91 s. 817.234, Florida Statutes, subject to investigation
92 by the Division of Insurance Fraud, and is grounds for
93 discipline by the appropriate licensing board of the
94 Florida Department of Health.

95 Section 3. Section 626.9894, Florida Statutes, is created
96 to read:

97 626.9894 Motor vehicle insurance fraud direct-support
98 organization.—

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



328022

100 (a) "Division" means the Division of Insurance Fraud of the
101 Department of Financial Services.

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

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

108 (2) ORGANIZATION ESTABLISHED.—The division may establish a
109 direct-support organization, to be known as the "Automobile
110 Insurance Fraud Strike Force," whose sole purpose is to support
111 the prosecution, investigation, and prevention of motor vehicle
112 insurance fraud. The organization shall:

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

115 (b) Be organized and operated to conduct programs and
116 activities; to raise funds; to request and receive grants,
117 gifts, and bequests of money; to acquire, receive, hold, invest,
118 and administer, in its own name, securities, funds, objects of
119 value, or other property, real or personal; and to make grants
120 and expenditures to or for the direct or indirect benefit of the
121 division, state attorneys' offices, the statewide prosecutor,
122 the Agency for Health Care Administration, and the Department of
123 Health to the extent that such grants and expenditures are to be
124 used exclusively to advance the purpose of prosecuting,
125 investigating, or preventing motor vehicle insurance fraud.
126 Grants and expenditures may include the cost of salaries or
127 benefits of dedicated motor vehicle insurance fraud
128 investigators, prosecutors, or support personnel if such grants



328022

and expenditures do not interfere with prosecutorial independence or otherwise create conflicts of interest which threaten the success of prosecutions.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



328022

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

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

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

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

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

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

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

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



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

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

627.4137 Disclosure of certain information required.—

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

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

627.730 Florida Motor Vehicle No-Fault Law.—Sections 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the “Florida Motor Vehicle No-Fault Law.”

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

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

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

(2) The Legislature intends to balance the insured’s



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interest in prompt payment of valid claims for insurance
benefits under the no-fault law with the public's interest in
reducing fraud, abuse, and overuse of the no-fault system. To
that end, the Legislature intends that the investigation and
prevention of fraudulent insurance acts in this state be
enhanced, that additional sanctions for such acts be imposed,
and that the no-fault law be revised to remove incentives for
fraudulent insurance acts. The Legislature intends that the no-
fault law be construed according to the plain language of the
statutory provisions, which are designed to meet these goals.

(3) The Legislature intends that:

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

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

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

(d) Insurers discover the names of all passengers involved
in an automobile accident before paying claims or benefits
pursuant to an insurance policy governed by the no-fault law. A



328022

rebuttable presumption must be established that a person was not involved in the event giving rise to the claim if that person's name does not appear on the police report.

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

Section 7. Section 627.7311, Florida Statutes, is created to read:

627.7311 Implementation of no-fault law.—The provisions, schedules, and procedures authorized under the no-fault law shall be implemented by insurers and have full force and effect regardless of their express inclusion in an insurance policy, and an insurer is not required to amend its policy to implement such provisions, schedules, or procedures.

Section 8. Section 627.732, Florida Statutes, is reordered and amended to read:

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

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-



328022

owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; or ~~nor does the term include~~ a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment may not ~~cannot~~ be used by patients who are not patients of the registered clinic



328022

~~for medical treatment of services.~~ Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period ~~provided in this paragraph~~ may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

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

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

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

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

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

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

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



328022

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

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

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

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

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

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

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

(5)~~(8)~~ "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the



328022

medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can respond immediately to any emergencies if needed.

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

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

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

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

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



328022

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

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

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

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

(1) REQUIRED BENEFITS.—Every insurance policy complying
with the security requirements of s. 627.733 must ~~shall~~ provide
personal injury protection to the named insured, relatives
residing in the same household, persons operating the insured
motor vehicle, passengers in such motor vehicle, and other



328022

persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to ~~the provisions of~~ subsection (2) and paragraph (4) (h) ~~(4) (e)~~, to a limit of \$10,000 for loss sustained by ~~any~~ such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

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

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

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

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



328022

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

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

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

b. A health care clinic that:

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

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

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

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

6. An acupuncturist licensed under chapter 457.



328022

506
507 If any services under this paragraph are provided by an entity
508 or clinic described in subparagraph 3., subparagraph 4., or
509 subparagraph 5., the entity or clinic must provide the insurer
510 at the initial submission of the claim with a form adopted by
511 the Department of Financial Services which documents that the
512 entity or clinic meets applicable criteria for such entity or
513 clinic and includes a sworn statement or affidavit to that
514 effect. Any change in ownership requires the filing of a new
515 form within 10 days after the date of the change in ownership.
516 ~~The Financial Services Commission shall adopt by rule the form~~
517 ~~that must be used by an insurer and a health care provider~~
518 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
519 ~~5. to document that the health care provider meets the criteria~~
520 ~~of this paragraph, which rule must include a requirement for a~~
521 ~~sworn statement or affidavit.~~

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

531 (c) *Death benefits.*—Death benefits equal to the lesser of
532 \$5,000 or the remainder of unused personal injury protection
533 benefits per individual. The insurer may pay such benefits to
534 the executor or administrator of the deceased, to any of the



328022

deceased's relatives by blood, ~~or~~ legal adoption, ~~or connection~~
~~by~~ marriage, or to any person appearing to the insurer to be
equitably entitled thereto.

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

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary,
except that benefits received under any workers' compensation
law shall be credited against the benefits provided by
subsection (1) and are ~~shall be~~ due and payable as loss accrues,



328022

upon the receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under the no-fault law ss. 627.730-627.7405. If ~~When~~ the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits are ~~under ss. 627.730-627.7405 shall be~~ subject to the provisions of the Medicaid program.

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

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

(c) If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to



328022

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

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

(e) The 30-day period for payment is tolled while the



328022

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

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



328022

not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

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

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

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

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

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2. if,~~provided~~ the relative at the time of the accident is domiciled in the owner's



328022

household and is not ~~himself or herself~~ the owner of a motor vehicle with respect to which security is required under the no-fault law ss. 627.730-627.7405.

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

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

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

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

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

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

1. Submits a false or misleading statement, document,



328022

record, or bill;

2. Submits false or misleading information; or

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

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

(1) Notwithstanding any remedies afforded by law, the
insurer may recover from a claimant who violates paragraph (k)
any sums previously paid to a claimant and may bring any
available common law and statutory causes of action. A claimant
has violated paragraph (k) committed, by a material act or
omission, any insurance fraud relating to personal injury
protection coverage under his or her policy, if the fraud is
admitted to in a sworn statement by the insured or if it is
established in a court of competent jurisdiction. Any insurance
fraud voids shall void all coverage arising from the claim
related to such fraud under the personal injury protection
coverage of the claimant insured person who committed the fraud,
irrespective of whether a portion of the insured person's claim
may be legitimate, and any benefits paid before prior to the
discovery of the insured person's insurance fraud is shall be
recoverable by the insurer from the claimant person who
committed insurance fraud in their entirety. The prevailing
party is entitled to its costs and attorney's fees in any action



328022

in which it prevails in an insurer's action to enforce its right of recovery under this paragraph. This paragraph does not preclude or limit an insurer's right to deny a claim based on other evidence of fraud or affect an insurer's right to plead and prove a claim or defense of fraud under common law. If a physician, hospital, clinic, or other medical institution violates paragraph (k), the injured party is not liable for, and the physician, hospital, clinic, or other medical institution may not bill the insured for, charges that are unpaid because of failure to comply with paragraph (k). Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

(a) Any records review need not be based on a physical examination and may be obtained at any time, including after reduction or denial of the claim.

1. The records review must be conducted by a practitioner within the same licensing chapter as the medical provider whose records are being reviewed unless the records review is performed by a physician licensed under chapter 458 or chapter 459.

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

3. The insured, claimant, or medical provider may impose a reasonable, cost-based fee that includes only the cost of



328022

copying and postage and not the cost of labor for copying.

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

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

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

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

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

(a)~~1.~~ Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, However, may such charges may not exceed the reimbursement schedule under this paragraph a charge be in excess of the amount the person or institution customarily



328022

~~charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.~~

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

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

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

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

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

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



328022

outpatient services.

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

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

~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization



328022

limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

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

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

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

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

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

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

e. Except for emergency treatment and care, if the insured failed to countersign a billing form or patient log related to such claim or charges. Failure to submit a countersigned billing



328022

883 form or patient log creates a rebuttable presumption that the
884 insured did not receive the alleged treatment. The insurer is
885 not considered to have been furnished with notice of the subject
886 treatment and loss until the insurer is able to verify that the
887 insured received the alleged treatment. As used in this sub-
888 subparagraph, the term "countersigned" means a second or
889 verifying signature, as on a previously signed document, and is
890 not satisfied by the statement "signature on file" or any
891 similar statement;

892 f.e. For any treatment or service that is upcoded, or that
893 is unbundled if ~~when~~ such treatment or services should be
894 bundled, in accordance with paragraph (d). To facilitate prompt
895 payment of lawful services, an insurer may change codes that it
896 determines to have been improperly or incorrectly upcoded or
897 unbundled, and may make payment based on the changed codes,
898 without affecting the right of the provider to dispute the
899 change by the insurer if, ~~provided that~~ before doing so, the
900 insurer contacts ~~must contact~~ the health care provider and
901 discusses ~~discuss~~ the reasons for the insurer's change and the
902 health care provider's reason for the coding, or makes ~~make~~ a
903 reasonable good faith effort to do so, as documented in the
904 insurer's file; and

905 g.f. For medical services or treatment billed by a
906 physician and not provided in a hospital unless such services
907 are rendered by the physician or are incident to his or her
908 professional services and are included on the physician's bill,
909 including documentation verifying that the physician is
910 responsible for the medical services that were rendered and
911 billed.



328022

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

(c)~~1~~. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant,



328022

the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may ~~shall~~ not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

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

~~2.3.~~ For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph, ~~+~~ and the insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it



328022

receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Centers for Medicare and Medicaid Services ~~Health Care Finance Administration~~.

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

BILLING REQUIREMENTS.—Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the first billing cycle statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly



328022

completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers ~~must shall~~, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the ~~Centers for Medicare and Medicaid Services (CMS)~~ 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A ~~No~~ statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4) (b), an insurer is ~~shall~~ not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills



328022

1028 comply with this paragraph, and unless the statements or bills
1029 are ~~comply with this paragraph, and unless the statements or~~
1030 ~~bills~~ are properly completed in their entirety as to all
1031 material provisions, with all relevant information being
1032 provided therein. If an insurer denies a claim due to a
1033 provider's failure to submit a properly completed form, the
1034 insurer shall notify the provider as to the provisions that were
1035 improperly completed, and the provider shall have 15 days after
1036 the receipt of such notice to submit a properly completed form.
1037 If the provider fails to comply with this requirement, the
1038 insurer is not required to pay for the services that were billed
1039 on the improperly completed form.

1040 (e)1. At the initial treatment or service provided, each
1041 physician, other licensed professional, clinic, or other medical
1042 institution providing medical services upon which a claim for
1043 personal injury protection benefits is based shall require an
1044 insured person, or his or her guardian, to execute a disclosure
1045 and acknowledgment form, which reflects at a minimum that:

1046 a. The insured, or his or her guardian, must countersign
1047 the form attesting to the fact that the services set forth
1048 therein were actually rendered. The services shall be described
1049 and listed on the disclosure and acknowledgement form in words
1050 readable by the insured. If the insured cannot read, the
1051 provider should verify, under penalty of perjury, that the
1052 services listed on the form were verbally explained to the
1053 insured before the insured signs the form. Listing CPT codes or
1054 other coding on the disclosure and acknowledgment form does not
1055 satisfy this requirement;

1056 b. The insured, or his or her guardian, has both the right



328022

and affirmative duty to confirm that the services were actually rendered;

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

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

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

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

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

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

5. An insurer is not considered to have been furnished with notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgment form is
~~shall be~~ furnished to the insurer pursuant to paragraph (4) (b)



328022

and sub-subparagraph 1.a. The disclosure and acknowledgement form may not be electronically furnished. A disclosure and acknowledgement form that does not meet the minimum requirements of sub-subparagraph 1.a. does not provide an insurer with notice of the amount of a covered loss or medical bills due.

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

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

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

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, which describes the treatment rendered in a language readable by the insured that is consistent with the services being rendered to the patient as



328022

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

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

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



328022

1144 (7)~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1145 DISPUTES.—

1146 (b) Every physician, hospital, clinic, or other medical
1147 institution providing, before or after bodily injury upon which
1148 a claim for personal injury protection insurance benefits is
1149 based, any products, services, or accommodations in relation to
1150 that or any other injury, or in relation to a condition claimed
1151 to be connected with that or any other injury, shall, if
1152 requested to do so by the insurer against whom the claim has
1153 been made, permit the insurer or the insurer's representative to
1154 conduct an onsite physical review and examination of the
1155 treatment location, treatment apparatuses, diagnostic devices,
1156 and any other medical equipment used for the services rendered
1157 within 10 days after the insurer's request, and furnish
1158 ~~forthwith~~ a written report of the history, condition, treatment,
1159 dates, and costs of such treatment of the injured person and why
1160 the items identified by the insurer were reasonable in amount
1161 and medically necessary, together with a sworn statement that
1162 the treatment or services rendered were reasonable and necessary
1163 with respect to the bodily injury sustained and identifying
1164 which portion of the expenses for such treatment or services was
1165 incurred as a result of such bodily injury, and produce
1166 forthwith, and permit the inspection and copying of, his or her
1167 or its records regarding such history, condition, treatment,
1168 dates, and costs of treatment ~~if, provided that this does shall~~
1169 not limit the introduction of evidence at trial. Such sworn
1170 statement ~~must shall~~ read as follows: "Under penalty of perjury,
1171 I declare that I have read the foregoing, and the facts alleged
1172 are true, to the best of my knowledge and belief." A ~~No~~ cause of



328022

1173 action for violation of the physician-patient privilege or
1174 invasion of the right of privacy may not be brought ~~shall be~~
1175 ~~permitted~~ against any physician, hospital, clinic, or other
1176 medical institution complying with ~~the provisions of this~~
1177 section. The person requesting such records and such sworn
1178 statement shall pay all reasonable costs connected therewith.

1179 1. If an insurer makes a written request for documentation
1180 or information under this paragraph within 30 days after having
1181 received notice of the amount of a covered loss under paragraph
1182 (4) (a), the amount or the partial amount that ~~which~~ is the
1183 subject of the insurer's inquiry is ~~shall become~~ overdue if the
1184 insurer does not pay in accordance with paragraph (4) (b) or
1185 within 10 days after the insurer's receipt of the requested
1186 documentation or information, whichever occurs later. For
1187 purposes of this subparagraph ~~paragraph~~, the term "receipt"
1188 includes, but is not limited to, inspection and copying pursuant
1189 to this paragraph. An ~~Any~~ insurer that requests documentation or
1190 information pertaining to reasonableness of charges or medical
1191 necessity under this paragraph without a reasonable basis for
1192 such requests as a general business practice is engaging in an
1193 unfair trade practice under the insurance code.

1194 2. If an insured seeking to recover benefits pursuant to
1195 the no-fault law assigns the contractual right to those benefits
1196 or payment of those benefits to any person or entity, the
1197 assignee must comply with the terms of the policy. In all
1198 circumstances, the assignee is obligated to cooperate under the
1199 policy, which includes, but is not limited to, participating in
1200 an examination under oath. Examinations under oath may be
1201 recorded by audio, video, court reporter, or any combination



328022

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

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer which are reasonably obtainable by the claimant.

b. Before requesting that an assignee participate in an examination under oath, the insurer must send a written request to the assignee requesting all information that the insurer believes is necessary to process the claim, including the information contemplated under this subparagraph.

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

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

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the



328022

examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person fails to appear for ~~unreasonably refuses to submit to~~ an examination, the personal injury protection carrier is not required to pay ~~no longer liable for subsequent~~ personal injury protection benefits incurred after the date of the first requested examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to the recovery of benefits.

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

(10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and enter into contracts with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which include ~~shall include~~ health care providers licensed under chapter 457, ~~chapter~~ chapters 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

(a) The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for



328022

personal injury protection benefits, if the requirements of this subsection are met. However, if the insurer offers a preferred provider option, it must also offer a nonpreferred provider policy. ~~If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section.~~

(b) If the insured elects the ~~to use a provider who is a preferred provider option,~~ the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. As an alternative, or in addition to such benefits, waiver, or reduction, the insurer may provide an actuarially appropriate premium discount as specified in an approved rate filing to an insured who selects the preferred provider option. If the preferred provider option provides a premium discount, the policy may provide that charges for nonemergency services provided within this state are payable only if performed by members of the preferred provider network unless there is no member of the preferred provider network located within 15 miles of the insured's place of residence whose scope of practice includes the required services, or unless the nonemergency services are rendered in the emergency room of a hospital licensed under chapter 395. ~~If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.~~

(c) The insurer shall provide each insured ~~policyholder~~ with a current roster of preferred providers in the county in



328022

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

(11) ~~(10)~~ DEMAND LETTER.—

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

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

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

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

3. To the extent applicable, the name of any medical
provider who rendered to an insured the treatment, services,
accommodations, or supplies that form the basis of such claim;



328022

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

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

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of



328022

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

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

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



328022

or the claimant first voluntarily dismisses the action.

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

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

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

Section 10. Paragraph (c) of subsection (7), and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.—

(7)

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third



328022

degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(10)~~(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than \$20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is \$20,000 or more, but less than \$100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is \$100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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

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

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

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

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



328022

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

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

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

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

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

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

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

Section 11. Subsection (1) of section 324.021, Florida Statutes, is amended to read:

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

(1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~ is designed and required to be licensed for use upon a highway, including trailers and semitrailers designed for use with such



328022

vehicles, except traction engines, road rollers, farm tractors, power shovels, and well drillers, and every vehicle that ~~which~~ is propelled by electric power obtained from overhead wires but not operated upon rails, but not including any bicycle or moped. However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~ motor vehicle as defined in s. 627.732(3) ~~if~~ ~~when~~ the owner of such vehicle has complied with the no-fault law requirements of ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s. 324.051 apply; and, in such case, the applicable proof of insurance provisions of s. 320.02 apply.

Section 12. Paragraph (k) of subsection (2) of section 456.057, Florida Statutes, is amended to read:

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

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

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

Section 13. Paragraph (b) of subsection (1) of section 627.7401, Florida Statutes, is amended to read:

627.7401 Notification of insured's rights.—

(1) The commission, by rule, shall adopt a form for the notification of insureds of their right to receive personal



328022

injury protection benefits under the ~~Florida Motor Vehicle~~ no-fault law. Such notice shall include:

(b) An advisory informing insureds that:

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

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

Section 14. This act shall take effect July 1, 2011.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 34 - 39

and insert:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; requiring short-form crash reports by a law enforcement officer to be maintained by the officer's agency; authorizing the investigation officer to testify at trial or



328022

provide an affidavit concerning the content of the reports; amending s. 400.991, F.S.; requiring that an application for licensure as a mobile clinic include a statement regarding insurance fraud; creating s. 626.9894, F.S.; providing definitions; authorizing the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for the organization and the organization's contract with the division; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; authorizing contributions from insurers; providing that any moneys received by the organization may be held in a separate depository account in the name of the organization; requiring the division to deposit certain proceeds into the Insurance Regulatory Trust Fund; amending s. 627.4137, F.S.; requiring a claimant's request about insurance coverage to be appropriately served upon the disclosing entity; amending s. 627.730, F.S.; conforming a cross-reference; amending s. 627.731, F.S.; providing legislative intent with respect to the Florida Motor Vehicle No-Fault Law; creating s. 627.7311, F.S.; requiring the provisions, schedules, and procedures of the no-fault law to be implemented by insurers regardless of whether they are expressly stated in the policy; amending s. 627.732, F.S.; defining the terms



328022

"claimant" and "no-fault law"; amending s. 627.736,
F.S.; conforming a cross-reference; adding
acupuncturists to the list of authorized
practitioners; requiring certain entities providing
medical services to document that they meet required
criteria; revising requirements relating to the form
that must be submitted by providers; requiring an
entity or clinic to file a new form within a specified
period after the date of a change of ownership;
revising provisions relating to when payment for a
benefit is due; providing that an insurer's failure to
send certain specification or explanation does not
waive other grounds for rejecting an invalid claim;
authorizing an insurer to obtain evidence and assert
any ground for adjusting or rejecting a claim;
providing that the time period for paying a claim is
tolled during the investigation of a fraudulent
insurance act; specifying when benefits are not
payable; preempting local lien laws with respect to
payment of benefits to medical providers; providing
that a claimant that violates certain provisions is
not entitled to any payment, regardless of whether a
portion of the claim may be legitimate; authorizing an
insurer to recover payments and bring a cause of
action to recover payments; providing that an insurer
may deny any claim based on other evidence of fraud;
forbidding a physician, hospital, clinic, or other
medical institution that fails to comply with certain
provisions from billing the injured person or the



328022

insured; providing that an insurer has a right to
conduct reasonable investigations of claims;
authorizing an insurer to require a claimant to
provide certain records; requiring a records review to
be conducted by the same type of practitioner as the
medical provider whose records are being reviewed or
by a physician; specifying when the period for payment
is tolled; authorizing an insurer to deny benefits if
an insured, claimant, or medical provider fails to
comply with certain provisions; forbidding the
claimant from filing suit unless the claimant complies
with the act; revising the insurer's reimbursement
limitation; providing a limit on the amount of
reimbursement; creating a rebuttable presumption that
the insured did not receive the alleged treatment if
the insured does not countersign the patient log;
authorizing the insurer to deny a claim if the
provider does not properly complete the required form
within a certain time; requiring the provider to
ensure that the insured understands the services being
provided; specifying requirements for furnishing the
insured with notice of the amount of covered loss;
deleting an obsolete provision; requiring the provider
to provide copies of the patient log within a certain
time if requested by the insurer; providing that
failure to maintain a patient log renders the
treatment unlawful and noncompensable; revising
requirements relating to discovery; authorizing the
insurer to conduct a physical review of the treatment



328022

location; requiring the insured and assignee to comply with certain provisions to recover benefits; requiring the provider to produce persons having the most knowledge in specified circumstances; requiring the insurer to request certain information before requesting an assignee to participate in an examination under oath; providing that an insurer that requests an examination under oath without a reasonable basis is engaging in an unfair and deceptive trade practice; providing that failure to appear for scheduled examinations establishes a rebuttable presumption that such failure was unreasonable; authorizing an insurer to contract with a preferred provider network; authorizing an insurer to provide a premium discount to an insured who selects a preferred provider; authorizing an insurance policy to not pay for nonemergency services performed by a nonpreferred provider in specified circumstances; authorizing an insurer to contract with a health insurer in specified circumstances; revising requirements relating to demand letters in an action for benefits; specifying when a demand letter is defective; requiring a second demand letter under certain circumstances; deleting obsolete provisions; providing that a demand letter may not be used to request the production of claim documents or records from the insurer; amending s. 817.234, F.S.; conforming a cross-reference; providing civil penalties for fraudulent insurance claims; amending



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ss. 324.021, 456.057, and 627.7401, F.S.; conforming
cross-references; providing an effective date.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL: SB 1930

INTRODUCER: Senator Bogdanoff

SUBJECT: Motor Vehicle Personal Injury Protection Insurance

DATE: March 27, 2011

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	Pre-meeting
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1930 revises the Florida Motor Vehicle No-Fault Law (No-Fault Law) and related statutory provisions. The bill:

- Requires law enforcement officers to use the *Florida Traffic Crash Report—Long Form* in accidents involving passengers or passenger complains of pain or discomfort.
- Requires an “Insurance Fraud Notice” to be included within the application for health care clinic licensure.
- Establishes the Fight Auto Fraud Fund direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud.
- Requires requests for the disclosure of liability insurance information made to a self-insured corporation to be sent by certified mail to the entity’s registered agent.
- Creates additional language expressing the Legislative intent of the Florida Motor Vehicle No-Fault Law.
- Defines “Claimant” to mean the person, organization, or entity seeking benefits, including all assignees.
- Revises provisions regarding Personal Injury Protection (PIP) policies offering a Preferred Provider (PPO) option for medical benefits. The bill authorizes motor vehicle insurers to contract with a health insurer to use its existing PPO network. The bill authorizes insurers to offer a discount to policyholders that select a policy that uses a PPO network to provide PIP benefits and specify that reimbursement will only be provided to network providers.
- Requires a clinic or entity that initially submits a PIP claim to an insurer to include a sworn affidavit that documents it is eligible to receive reimbursement.

- Requires the insured and a medical provider that accepts an assignment of no-fault benefits to comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO).
- Revises provisions related to demand letters.
 - The claimant filing suit must submit the demand letter.
 - A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
 - Demand letters may not be used to request record production from the insurer.
 - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are properly completed in their entirety.
- Requires health care providers to provide disclosures and patient logs to the injured person describing treatment in readable language. The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer.
- Clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.
- States that the insurer may define in the insurance policy what constitutes “reasonable proof” that the insurer is not liable to provide PIP benefits.
- Tolls the 30-day period for payment if the insurer reasonably believes a fraudulent insurance act was committed. The insurer must investigate and reach a claims decision within 120 days.
- Prohibits a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate.
- Prohibits a provider from billing the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts.
- Authorizes the insurer to require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer.
- Creates a rebuttable presumption that the injured party’s failure to appear for a mental or physical examination was unreasonable. The insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination.
- Authorizes an insurer to conduct an on-site physical review and examination of the treatment location.
- Specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider.
- Prohibits a claimant from filing suit until it complies with the insurer’s investigation.
- Provides that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement.

The bill is effective upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.991, 627.4137, 627.730, 627.731, 627.732, 627.736, 324, 324.021, 456.057, 627.7401, and 817.234.

This bill creates the following section of the Florida Statutes: 626.9894

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of \$10,000 for bodily injury to any one person and \$20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a \$10,000 minimum benefit. A \$5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.¹ The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to \$10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

¹ (Chapter 2007-324, L.O.F.)

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)² has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"³ from 2007-2009, according to the National Insurance Crime Bureau (NICB).⁴

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 hundred PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following

² The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.

³ The NICB defines a "questionable claim" as one in which indications of the behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.

⁴ The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies with law enforcement

description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

“Florida’s no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering...

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division of Insurance Fraud have identified the following as sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by insurance company’s attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,⁵ that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state’s No-Fault Law, which provides how insurers may obtain information from health care providers and that. A dissent in the case stated that the policy required the medical provider to submit to an examination under oath because the State Farm policy clearly stated that the medical provider must submit to an EUO under the State

⁵ *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Farm policy because it required each “claimant” to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Demand Letter

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of an intent to initiate litigation. The notice must include an itemized statement detailing the exact amount and type of treatment asserted to be due. If the insurer pays the claim within 30 days (with interest and penalty) after receiving the demand letter then no action may be brought against the insurer. A suit may not be filed to obtain benefits and potentially collect attorney’s fees until the end of this 30-day period.

Florida Uniform Crash Reports

Section 316.066, F.S., provides that a Florida Traffic Crash Report-Long Form must be completed and submitted to the Department within 10 days after an investigation by every law enforcement who, in the regular course of duty, investigates a motor vehicle crash that resulted in death or personal injury, that involved a violation of s. 316.061(1), F.S., or s. 316.193, F.S., and in which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if the action is appropriate, in the officer’s discretion. For every crash for which a Florida traffic crash report long form is not required by s. 316.066, F.S., the law enforcement officer may complete a short form crash report or provide a short form crash report to be completed by each party involved in the crash.

Health Care Clinic Licensure

The Health Care Clinic Licensure Act (ss. 400.990-400.995, F.S.) was enacted by the 2003 Legislature for the purpose of preventing cost and harm to consumers by providing for the licensure, establishment and enforcement of basic standards for health care clinics. The definition of a health care “clinic” is expansive: “an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider.”⁶ However, the statute contains a multitude of exemptions from licensure. For instance, an entity owned by a Florida-licensed health care practitioner or by a Florida-licensed health care facility is exempt from the clinic licensure requirements. Furthermore, clinic exemptions are voluntary and the Agency for Health Care Administration (AHCA) has no statutory authority to verify that an entity qualifies for an exemption as claimed. As of January 20, 2011, there were 3,417 licensed health care clinics and 7,956 exemptions from licensure.

An applicant⁷ for clinic licensure must submit to and pass a level 2 background screening pursuant to section 435.04, Florida Statutes, which requires taking fingerprints of each applicant and conducting a statewide criminal history check through the Department of Law Enforcement (FDLE) and national criminal history check through the Federal Bureau of Investigation (FBI).

⁶ Section 400.9905(4), F.S.

⁷ An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.

AHCA also reviews the finances of the proposed clinic and inspects the facility to verify that the proposed clinic complies with licensure requirements.

Direct Support Organizations

A direct service organization (DSO) collects funds through grants, donations and other sources, and distributes them to entities that will use the funds to further a legislative purpose. Florida's nondelegation doctrine derives from Article II, Section 3 of the Florida Constitution and prohibits one branch of government from encroaching on another branch's power and also prohibits any branch from delegating its constitutionally assigned powers to another branch.⁸ Accordingly, a DSO cannot exceed its grant of statutory authority. Additionally, as a statutorily created organization, the DSO is subject to the Government in the Sunshine law under ch. 119, F.S.⁹ Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within five months after the end of the fiscal year.¹⁰

III. Effect of Proposed Changes:

Section 1. Amends s. 316.066(1), F.S., to require the law enforcement officer investigating a motor vehicle crash to use the *Florida Traffic Crash Report—Long Form* if passengers are in any of the vehicles involved in the crash or any party or passenger complains of pain or discomfort. The long-form and short-form crash report must also list the names and addresses of all passengers involved in the crash and identify the vehicle where the passenger was located. The bill also specifies that the investigating officer may testify at trial or provide a signed affidavit to confirm or supplement the information on the long-form or short-form report.

Section 2. Amends s. 400.991(6), F.S., to require an “Insurance Fraud Notice” to be included within the application for health care clinic licensure and the application for an exemption from such licensure. The notice states that submitting a false, misleading, or fraudulent application or document when applying for health care clinic licensure, seeking an exemption from licensure, or demonstrating compliance with Part X of ch. 400, F.S. (the Health Care Clinic Act) is a fraudulent insurance act pursuant to s. 626.989, F.S. Such act is subject to investigation by the Division of Insurance Fraud and grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Creates s. 626.9894, F.S., establishing the Fight Auto Fraud Fund (Fund) direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The Fund will operate under a written contract with the Division of Insurance Fraud that requires the division to approve the Fund's articles of incorporation and bylaws, approve the annual budget, and certify that the Fund is complying with the terms of the contract

⁸ See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla.2005)

⁹ See s. 119.011(2), F.S. (defines “agency” as “any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.”) (emphasis added). See also *Crespo v. Florida Entertainment Direct Support Organization, Inc.*, 674 So.2d 154 (Fla. 3rd DCA 1996).

¹⁰ See ss. 11.45, 215.981, F.S.

and consistent with the goals of the DFS and best interests of the state. The Fund's contract with the Division of Insurance Fraud must provide for the allocation of monies to address motor vehicle fraud and the reversion of money and property held in trust by the Fund if it ceases to exist.

The Fund must be a not-for-profit corporation under ch. 617, F.S., and use all of its grants and expenditures solely to prevent and decrease motor vehicle insurance fraud. The fund is authorized to obtain money and property necessary to conduct its mission to allocate monies to address motor vehicle fraud in the following ways:

- Raise funds;
- Request and receive grants, gifts, and bequests of money; and
- Acquire, receive, hold, invest, and administer securities, funds, and real or personal property.

The Fund may make grants and expenditures that directly or indirectly benefit the Division of Insurance Fraud, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration (AHCA), and the Department of Health. Grants or expenditures made by the Fund must be used exclusively to prevent, investigate, and prosecute motor vehicle insurance fraud. Proper grants and expenditure include the salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel so long as the money does not interfere with prosecutorial independence or create conflicts of interest that threaten the prosecution's success.

Moneys received by the Fund may be held in a separate depository account in the Fund's name but are subject to the written contract with the Division of Insurance Fraud. The DFS is authorized to permit the Fund to use department property without expense and is granted rulemaking authority to prescribe the procedures and conditions for use of department property. Use of grants or expenditures to lobby is prohibited and the Fund is subject to an annual financial audit. All contributions made by an insurer are allowed as an appropriate business expense for regulatory purposes.

The Fund will have a 7-member board of directors consisting of the Chief Financial Officer (or designee), two state attorney's appointed by the Attorney General, two representatives of motor vehicle insurers appointed by the Chief Financial Officer, and two representatives of local law enforcement agencies (the CFO and Attorney General each get one appointment). Board-members serve a 4 year term, until the appointing officer leaves office, or until the member ceases to be qualified. The Fund's contract must provide criteria for use by the Fund's board of directors to evaluate the effectiveness of the Fund's spending to combat fraud.

Section 4. Amends s. 627.4137, F.S., which requires an insurer to provide a sworn disclosure setting forth information regarding each known policy providing liability insurance that may be available to pay a claim. The sworn statement must include the names of the insurer and each insured, the liability coverage limits, a copy of the policy, and a statement of all defenses the insurer reasonably believes it has. The bill requires requests for the disclosure made to a self-insured corporation must be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Amends s. 627.730, F.S., to clarify that s. 627.7407, F.S., is part of the Florida Motor Vehicle No-Fault Law.

Section 6. Amends s. 627.731, F.S., to create additional intent language for the Florida Motor Vehicle No-Fault Law. Current law states that the purpose of the no-fault law is to require motor vehicle insurance that provides specified benefits without regard to fault, to require the registration of motor vehicles, and create a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. The bill expands upon this language by stating that the Legislature intends to balance the insured's interest in prompt claim payment with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. Accordingly, the investigation and prevention of fraudulent insurance acts must be enhanced, additional sanctions for such acts must be imposed. The intent language also specifies how the Legislature intends the no-fault law to be interpreted. The no-fault law should be construed according to the plain language of the statutory provisions, which are designed to meet the goals specified by the legislature.

The Legislature provides two findings of fact within the intent language. The first is that automobile insurance fraud remains a major problem for state consumers, as evidenced by the National Insurance Crime Bureau's finding that the state is amongst those with the highest number of fraudulent and questionable claims. The second finding of fact is that the current regulatory process for health care clinics is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance.

The intent language concludes with statements of legislative intent regarding various provisions of the bill:

- The provisions, schedules and procedures authorized under the no fault law are effective regardless of their express inclusion in an insurance policy, and an insurer need not amend its policy to implement them.
- In order to properly investigate a claim, the insurer must be able to take pre-litigation examinations under oath and sworn statements of claimants and request mental and physical examinations of persons seeking PIP coverage or benefits.
- Any false, misleading, or fraudulent activity renders the entire claim invalid. Insurers must be able to raise fraud as a defense to a PIP claim when there has not been an adjudication of guilt or a determination of fraud by the DFS.
- Insurers should toll the payment or denial of a claim if the insurer reasonably believes that a fraudulent insurance act has been committed.
- A rebuttable presumption must be established that a person was not involved in a motor vehicle accident if that person's name is not in the police report.
- Courts should limit attorney fee awards to eliminate the incentive for attorneys to manufacture unnecessary litigation because the insured's interest in obtaining competent counsel should be balanced with the public's interest in a no-fault system that does not encourage unnecessary litigation.

Section 7. Amends s. 627.732, F.S., to define "claimant" and "No-Fault Law" within the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7407, F.S.). "Claimant" means the person, organization, or entity seeking benefits, including all assignees. Medical providers that accept an

assignment of benefits from the insured will be claimants under the No-Fault Law and subject to all statutory provisions related to a claimant under the law.

Section 8. Amends s. 627.736, F.S., which contains the statutory provisions governing the provision of Personal Injury Protection insurance coverage. The bill makes numerous revisions, which are detailed and explained herein.

Benefits – No-Fault Preferred Provider Networks [s. 627.736(10), F.S.]

Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a “preferred provider” (PPO) option. However, if the insured uses an “out-of-network” provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law. The current PPO option does little to reduce PIP costs because there is no incentive for the insured to utilize network providers and thus little incentive for medical providers to contract with the PIP insurer. Additionally, many motor vehicle insurance carriers lack the expertise to create the medical provider network necessary to offer a preferred provider option.

The bill modifies the no-fault preferred provider option by authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider. If a premium discount is provided, the insurer may restrict reimbursement of non-emergency services to members of the preferred provider network unless there are no network providers within 15 miles of the insured’s place of residence. The insurer may contract with a health insurer to use an existing preferred provider network, with any other arrangement subject to OIR approval.

Assignment of Benefits [s. 627.736(7)(b), F.S.]

The bill states that a medical provider that accepts an assignment of no-fault benefits from an insured, the medical provider and the insured must comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO). Compliance is a condition precedent to recovering benefits under the no-fault law.

Provider Billing Submissions – Notice of Licensure Compliance [s. 627.736(1)(a), F.S.]

A clinic or entity that initially submits a PIP claim to an insurer must include a sworn affidavit that documents that the entity or clinic is eligible to receive reimbursement for the treatment of bodily injuries covered by PIP insurance. The following entities must execute the affidavit:

- An entity that is wholly owned by one or more licensed physicians, chiropractors, or dentists or by the spouse, parent, child, or sibling of such medical practitioners.
- Wholly owned by a hospital or hospitals.
- A licensed health care clinic.

The affidavit must be executed on a form adopted by the DFS. If the entity or clinic changes ownership, a new sworn affidavit must be provided to the insurer within 10 days.

Provider Billing Submissions – Proper Submission of Billing Required for Insurer to Have Notice [s. 627.736(6)(d), F.S.]

The bill specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are submitted on an approved form, follow the proper coding requirements, and contain the professional license number of the provider. The remaining portions of statements and bills must be properly completed in their entirety. Current law contains a less stringent standard requiring bills and statements to be properly completed in their entirety “as to all material provisions, with all relevant information being provided therein.”

Section 627.736(6)(c), F.S., generally requires health care providers to submit a statement of charges within 35 days of when the treatment was rendered. If a provider fails to submit the billing within the time frame, the insurer is not required to provide payment. Accordingly, if a provider fails to meet the bill’s requirement to properly submit a bill, the insurer will not be considered to have notice of the bill and the provider may be unable to obtain reimbursement for such services.

Provider Billing Submissions – Initial Disclosure Form and Patient Treatment Log [s. 627.736(6)(e), F.S.]

Current law requires a medical provider providing treatment for bodily injury covered by PIP insurance to obtain at the initial treatment a disclosure form of the insured’s rights that details the treatment to be provided and is signed by the injured person and subsequently countersigned by the injured person verifying that the treatment was rendered. The disclosure and acknowledgement form is not required for emergency services or for ambulance transport and treatment. For subsequent treatments, the provider must maintain a patient log of services rendered in chronological order.

The bill states that the insurer does not have notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgement form is provided to the insurer with the countersignature of the insured and accurately describes the services rendered as required by s. 627.736(6)(e)1.a., F.S. The services rendered must be described on the form in a manner readable by the insured; listing billing codes is not allowed. The provider must determine whether the insured can read the disclosure. If not, the provider must verify, under penalty of perjury, that the services were verbally explained to the insured.

The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer. If the provider does not maintain a patient log, the treatment is unlawful and noncompensable. The patient log must describe subsequent services rendered in readable language; listing billing codes is not allowed.

Claim Payments – PIP Fee Schedule [s. 627.736(6)(a)2., F.S.]

The bill clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.

Claim Payments – Reasonable Proof [s. 627.736(4)(d), F.S.]

Under current law, a claims payment is not overdue if the insurer has reasonable proof that it is not responsible for payment. “Reasonable proof” is not defined in statute. The bill states that “reasonable proof” may be defined in the insurance policy and says an insurer may request information that will aid it in its claim investigation.

Insurer Investigation of Possible Fraudulent Insurance Acts [s. 627.736(4)(d), F.S.]

The 30-day period for payment is tolled during the insurer’s investigation of a fraudulent insurance act, as defined in s. 626.989, F.S., for any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify that claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date the insurer has a reasonable belief the act was committed. The insurer must pay or deny the claim within 120 days.

Benefits are not due to a claimant who submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate. The insurer may recover sums previously paid to such claimants and bring a common law and statutory cause of action against the claimant if the fraud is admitted to in a sworn statement or established in court. Insurance fraud voids all coverage arising for the claim and all claims for attorneys fees, regardless of whether a portion of the claim is legitimate.

The insurer may recover any benefits or attorney’s fees paid before the discovery of fraud. The paragraph does not preclude or limit the insurer’s right to deny a claim on other evidence of fraud and to prove a claim or defense of fraud under common law. The injured party is not liable for fraudulent acts committed by a physician, hospital, clinic, or other medical institution. The provider not bill the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts in paragraph (j).

Insurer Investigations – Records Review [s. 627.736(5), F.S.]

The bill states that the insurer had the right and duty to reasonably investigate the claim. As part of the insurer’s claim investigation, it may require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer. The insurer’s choice of physician to conduct the records review is not limited by the physician’s practice area or licensing chapter. The records review tolls the 30-day period for payment from the date the insurer sends a request for treatment records to the date the insurer receives the treatment records.

Insurer Investigations – Examinations Under Oath [s. 627.736(7)(b), F.S.]

A medical provider that accepts an assignment of benefits must submit to an examination under oath upon the request of the insurer. The provider must produce the persons having the most knowledge of the issues identified by the insurer in the EUO request. All claimants (the person

receiving treatment and the provider) must produce and provide for inspection all reasonably obtainable documents requested by the insurer. The EUO may be recorded by audio, video, or court reporter. Unreasonably requesting EUOs as a general practice is an unfair or deceptive trade practice.

Insurer Investigations – Mental & Physical Examination of Insured [s. 627.736(8), F.S.]

Current law authorizes the insurer to require an injured person to submit to a mental or physical examination whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future PIP insurance benefits. The bill specifies that the insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination. The bill also creates a rebuttable presumption that the injured party's failure to appear for an examination was unreasonable.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 53 Fla. L. Weekly S640 (Fla. 2010). In *Custer*, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Insurer Investigations – On-Site Inspection of Medical Provider [s. 627.736(7)(b), F.S.]

The bill authorizes each insurer to conduct an on-site physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and medical equipment used for services rendered within 10 days of the insurer's request.

Claim Denial – Grounds for Denying a PIP Claim or Refusing a Provider Billing [s. 627.736(5), F.S.]

The bill specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider. The insurer may deny a claim or reduce reimbursement if:

- The medical provider fails to maintain adequate records that would allow the insurer to obtain a records review.
- The insured, claimant, or medical provider fails to comply with the statutory requirements for a records review.
- The insured, claimant, or medical provider fails to cooperate in the insurer's investigation.
- The insured, claimant, or medical provider commits a fraud or material misrepresentation.

The claimant may not file suit:

- Until the records review is completed;

- If the claimant fails to cooperate with the insurer's claim investigation; or
- The claimant commits fraud or makes a material misrepresentation.

Under current law, subsection (6) specifies when the insurer or insured is not required to pay a claim or charges. The bill provides that the insurer or insured is not required to make a payment if the insured has not countersigned the billing forms and patient logs. The bill also states the insurer need not pay a bill or statement that does not comply with the billing requirements of subsections (c), (d), or (e). Subsection (c) generally requires the provider to submit a statement of charges to the insurer within 35 days of providing treatment. Subsection (d) requires the use of specified forms and practice codes when submitting a bill to the insurer. Subsection (e) directs the provider to require the insured person to execute a signed disclosure form during the initial treatment and to obtain the patient's countersignature on a treatment log that describes subsequent treatments.

Claim Denial – Insurer's Itemized Specification of Reduced or Denied Benefits [s. 627.736(4)(c), F.S.]

The bill states that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement. Current law requires an insurer that denies or only pays a portion of a PIP claim to provide an itemized specification of each item the insurer declined to pay or denied. The itemized specification includes information the insurer wants the claimant to consider related to the medical necessity of the treatment or to explain why the insurer was reasonable in reducing the charge, provided the information does not limit the introduction of evidence at trial.

Demand Letters [s. 627.736(11), F.S.]

Under current law, the claimant must provide a written demand letter specifying the PIP benefits and amounts that the claimant asserts are due under the policy prior to filing suit. If the insurer pays the overdue claim specified in the demand letter with interest and a 10 percent penalty, the claimant may not file suit. The bill modifies the demand letter requirement as follows:

- The claimant filing suit must submit the demand letter.
- A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
 - A defective demand letter cannot be cured unless the court abates the action or the claimant voluntarily dismisses the action.
 - If the insurer pays the benefits during abatement or dismissal, the insurer is not liable for attorney's fees.
- If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Demand letters may not be used to request record production from the insurer.
- Removes the requirement that a demand letter involving future treatment must include the insurer's notice of withdrawing payment for future treatment. Under current law, the insurer

may withdraw patient for a treating physician if the insurer retains a physician under that performs a mental or physical examination of the patient pursuant to s. 627.736(7), F.S., and the physician reports that the treatment is not reasonable, related, or necessary.

Section 9. Amends s. 324.021, F.S., by making technical, conforming changes to the definition of “motor vehicle” in the financial responsibility law.

Section 10. Amends s. 456.057(2)(k), F.S., by making a technical conforming change to a statutory reference.

Section 11. Amends s. 627.7401(1)(b), F.S., by making technical conforming changes to statutory references.

Section 12. Amends s. 817.234(7)(c), F.S., by making a technical conforming change to a statutory reference.

Section 13. The act is effective July 1, 2011.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

To the extent that the bill’s provisions are effective in reducing motor vehicle insurance fraud, policyholders will benefit through a reduction in rates for such insurance.

C. Government Sector Impact:

The Fight Auto Fraud direct support organization may increase funding to the Division of Insurance Fraud and other law enforcement agencies to combat motor vehicle insurance fraud.

The Department of Highway Safety and Motor Vehicles states that the requirement to utilize the long-form traffic crash report when passengers are involved in an accident or there are indications that a party to the accident is experiencing pain or discomfort will create additional costs for the department. Based on historical trends, this change could increase the number of long form crash reports received by the department by approximately 90,000 per year. In 2009, the department received 76,258 short form reports that included one or more passengers involved in the accident. Based on estimates and the department's current contract for processing crash reports, the new requirements could cost the department to process the additional reports an estimated \$104,687 per year. The department further estimates an additional 45,000 hours per year of time would be needed by officers of the state to complete the long form as opposed to the time it takes to complete the short form.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.



767910

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bennett) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Subsection (8) of section 627.736, Florida
Statutes, is amended, and subsections (17) and (18) are added to
that section, to read:

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

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—
With respect to any dispute under the provisions of ss. 627.730-
627.7405 between the insured and the insurer, or between an



767910

assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (10) and (15), and except that any attorney's fees recovered are limited to the lesser of \$200 per billable hour or:-

(a) For a disputed amount less than \$500, 15 times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of \$5,000.

(b) For a disputed amount of \$500 or more and less than \$5,000, 10 times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of \$10,000.

(c) For a disputed amount of \$5,000 or more and up to \$10,000, five times the disputed amount recovered by the attorney under ss. 627.730-627.7407, up to a total of \$15,000.

(17) CLASS ACTIONS.—Attorney's fees in a class action under ss. 627.730-627.7407 are limited to the lesser of \$50,000 or three times the total of the disputed amount recovered in the class action proceeding.

(18) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the attorney's fees recovered under ss. 627.730-627.7407 shall be calculated without regard to any contingency risk multiplier.

Section 2. This act shall take effect July 1, 2011.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled
An act relating to motor vehicle personal injury
protection insurance; amending s. 627.736, F.S.;



767910

42 limiting attorney's fees based on the disputed amount;
43 limiting attorney's fees in class actions; providing
44 that attorney's fees are calculated without regard to
45 a contingency risk multiplier; providing an effective
46 date.



447460

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment to Amendment (767910) (with title amendment)

Delete lines 5 - 32

and insert:

Section 1. Subsection (2) of section 26.012, Florida Statutes, is amended to read:

26.012 Jurisdiction of circuit court.—

(2) The circuit court ~~They~~ shall have exclusive original jurisdiction:

(a) In all actions at law not cognizable by the county courts. ~~†~~



447460

(b) Of proceedings relating to the settlement of the estates of decedents and minors, the granting of letters testamentary, guardianship, involuntary hospitalization, the determination of incompetency, and other jurisdiction usually pertaining to courts of probate.~~+~~

(c) In all cases in equity including all cases relating to juveniles except traffic offenses as provided in chapters 316 and 985.~~+~~

(d) Of all felonies and of all misdemeanors arising out of the same circumstances as a felony which is also charged.~~+~~

(e) In all cases involving legality of any tax assessment or toll or denial of refund, except as provided in s. 72.011.~~+~~

(f) In actions of ejectment.~~+~~~~and~~

(g) In all actions involving the title and boundaries of real property.

(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7407, where arbitration of an existing controversy is agreed to pursuant to s. 682.02 and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.-

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

Section 3. Paragraph (c) of subsection (7) and subsections (10) through (12) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.-



447460

(7)

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

~~(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Office of Insurance Regulation under the Florida Insurance Code.~~

(10) ~~(11)~~ If the value of any property involved in a violation of this section:

(a) Is less than \$20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is \$20,000 or more, but less than \$100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is \$100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(11) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle



447460

insurance contract is subject to a civil penalty.

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

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

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

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

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

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

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

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

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

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

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

===== T I T L E A M E N D M E N T =====



447460

And the title is amended as follows:

Delete lines 41 - 45

and insert:

protection insurance; amending s. 26.012, F.S.;
providing that the circuit court has exclusive
jurisdiction in actions involving challenges to
arbitration decisions under the Florida Motor Vehicle
No-Fault Law; amending s. 627.4137, F.S.; requiring a
claimant's request about insurance coverage to be
appropriately served upon the disclosing entity;
amending s. 817.234, F.S.; providing civil penalties
for fraudulent insurance claims involving motor
vehicle insurance; providing an effective



922322

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment (with title amendment)

Delete lines 70 - 359
and insert:

(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7407, where arbitration of an existing controversy is agreed to pursuant to s. 682.02 and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant



922322

13 to this section shall be sent by certified mail to the
14 registered agent of the disclosing entity.

15 Section 3. Present subsections (10), (11), and (12) of
16 section 817.234, Florida Statutes, are renumbered as subsections
17 (11), (12), and (13), respectively, and a new subsection (10) is
18 added to that section, to read:

19 817.234 False and fraudulent insurance claims.—

20 (10) In addition to any criminal liability, a person
21 convicted of violating any provision of this section for the
22 purpose of receiving insurance proceeds from a motor vehicle
23 insurance contract is subject to a civil penalty.

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

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

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

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

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

33 (c) The civil penalty shall be paid to the Insurance
34 Regulatory Trust Fund within the Department of Financial
35 Services and used by the department for the investigation and
36 prosecution of insurance fraud.

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



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===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 10 - 44

and insert:

amending s. 817.234, F.S.; providing civil penalties
for fraudulent insurance claims involving motor
vehicle insurance; providing an effective date.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL: SB 1694

INTRODUCER: Senator Richter

SUBJECT: Motor Vehicle Personal Injury Protection Insurance

DATE: March 27, 2011

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	Pre-meeting
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1694 amends the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.). The bill requires any person seeking personal injury protection (PIP) benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). The bill also creates a rebuttable presumption that a claimant's failure to appear for an independent medical examination is unreasonable, and specifies that the insurer is not liable for any PIP benefits incurred after the date of the first request for examination.

The bill specifies that the Medicare fee schedule in effect on January 1 applies for the rest of the calendar year. The bill also clarifies the maximum PIP reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory and for medical care and services provided in an ambulatory surgical center.

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of \$10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of \$50,000 or three times the recovery. The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the arbitration of claims disputes over PIP benefits. The policy may require arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. The arbitrator's decision is binding on each party, but may be challenged by either party in Circuit Court. The arbitration challenge is limited to a review of the record and not de novo review. If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney's fees under s. 627.428, F.S., and interest will not accrue on the

amount in dispute during the litigation. The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration.

Written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

This bill substantially amends the following sections of the Florida Statutes: 26.012, 627.4137, 627.731, and 627.736.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase \$10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of \$10,000 for bodily injury to any one person and \$20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a \$10,000 minimum benefit. A \$5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.¹ The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to \$10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

¹ See ch. 2007-324, L.O.F.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)² has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"³ from 2007-2009, according to the National Insurance Crime Bureau (NICB).⁴

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud

² The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.

³ The NICB defines a "questionable claim" as one in which indications of behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.

⁴ The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies.

referrals received by the Division during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

“Florida’s no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering...

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division have identified the following sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by the insurance company’s attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*, 37 So. 3d 329 (Fla. 5th DCA 2010), that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state’s No-Fault Law, which provides how insurers may obtain information from health care providers. A dissent in the case stated that the *Shaw* policy clearly stated that the medical provider must

submit to an EUO under the State Farm policy because it required each “claimant” to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Attorney Fee Awards

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court engages in a “Lodestar” calculation, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.⁵ In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar⁶:

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

In personal injury cases in which the prevailing claimant’s attorney has worked on a contingency fee basis, it is within the court’s discretion whether or not to use a contingency risk multiplier of up to 2.5 times the “Lodestar” amount in determining the fee award.⁷ In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.⁸ A trial court has discretion regarding whether to apply a contingency risk multiplier, using the following criteria to determine whether a multiplier is necessary: (1) whether the relevant market requires a multiplier to obtain competent counsel; (2) whether the attorney could mitigate the risk of nonpayment; and (3) the amount involved, the results obtained, and the type of fee arrangement between the attorney and his client.⁹ If the trial court determines that a multiplier is necessary, it may apply the following multipliers:

- A multiplier of 1 to 1.5 if success was more likely than not at the outset;
- A multiplier of 1.5 to 2.0 if the likelihood of success was approximately even at the outset;
- A multiplier of 2.0 to 2.5 if success was unlikely at the outset of the case.¹⁰

⁵ See *Florida Patient’s Compensation Fund v. Rowe*, 472 So. 2d 1145 (Fla. 1985).

⁶ See R. Regulating Fla. Bar 4-1.5(b).

⁷ See *Standard Guaranty Ins. Co. v. Quanstrom*, 555 So. 2d 828 (Fla. 1990).

⁸ See *Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).

⁹ See *supra* note 8 at 834.

¹⁰ See *id.*

Florida Arbitration Code

The Florida Arbitration Code (ss. 682.01-682.22, F.S.) authorizes two or more parties to agree in writing to resolve controversies between the parties in arbitration proceedings governed by the provisions of the code.¹¹ Agreements to arbitrate under the Florida Arbitration Code are valid, enforceable, and irrevocable.¹² A party to an arbitration agreement may petition a court for an order directing the parties to proceed with arbitration, and court actions involving issues governed by the arbitration agreement must be stayed upon a request for such an order.¹³

The arbitration agreement governs the method of selecting arbitrators, in which the court selects the arbitrators if the agreement is silent on the issue or the method in the arbitration agreement fails.¹⁴ If multiple arbitrators are selected, an umpire may also be selected that will render the arbitration award if the arbitrators are unable to agree. The arbitration hearing may be governed by the arbitration agreement or the arbitration code, the latter of which directs the arbitrators to provide notice of the hearing, review evidence, and render a decision.¹⁵ The parties are entitled to be heard during the arbitration hearing, to present material evidence, to cross examine witnesses, and to have an attorney present. The arbitration award must be in writing and signed by the arbitrators.¹⁶ Under the Florida Arbitration Code, the arbitration award may only be appealed in limited circumstances¹⁷, and an arbitration award may only be vacated because it was procured by corruption, fraud, or undue means; the arbitrators or umpire were corrupt or partial; the arbitrators or umpire exceeded their powers or improperly refused to continue a proceeding or hear material evidence; or there was no valid agreement to arbitrate.¹⁸

In 2000, the Florida Supreme Court decided *Nationwide Mutual Fire Ins. Co. v. Pinnacle Medical, Inc.*, 753 So.2d 55 (Fla. 2000), which invalidated a statutory provision that required medical providers that receive an assignment of benefits under the No-Fault law to enter arbitration and prohibited such providers from pursuing a breach of contract claim in court. The Court declared that the arbitration provision violated the right of medical providers to access courts pursuant to article I, section 21 of the Florida Constitution. The court had previously declared a statute constitutional that directed parties to resolve disputes via arbitration before filing an action in circuit court because the statute provided for a trial de novo¹⁹ in circuit court for a party who appealed the arbitration award.²⁰ The court also noted that a statutory requirement that the arbitration board's decision be presumed correct in the trial de novo would raise serious concerns regarding the constitutionality of such a provision.²¹

¹¹ See s. 682.02, F.S.

¹² See *id.*

¹³ See s. 682.03, F.S.

¹⁴ See s. 682.05, F.S.

¹⁵ See s. 682.06, F.S.

¹⁶ See s. 682.09, F.S.

¹⁷ See s. 682.20, F.S.

¹⁸ See s. 682.13, F.S. See *District School Board of St. Johns County v. Timoney*, 524 So. 2d 1129, 1131 (Fla. 5th DCA 1998); See *Prudential-Bache Securities, Inc. v. Shuman*, 483 So. 2d 888 (Fla. 3d DCA 1986).

¹⁹ A "trial de novo" is a new trial on appeal in which the court determines the matter anew, and the prior adjudication has no weight.

²⁰ See *Chrysler Corporation v. Pitsirelos*, 721 So. 2d 710, 713 (Fla. 1998).

²¹ See *supra* note 21 at 714.

III. Effect of Proposed Changes:

Section 1. Amends s. 26.012(2), F.S., which specifies the original jurisdiction of Circuit Courts.

Circuit Court Jurisdiction of PIP Disputes

The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration. Pursuant to s. 34.01, F.S., county courts have original jurisdiction of civil actions in which the matter in dispute does not exceed \$15,000, not including interest, costs, and attorney's fees, except for disputes that are within the exclusive jurisdiction of the circuit court. Currently, county courts have original jurisdiction over many disputes involving the No-Fault law because the amount in controversy is less than \$15,000.

Section 2. Amends s. 627.4137, F.S., which requires liability insurers to disclose coverage information. The bill requires that written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

Section 3. Amends s. 627.731, F.S., which states the purpose of the Florida Motor Vehicle No-Fault Law.

Legislative Intent of the No-Fault Law

The bill provides a statement of legislative intent regarding the No-Fault Law. Three statements of legislative intent are provided:

- The provisions, schedules, and procedures authorized in the no-fault law are to be implemented by insurers and have full effect regardless of whether they are included in the insurance policy, and thus an insurer is not required to amend its policy form.
- Insurers should properly investigate claims. Accordingly, insurers may obtain examinations under oath and sworn statements from claimants seeking no-fault insurance benefits and may request mental and physical independent medical examinations of persons seeking PIP coverage or benefits.
- The insured's interest in obtaining competent counsel must be balanced with the public's interest in not encouraging PIP litigation because of exorbitant attorney's fees. Courts should limit attorney fee awards in order to eliminate incentives for attorneys to manufacture unnecessary litigation.

Section 4. Amends s. 627.736, F.S., governing PIP benefits. The bill makes the following changes:

Clarification of the PIP Fee Schedule

The PIP fee schedule utilizes the Medicare fee schedule in setting the maximum reimbursement that providers may obtain for many services and treatments. The bill requires use of the Medicare fee schedule in effect on January 1 of the year in which medical services, supplies, or care was provided.

The bill clarifies that the maximum reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory is 200 percent of the Medicare Part B fee schedule. The bill also clarifies that the maximum reimbursement for medical care and services provided in an ambulatory surgical center is 80 percent of the maximum reimbursement available under the workers' compensation fee schedule.

Compliance with Policy Terms and Submission to Examinations Under Oath

The bill requires any person seeking benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). Compliance with policy terms is a condition precedent to receiving benefits under the No-Fault law. However, insurers are prohibited from, as a general business practice, requesting EUOs in a manner inconsistent with the terms of the applicable insurance policy. When an insurer requests an EUO of a claimant or medical provider that has been assigned benefits by the claimant, the following statutory provisions apply:

- All claimants and medical providers must produce all documents requested by the insurer that are reasonably obtainable and allow them to be inspected.
- A medical provider that is requested to submit to an EUO must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination.
- The EUO may be recorded by audio, video, and court reporter.

The provision is intended to reverse the Florida Third District Court of Appeal's decision in *Shaw*, 37 So.3d 329.

Unreasonable Failure to Submit to a Medical Examination [s. 627.736(7), F.S.]

Current law authorizes an insurer to require that an injured PIP claimant submit to a physical or mental examination conducted by a physician of the insured's choosing. If a person unreasonably refuses to submit to an examination, the insurance carrier is no longer liable for subsequent PIP benefits. The bill clarifies that the carrier is not liable for any PIP benefits incurred after the date of the first request for examination. The bill also creates a rebuttable presumption that the claimant's failure to appear for the examination was unreasonable. The bill makes submission to a physical or mental examination a condition precedent to receiving benefits.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 35 Fla. L. Weekly S640 (Fla. November 4, 2010). In *Custer*, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Limitations on Attorney's Fees

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of \$10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of \$50,000 or three times the recovery.

The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

Arbitration of PIP Disputes

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the insurer or claimant to demand arbitration of claims disputes over PIP benefits. The policy may require the insurer or claimant to demand arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. Arbitration will be subject to the Florida Arbitration Code, except as otherwise provided in the statute.

The arbitration process will be as follows:

- *Demand for Arbitration* – The arbitration demand must be in writing and mailed to the insurer or claimant by certified mail.
- *Timeframe and Location of Arbitration:*
 - Arbitration may not be initiated until 30 days after the request for arbitration is received and 20 days after documents are received from the claimant and insurer.
 - Arbitration shall take place in the county where treatment was rendered. If treatment was rendered outside Florida, arbitration shall take place in the insured's county of residence unless the parties agree to another location.
- *Selection of the Arbitrator* – The parties shall mutually agree to the selection of an arbitrator within 20 days. If the parties cannot agree, the arbitrator will be selected by the chief judge of the circuit in which the arbitration is pending.
- *Document Discovery in Arbitration:*
 - The insurer may request in writing that the claimant make the entire file (including medical records) pertaining to the insured who is the subject of arbitration available for inspection.
 - The claimant may request in writing prior to the arbitration that the insurer make the evidence upon which it is relying in adjusting or rejecting the claim available for inspection or copying. The claimant may only discover items related to insurance coverage. Discovery is not available pertaining to issues of potential bad faith claims handling, nor is discovery available for privileged items, underwriting files, or documents the insurer does not intend to rely on as evidence supporting its adjustment or rejection of the claim.
- *The Arbitration Decision:*
 - The arbitrator's decision is binding on each party, unless challenged. The decision must be furnished in writing to each party.
 - The arbitrator's award may not exceed the applicable coverage limits remaining on the policy.
- *Attorney's Fees* – Attorney's fees may be recovered by the claimant, but are limited to three times the lesser of \$10,000 or three times the amount recovered.

- *Circuit Court Challenge of the Arbitration Award* – Either party may challenge the arbitration decision by filing a complaint in circuit court enclosing a copy of the arbitration decision. The arbitration challenge is limited to a review of the record and not de novo review.
- *Limits on Attorney’s Fees and Interest During an Arbitration Award Challenge* – If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney’s fees under s. 627.428, F.S. In this circumstance interest on the amount in dispute will not accrue during the litigation.

Section 5. The act is effective upon becoming law.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill’s authorization of insurance policies that require PIP disputes be submitted to arbitration may be unconstitutional pursuant to *Pinnacle Medical, Inc.*, 753 So. 2d 55. In *Pinnacle*, the Florida Supreme Court ruled unconstitutional a statute requiring medical providers to resolve PIP disputes through arbitration and prohibiting such providers from filing suit. Though the arbitration provision in this bill does not prohibit filing suit, the extremely limited grounds by which an arbitration award may be overturned (essentially a fraudulent proceeding) likely would be a violation of the right of access to courts guaranteed under the Florida Constitution. If appeal of arbitration via a trial de novo were provided, the arbitration provision should meet the standard articulated in the *Pinnacle* decision.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.



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LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Subsection (4) is added to section 626.9541,
Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or
deceptive acts or practices defined.—

(4) PARTICIPATION IN A WELLNESS OR HEALTH IMPROVEMENT
PROGRAM.—

(a) Authorization to offer rewards or incentives for
participation.—An insurer issuing a group or individual health



666250

benefit plan may offer a voluntary wellness or health improvement program and may encourage or reward participation in the program by authorizing rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts. Any advertisement of the program is not subject to the limitations set forth in paragraph (1)(m).

(b) Verification of medical condition by nonparticipants due to medical condition.—An insurer may require a member of a health benefit plan to provide verification, such as an affirming statement from the member's physician, that the member's medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program in order for that nonparticipant to receive the reward or incentive.

(c) Disclosure requirement.—A reward or incentive offered under this subsection shall be disclosed in the policy or certificate.

(d) Other incentives.—This subsection does not prohibit insurers from offering other incentives or rewards for adherence to a wellness or health improvement program if otherwise authorized by state or federal law.

Section 2. Subsection (15) is added to section 641.3903, Florida Statutes, to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:



666250

42 (15) PARTICIPATION IN A WELLNESS OR HEALTH IMPROVEMENT
43 PROGRAM.—

44 (a) Authorization to offer rewards or incentives for
45 participation.—A health maintenance organization issuing a group
46 or individual health benefit plan may offer a voluntary wellness
47 or health improvement program and may encourage or reward
48 participation in the program by authorizing rewards or
49 incentives, including, but not limited to, merchandise, gift
50 cards, debit cards, premium discounts, contributions to a
51 member's health savings account, or modifications to copayment,
52 deductible, or coinsurance amounts.

53 (b) Verification of medical condition by nonparticipants
54 due to medical condition.—A health maintenance organization may
55 require a member of a health benefit plan to provide
56 verification, such as an affirming statement from the member's
57 physician, that the member's medical condition makes it
58 unreasonably difficult or inadvisable to participate in the
59 wellness or health improvement program in order for that
60 nonparticipant to receive the reward or incentive.

61 (c) Disclosure requirement.—A reward or incentive offered
62 under this subsection shall be disclosed in the policy or
63 certificate.

64 (d) Other incentives.—This subsection does not prohibit
65 health maintenance organizations from offering other incentives
66 or rewards for adherence to a wellness or health improvement
67 program if otherwise authorized by state or federal law.

68 Section 3. This act shall take effect July 1, 2011.

69
70 ===== T I T L E A M E N D M E N T =====



666250

71 And the title is amended as follows:

72 Delete everything before the enacting clause
73 and insert:

74 A bill to be entitled

75 An act relating to wellness or health improvement
76 programs; amending ss. 626.9541 and 641.3903, F.S.;
77 authorizing insurers and health maintenance
78 organizations to offer a voluntary wellness or health
79 improvement program and to encourage or reward
80 participation in the program by offering rewards or
81 incentives to members; authorizing insurers and health
82 maintenance organizations to require plan members not
83 participating in the wellness or health improvement
84 programs to provide verification that their medical
85 condition warrants nonparticipation in order for the
86 nonparticipants to receive rewards or incentives;
87 requiring that the reward or incentive be disclosed in
88 the policy or certificate; providing that the act does
89 not prohibit insurers or health maintenance
90 organizations from offering other incentives or
91 rewards for adherence to a wellness or health
92 improvement program; providing an effective date.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: CS/SB 1522

INTRODUCER: Health Regulation Committee and Senator Gaetz

SUBJECT: Wellness or Health Improvement Programs

DATE: April 8, 2011

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	Fav/CS
2.	Matiyow	Burgess	BI	Pre-meeting
3.			RC	
4.				
5.				
6.				

I. Summary:

The bill specifies that an insurer or health maintenance organization (HMO) issuing a group or individual health benefit plan may offer a voluntary wellness or health improvement program and may encourage participation in the program by way of authorizing rewards or incentives. The bill provides that any advertisement of the wellness or health improvement program by insurers is not subject to certain statutory limitations. The bill authorizes insurers and HMOs to require a plan member to provide verification that the member's medical condition inhibits participation in the wellness or health improvement program. The bill requires that the reward or incentive must be disclosed in the insurance policy or certificate and that the bill does not prohibit insurers or HMOs from offering other incentives or rewards for adherence to a wellness or health improvement program otherwise authorized by state or federal law. The bill amends statutes that currently allow insurance rebates for healthy lifestyles in individual and group health insurance policies and health maintenance contracts to conform to provisions created by the bill.

This bill substantially amends the following section of the Florida Statutes: 626.9541, 627.6402, 627.65626, 641.31, 641.3903.

II. Present Situation:

Chapters 626 and 627, F.S., regulate health insurance and health insurers within the state of Florida. Chapter 626 governs the practices of insurance agents and the operations of insurance companies.¹ Chapter 627 regulates insurance rates and contracts.²

¹ See ss. 626.011 through 626.99296, F.S.

² See ss. 627.011 through 627.987, F.S.

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices

Section 626.9541, F.S., defines unfair methods of competition and unfair or deceptive acts or practices. The section specifies 32 different acts that qualify under the definition.³ Among the prohibited acts relating to rates that may be charged to policyholders are: “unfair discrimination,” which is defined as knowingly making an unfair discrimination between individuals of the same actuarially supportable class in the amount of premium charged for a policy, or in the benefits payable under the contract, or in the terms and conditions of the contract;⁴ and “unlawful rebates,” which prohibits paying, directly or indirectly, any valuable consideration or inducement not specified in the contract.⁵

Insurance Rebates for Healthy Lifestyles

In 2004, the Legislature required health insurers offering group or individual policies and health maintenance organizations (HMOs), when filing rates, rating schedules, or rating manuals with the Office of Insurance Regulation (OIR), to provide for premium rebates based on participation in health wellness, maintenance, or improvement programs, based on certain parameters.⁶

Insurers issuing individual health insurance policies may provide for a rebate on premiums when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the health plan. To qualify for a rebate, a covered individual must provide evidence of maintenance or improvement of the individual’s health status. The measurement is accomplished by assessing health status indicators, agreed upon in advance by the individual and the insurer, such as weight loss, decrease in body mass index, and smoking cessation. The premium rebate is effective for the covered individual on an annual basis, unless the individual fails to maintain his or her health status while participating in the wellness program or evidence shows that the individual is not participating in the approved wellness program. The rebate may not exceed 10 percent of paid premiums.⁷

For group health plans, a rebate may be provided when the majority of members of the health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. Evidence of maintenance or improvement of the enrollees’ health status is achieved through assessment of health status indicators similar to those included for individual health policies. The group or health insurer may contract with a third party administrator to gather the necessary information regarding enrollees’ health status and provide the necessary report to the insurer. The premium rebate, which may not exceed 10 percent of paid premiums, is effective for an insured on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program.⁸

For HMO coverage, a rebate may be provided when the majority of members of a group health plan are enrolled in and have maintained participation in any health wellness, maintenance, or

³ See s. 626.9541(1)(a) through (ff), F.S.

⁴ See s. 626.9541(1)(g), F.S.

⁵ See s. 626.9541(1)(h), F.S.

⁶ See ss. 32 through 34, ch. 2004-297, Laws of Florida.

⁷ See s. 627.6402, F.S.

⁸ See s. 627.65626, F.S.

improvement program offered by the group contract holder. Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators similar to those included for individual and group health policies. The premium rebate, which may not exceed 10 percent of paid premiums, is effective for a subscriber on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program. In addition to group contracts, HMOs are also allowed to offer a premium rebate on individual contracts for a healthy lifestyle program, consistent with the parameters for group contracts.⁹

The Patient Protection and Affordable Care Act

In 2010, President Obama signed into law The Patient Protection and Affordable Care Act (PPACA or the Act). The Act was part of sweeping overhauls pertaining to the nation's healthcare system. Pursuant to the Act,¹⁰ insurers are allowed to offer wellness and prevention programs in an effort to address:

- Smoking cessation
- Weight management
- Stress management
- Physical fitness
- Nutrition
- Heart disease prevention
- Healthy lifestyle support
- Diabetes prevention

PPACA requires the Secretary of Health and Human Services to promulgate regulations pertaining to the criteria for the reimbursement structure of such programs.¹¹ Further, insurers offering such wellness programs must report their cost savings to Congress within 180 days after the regulations are promulgated.¹²

III. Effect of Proposed Changes:

Section 1 amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices by health insurers to specify that rewards or incentives offered by insurers relating to participation in wellness or health improvement programs are authorized despite the statute's prohibition against certain other practices that constitute unfair or deceptive acts, some of which are related to reduced charges for insurance.¹³ The bill provides that any advertisement of such program is not subject to limitations set forth in s. 626.9541(1)(m), F.S.¹⁴

⁹ See s. 641.31(40), F.S.

¹⁰ PPACA & HCERA, Pub. L. No. 111-148 & 111-152, SEC. 2717(b)

¹¹ PPACA & HCERA, Pub. L. No. 111-148 & 111-152, SEC. 2717(d)

¹² PPACA & HCERA, Pub. L. No. 111-148 & 111-152, SEC. 2717(e)

¹³ See s. 626.9541(1)(o), F.S.

¹⁴ Section 626.9541(1)(m), F.S., provides that certain prohibitions created by s. 626.9541(1), F.S., do not prohibit a licensed insurer or its agent from giving to insureds, prospective insureds, and others, for the purpose of advertising, any article of merchandise having a value of \$25 or less.

The bill creates subsection (4) of s. 626.9541, F.S., and specifies that an insurer issuing group or individual health benefit plans may offer a voluntary wellness or health improvement program and may encourage participation in the program by way of authorizing rewards or incentives. Such rewards or incentives could include, but are not limited to, merchandise, gift cards, debit cards, premium discounts or rebates, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts.

The bill authorizes insurers to require a plan member to provide verification that the member's medical condition inhibits participation in the wellness or health improvement program in order for that nonparticipant to receive the reward or incentive. The bill requires an insurer to disclose in the policy or certificate any reward or incentive offered by the program and that s. 626.9541(4), F.S., does not prohibit insurers from offering other incentives or rewards for adherence to wellness or health improvement programs otherwise authorized by state or federal law.

Section 2 amends s. 627.6402, F.S., relating to insurance rebates for healthy lifestyles in individual health insurance policies, to conform to the provisions of s. 626.9541(4), F.S.

Section 3 amends s. 627.65626, F.S., relating to insurance rebates for healthy lifestyles in group health insurance policies, to conform to the provisions of s. 626.9541(4), F.S.

Section 4 amends subsection (40) of s. 641.31, F.S., relating to rebates for health management contracts for healthy lifestyles, and replaces the current provisions of that subsection by providing that HMOs issuing individual or group contracts may offer a reward or premium rebate pursuant to s. 626.9541(4), F.S., for a healthy lifestyle program.

Section 5 amends s. 641.3903, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices by HMOs, by creating subsection (15), which provides an exception to the prohibitions against unfair methods of competition and unfair or deceptive acts by allowing HMOs to offer rewards or incentives for participation in wellness or health improvement programs.

The bill provides authorization for HMOs to offer a voluntary wellness or health improvement program and to encourage participation in the program by way of authorizing rewards or incentives identical to those authorized for individual and group insurance policies.

The bill authorizes HMOs to require a plan member to provide verification that the member's medical condition inhibits participation in the wellness or health improvement program. The bill provides that a reward or incentive offered under s. 641.3903(15), F.S., is not a violation of s. 641.3903, F.S., if the program is disclosed in the contract or certificate and that s. 641.3903(15), F.S., does not prohibit an HMO from offering other incentives or rewards for adherence to a wellness or health improvement program otherwise authorized by state or federal law.

Section 6 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

To the extent that wellness or health improvement programs are implemented under the bill, and to the extent that insurers and HMOs provide gift cards, debit cards, premium discounts or rebates not already provided under existing law, contributions to health savings accounts, or modifications to copayments, deductibles, or coinsurance amounts, participants in such wellness or health improvement programs could have an indeterminate amount of increased monetary resources at their disposal. And, to the extent that insurers and HMOs pay for such rewards, they could experience an indeterminate amount of financial costs; however, those costs could be offset by a reduction in the insurer's or HMO's medical expenses due to having a healthier pool of covered individuals.

C. Government Sector Impact:

The OIR advises that under the bill, insurers would need to revise their health insurance contracts and submit the forms for review and approval by the OIR's Life and Health Product Review staff. Each time the rewards or incentive programs are changed, new filings would be necessary. OIR indicates that this additional increase in workload can be absorbed within current resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Regulations promulgated by the Secretary of Health and Human Services, as required by PPACA, could impact how Wellness Programs are administered.

VIII. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Regulation on March 22, 2011:

Instead of authorizing new rewards and incentives for wellness or health improvement programs independent of existing law authorizing insurance premium rebates for similar programs, the CS reconciles the new rewards and incentives, which may include rebates in addition to other rewards and incentives, with those of existing law. The CS authorizes the new rewards and incentives for health maintenance contracts, which were omitted in the bill as filed. The CS also replaces existing law relating to HMO rebates for healthy lifestyles in favor of the bill's provisions relating to rewards and incentives for wellness or health improvement programs.

- B. **Amendments:**

None.



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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/04/2011	.	
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The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Paragraphs (f), (h), (j), and (l) of subsection
(1) and paragraph (a) of subsection (2) of section 409.1671,
Florida Statutes, are amended to read:

409.1671 Foster care and related services; outsourcing.—

(1)

(f) ~~1-~~ The Legislature finds that the state has
traditionally provided foster care services to children who are
~~have been~~ the responsibility of the state. As such, foster



244096

children have not had the right to recover for injuries beyond the limitations specified in s. 768.28. The Legislature has also determined that foster care and related services need to be outsourced ~~pursuant to this section~~ and that the provision of such services is of paramount importance to the state. The purpose for such outsourcing is to increase the level of safety, security, and stability of children who are or become the responsibility of the state.

1. One of the components necessary to secure a safe and stable environment for such children is for ~~that~~ private providers to maintain liability insurance. ~~As~~ Such insurance needs to be available and remain available to nongovernmental foster care and related services providers without the resources of such providers being significantly reduced by the cost of maintaining such insurance. To ensure that these resources are not significantly reduced, specified limits of liability are necessary for eligible lead community-based providers and subcontractors engaged in the provision of services previously performed by the Department of Children and Family Services.

2. The Legislature further finds that, by requiring the following minimum levels of insurance, children in outsourced foster care and related services will gain increased protection ~~and rights of recovery in the event of injury than provided for in s. 768.28.~~

(h) Other than an entity to which s. 768.28 applies, any eligible lead community-based provider, ~~as defined in paragraph (e),~~ or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of \$500,000 ~~\$1 million~~



244096

per occurrence or claim with a policy limit aggregate of ~~\$2~~ \$3
million ~~per incident~~ in general liability insurance coverage.

1. The eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities to obtain minimum bodily injury liability insurance in the amount of \$100,000 per person claim, \$300,000 per accident incident, on their personal automobiles. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household ~~but only~~ while the automobiles are used in connection with the provider's business. The nonowned automobile coverage for the provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of \$1 million per occurrence and \$2 million in the aggregate for ~~in~~ nonowned automobile coverage.

2. In any tort action brought against ~~such~~ an eligible lead community-based provider or employee, net economic damages are ~~shall be~~ limited to \$500,000 ~~\$1 million~~ per occurrence, \$1 million in the aggregate, ~~liability claim~~ and \$100,000 per automobile claim, including, but not limited to, past and future



244096

71 medical expenses, wage loss, and loss of earning capacity,
72 offset by any collateral source payment paid or payable. In any
73 tort action for economic damages, the total amount recoverable
74 by all claimants is limited to no more than \$1 million against
75 the Department of Children and Family Services, lead agencies,
76 and all subcontractors involved in the same incident or
77 occurrence, when totaled together. In any tort action brought
78 against such an eligible lead community-based provider,
79 noneconomic damages are ~~shall be~~ limited to \$200,000 per
80 occurrence and \$500,000 in the aggregate. In any tort action for
81 noneconomic damages, the total amount recoverable by all
82 claimants is limited to no more than \$1 million against the
83 department, lead agencies, and all subcontractors involved in
84 the same incident or occurrence, when totaled together ~~claim.~~

85 3. A claims bill may be brought on behalf of a claimant
86 pursuant to s. 768.28 for any amount exceeding the limits
87 specified in this paragraph. Any offset of collateral source
88 payments made as of the date of the settlement or judgment shall
89 be in accordance with s. 768.76. The lead community-based
90 provider is ~~shall~~ not be liable in tort for the acts or
91 omissions of its subcontractors or the officers, agents, or
92 employees of its subcontractors.

93 (j) Any subcontractor of an eligible lead community-based
94 provider, ~~as defined in paragraph (e),~~ which is a direct
95 provider of foster care and related services to children and
96 families, and its employees or officers, except as otherwise
97 provided in paragraph (i), must, as a part of its contract,
98 obtain general liability insurance coverage for a minimum of
99 \$500,000 ~~\$1 million~~ per occurrence or claim with a policy limit



244096

aggregate of/ \$2 ~~\$3~~ million ~~per incident~~ in general liability insurance coverage.

1. The subcontractor of an eligible lead community-based provider must also require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of \$100,000 per person claim, \$300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the subcontractor's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor is ~~shall be~~ primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of \$1 million per occurrence and \$2 million in the aggregate in nonowned automobile coverage.

2. In any tort action brought against such subcontractor or employee, net economic damages are ~~shall be~~ limited to \$500,000 ~~\$1 million~~ per occurrence, \$1 million in the aggregate, ~~liability claim~~ and \$100,000 per automobile claim, including,



244096

but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action for economic damages, the total amount recoverable by all claimants is limited to no more than \$2 million against the Department of Children and Family Services, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together. In any tort action brought against such subcontractor, noneconomic damages shall be limited to \$200,000 per claim and \$500,000 per incident. In any tort action for noneconomic damages, the total amount recoverable by all claimants is limited to no more than \$1 million against the department, lead agencies, and all subcontractors involved in the same incident or occurrence, when totaled together.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76.

~~(1) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2) (a) The Department of Children and Family Services may contract for the delivery, administration, or management of



244096

protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate. The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services are of high quality and~~ delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of an eligible lead community-based provider or the officers, agents, or employees of the provider, nor is the department liable in tort for the acts or omissions of the subcontractors of eligible lead community-based providers or the officers, agents, or employees of its subcontractors. The department may not require an eligible lead community-based provider or its subcontractors to indemnify the department for the department's own acts or omissions, nor may the department require an eligible lead community-based provider or its subcontractors to include the department as an additional insured on any insurance policy. A lead community-based provider may not require its subcontractors to add the lead community-based provider as an additional insured on a liability policy. The department shall ~~must~~ adopt written policies and procedures for monitoring the contract for the delivery of services by lead community-based providers. The ~~These~~ policies and procedures must, at a minimum, address the evaluation of fiscal accountability and program operations, including provider achievement of performance standards, provider monitoring of subcontractors, and timely followup of corrective actions for significant monitoring findings related to providers and subcontractors. These policies and procedures



244096

must also include provisions for reducing the duplication of the department's program monitoring activities both internally and with other agencies, to the extent possible. The department's written procedures must ensure that the written findings, conclusions, and recommendations from monitoring the contract ~~for services of lead community-based providers~~ are communicated to the director of the provider agency as expeditiously as possible.

Section 2. This act shall take effect July 1, 2011.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled

An act relating to community-based care providers;
amending s. 409.1671, F.S.; decreasing the requisite
amount of insurance coverage for lead community-based
providers and their subcontractors; decreasing the
total amount of economic and noneconomic damages
recoverable from the Department of Children and Family
Services, the lead agencies, and all subcontractors;
providing immunity from liability for the department
for acts or omissions of a community-based provider or
subcontractor, or the officers, agents, or employees
thereof; prohibiting the department from requiring the
lead agency to indemnify the department or for a
subcontractor from requiring its subcontractors to add
the lead agency as an additional insured; providing an



244096

effective date.

WHEREAS, lead community-based providers were established to provide foster care and related services, and

WHEREAS, the goal of establishing these providers was to strengthen the support and commitment of communities to the reunification of families and the care of children and families and to increase the efficiency and accountability of providers, and

WHEREAS, lead community-based providers provide services identical to those previously provided by the Department of Children and Family Services, which was protected when delivering those services by the state's sovereign immunity limits, and

WHEREAS, the costs of litigation and attorney's fees diminishes the resources available to the children and families served by lead community-based providers, and

WHEREAS, the Legislature finds that the limits of liability for lead community-based providers should be reviewed, NOW, THEREFORE,



466760

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

Senate Amendment (with title amendment)

Delete lines 64 - 197
and insert:

(h) Other than an entity to which s. 768.28 applies, any eligible lead community-based provider, ~~as defined in paragraph (e)~~, or its employees or officers, except as otherwise provided in paragraph (i), must, as a part of its contract, obtain general liability coverage for a minimum of \$1 million per occurrence or claim with a policy limit aggregate of ~~\$2~~ \$3 million ~~per incident~~ in general liability insurance coverage.

1. The eligible lead community-based provider must also



466760

require that staff who transport client children and families in their personal automobiles in order to carry out their job responsibilities obtain minimum bodily injury liability insurance in the amount of \$100,000 per person ~~claim~~, \$300,000 per accident ~~incident~~, on their personal automobiles. In lieu of personal motor vehicle insurance, the lead community-based provider's casualty, liability, or motor vehicle insurance carrier may provide nonowned automobile liability coverage. This insurance provides liability insurance for automobiles that the provider uses in connection with the provider's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the provider or a member of the employee's household ~~but only~~ while the automobiles are used in connection with the provider's business. The nonowned automobile coverage for the provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the provider shall be primary insurance, and the nonowned automobile coverage of the provider acts as excess insurance to the primary insurance. The provider shall provide a minimum limit of \$1 million per occurrence and \$2 million in the aggregate for ~~in~~ nonowned automobile coverage.

2. In any tort action brought against ~~such~~ an eligible lead community-based provider or employee, net economic damages are ~~shall be~~ limited to \$1 million per occurrence, \$2 million in the aggregate, liability claim and \$100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such an eligible lead community-based provider,



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42 noneconomic damages are ~~shall be~~ limited to \$200,000 per
43 occurrence and \$400,000 in the aggregate ~~claim~~.

44 3. A claims bill may be brought on behalf of a claimant
45 pursuant to s. 768.28 for any amount exceeding the limits
46 specified in this paragraph. Any offset of collateral source
47 payments made as of the date of the settlement or judgment shall
48 be in accordance with s. 768.76. The lead community-based
49 provider is ~~shall~~ not be liable in tort for the acts or
50 omissions of its subcontractors or the officers, agents, or
51 employees of its subcontractors.

52 (j) Any subcontractor of an eligible lead community-based
53 provider, ~~as defined in paragraph (e),~~ which is a direct
54 provider of foster care and related services to children and
55 families, and its employees or officers, except as otherwise
56 provided in paragraph (i), must, as a part of its contract,
57 obtain general liability insurance coverage for a minimum of \$1
58 million per occurrence or claim with a policy limit aggregate
59 ~~of/ \$2 \$3 million per incident~~ in general liability insurance
60 coverage.

61 1. The subcontractor of an eligible lead community-based
62 provider must also require that staff who transport client
63 children and families in their personal automobiles in order to
64 carry out their job responsibilities obtain minimum bodily
65 injury liability insurance in the amount of \$100,000 per person
66 ~~claim~~, \$300,000 per accident ~~incident~~, on their personal
67 automobiles. In lieu of personal motor vehicle insurance, the
68 subcontractor's casualty, liability, or motor vehicle insurance
69 carrier may provide nonowned automobile liability coverage. This
70 insurance provides liability insurance for automobiles that the



466760

subcontractor uses in connection with the subcontractor's business but does not own, lease, rent, or borrow. This coverage includes automobiles owned by the employees of the subcontractor or a member of the employee's household but only while the automobiles are used in connection with the subcontractor's business. The nonowned automobile coverage for the subcontractor applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the subcontractor is ~~shall be~~ primary insurance, and the nonowned automobile coverage of the subcontractor acts as excess insurance to the primary insurance. The subcontractor shall provide a minimum limit of \$1 million per occurrence and \$2 million in the aggregate in nonowned automobile coverage.

2. In any tort action brought against such subcontractor or employee, net economic damages are ~~shall be~~ limited to \$1 million per occurrence, \$2 million in the aggregate, liability claim and \$100,000 per automobile claim, including, but not limited to, past and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid or payable. In any tort action brought against such subcontractor, noneconomic damages shall be limited to \$200,000 per claim and \$400,000 in the aggregate.

3. A claims bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits specified in this paragraph. Any offset of collateral source payments made as of the date of the settlement or judgment shall be in accordance with s. 768.76.

~~(1) The Legislature is cognizant of the increasing costs of goods and services each year and recognizes that fixing a set~~



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~~amount of compensation actually has the effect of a reduction in compensation each year. Accordingly, the conditional limitations on damages in this section shall be increased at the rate of 5 percent each year, prorated from the effective date of this paragraph to the date at which damages subject to such limitations are awarded by final judgment or settlement.~~

(2) (a) The Department of Children and Family Services may contract for the delivery, administration, or management of protective services, the services specified in subsection (1) relating to foster care, and other related services or programs, as appropriate. The department shall use diligent efforts to ensure that ~~retain responsibility for the quality of~~ contracted services and programs ~~and shall ensure that services are of high quality and~~ delivered in accordance with applicable federal and state statutes and regulations. However, the department is not liable in tort for the acts or omissions of an eligible lead community-based provider or the officers, agents, or employees of the provider, nor is the department liable in tort for the acts or omissions of the subcontractors of eligible lead community-based providers or the officers, agents, or employees of its subcontractors. The department may not require an eligible lead community-based provider or its subcontractors to indemnify the department for the department's own acts or omissions, nor may the department require an eligible lead community-based provider or its subcontractors to include the department as an additional insured on any insurance policy. A lead community-based provider may not require its subcontractors to add the lead community-based provider as an additional insured on a liability policy. The department shall ~~must~~ adopt



466760

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 2 - 9

and insert:

An act relating to community-based care providers;
amending s. 409.1671, F.S.; decreasing the aggregate
amount of insurance coverage required for lead
community-based providers and their subcontractors;
providing immunity from liability for the department
for acts or omissions of a community-based provider or
subcontractor, or the officers, agents, or employees
thereof; prohibiting the department from requiring the
lead agency to indemnify the department or a
subcontractor from requiring its subcontractors to add
the lead agency as an additional insured; providing an
effective date.



370746

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete line 170
and insert:

(1) The limitations on liability specified in paragraphs (h) and (j) do not apply to an eligible lead community-based provider or subcontractor who compensates an executive employee, inclusive of any bonuses, at a level above the salary level of the Governor as established by law. Such lead community-based provider or subcontractor must maintain general liability insurance coverage for a minimum of \$1 million per claim and \$3 million per incident. ~~The Legislature is cognizant of the~~



370746

~~increasing costs of~~

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 5

and insert:

providers and subcontractors; increasing the requisite
insurance coverage for certain providers and
subcontractors; providing immunity from

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL: SB 1500

INTRODUCER: Senator Latvala

SUBJECT: Foster Care Providers

DATE: March 27, 2011

REVISED: 4/11/11

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	Pre-meeting
2.			CF	
3.			JU	
4.			BC	
5.				
6.				

I. Summary:

The Legislature established a community-based care system to strengthen community support and increase accountability for the state's child welfare program. The system began in 1996 when the Legislature required the establishment of a minimum of five pilot programs to privatize foster care and related services through contracts with established, community-based care (CBCs) agencies. By 2006, the Department of Children and Families (DCF) had implemented the community-based care model statewide by contracting with 20 CBCs or lead agencies.

Pursuant to s. 409.1671, F.S., the CBCs and their subcontractors are required to meet certain state and federal requirements, including the maintenance of specified levels of liability insurance. The bill provides the following changes relating to liability insurance and tort actions:

- The bill reduces the general liability insurance coverage requirements for CBCs and subcontractors to \$500,000 per claim and a policy limit aggregate of \$1.5 million from the current \$1 million per claim and \$3 million per incident.
- In tort actions against CBC lead agencies and subcontractors:
 - Limits economic damages recoverable per claimant to \$500,000 and capped at \$1.5 million for all claimants per incident from the current \$1 million per liability claim. The bill also limits the total amount of economic damages recoverable by all claimants to \$2 million against a CBC and all subcontractors involved in the same incident.

- Limits noneconomic damages to \$200,000 per claimant and \$500,000 per incident. The bill also limits the total amount of noneconomic damages recoverable by all claimants to \$1 million against a CBC and all subcontractors involved in the same accident.
- The bill revises the DCF's duties and responsibilities relating to contracted services of CBCs.
 - Revises the DCF's responsibility in regards to such contracts by requiring the DCF to use diligent efforts to ensure that such services are delivered in accordance with federal and state requirements. Under current law, the DCF is required to retain responsibility for the quality of contracted services and programs and to ensure that such services are delivered in accordance with federal and state requirements.
 - Provides that the DCF is not liable in tort for acts or omissions of a lead agency, or a subcontractor of the lead agency, or the officers, agents, or employees of the lead agency or subcontractor.
 - Prohibits the DCF from requiring a lead agency or a subcontractor to indemnify DCF against the DCF's own acts or omission.
 - Prohibits the DCF from requiring a lead agency or subcontractor to include the DCF as an additional insured on any insurance policy.

This bill substantially amends section 409.1671 of the Florida Statutes.

II. Present Situation:

Overview of Community-Based Care System in Florida

The Legislature created the community-based care system to strengthen community support and increase accountability for the child welfare program. The Legislature found that the purpose of such outsourcing “is to increase the level of safety, security, and stability of children who are or become the responsibility of the state.”¹ Pursuant to s. 409.1671(e), F.S., the DCF is required to contract with a single agency, referred to as an “eligible lead community-based provider,” for the provision of child protective services in a community. Under this current system, lead agencies are responsible for providing foster care and related services, including family preservation, emergency shelter, and adoption. A competent lead agency must:

- Have the ability to coordinate, integrate, and manage all child protective services in the designated community, and to ensure continuity of care.
- Provide directly, or contract for through a local network of providers, no more than 35 percent of all child protective services.
- Accept accountability for meeting all related state and Federal outcome standards, and serve all children referred, regardless of the level of funding allocated to the community by the state.

The DCF is responsible for program oversight, operating the abuse hotline, child protective investigations, and the provision of child welfare legal services. Pursuant to s. 409.1671(2)(a), F.S., the DCF is responsible for contracting for the delivery, administration, or management of protective services, foster care, and other related services or programs, as appropriate. The DCF

¹ Section 409.1671(1)(f), F.S.

has the responsibility for the quality of contracted services and programs and is responsible for ensuring that services are delivered in accordance with applicable federal laws and regulations as well as state laws and contractual agreements. Notwithstanding the outsourcing of foster care and related services, the DCF retains custody of the children in foster care and remains responsible for the services they are provided.

Overview: Commercial General Liability and Professional Liability Insurance

A commercial general liability policy insures for bodily injury to a third party caused by the insured and loss damage to property owned by third parties caused by the insured. Typically, a general liability policy limits the amount the insurer will pay for each claim for each person (a per-occurrence limit) or the total amount for the policy period (an aggregate limit). Professional liability insurance provides coverage for claims arising from a professional's faulty services or failure to meet the standard of service expected under the circumstances.

An additional insured is a person added to a policy as an insured but not as a named insured. Generally, ISO² endorsements furnish coverage to the additional insured for liability arising out of the named insured's work, operations, or premises.³ Once a party becomes an additional insured, the insurer is obligated to defend and indemnify that additional insured in accordance with the policy terms and conditions.⁴

In regards to defense costs, Rule 69O-167.007 F.A.C., clarifies that defense cost must be in addition to the policy limits. This rule applies to all admitted carriers.

Insurance Requirements for Lead Agencies and Subcontractors

Section 409.1671(h) and (j), F.S., requires lead agencies and their subcontractors to provide general liability insurance coverage as well as automobile insurance coverage. Lead agencies and subcontractors are required to maintain a minimum level of general liability insurance of \$1 million per claimant and \$3 million per incident. In addition to the mandatory liability insurance limits, current law allows for a yearly increase of 5 percent in the conditional limitation on damages available to claimants to account for the annual increase in the cost of goods and services. Economic⁵ damages per claimant are capped at \$1,550,000.⁶ Noneconomic⁷ damages per claimant are capped at \$310,000.⁸

² The Insurance Services Office (ISO) is an organization that produces standard insurance forms. In Florida, forms and rates require approval by the Office of Insurance Regulation pursuant to the insurance code.

³ What Does an Additional Insured Endorsement Cover? <http://www.irmi.com/expert/articles/2000/postel07.aspx> (last visited March 27, 2011).

⁴ Last, William C., *Additional Insured Endorsements Revisited*.

<http://www.lhfconstructlaw.com/CM/Articles/Articles121.asp> (Last visited March 27, 2011).

⁵ See, e.g., s. 766.202(3), F.S., defining "economic damages" as financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, past and future medical expenses, wage loss, loss of future earnings capacity, funeral expenses, and loss of prospective net accumulations of an estate.

⁶ The original limit on economic damages was set at \$1,000,000, in ch. 2009-206, L.O.F. The current limit on economic damages includes the annual 5 percent increase allowed by law.

⁷ See, e.g., s. 766.202(8), F.S., defining "noneconomic damages" as non-financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, pain and suffering, loss of support and services, loss of companionship or consortium, inconvenience, physical impairment, mental anguish, disfigurement, and loss of capacity for enjoyment of life.

⁸ The original limit on noneconomic damages per claimant was set at \$200,000 in ch. 2009-206, L.O.F. The current limit on noneconomic damages includes the annual 5 percent increase allowed by law.

In addition, lead agencies and subcontractors must maintain minimum bodily injury liability insurance coverage of \$100,000 per claim and \$300,000 per incident. Providers also must maintain \$1,000,000 in non-owned automobile insurance coverage. This coverage is secondary to the primary insurance coverage of \$100,000 per claim and \$300,000 per incident that must be maintained by employees of lead agencies or subcontractors who use their personal vehicles to transport children and families in the course of providing services.

In addition to the statutory insurance requirements, the DCF also requires CBCs to maintain professional liability insurance and to name the DCF as an additional insured. The statutory and contractual coverage requirements do not appear to be risk-based since the minimum levels of coverage do not appear to take into consideration the size or volume of services provided by a particular CBC.

Commercial general liability insurance covers bodily injury and property damage arising out of an accident and generally excludes coverage for the abuse, neglect, and other types of errors and omissions claims to which lead community-based providers and subcontractors are exposed. Generally, some type of liability insurance or rider would cover these risks. The statute does not mandate such coverage. However, the availability and affordability of such coverage is indeterminate at this time.

The limits on liability provided for lead agencies and their subcontractors are not applicable if the lead agency or the subcontractor “acts in a culpably negligent manner or with willful and wanton disregard or unprovoked physical aggression when such acts result in injury or death or such acts proximately cause such injury or death...”⁹ Culpable negligence is defined as “reckless indifference or grossly careless disregard of human life.”¹⁰ Further, the statute authorizes “a claim bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits” provided to lead agencies and their subcontractors.¹¹

Each contract with a CBC provider is required to provide for the payment by the DCF to the provider of a reasonable administrative cost in addition to funding for the provision of services pursuant to s. 409.1671, F.S. Administrative costs would generally include operating costs such as insurance premiums.

Sovereign Immunity

The term “sovereign immunity” originally referred to the English common law concept that the government may not be sued because “the King can do no wrong.” Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law.

Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state.

⁹ Section 4909.1671(1)(i) and (k), F.S.

¹⁰ *Id.*

¹¹ Section 409.1671(1)(h) and (j), F.S.

Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.¹² Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to \$100,000 for one incident and limits all recovery related to one incident to a total of \$200,000.¹³ Parties may pursue a claim bill with the Legislature for any excess judgment or equitable claim that is not recovered from a state agency or other entity covered by the waiver of sovereign immunity.¹⁴

Division of Risk Management of the Department of Financial Services

The division is responsible for the management of claims reported by or against state agencies for coverage under the self-insurance fund known as the “State Risk Management Trust Fund.” The division has the responsibility of investigating, evaluating, negotiating, defending, and making appropriate disposition of claims/lawsuits filed against the state because of a negligent act or omission. Investigations of claims are conducted by staff and/or in concert with a contracted adjusting service. The Attorney General’s Office, contract law firms, or state agency attorneys provide defense of litigated claims.

General liability coverage is one of the types of coverage provided through the trust fund. For purposes of general liability coverage, the state is liable for damages for injury, death, or loss of property caused by the negligence of its employees, agents or volunteers while acting within the course and scope of their employment or responsibilities. The self-insurance coverage includes premises and operations, personal injury, and professional liability. In accordance with s. 768.28, F.S., the limits of liability (under the waiver of sovereign immunity law) are \$100,000 per person’s claim, \$200,000 per occurrence for all claims.

The division provides coverage to the DCF for claims from foster children alleging negligence or civil rights violations relating to their care. Prior to the creation of CBC’s and the privatization of foster care, the DCF provided all foster care services. The division does not provide coverage to the CBC’s or their subcontractors. Consequently, the division does not have any data on how many claims the CBC’s or their subcontractors have received or paid since their creation.

III. Effect of Proposed Changes:

Section 1 amends s. 409.1671, F.S., relating to liability insurance requirements and limits of liability for CBCs, CBC subcontractors, and the DCF.

¹² Section 768.28(9)(a), F.S.

¹³ Section 1, ch. 2010-26, Laws of Florida, amended s. 768.28(5), F.S., effective October 1, 2011, to increase the limits to \$200,000 for one person for one incident and \$300,000 for all recovery related to one incident, to apply to claims arising on or after that effective date.

¹⁴ Section 768.28(5), F.S., provides that any portion of a judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature.

The bill reduces the mandatory general liability insurance coverage requirement for lead agencies and subcontractors to \$500,000 per claim and a policy limit aggregate of \$1.5 million from \$1 million per claim and \$3 million per incident.

The limit on economic damages available to a claimant is reduced to \$500,000 per claim and capped at \$1.5 million for all claimants per incident from \$1 million per liability claim. The total amount of economic damages recoverable by all claimants is limited to \$2 million against a CBC and all subcontractors involved in the same incident.

The bill also limits noneconomic damages to \$200,000 per claimant and \$500,000 per incident. Currently, the noneconomic damages are limited to \$200,000 per claim. The bill limits the total amount of noneconomic damages recoverable by all claimants to \$1 million against a lead agency and all subcontractors involved in the same incident.

The bill repeals s. 409.1671(1)(l), F.S., thereby eliminating the 5 percent annual increase in the conditional limitations on economic and noneconomic damages.

The bill adds language to s. 409.1671(2)(a), F.S., to provide that the DCF is not liable in tort for the acts or omissions of a lead agency, or a subcontractor of a lead agency, or the officers, agents, or employees of a lead agency, or subcontractor of a lead agency. The DCF may not require a lead agency or subcontractor of a lead agency to indemnify the department for its own acts or omissions. Lastly, the department may not require a lead agency or subcontractor to include the department as an additional insured on any insurance policy.

The bill deletes legislative findings that the minimum levels of insurance were to be in excess of the rights of recovery under s. 768.28, F.S.

Section 2 provides that the bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Lower liability insurance limits should reduce insurance premiums for the CBCs and subcontractors. The elimination of the DCF as an additional insured may result in some indeterminate reduction in premiums for the CBCs.

The lower liability insurance requirements may limit the amount of money claimants can recover from CBCs and subcontractors.

C. Government Sector Impact:

According to the Division of Risk Management of the Department of Financial Services (DFS), the lower liability insurance requirements could result in foster children and their attorneys seeking more money from the state either in claims settlements or in claims bills. The DFS provided the following comments:

“The bill reduces the amounts of general liability insurance a CBC is required to carry, it also reduces the amounts a claimant can recover for economic and non-economic damages. If a claimant can recover sufficient money from a CBC, they are less likely to press their claim against DCF and Risk Management or to file a claims bill against DCF.”¹⁵

VI. Technical Deficiencies:**Commercial General Liability**

According to the Office of Insurance Regulation,¹⁶ typically general liability insurance is sold with an occurrence limit and an aggregate limit on the total cost of the claims occurring in an annual policy period. The bill requires a minimum of \$500,000 per claim with a policy limit of \$1.5 million. There is no standard legal definition of ‘incident’ within the typical context of general liability. These definitional issues can lead to litigation.

The additional limits of noneconomic damages on top of the economic damage limits for economic damage may create total costs on an occurrence that are higher than the legally mandated minimum per limits of insurance. That results in a situation where the damage caps do not match the required limits of insurance. Specifically, economic damages are capped at \$500,000 per claim and noneconomic damages are capped at \$200,000 per claim. The minimum general liability limit is \$500,000 per claim.

VII. Related Issues:

Under current law, insurers of lead community-based providers’ and subcontractors are not required to give the DCF written notice of any cancellation or nonrenewal and the lead

¹⁵ Department of Financial Services Bill Analysis of SB 1500, dated March 9, 2011.

¹⁶ Office of Insurance Regulation Comments, dated April 4, 2011.

community-based providers are not required to provide the DCF with copies of policies, endorsements, and certificates. Instead, the DCF contract with a CBC may require the insurer to give the DCF written notice of any intention to cancel or refuse to renew the policy at least 30 days prior to such action. The DCF needs notification of any cancellation or nonrenewal of a CBC policy and copies of policies, endorsements, and certificates in order to monitor compliance by the lead community-based providers and subcontractors with the statutory insurance coverage requirements. Gaps in coverage and other noncompliance by a CBC could result in liability exposure for the DCF. Pursuant to s. 627.4133, F.S., an insurer is required to provide notice to the named insured at least 45 days prior to nonrenewal, cancellation, or termination.

Although the bill does not amend the automobile insurance requirements, the provision in the law for personal automobile policies does not match the language present in most personal automobile policies. The current law requires a minimum bodily injury liability insurance of \$100,000 per claim and \$300,000 per incident on personal automobiles used by staff of a CBC or subcontractor. The OIR notes that the typical personal automobile insurance requirements are stated in terms of a monetary limit per person and another monetary limit for all damages resulting from any one automobile accident.

VIII. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

- B. **Amendments:**

None.



155418

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Hays) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 458.3175, Florida Statutes, is created
to read:

458.3175 Expert witness certificate.—

(1) (a) The department shall issue a certificate authorizing
a physician who holds an active and valid license to practice
medicine in another state or a province of Canada to provide
expert testimony in this state, if the physician submits to the
department:



155418

13 1. A complete registration application containing the
14 physician's legal name, mailing address, telephone number,
15 business locations, the names of the jurisdictions where the
16 physician holds an active and valid license to practice
17 medicine, and the license number or other identifying number
18 issued to the physician by the jurisdiction's licensing entity;
19 and

20 2. An application fee of \$50.

21 (b) The department shall approve an application for an
22 expert witness certificate within 7 business days after receipt
23 of the completed application and payment of the application fee
24 if the applicant holds an active and valid license to practice
25 medicine in another state or a province of Canada and has not
26 had a previous expert witness certificate revoked by the board.
27 An application is approved by default if the department does not
28 act upon the application within the required period. A physician
29 must notify the department in writing of his or her intent to
30 rely on a certificate approved by default.

31 (c) An expert witness certificate is valid for 2 years
32 after the date of issuance.

33 (2) An expert witness certificate authorizes the physician
34 to whom the certificate is issued to do only the following:

35 (a) Provide a verified written medical expert opinion as
36 provided in s. 766.203.

37 (b) Provide expert testimony about the prevailing
38 professional standard of care in connection with medical
39 negligence litigation pending in this state against a physician
40 licensed under this chapter or chapter 459.

41 (3) An expert witness certificate does not authorize a



155418

physician to engage in the practice of medicine as defined in s. 458.305. A physician issued a certificate under this section who does not otherwise practice medicine in this state is not required to obtain a license under this chapter or pay any license fees, including, but not limited to, a neurological injury compensation assessment. An expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.

Section 2. Subsection (11) is added to section 458.331, Florida Statutes, paragraphs (oo) through (qq) of subsection (1) of that section are redesignated as paragraphs (pp) through (rr), respectively, and a new paragraph (oo) is added to that subsection, to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(oo) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 3. Subsection (6) of section 458.351, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section to read:

458.351 Reports of adverse incidents in office practice



155418

71 settings.—

72 (6) (a) The board shall adopt rules establishing a standard
73 informed consent form that sets forth the recognized specific
74 risks related to cataract surgery. The board must propose such
75 rules within 90 days after the effective date of this
76 subsection.

77 (b) Before formally proposing the rule, the board must
78 consider information from physicians licensed under this chapter
79 or chapter 459 regarding recognized specific risks related to
80 cataract surgery and the standard informed consent forms adopted
81 for use in the medical field by other states.

82 (c) A patient's informed consent is not executed until the
83 patient, or a person authorized by the patient to give consent,
84 and a competent witness sign the form adopted by the board.

85 (d) An incident resulting from recognized specific risks
86 described in the signed consent form is not considered an
87 adverse incident for purposes of s. 395.0197 and this section.

88 (e) In a civil action or administrative proceeding against
89 a physician based on his or her alleged failure to properly
90 disclose the risks of cataract surgery, a patient's informed
91 consent executed as provided in paragraph (c) on the form
92 adopted by the board is admissible as evidence and creates a
93 rebuttable presumption that the physician properly disclosed the
94 risks.

95 Section 4. Section 459.0066, Florida Statutes, is created
96 to read:

97 459.0066 Expert witness certificate.—

98 (1) (a) The department shall issue a certificate authorizing
99 a physician who holds an active and valid license to practice



155418

osteopathic medicine in another state or a province of Canada to
provide expert testimony in this state, if the physician submits
to the department:

1. A complete registration application containing the
physician's legal name, mailing address, telephone number,
business locations, the names of the jurisdictions where the
physician holds an active and valid license to practice
osteopathic medicine, and the license number or other
identifying number issued to the physician by the jurisdiction's
licensing entity; and

2. An application fee of \$50.

(b) The department shall approve an application for an
expert witness certificate within 7 business days after receipt
of the completed application and payment of the application fee
if the applicant holds an active and valid license to practice
osteopathic medicine in another state or a province of Canada
and has not had a previous expert witness certificate revoked by
the board. An application is approved by default if the
department does not act upon the application within the required
period. A physician must notify the department in writing of his
or her intent to rely on a certificate approved by default.

(c) An expert witness certificate is valid for 2 years
after the date of issuance.

(2) An expert witness certificate authorizes the physician
to whom the certificate is issued to do only the following:

(a) Provide a verified written medical expert opinion as
provided in s. 766.203.

(b) Provide expert testimony about the prevailing
professional standard of care in connection with medical



155418

negligence litigation pending in this state against a physician licensed under chapter 458 or this chapter.

(3) An expert witness certificate does not authorize a physician to engage in the practice of osteopathic medicine as defined in s. 459.003. A physician issued a certificate under this section who does not otherwise practice osteopathic medicine in this state is not required to obtain a license under this chapter or pay any license fees, including, but not limited to, a neurological injury compensation assessment. An expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.

Section 5. Subsection (11) is added to section 459.015, Florida Statutes, paragraphs (qq) through (ss) of subsection (1) of that section are redesignated as paragraphs (rr) through (tt), respectively, and a new paragraph (qq) is added to that subsection, to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(qq) Providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of osteopathic medicine.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.



155418

158 Section 6. Section 466.005, Florida Statutes, is created to
159 read:

160 466.005 Expert witness certificate.—

161 (1)(a) The department shall issue a certificate authorizing
162 a dentist who holds an active and valid license to practice
163 dentistry in another state or a province of Canada to provide
164 expert testimony in this state, if the dentist submits to the
165 department:

166 1. A complete registration application containing the
167 dentist's legal name, mailing address, telephone number,
168 business locations, the names of the jurisdictions where the
169 dentist holds an active and valid license to practice dentistry,
170 and the license number or other identifying number issued to the
171 dentist by the jurisdiction's licensing entity; and

172 2. An application fee of \$50.

173 (b) The department shall approve an application for an
174 expert witness certificate within 7 business days after receipt
175 of the completed application and payment of the application fee
176 if the applicant holds an active and valid license to practice
177 dentistry in another state or a province of Canada and has not
178 had a previous expert witness certificate revoked by the board.
179 An application is approved by default if the department does not
180 act upon the application within the required period. A dentist
181 must notify the department in writing of his or her intent to
182 rely on a certificate approved by default.

183 (c) An expert witness certificate is valid for 2 years
184 after the date of issuance.

185 (2) An expert witness certificate authorizes the dentist to
186 whom the certificate is issued to do only the following:



155418

187 (a) Provide a verified written medical expert opinion as
188 provided in s. 766.203.

189 (b) Provide expert testimony about the prevailing
190 professional standard of care in connection with medical
191 negligence litigation pending in this state against a dentist
192 licensed under this chapter.

193 (3) An expert witness certificate does not authorize a
194 dentist to engage in the practice of dentistry as defined in s.
195 466.003. A dentist issued a certificate under this section who
196 does not otherwise practice dentistry in this state is not
197 required to obtain a license under this chapter or pay any
198 license fees. An expert witness certificate shall be treated as
199 a license in any disciplinary action, and the holder of an
200 expert witness certificate shall be subject to discipline by the
201 board.

202 Section 7. Subsection (8) is added to section 466.028,
203 Florida Statutes, paragraph (ll) of subsection (1) of that
204 section is redesignated as paragraph (mm), and a new paragraph
205 (ll) is added to that subsection, to read:

206 466.028 Grounds for disciplinary action; action by the
207 board.—

208 (1) The following acts constitute grounds for denial of a
209 license or disciplinary action, as specified in s. 456.072(2):

210 (ll) Providing misleading, deceptive, or fraudulent expert
211 witness testimony related to the practice of dentistry.

212 (8) The purpose of this section is to facilitate uniform
213 discipline for those acts made punishable under this section
214 and, to this end, a reference to this section constitutes a
215 general reference under the doctrine of incorporation by



155418

reference.

Section 8. Subsection (6) of section 459.026, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section to read:

459.026 Reports of adverse incidents in office practice settings.—

(6) (a) The board shall adopt rules establishing a standard informed consent form that sets forth the recognized specific risks related to cataract surgery. The board must propose such rules within 90 days after the effective date of this subsection.

(b) Before formally proposing the rule, the board must consider information from physicians licensed under chapter 458 or this chapter regarding recognized specific risks related to cataract surgery and the standard informed consent forms adopted for use in the medical field by other states.

(c) A patient's informed consent is not executed until the patient, or a person authorized by the patient to give consent, and a competent witness sign the form adopted by the board.

(d) An incident resulting from recognized specific risks described in the signed consent form is not considered an adverse incident for purposes of s. 395.0197 and this section.

(e) In a civil action or administrative proceeding against a physician based on his or her alleged failure to properly disclose the risks of cataract surgery, a patient's informed consent executed as provided in paragraph (c) on the form adopted by the board is admissible as evidence and creates a rebuttable presumption that the physician properly disclosed the risks.



155418

Section 9. Paragraph (b) of subsection (1) of section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.—

(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or s. 624.462 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:

~~(b)1. Except as provided in subparagraph 2., a clause authorizing the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.~~

~~2.a. With respect to dentists licensed under chapter 466, A~~
clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the



155418

permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.

~~2.b.~~ If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

Section 10. Subsections (3), (4), and (5) of section 766.102, Florida Statutes, are amended, subsection (12) of that section is renumbered as subsection (14), and new subsections (12) and (13) are added to that section, to read:

766.102 Medical negligence; standards of recovery; expert witness.—

(3)(a) As used in this subsection, the term:

1. "Insurer" means any public or private insurer, including



155418

the Centers for Medicare and Medicaid Services.

2. "Reimbursement determination" means an insurer's determination of the amount that the insurer will reimburse a health care provider for health care services.

3. "Reimbursement policies" means an insurer's policies and procedures governing its decisions regarding health insurance coverage and method of payment and the data upon which such policies and procedures are based, including, but not limited to, data from national research groups and other patient safety data as defined in s. 766.1016.

(b) The existence of a medical injury ~~does~~ shall not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider. Any records, policies, or testimony of an insurer's reimbursement policies or reimbursement determination regarding the care provided to the plaintiff are not admissible as evidence in any medical negligence action. However, the discovery of the presence of a foreign body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

(4)(a) The Legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers. The failure of a health care provider to order, perform, or



155418

administer supplemental diagnostic tests is ~~shall~~ not be actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care.

(b) In an action for damages based on death or personal injury which alleges that such death or injury resulted from the failure of a health care provider to order, perform, or administer supplemental diagnostic tests, the claimant has the burden of proving by clear and convincing evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care.

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless the ~~that~~ person is a ~~licensed~~ health care provider who holds an active and valid license and conducts a complete review of the pertinent medical records and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with



155418

respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice or consultation as a general practitioner;

2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:



155418

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;

2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

(12) If a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 is the party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must be licensed under chapter 458, chapter 459, or chapter 466 or possess a valid expert witness certificate issued under s. 458.3175, s. 459.0066, or s. 466.005.

(13) A health care provider's failure to comply with or breach of any federal requirement is not admissible as evidence in any medical negligence case in this state.

Section 11. Paragraph (a) of subsection (2), subsection (5), and paragraph (b) of subsection (6) of section 766.106, Florida Statutes, are amended to read:

766.106 Notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.—



155418

(2) PRESUIT NOTICE.—

(a) After completion of presuit investigation pursuant to s. 766.203(2) and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, ~~and~~ copies of all of the medical records relied upon by the expert in signing the affidavit, and the executed authorization form provided in s. 766.1065. ~~The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.~~

(5) DISCOVERY AND ADMISSIBILITY.—~~A~~ No statement, discussion, written document, report, or other work product generated by the presuit screening process is not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process. This subsection does not prevent a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 who submits a verified written expert medical opinion from being subject to denial of a license or disciplinary action



155418

under s. 458.331(1)(oo), s. 459.015(1)(qq), or s.
466.028(1)(ll).

(6) INFORMAL DISCOVERY.—

(b) Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations, as follows:

1. Unsworn statements.—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

2. Documents or things.—Any party may request discovery of documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce discoverable documents or things within that party's possession or control. Medical records shall be produced as provided in s. 766.204.

3. Physical and mental examinations.—A prospective



155418

defendant may require an injured claimant to appear for examination by an appropriate health care provider. The prospective defendant shall give reasonable notice in writing to all parties as to the time and place for examination. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination must be determined by the nature of the claimant's condition, as it relates to the liability of each prospective defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

4. Written questions.—Any party may request answers to written questions, the number of which may not exceed 30, including subparts. A response must be made within 20 days after receipt of the questions.

5. Ex parte interviews of treating health care providers.—A prospective defendant or his or her legal representative may interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative.

6.5. Unsworn statements of treating health care providers
~~Medical information release. The claimant must execute a medical information release that allows~~ A prospective defendant or his or her legal representative may also ~~to~~ take unsworn statements of the claimant's treating health care providers ~~physicians~~. The statements must be limited to those areas that are potentially



155418

relevant to the claim of personal injury or wrongful death. Subject to the procedural requirements of subparagraph 1., a prospective defendant may take unsworn statements from a claimant's treating physicians. Reasonable notice and opportunity to be heard must be given to the claimant or the claimant's legal representative before taking unsworn statements. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.

Section 12. Section 766.1065, Florida Statutes, is created to read:

766.1065 Authorization for release of protected health information.—

(1) Presuit notice of intent to initiate litigation for medical negligence under s. 766.106(2) must be accompanied by an authorization for release of protected health information in the form specified by this section, authorizing the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2).

(2) If the authorization required by this section is revoked, the presuit notice under s. 766.106(2) is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

(3) The authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" in 45 C.F.R. parts 160 and 164:



155418

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, (...Name of patient or authorized representative...) [hereinafter "Patient"], authorize that (...Name of health care provider to whom the presuit notice is directed...) and his/her/its insurer(s), self-insurer(s), and attorney(s) may obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. Facilitating the investigation and evaluation of the medical negligence claim described in the accompanying presuit notice; or

2. Defending against any litigation arising out of the medical negligence claim made on the basis of the accompanying presuit notice.

B. The health information obtained, used, or disclosed extends to, and includes, the verbal as well as the written and is described as follows:

1. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient in connection with injuries complained of after the alleged act of negligence: (List the name and current address of all health care providers). This authorization extends to any additional health care providers that may in the future evaluate, examine, or treat the Patient for the injuries complained of.



155418

2. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient during a period commencing 2 years before the incident that is the basis of the accompanying presuit notice.

(List the name and current address of such health care providers, if applicable.)

C. This authorization does not apply to the following list of health care providers possessing health care information about the Patient because the Patient certifies that such health care information is not potentially relevant to the claim of personal injury or wrongful death that is the basis of the accompanying presuit notice.

(List the name of each health care provider to whom this authorization does not apply and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure. If none, specify "none.")

D. The persons or class of persons to whom the Patient authorizes such health information to be disclosed or by whom such health information is to be used:

1. Any health care provider providing care or treatment for the Patient.

2. Any liability insurer or self-insurer



155418

providing liability insurance coverage, self-
insurance, or defense to any health care provider to
whom presuit notice is given regarding the care and
treatment of the Patient.

3. Any consulting or testifying expert employed
by or on behalf of (name of health care provider to
whom presuit notice was given), his/her/its
insurer(s), self-insurer(s), or attorney(s) regarding
to the matter of the presuit notice accompanying this
authorization.

4. Any attorney (including secretarial, clerical,
or paralegal staff) employed by or on behalf of (name
of health care provider to whom presuit notice was
given) regarding the matter of the presuit notice
accompanying this authorization.

5. Any trier of the law or facts relating to any
suit filed seeking damages arising out of the medical
care or treatment of the Patient.

E. This authorization expires upon resolution of
the claim or at the conclusion of any litigation
instituted in connection with the matter of the
presuit notice accompanying this authorization,
whichever occurs first.

F. The Patient understands that, without
exception, the Patient has the right to revoke this
authorization in writing. The Patient further
understands that the consequence of any such
revocation is that the presuit notice under s.
766.106(2), Florida Statutes, is deemed retroactively



155418

void from the date of issuance, and any tolling effect
that the presuit notice may have had on any applicable
statute-of-limitations period is retroactively
rendered void.

G. The Patient understands that signing this
authorization is not a condition for continued
treatment, payment, enrollment, or eligibility for
health plan benefits.

H. The Patient understands that information used
or disclosed under this authorization may be subject
to additional disclosure by the recipient and may not
be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative:

Date:

Name of Patient/Representative:

Description of Representative's Authority:

Section 13. Subsection (2) of section 766.206, Florida
Statutes, is amended to read:

766.206 Presuit investigation of medical negligence claims
and defenses by court.—

(2) If the court finds that the notice of intent to
initiate litigation mailed by the claimant does is not comply in
compliance with the reasonable investigation requirements of ss.
766.201-766.212, including a review of the claim and a verified
written medical expert opinion by an expert witness as defined
in s. 766.202, or that the authorization accompanying the notice
of intent required under s. 766.1065 is not completed in good
faith by the claimant, the court shall dismiss the claim, and



155418

the person who mailed such notice of intent, whether the claimant or the claimant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 14. Section 768.0981, Florida Statutes, is amended to read:

768.0981 Limitation on actions against insurers, prepaid limited health service organizations, health maintenance organizations, hospitals, or prepaid health clinics.—An entity licensed or certified under chapter 395, chapter 624, chapter 636, or chapter 641 ~~is shall~~ not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

Section 15. This act shall take effect July 1, 2011.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled
An act relating to medical malpractice; creating ss.
458.3175, 459.0066, and 466.005, F.S.; requiring the
Department of Health to issue expert witness
certificates to certain physicians and dentists



155418

licensed outside of the state; providing application and certification requirements; establishing application fees; providing for the validity and use of certifications; exempting physicians and dentists issued certifications from certain licensure and fee requirements; amending ss. 458.331, 459.015, and 466.028, F.S.; providing additional acts that constitute grounds for denial of a license or disciplinary action to which penalties apply; providing construction with respect to the doctrine of incorporation by reference; amending ss. 458.351 and 459.026, F.S.; requiring the Board of Medicine and the Board of Osteopathic Medicine to adopt within a specified period certain patient forms specifying cataract surgery risks; specifying that an incident resulting from risks disclosed in the patient form is not an adverse incident; providing for the execution and admissibility of the patient forms in civil and administrative proceedings; creating a rebuttable presumption that a physician disclosed cataract surgery risks if the patient form is executed; amending s. 627.4147, F.S.; deleting a requirement that medical malpractice insurance contracts contain a clause authorizing the insurer to make and conclude certain offers within policy limits over the insured's veto; amending s. 766.102, F.S.; defining terms; providing that certain insurance information is not admissible as evidence in medical negligence actions; establishing the burden of proof that a claimant must



155418

meet in certain damage claims against health care providers based on death or personal injury; requiring that certain expert witnesses who provide certain expert testimony meet certain licensure or certification requirements; excluding a health care provider's failure to comply with or breach of federal requirements from evidence in medical negligence cases in the state; amending s. 766.106, F.S.; requiring claimants for medical malpractice to execute an authorization form; allowing prospective medical malpractice defendants to interview a claimant's treating health care provider without notice to or the presence of the claimant or the claimant's legal representative; authorizing prospective defendants to take unsworn statements of a claimant's health care provider; creating s. 766.1065, F.S.; requiring that presuit notice for medical negligence claims be accompanied by an authorization for release of protected health information; providing requirements for the form of such authorization; amending s. 766.206, F.S.; requiring dismissal of a medical malpractice claim if such authorization is not completed in good faith; amending s. 768.0981, F.S.; limiting the liability of hospitals related to certain medical negligence claims; providing an effective date.



724436

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Smith) recommended the following:

Senate Amendment to Amendment (155418) (with title amendment)

Between lines 244 and 245
insert:

Section 9. Paragraph (f) of subsection (7) of section 627.062, Florida Statutes, is redesignated as paragraph (g), and paragraph (f) is added to that subsection, to read:

627.062 Rate standards.—

(7)

(f) In reviewing any rate filing under this subsection, the office shall consider as part of the insurer's rate base the



724436

insurer's loss adjustment expenses or defense and cost
containment expenses only to the extent that the expenses are
below or do not exceed the national average for such expenses,
as determined by the office, for the prior calendar year. An
insurer's loss adjustment expenses or defense and cost
containment expenses in excess of the national average may not
be used to justify a rate or rate change.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 700

and insert:

surgery risks if the patient form is executed;
amending s. 627.062, F.S.; requiring the Office of
Insurance Regulation to consider, as part of the
insurer's rate base, the insurer's loss adjustment
expenses or defense and cost containment expenses;
providing that a rate or rate change may not be
justified by an insurer's loss adjustment expenses or
defense and cost containment expenses in excess of the
national average;



363290

LEGISLATIVE ACTION

Senate

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House

The Committee on Banking and Insurance (Smith) recommended the following:

Senate Amendment (with title amendment)

Between lines 147 and 148
insert:

Section 5. Present paragraph (f) of subsection (7) of
section 627.062, Florida Statutes, is redesignated as paragraph
(g), and a new paragraph (f) is added to that subsection, to
read:

627.062 Rate standards.—

(7)

(f) In reviewing any rate filing under this subsection, the
office shall consider as part of the insurer's rate base the



363290

insurer's loss adjustment expenses or defense and cost
containment expenses only to the extent that the expenses are
below or do not exceed the national average for such expenses,
as determined by the office, for the prior calendar year. An
insurer's loss adjustment expenses or defense and cost
containment expenses in excess of the national average may not
be used to justify a rate or rate change.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 15

and insert:

apply; amending s. 627.062, F.S.; requiring the Office
of Insurance Regulation to consider, as part of the
insurer's rate base, the insurer's loss adjustment
expenses or defense and cost containment expenses;
providing that a rate or rate change may not be
justified by an insurer's loss adjustment expenses or
defense and cost containment expenses in excess of the
national average; amending s. 627.4147, F.S.; deleting
a

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: SB 1590

INTRODUCER: Senators Hays and Gaetz

SUBJECT: Medical Malpractice Actions

DATE: April 10, 2011

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HR	Favorable
2.	Arzillo/Knudson	Burgess	BI	Pre-Meeting
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate bill 1590 revises statutes related to medical malpractice claims. The bill requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under ch. 458, The Medical Practice Act, or ch. 459, F.S., The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the Board of Medicine (BOM) or the Board of Osteopathic Medicine (BOOM). Florida licensed physicians will be subject to disciplinary action by the BOM or the BOOM for offering false or misleading information as an expert witness, while physicians outside Florida will be subject to revocation of the expert witness certificate for offering such testimony.

The bill reduces the period of time immediately preceding the date of the occurrence that is the basis for the action within which the expert witness must have performed certain activities. The time frames and activities depend upon whether the health care provider against whom or on whose behalf the testimony is offered is a specialist, a general practitioner, other type of health care provider, or was providing emergency medical services in a hospital emergency department.

The bill requires a clause in an insurance policy or self-insurance policy for medical malpractice coverage to clearly state whether or not the insured has the exclusive right of veto of any admission of liability or offer of judgment. The bill repeals the authority for a self-insurance policy or insurance policy for medical malpractice to grant authority for the insurer to bring the case to closure without the permission of the insured if the action is within the policy limits.

The bill requires a claimant to submit, along with the other required information, an executed authorization form for the release of protected health information that is potentially relevant to

the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence.

The bill authorizes a prospective defendant or his or her legal representative access to conduct ex-parte interviews of the claimant's treating health care providers without notice to, or the presence of, the claimant or the claimant's legal representative.

This bill substantially amends the following sections of the Florida Statutes: 458.331, 459.015, 627.4147, 766.102, 766.106, and 766.206. The bill creates the following sections of the Florida Statutes: 458.3175, 459.0066, and 766.1065.

II. Present Situation:

Standard of Proof in Medical Malpractice Actions

In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that the death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving by the greater weight of evidence that the alleged action of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.¹

Presuit Investigation²

Prior to the filing of a lawsuit, the person allegedly injured by medical negligence or a party bringing a wrongful death action arising from an alleged incidence of medical malpractice (the claimant) and the defendant (the health care professional or health care facility) are required to conduct presuit investigations to determine whether medical negligence occurred and what damages, if any, are appropriate.

The claimant is required to conduct an investigation to ascertain that there are reasonable grounds to believe that:

- A named defendant in the litigation was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.

Corroboration of reasonable grounds to initiate medical negligence litigation must be provided by the claimant's submission of a verified written medical expert opinion from a medical expert.

Before the defendant issues his or her response, the defendant or his or her insurer or self-insurer is required to ascertain whether there are reasonable grounds to believe that:

¹ S. 766.102, F.S.

² S. 766.203, F.S.

- The defendant was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.

Corroboration of the lack of reasonable grounds for medical negligence litigation must be provided by submission of a verified written medical expert opinion which corroborates reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

These expert opinions are subject to discovery. Furthermore, the opinion must specify whether any previous opinion by that medical expert has been disqualified and if so, the name of the court and the case number in which the ruling was issued.

Qualification of Medical Expert³ Witnesses

A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

- If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:
 - Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and
 - Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
 - The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;
 - Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or
 - A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
- If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:
 - The active clinical practice or consultation as a general practitioner;
 - The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
 - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
- If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

³ S. 766.102(5), (9), and (12), F.S.

- The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;
- The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or
- A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.
- If the claim of negligence is against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

These provisions do not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section (s. 766.102, F.S.). Relevant portions of the Florida Evidence Code provide requirements for expert opinion testimony.⁴ The Florida Rules of Civil Procedure define “expert witness” as a person duly and regularly engaged in the practice of a profession who holds a professional degree from a university or college and has had special professional training and experience, or one possessed of special knowledge or skill about the subject upon which called to testify.⁵

The court must refuse to consider the testimony or opinion attached to any notice of intent or to any response rejecting a claim of an expert who has been disqualified three times.⁶

After Claimant’s Presuit Investigation⁷

After completion of the presuit investigation and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.

A suit may not be filed for a period of 90 days after notice is mailed to any prospective defendant. The statute of limitations is tolled during the 90-day period. During the 90-day period, the prospective defendant or the defendant’s insurer or self-insurer shall conduct a presuit investigation to determine the liability of the defendant. Each insurer or self-insurer shall have a

⁴ Sections 90.702 and 90.704, F.S.

⁵ Fla. R. Civ. P. 1.390(a).

⁶ S. 766.206, F.S.

⁷ S. 766.106, F.S.

procedure for the prompt investigation, review, and evaluation of claims during the 90-day period.

Each insurer or self-insurer must investigate the claim in good faith, and both the claimant and prospective defendant must cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There is no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

At or before the end of the 90 days, the prospective defendant or the prospective defendant's insurer or self-insurer shall provide the claimant with a response:

- Rejecting the claim;
- Making a settlement offer; or
- Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only on the issue of damages. This offer may be made contingent upon a limit of general damages.

The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt shall be deemed a final rejection of the claim for purposes of this section.

Discovery and Admissibility of Evidence

Statements, discussions, written documents, reports, or other work product generated by the presuit screening process are not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.⁸

Upon receipt by a prospective defendant of a notice of claim, the parties are required to make discoverable information available without undertaking formal discovery. Informational discovery may be used to obtain unsworn statements, the production of documents or things, and physical and mental examinations as follows:⁹

- Unsworn statements – Any party may require other parties to appear for the taking of an unsworn statement. Unsworn statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party.
- Documents or things – Any party may request discovery of documents or things. This includes medical records.

⁸ S. 766.106(5), F.S.

⁹ S. 766.106(6), F.S.

- Physical and mental examination – A prospective defendant may require an injured claimant to be examined by an appropriate health care provider. Unless otherwise impractical, a claimant is required to submit to only one examination of behalf of all potential defendants. The examination report is available to the parties and their attorney and may be used only for the purpose of presuit screening. Otherwise the examination is confidential.
- Written questions – Any party may request answers to written questions.
- Medical information release – The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians that address areas that are potentially relevant to the claim of personal injury or wrongful death. The claimant or claimant's legal representative has the right to attend the taking of these unsworn statements.

The failure to cooperate on the part of any party during the presuit investigation may be grounds to strike any claim made, or defense raised in the suit.

Medical Malpractice Insurance Policies

Section 627.4147, F.S., provides that medical malpractice insurance policies must authorize the insurer or self-insurer to make decisions without the permission of the insured regarding any offer of admission of liability and for arbitration, settlement offer, or offer of judgment, if the offer is within the policy limits. The statute states that it is against public policy to give the insured exclusive right to veto the insurer or self-insurer's decision when the offer is within policy limits. However, malpractice insurance policies issued to licensed dentists provide dentists with an exclusive right to veto, as long as it is clearly stated in the policy, and the policy states that the insurer or self-insurer may not make admissions to liability and arbitration, settlement offer or offer of judgment that are outside the policy limits. Nevertheless, in both instances, the insurer or self-insurer must make a good faith admission of liability, settlement offer, or offer of judgment and it must be in the best interest of the insured.

III. Effect of Proposed Changes:

Section 1 and section 3 create s. 458.3175, F.S., and s. 459.0066, F.S., respectively, to authorize the BOM or the BOOM to issue a certificate to a physician or osteopathic physician who is licensed to practice medicine or osteopathic medicine in another state or a province of Canada to provide expert testimony in this state pertaining to medical negligence litigation against a physician. The expert witness certificate authorizes the physician or osteopathic physician to provide a verified written medical opinion for purposes of presuit investigation of medical negligence claims and provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under ch. 458, F.S., or ch. 459, F.S. These sections allow the BOM and BOOM to enforce jurisdiction, currently not available, over out-of-state physicians who provide expert testimony in medical malpractice cases concerning the prevailing professional standard of care that physicians who are licensed in the State under ch. 458 and ch. 459 should provide. A physician who is not licensed in this state but intends to provide expert testimony in this state must submit a completed application and pay an application fee in an amount not to exceed \$50. The BOM or the BOOM may not issue a certificate to a physician who has had a previous expert witness certificate revoked by the BOM or the BOOM. The BOM or the BOOM is required to

approve or deny the application within 5 business days after receipt of the completed application and fee, otherwise the application is approved by default. If a physician intends to rely on a certificate that is approved by default, he or she must notify the BOM or BOOM in writing. An expert witness certificate is valid for 2 years.

The expert witness certificate does not authorize the physician to practice medicine or osteopathic medicine in this state, and a physician who does not otherwise practice medicine in this state is not required to obtain a license to practice medicine in this state, or pay other fees, including the neurological injury compensation assessment.

The BOM and the BOOM are required to adopt rules to administer their respective section of law.

Section 2 and section 4 amend s. 458.331, F.S., and s. 459.015, F.S., respectively, to add that providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine is grounds for denial of a license or other disciplinary action against a physician or osteopathic physician licensed in this state under ch. 458 and ch. 459. These sections create statutory authority for the BOM or the BOOM to enforce jurisdiction over physicians licensed in the State who provide misleading or false testimony.

Section 5 amends s. 627.4147, F.S., to repeal the requirement that a self-insurance policy or insurance policy that provides coverage for medical malpractice must authorize the insurer or self-insurer to determine, make, and conclude any offer of admission of liability and for arbitration, settlement offer, or offer of judgment if the offer is within the policy limits without the permission of the insured. The bill also repeals the statement that it is against public policy for an insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto an offer for admission of liability and for arbitration, settlement offer, or offer of judgment, when the offer is within the policy limits.

Instead, the bill requires a clause in all malpractice insurance policies that clearly states whether or not the insured has the exclusive right of veto if the offer is within policy limits. The policy must also prohibit the insurer or self-insurer from making or concluding, without the permission of the insured, any offer of admission of liability and for arbitration, settlement offer, or offer of judgment, if such offer is outside the policy limit. In current law, these provisions only apply policies covering licensed dentists.

Section 6 amends s. 766.102, F.S., to reduce the period of time immediately preceding the date of the occurrence that is the basis for the action within which the expert witness must have performed certain activities. If the health care provider against whom or on whose behalf the testimony is offered is:

- A specialist, in addition, to other things, the expert witness must have devoted professional time during the 2 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
 - The active clinical practice of, or consulting with respect to, the same or similar specialty,
 - Instructing students in an accredited health professional school or accrediting residency or clinical research program in the same or similar specialty, or

- A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
- A general practitioner, the expert witness must have devoted professional time during the 2 years, rather than 5 years, immediately preceding the date of the occurrence that is the basis for the action to:
 - The active clinic practice or consultation as a general practitioner,
 - Instructing students in an accredited health professional school or accrediting residency program in the general practice of medicine, or
 - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
- A health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 2 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
 - The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered,
 - Instructing students in an accredited health professional school or accrediting residency program in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered, or
 - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.
- A physician, osteopathic physician, podiatric physician, or chiropractic physician providing emergency medical services in a hospital emergency department, the expert witness must have had substantial professional experience within the preceding 2 years, rather than 5 years, while assigned to provide emergency medical services in a hospital emergency department.

In addition, this section requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under The Medical Practice Act or The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the BOM or the BOOM.

Section 7 amends s. 766.106, F.S., to require a claimant to submit, along with the other required information, an executed authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence. This expands the current requirement that the claimant provide a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit.

This section provides that notwithstanding the immunity from civil liability arising from participation in the presuit screening process that is currently afforded under the law, a physician who is licensed under the Medical Practice Act or the Osteopathic Medical Practice Act who submits a verified written expert medical opinion is subject to denial of a license or disciplinary

action for providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine or osteopathic medicine.

Unlike the current requirement to request permission from the plaintiff to perform an unsworn interview with the claimant's health care providers, the bill authorizes a prospective defendant or his or her legal representative access to interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative. However, a prospective defendant or his or her legal representative who takes an unsworn statement from a claimant's treating physicians must provide reasonable notice and opportunity to be heard to the claimant or the claimant's legal representative before taking unsworn statements. Unsworn statements are used for presuit screening and are not discoverable or admissible in a civil action for any purpose by any party.

Section 8 creates s. 766.1065, F.S., to establish an authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The bill sets forth the specific content of the form, including identification of the parties; authorizing the disclosure of protected health information for specified purposes; description of the information and the health care providers from whom the information is available; identification of health care providers to whom the authorization for disclosure does not apply because the health care information is not potentially relevant to the claim of personal injury or wrongful death; the persons to whom the patient authorizes the information to be disclosed; a statement regarding the expiration of the authorization; acknowledgement that the patient understands that he or she has the right to revoke the authorization in writing, the consequences for the revocation, signing the authorization is not a condition for health plan benefits, and that the information authorized for disclosure may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations;¹⁰ and applicable signature by the patient or his or her representative.

The bill provides that the presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2), F.S. If the authorization is revoked, the presuit notice is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on the applicable statute-of-limitations period is retroactively rendered void.

Section 9 amends s. 766.206, F.S., to authorize the court to dismiss the claim if the court finds that the authorization form accompanying the notice of intent to initiate litigation for medical negligence was not completed in good faith by the claimant. If the court dismisses the claim, the claimant or the claimant's attorney is personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 10 provides an effective date of July 1, 2011.

¹⁰ HIPAA is the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-194) and generally include the privacy rules adopted thereunder. With certain exceptions, the HIPAA privacy rules preempt contrary provisions in state law, unless the state law is more stringent than the federal rules. See 45 C.F.R. Part 164.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Section 1 and section 3 of the bill change provisions relating to expert witnesses. Article V, s. 2(a), Fla. Const., provides that the Florida Supreme Court "shall adopt rules for the practice and procedure" in all courts. The Florida Supreme Court has interpreted this provision to mean that the court has the exclusive power to create rules of practice and procedure. Section 1 and section 3 provide requirements for expert witnesses who do not possess a Florida license. If a court were to find that any of these requirements encroached on the court's rulemaking power, it could hold the provisions invalid. Fiscal Impact Statement:

E. Tax/Fee Issues:

None.

F. Private Sector Impact:

The bill requires physicians and dentists licensed in another state or Canada to pay a fee of not more than \$50 to obtain an expert witness certificate in order to provide an expert witness opinion or provide expert testimony relating to the standard of care in a medical malpractice case involving a physician or dentist. The department estimates that during the first year there will be approximately 2,478 expert witness certificates applied for, thereby resulting in revenues of \$123,900 to be deposited within the Medical Quality Assurance Trust Fund.

A party seeking to use an expert witness who is not a physician or osteopathic physician licensed in this state may only use an expert witness who has a certificate from the Florida BOM or the Florida BOOM. Proponents of the bill assert that this will help ensure that medical expert witness testimony is accurate. Opponents of the bill assert that this requirement, and the reduced timeframe in which substantial professional experience qualifies a person as an expert witness, might limit or delay a claimant's ability to engage

an expert witness to conduct a presuit investigation and proceed with a claim for medical negligence.

The specific HIPAA-compliant form will facilitate the release and disclosure of protected health information and more clearly protect persons who release that information. The defense will have an additional discovery tool with the authorization to conduct ex parte interviews of treating health care providers.

The changes to insurance and self-insurance policies provide physicians with greater control over the disposition of medical malpractice claims.

G. Government Sector Impact:

The BOM and the BOOM will be required to develop application forms and rules to administer the certification program for expert witnesses. Additional regulatory and enforcement activities may emerge as a result of the bill.

V. Technical Deficiencies:

None.

VI. Related Issues:

None.

VII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.