1 A bill to be entitled
2 An act relating to motor vehicle insurance
3 costs; providing a short title; providing
4 legislative findings and purpose; amending s.
5 119.105, F.S.; prohibiting disclosure of
6 confidential police reports for purposes of
7 commercial solicitation; amending s. 316.066,
8 F.S.; requiring the filing of a sworn statement
9 as a condition to accessing a crash report
10 stating the report will not be used for
11 commercial solicitation; providing a penalty;
12 creating part XIII of ch. 400, F.S., entitled
13 the Health Care Clinic Act; providing for
14 definitions and exclusions; providing for the
15 licensure, inspection, and regulation of health
16 care clinics by the Agency for Health Care
17 Administration; requiring licensure and
18 background screening; providing for clinic
19 inspections; providing rulemaking authority;
20 providing licensure fees; providing fines and
21 penalties for operating an unlicensed clinic;
22 providing for clinic responsibilities with
23 respect to personnel and operations; providing
24 accreditation requirements; providing for
25 injunctive proceedings and agency actions;
26 providing administrative penalties; amending s.
27 456.0375, F.S.; excluding certain entities from
28 clinic registration requirements; providing
29 retroactive application; amending s. 456.072,
30 F.S.; providing that making a claim with
31 respect to personal injury protection which is



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1 upcoded or which is submitted for payment of
2 services not rendered constitutes grounds for
3 disciplinary action; amending s. 626.7451,
4 F.S.; providing a per-policy fee to be remitted
5 to the insurer's Special Investigations Unit,
6 the Division of Insurance Fraud of the
7 Department of Financial Services, and the
8 Office of Statewide Prosecution for purposes of
9 preventing, detecting, and prosecuting motor
10 vehicle insurance fraud; amending s. 627.732,
11 F.S.; providing definitions; providing that
12 benefits are void if fraud is committed;
13 providing for award of attorney's fees in
14 actions to recover benefits; providing that
15 consideration shall be given to certain factors
16 regarding the reasonableness of charges;
17 specifying claims or charges that an insurer is
18 not required to pay; requiring the Department
19 of Health, in consultation with medical boards,
20 to identify certain diagnostic tests as
21 non-compensable; specifying effective dates;
22 deleting certain provisions governing
23 arbitration; providing for compliance with
24 billing procedures; requiring certain providers
25 to require an insured to sign a disclosure
26 form; prohibiting insurers from authorizing
27 physicians to change opinion in reports;
28 providing requirements for physicians with
29 respect to maintaining such reports; limiting
30 the application of contingency risk multipliers
31 for awards of attorney's fees; expanding

1 provisions providing for a demand letter;
2 authorizing the Financial Services Commission
3 to determine cost savings under personal injury
4 protection benefits under specified conditions;
5 allowing a person who elects a deductible or
6 modified coverage to claim the amount deducted
7 from a person legally responsible; amending s.
8 627.739, F.S.; specifying application of a
9 deductible amount; amending s. 817.234, F.S.;
10 providing that it is a material omission and
11 insurance fraud for a physician or other
12 provider to waive a deductible or copayment or
13 not collect the total amount of a charge;
14 increasing the penalties for certain acts of
15 solicitation of accident victims; providing
16 mandatory minimum penalties; prohibiting
17 certain solicitation of accident victims;
18 providing penalties; prohibiting a person from
19 participating in an intentional motor vehicle
20 accident for the purpose of making motor
21 vehicle tort claims; providing penalties,
22 including mandatory minimum penalties; amending
23 s. 817.236, F.S.; increasing penalties for
24 false and fraudulent motor vehicle insurance
25 application; creating s. 817.2361, F.S.;
26 prohibiting the creation or use of false or
27 fraudulent motor vehicle insurance cards;
28 providing penalties; amending s. 921.0022,
29 F.S.; revising the offense severity ranking
30 chart of the Criminal Punishment Code to
31 reflect changes in penalties and the creation



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of additional offenses under the act; providing legislative intent with respect to the retroactive application of certain provisions; repealing s. 456.0375, F.S., relating to the regulation of clinics by the Department of Health; requiring certain insurers to make a rate filing to conform the per-policy fee to the requirements of the act; specifying the application of any increase in benefits approved by the Financial Services Commission; providing for application of other provisions of the act; requiring reports; providing an appropriation and authorizing additional positions; repealing of ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S., relating to the Florida Motor Vehicle No-Fault Law, unless reenacted by the 2005 Regular Session, and specifying certain effect; authorizing insurers to include in policies a notice of termination relating to such repeal; providing effective dates.

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

Section 1. Florida Motor Vehicle Insurance Affordability Reform Act; legislative findings; purpose.--

(1) This act may be cited as the "Florida Motor Vehicle Insurance Affordability Reform Act."

(2) The Legislature finds and declares that:



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1 (a) The Florida Motor Vehicle No-Fault Law, enacted 32
2 years ago, has provided valuable benefits over the years to
3 consumers in this state. The principle underlying the
4 philosophical basis of the no-fault or personal injury
5 protection (PIP) insurance system is that of a trade-off of
6 one benefit for another, specifically providing medical and
7 other benefits in return for a limitation on the right to sue
8 for nonserious injuries.
9 (b) The PIP insurance system has provided benefits in
10 the form of medical payments, lost wages, replacement
11 services, funeral payments, and other benefits, without regard
12 to fault, to consumers injured in automobile accidents.
13 (c) However, the goals behind the adoption of the
14 no-fault law in 1971, which were to quickly and efficiently
15 compensate accident victims regardless of fault, to reduce the
16 volume of lawsuits by eliminating minor injuries from the tort
17 system, and to reduce overall motor vehicle insurance costs,
18 have been significantly compromised due to the fraud and abuse
19 that has permeated the PIP insurance market.
20 (d) Motor vehicle insurance fraud and abuse, other
21 than in the hospital setting, whether in the form of
22 inappropriate medical treatments, inflated claims, staged
23 accidents, solicitation of accident victims, falsification of
24 records, or in any other form, has increased premiums for
25 consumers and must be uncovered and vigorously prosecuted. The
26 problem of inappropriate medical treatment and inflated claims
27 for PIP have generally not occurred in the hospital setting.
28 (e) The no-fault system has been weakened in part due
29 to certain insurers not adequately or timely compensating
30 injured accident victims or health care providers. In
31 addition, the system has become increasingly litigious with

1 attorneys obtaining large fees by litigating, in certain
2 instances, over relatively small amounts that are in dispute.
3 (f) It is a matter of great public importance that, in
4 order to provide a healthy and competitive automobile
5 insurance market, consumers be able to obtain affordable
6 coverage, insurers be entitled to earn an adequate rate of
7 return, and providers of services be compensated fairly.
8 (g) It is further a matter of great public importance
9 that, in order to protect the public's health, safety, and
10 welfare, it is necessary to enact the provisions contained in
11 this act in order to prevent PIP insurance fraud and abuse and
12 to curb escalating medical, legal, and other related costs,
13 and the Legislature finds that the provisions of this act are
14 the least restrictive actions necessary to achieve this goal.
15 (h) Therefore, the purpose of this act is to restore
16 the health of the PIP insurance market in Florida by
17 addressing these issues, preserving the no-fault system, and
18 realizing cost-savings for all people in this state.
19 Section 2. Section 119.105, Florida Statutes, is
20 amended to read:
21 119.105 Protection of victims of crimes or
22 accidents.--Police reports are public records except as
23 otherwise made exempt or confidential by general or special
24 law. Every person is allowed to examine nonexempt or
25 nonconfidential police reports. A ~~No~~ person who comes into
26 possession of exempt or confidential information contained in
27 police reports may not ~~inspects or copies police reports for~~
28 ~~the purpose of obtaining the names and addresses of the~~
29 ~~victims of crimes or accidents shall~~ use that ~~any~~ information
30 ~~contained therein~~ for any commercial solicitation of the
31 victims or relatives of the victims of the reported crimes or



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1 accidents and may not knowingly disclose such information to
2 any third party for the purpose of such solicitation during
3 the period of time that information remains exempt or
4 confidential. This section does not ~~Nothing herein shall~~
5 prohibit the publication of such information to the general
6 public by any news media legally entitled to possess that
7 information or the use of such information for any other data
8 collection or analysis purposes by those entitled to possess
9 that information.
10 Section 3. Paragraph (c) of subsection (3) of section
11 316.066, Florida Statutes, is amended, and paragraph (f) is
12 added to that subsection, to read:
13 316.066 Written reports of crashes.--
14 (3)
15 (c) Crash reports required by this section which
16 reveal the identity, home or employment telephone number or
17 home or employment address of, or other personal information
18 concerning the parties involved in the crash and which are
19 received or prepared by any agency that regularly receives or
20 prepares information from or concerning the parties to motor
21 vehicle crashes are confidential and exempt from s. 119.07(1)
22 and s. 24(a), Art. I of the State Constitution for a period of
23 60 days after the date the report is filed. However, such
24 reports may be made immediately available to the parties
25 involved in the crash, their legal representatives, their
26 licensed insurance agents, their insurers or insurers to which
27 they have applied for coverage, persons under contract with
28 such insurers to provide claims or underwriting information,
29 prosecutorial authorities, radio and television stations
30 licensed by the Federal Communications Commission, newspapers
31 qualified to publish legal notices under ss. 50.011 and

50.031, and free newspapers of general circulation, published once a week or more often, available and of interest to the public generally for the dissemination of news. For the purposes of this section, the following products or publications are not newspapers as referred to in this section: those intended primarily for members of a particular profession or occupational group; those with the primary purpose of distributing advertising; and those with the primary purpose of publishing names and other personally identifying information concerning parties to motor vehicle crashes. Any local, state, or federal agency, agent, or employee that is authorized to have access to such reports by any provision of law shall be granted such access in the furtherance of the agency's statutory duties notwithstanding the provisions of this paragraph. Any local, state, or federal agency, agent, or employee receiving such crash reports shall maintain the confidential and exempt status of those reports and shall not disclose such crash reports to any person or entity. As a condition precedent to accessing a ~~Any person attempting to access~~ crash report ~~reports~~ within 60 days after the date the report is filed, a person must present a valid driver's license or other photographic identification, proof of status ~~legitimate credentials~~ or identification that demonstrates his or her qualifications to access that information, and file a written sworn statement with the state or local agency in possession of the information stating that information from a crash report made confidential by this section will not be used for any commercial solicitation of accident victims, or knowingly disclosed to any third party for the purpose of such solicitation, during the period of time that the information remains confidential. In lieu of

1 requiring the written sworn statement, an agency may provide
2 crash reports by electronic means to third-party vendors under
3 contract with one or more insurers, but only when such
4 contract states that information from a crash report made
5 confidential by this section will not be used for any
6 commercial solicitation of accident victims by the vendors, or
7 knowingly disclosed by the vendors to any third party for the
8 purpose of such solicitation, during the period of time that
9 the information remains confidential, and only when a copy of
10 such contract is furnished to the agency as proof of the
11 vendor's claimed status. This subsection does not prevent the
12 dissemination or publication of news to the general public by
13 any legitimate media entitled to access confidential
14 information pursuant to this section. A law enforcement
15 officer as defined in s. 943.10(1) may enforce this
16 subsection.This exemption is subject to the Open Government
17 Sunset Review Act of 1995 in accordance with s. 119.15, and
18 shall stand repealed on October 2, 2006, unless reviewed and
19 saved from repeal through reenactment by the Legislature.
20 (d) Any employee of a state or local agency in
21 possession of information made confidential by this section
22 who knowingly discloses such confidential information to a
23 person not entitled to access such information under this
24 section is guilty of a felony of the third degree, punishable
25 as provided in s. 775.082, s. 775.083, or s. 775.084.
26 (e) Any person, knowing that he or she is not entitled
27 to obtain information made confidential by this section, who
28 obtains or attempts to obtain such information is guilty of a
29 felony of the third degree, punishable as provided in s.
30 775.082, s. 775.083, or s. 775.084.
31



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1 (f) Any person who knowingly uses confidential
2 information in violation of a filed written sworn statement or
3 contractual agreement required by this section commits a
4 felony of the third degree, punishable as provided in s.
5 775.082, s. 775.083, or s. 775.084.
6 Section 4. Effective October 1, 2003, part XIII of
7 chapter 400, Florida Statutes, consisting of sections 400.901,
8 400.903, 400.905, 400.907, 400.909, 400.911, 400.913, 400.915,
9 400.917, 400.919, and 400.921 is created to read:
10 400.901 Short title; legislative findings.--
11 (1) This part, consisting of ss. 400.901-400.921, may
12 be cited as the "Health Care Clinic Act."
13 (2) The Legislature finds that the regulation of
14 health care clinics must be strengthened to prevent
15 significant cost and harm to consumers. The purpose of this
16 part is to provide for the licensure, establishment, and
17 enforcement of basic standards for health care clinics and to
18 provide administrative oversight by the Agency for Health Care
19 Administration.
20 400.903 Definitions.--
21 (1) "Agency" means the Agency for Health Care
22 Administration.
23 (2) "Applicant" means an individual owner,
24 corporation, partnership, firm, business, association, or
25 other entity that owns or controls, directly or indirectly, 5
26 percent or more of an interest in the clinic and that applies
27 for a clinic license.
28 (3) "Clinic" means an entity at which health care
29 services are provided to individuals and which tenders charges
30 for reimbursement for such services. For purposes of this part
31

1 the term does not include and the licensure requirements of
2 this part do not apply to:
3 (a) Entities licensed or registered by the state under
4 chapter 390, chapter 394, chapter 395, chapter 397, this
5 chapter, chapter 463, chapter 465, chapter 466, chapter 478,
6 chapter 480, chapter 484, or chapter 651.
7 (b) Entities that own, directly or indirectly,
8 entities licensed or registered by the state pursuant to
9 chapter 390, chapter 394, chapter 395, chapter 397, this
10 chapter, chapter 463, chapter 465, chapter 466, chapter 478,
11 chapter 480, chapter 484, or chapter 651.
12 (c) Entities that are owned, directly or indirectly,
13 by an entity licensed or registered by the state pursuant to
14 chapter 390, chapter 394, chapter, 395, chapter 397, this
15 chapter, chapter 463, chapter 465, chapter 466, chapter 478,
16 chapter 480, chapter 484, or chapter 651.
17 (d) Entities that are under common ownership, directly
18 or indirectly, with an entity licensed or registered by the
19 state pursuant to chapter 390, chapter 394, chapter 395,
20 chapter 397, this chapter, chapter 463, chapter 465, chapter
21 466, chapter 478, chapter 480, chapter 484, or chapter 651.
22 (e) An entity that is exempt from federal taxation
23 under 26 U.S.C. s. 501(c)(3) and any community college or
24 university clinic.
25 (f) A sole proprietorship, group practice,
26 partnership, or corporation that provides health care services
27 by licensed health care practitioners under chapter 457,
28 chapter 458, chapter 459, chapter 460, chapter 461, chapter
29 462, chapter 463, chapter 466, chapter 467, chapter 484,
30 chapter 486, chapter 490, chapter 491, or part I, part III,
31 part X, part XIII, or part XIV of chapter 468, or s. 464.012,



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1 which are wholly owned by a licensed health care practitioner,
2 or the licensed health care practitioner and the spouse,
3 parent, or child of a licensed health care practitioner, so
4 long as one of the owners who is a licensed health care
5 practitioner is supervising the services performed therein and
6 is legally responsible for the entity's compliance with all
7 federal and state laws. However, a health care practitioner
8 may not supervise services beyond the scope of the
9 practitioner's license.
10 (g) Clinical facilities affiliated with an accredited
11 medical school at which training is provided for medical
12 students, residents, or fellows.
13 (4) "Medical director" means a physician who is
14 employed or under contract with a clinic and who maintains a
15 full and unencumbered physician license in accordance with
16 chapter 458, chapter 459, chapter 460, or chapter 461.
17 However, if the clinic is limited to providing health care
18 services pursuant to chapter 457, chapter 484, chapter 486,
19 chapter 490, or chapter 491 or part I, part III, part X, part
20 XIII, or part XIV of chapter 468, the clinic may appoint a
21 health care practitioner licensed under that chapter to serve
22 as a clinic director who is responsible for the clinic's
23 activities. A health care practitioner may not serve as the
24 clinic director if the services provided at the clinic are
25 beyond the scope of that practitioner's license.
26 400.905 License requirements; background screenings;
27 prohibitions.--
28 (1) Each clinic, as defined in s. 400.903, must be
29 licensed and shall at all times maintain a valid license with
30 the agency. Each clinic location shall be licensed separately
31 regardless of whether the clinic is operated under the same



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1 business name or management as another clinic. Mobile clinics
2 must provide to the agency, at least quarterly, their
3 projected street locations to enable the agency to locate and
4 inspect such clinics.
5 (2) The initial clinic license application shall be
6 filed with the agency by all clinics, as defined in s.
7 400.903, on or before March 1, 2004. A clinic license must be
8 renewed biennially.
9 (3) Applicants that submit an application on or before
10 March 1, 2004, which meets all requirements for initial
11 licensure as specified in this section shall receive a
12 temporary license until the completion of an initial
13 inspection verifying that the applicant meets all requirements
14 in rules authorized by s. 400.911. However, a clinic engaged
15 in magnetic resonance imaging services may not receive a
16 temporary license unless it presents evidence satisfactory to
17 the agency that such clinic is making a good-faith effort and
18 substantial progress in seeking accreditation required under
19 s. 400.915.
20 (4) Application for an initial clinic license or for
21 renewal of an existing license shall be notarized on forms
22 furnished by the agency and must be accompanied by the
23 appropriate license fee as provided in s. 400.911. The agency
24 shall take final action on an initial license application
25 within 60 days after receipt of all required documentation.
26 (5) The application shall contain information that
27 includes, but need not be limited to, information pertaining
28 to the name, residence and business address, phone number,
29 social security number, and license number of the medical or
30 clinic director, of the licensed medical providers employed or
31 under contract with the clinic, and of each person who,



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1 directly or indirectly, owns or controls 5 percent or more of
2 an interest in the clinic, or general partners in limited
3 liability partnerships.
4 (6) The applicant must file with the application
5 satisfactory proof that the clinic is in compliance with this
6 part and applicable rules, including:
7 (a) A listing of services to be provided either
8 directly by the applicant or through contractual arrangements
9 with existing providers;
10 (b) The number and discipline of each professional
11 staff member to be employed; and
12 (c) Proof of financial ability to operate. An
13 applicant must demonstrate financial ability to operate a
14 clinic by submitting a balance sheet and an income and expense
15 statement for the first year of operation which provide
16 evidence of the applicant's having sufficient assets, credit,
17 and projected revenues to cover liabilities and expenses. The
18 applicant shall have demonstrated financial ability to operate
19 if the applicant's assets, credit, and projected revenues meet
20 or exceed projected liabilities and expenses. All documents
21 required under this subsection must be prepared in accordance
22 with generally accepted accounting principles, may be in a
23 compilation form, and the financial statement must be signed
24 by a certified public accountant. As an alternative to
25 submitting a balance sheet and an income and expense statement
26 for the first year of operation, the applicant may file a
27 surety bond of at least $500,000 which guarantees that the
28 clinic will act in full conformity with all legal requirements
29 for operating a clinic, payable to the agency. The agency may
30 adopt rules to specify related requirements for such surety
31 bond.



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1 (7) Each applicant for licensure shall comply with the
2 following requirements:
3 (a) As used in this subsection, the term "applicant"
4 means individuals owning or controlling, directly or
5 indirectly, 5 percent or more of an interest in a clinic; the
6 medical or clinic director, or a similarly titled person who
7 is responsible for the day-to-day operation of the licensed
8 clinic; the financial officer or similarly titled individual
9 who is responsible for the financial operation of the clinic;
10 and licensed medical providers at the clinic.
11 (b) Upon receipt of a completed, signed, and dated
12 application, the agency shall require background screening of
13 the applicant, in accordance with the level 2 standards for
14 screening set forth in chapter 435. Proof of compliance with
15 the level 2 background screening requirements of chapter 435
16 which has been submitted within the previous 5 years in
17 compliance with any other health care licensure requirements
18 of this state is acceptable in fulfillment of this paragraph.
19 (c) Each applicant must submit to the agency, with the
20 application, a description and explanation of any exclusions,
21 permanent suspensions, or terminations of an applicant from
22 the Medicare or Medicaid programs. Proof of compliance with
23 the requirements for disclosure of ownership and control
24 interest under the Medicaid or Medicare programs may be
25 accepted in lieu of this submission. The description and
26 explanation may indicate whether such exclusions, suspensions,
27 or terminations were voluntary or not voluntary on the part of
28 the applicant.
29 (d) A license may not be granted to a clinic if the
30 applicant has been found guilty of, regardless of
31 adjudication, or has entered a plea of nolo contendere or

1 guilty to, any offense prohibited under the level 2 standards
2 for screening set forth in chapter 435, or a violation of
3 insurance fraud under s. 817.234, within the past 5 years. If
4 the applicant has been convicted of an offense prohibited
5 under the level 2 standards or insurance fraud in any
6 jurisdiction, the applicant must show that his or her civil
7 rights have been restored prior to submitting an application.
8 (e) The agency may deny or revoke licensure if the
9 applicant has falsely represented any material fact or omitted
10 any material fact from the application required by this part.
11 (8) Requested information omitted from an application
12 for licensure, license renewal, or transfer of ownership must
13 be filed with the agency within 21 days after receipt of the
14 agency's request for omitted information, or the application
15 shall be deemed incomplete and shall be withdrawn from further
16 consideration.
17 (9) The failure to file a timely renewal application
18 shall result in a late fee charged to the facility in an
19 amount equal to 50 percent of the current license fee.
20 400.907 Clinic inspections; emergency suspension;
21 costs.--
22 (1) Any authorized officer or employee of the agency
23 shall make inspections of the clinic as part of the initial
24 license application or renewal application. The application
25 for a clinic license issued under this part or for a renewal
26 license constitutes permission for an appropriate agency
27 inspection to verify the information submitted on or in
28 connection with the application or renewal.
29 (2) An authorized officer or employee of the agency
30 may make unannounced inspections of clinics licensed pursuant
31 to this part as are necessary to determine that the clinic is

1 in compliance with this part and with applicable rules. A
2 licensed clinic shall allow full and complete access to the
3 premises and to billing records or information to any
4 representative of the agency who makes an inspection to
5 determine compliance with this part and with applicable rules.
6 (3) Failure by a clinic licensed under this part to
7 allow full and complete access to the premises and to billing
8 records or information to any representative of the agency who
9 makes a request to inspect the clinic to determine compliance
10 with this part or failure by a clinic to employ a qualified
11 medical director or clinic director constitutes a ground for
12 emergency suspension of the license by the agency pursuant to
13 s. 120.60(6).
14 (4) In addition to any administrative fines imposed,
15 the agency may assess a fee equal to the cost of conducting a
16 complaint investigation.
17 400.909 License renewal; transfer of ownership;
18 provisional license.--
19 (1) An application for license renewal must contain
20 information as required by the agency.
21 (2) Ninety days before the expiration date, an
22 application for renewal must be submitted to the agency.
23 (3) The clinic must file with the renewal application
24 satisfactory proof that it is in compliance with this part and
25 applicable rules. If there is evidence of financial
26 instability, the clinic must submit satisfactory proof of its
27 financial ability to comply with the requirements of this
28 part.
29 (4) When transferring the ownership of a clinic, the
30 transferee must submit an application for a license at least
31 60 days before the effective date of the transfer. An



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1 application for change of ownership of a license is required
2 only when 45 percent or more of the ownership, voting shares,
3 or controlling interest of a clinic is transferred or
4 assigned, including the final transfer or assignment of
5 multiple transfers or assignments over a 2-year period that
6 cumulatively total 45 percent or greater.
7 (5) The license may not be sold, leased, assigned, or
8 otherwise transferred, voluntarily or involuntarily, and is
9 valid only for the clinic owners and location for which
10 originally issued.
11 (6) A clinic against whom a revocation or suspension
12 proceeding is pending at the time of license renewal may be
13 issued a provisional license effective until final disposition
14 by the agency of such proceedings. If judicial relief is
15 sought from the final disposition, the agency that has
16 jurisdiction may issue a temporary permit for the duration of
17 the judicial proceeding.
18 400.911 Rulemaking authority; license fees.--
19 (1) The agency shall adopt rules necessary to
20 administer the clinic administration, regulation, and
21 licensure program, including rules establishing the specific
22 licensure requirements, procedures, forms, and fees. It shall
23 adopt rules establishing a procedure for the biennial renewal
24 of licenses. The rules shall specify the expiration dates of
25 licenses, the process of tracking compliance with financial
26 responsibility requirements, and any other conditions of
27 renewal required by law or rule.
28 (2) The agency shall adopt rules specifying
29 limitations on the number of licensed clinics and licensees
30 for which a medical director or a clinic director may assume
31 responsibility for purposes of this part. In determining the



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1 quality of supervision a medical director or a clinic director
2 can provide, the agency shall consider the number of clinic
3 employees, the clinic location, and the health care services
4 provided by the clinic.
5 (3) License application and renewal fees must be
6 reasonably calculated by the agency to cover its costs in
7 carrying out its responsibilities under this part, including
8 the cost of licensure, inspection, and regulation of clinics,
9 and must be of such amount that the total fees collected do
10 not exceed the cost of administering and enforcing compliance
11 with this part. Clinic licensure fees are nonrefundable and
12 may not exceed $2,000. The agency shall adjust the license fee
13 annually by not more than the change in the Consumer Price
14 Index based on the 12 months immediately preceding the
15 increase. All fees collected under this part must be deposited
16 in the Health Care Trust Fund for the administration of this
17 part.
18 400.913 Unlicensed clinics; penalties; fines;
19 verification of licensure status.--
20 (1) It is unlawful to own, operate, or maintain a
21 clinic without obtaining a license under this part.
22 (2) Any person who owns, operates, or maintains an
23 unlicensed clinic commits a felony of the third degree,
24 punishable as provided in s. 775.082, s. 775.083, or s.
25 775.084. Each day of continued operation is a separate
26 offense.
27 (3) Any person found guilty of violating subsection
28 (2) a second or subsequent time commits a felony of the second
29 degree, punishable as provided under s. 775.082, s. 775.083,
30 or s. 775.084. Each day of continued operation is a separate
31 offense.



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1 (4) Any person who owns, operates, or maintains an
2 unlicensed clinic due to a change in this part or a
3 modification in agency rules within 6 months after the
4 effective date of such change or modification and who, within
5 10 working days after receiving notification from the agency,
6 fails to cease operation or apply for a license under this
7 part commits a felony of the third degree, punishable as
8 provided in s. 775.082, s. 775.083, or s. 775.084. Each day of
9 continued operation is a separate offense.
10 (5) Any clinic that fails to cease operation after
11 agency notification may be fined for each day of noncompliance
12 pursuant to this part.
13 (6) When a person has an interest in more than one
14 clinic, and fails to obtain a license for any one of these
15 clinics, the agency may revoke the license, impose a
16 moratorium, or impose a fine pursuant to this part on any or
17 all of the licensed clinics until such time as the unlicensed
18 clinic is licensed or ceases operation.
19 (7) Any person aware of the operation of an unlicensed
20 clinic must report that facility to the agency.
21 (8) Any health care provider who is aware of the
22 operation of an unlicensed clinic shall report that facility
23 to the agency. Failure to report a clinic that the provider
24 knows or has reasonable cause to suspect is unlicensed shall
25 be reported to the provider's licensing board.
26 (9) The agency may not issue a license to a clinic
27 that has any unpaid fines assessed under this part.
28 400.915 Clinic responsibilities.--
29 (1) Each clinic shall appoint a medical director or
30 clinic director who shall agree in writing to accept legal
31

responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(a) Have signs identifying the medical director or clinic director posted in a conspicuous location within the clinic readily visible to all patients.

(b) Ensure that all practitioners providing health care services or supplies to patients maintain a current active and unencumbered Florida license.

(c) Review any patient referral contracts or agreements executed by the clinic.

(d) Ensure that all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided.

(e) Serve as the clinic records owner as defined in s. 456.057.

(f) Ensure compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of chapter 456, the respective practice acts, and rules adopted under this part.

(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action.

(2) Any business that becomes a clinic after commencing operations must, within 5 days after becoming a clinic, file a license application under this part and shall be subject to all provisions of this part applicable to a clinic.

(3) Any contract to serve as a medical director or a clinic director entered into or renewed by a physician or a licensed health care practitioner in violation of this part is



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1 void as contrary to public policy. This subsection shall apply
2 to contracts entered into or renewed on or after March 1,
3 2004.
4 (4) All charges or reimbursement claims made by or on
5 behalf of a clinic that is required to be licensed under this
6 part, but that is not so licensed, or that is otherwise
7 operating in violation of this part, are unlawful charges, and
8 therefore are noncompensable and unenforceable.
9 (5) Any person establishing, operating, or managing an
10 unlicensed clinic otherwise required to be licensed under this
11 part, or any person who knowingly files a false or misleading
12 license application or license renewal application, or false
13 or misleading information related to such application or
14 department rule, commits a felony of the third degree,
15 punishable as provided in s. 775.082, s. 775.083, or s.
16 775.084.
17 (6) Any licensed health care provider who violates
18 this part is subject to discipline in accordance with this
19 chapter and his or her respective practice act.
20 (7) The agency may fine, or suspend or revoke the
21 license of, any clinic licensed under this part for operating
22 in violation of the requirements of this part or the rules
23 adopted by the agency.
24 (8) The agency shall investigate allegations of
25 noncompliance with this part and the rules adopted under this
26 part.
27 (9) Any person or entity providing health care
28 services which is not a clinic, as defined under s. 400.903,
29 may voluntarily apply for licensure under its exempt status
30 with the agency on a form that sets forth its name or names
31 and addresses, a statement of the reasons why it cannot be



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1 defined as a clinic, and other information deemed necessary by
2 the agency.
3 (10) The clinic shall display its license in a
4 conspicuous location within the clinic readily visible to all
5 patients.
6 (11)(a) Each clinic engaged in magnetic resonance
7 imaging services must be accredited by the Joint Commission on
8 Accreditation of Healthcare Organizations, the American
9 College of Radiology, or the Accreditation Association for
10 Ambulatory Health Care, within 1 year after licensure.
11 However, a clinic may request a single, 6-month extension if
12 it provides evidence to the agency establishing that, for good
13 cause shown, such clinic can not be accredited within 1 year
14 after licensure, and that such accreditation will be completed
15 within the 6-month extension. After obtaining accreditation as
16 required by this subsection, each such clinic must maintain
17 accreditation as a condition of renewal of its license.
18 (b) The agency may disallow the application of any
19 entity formed for the purpose of avoiding compliance with the
20 accreditation provisions of this subsection and whose
21 principals were previously principals of an entity that was
22 unable to meet the accreditation requirements within the
23 specified timeframes. The agency may adopt rules as to the
24 accreditation of magnetic resonance imaging clinics.
25 (12) The agency shall give full faith and credit
26 pertaining to any past variance and waiver granted to a
27 magnetic resonance imaging clinic from Rule 64-2002, Florida
28 Administrative Code, by the Department of Health, until
29 September 2004. After that date, such clinic must request a
30 variance and waiver from the agency under s. 120.542.
31 400.917 Injunctions.--

1 (1) The agency may institute injunctive proceedings in
2 a court of competent jurisdiction in order to:
3 (a) Enforce the provisions of this part or any minimum
4 standard, rule, or order issued or entered into pursuant to
5 this part if the attempt by the agency to correct a violation
6 through administrative fines has failed; if the violation
7 materially affects the health, safety, or welfare of clinic
8 patients; or if the violation involves any operation of an
9 unlicensed clinic.
10 (b) Terminate the operation of a clinic if a violation
11 of any provision of this part, or any rule adopted pursuant to
12 this part, materially affects the health, safety, or welfare
13 of clinic patients.
14 (2) Such injunctive relief may be temporary or
15 permanent.
16 (3) If action is necessary to protect clinic patients
17 from life-threatening situations, the court may allow a
18 temporary injunction without bond upon proper proof being
19 made. If it appears by competent evidence or a sworn,
20 substantiated affidavit that a temporary injunction should
21 issue, the court, pending the determination on final hearing,
22 shall enjoin operation of the clinic.
23 400.919 Agency actions.--Administrative proceedings
24 challenging agency licensure enforcement action shall be
25 reviewed on the basis of the facts and conditions that
26 resulted in the agency action.
27 400.921 Agency administrative penalties.--
28 (1) The agency may impose administrative penalties
29 against clinics of up to $5,000 per violation for violations
30 of the requirements of this part. In determining if a penalty
31

1 is to be imposed and in fixing the amount of the fine, the
2 agency shall consider the following factors:
3 (a) The gravity of the violation, including the
4 probability that death or serious physical or emotional harm
5 to a patient will result or has resulted, the severity of the
6 action or potential harm, and the extent to which the
7 provisions of the applicable laws or rules were violated.
8 (b) Actions taken by the owner, medical director, or
9 clinic director to correct violations.
10 (c) Any previous violations.
11 (d) The financial benefit to the clinic of committing
12 or continuing the violation.
13 (2) Each day of continuing violation after the date
14 fixed for termination of the violation, as ordered by the
15 agency, constitutes an additional, separate, and distinct
16 violation.
17 (3) Any action taken to correct a violation shall be
18 documented in writing by the owner, medical director, or
19 clinic director of the clinic and verified through followup
20 visits by agency personnel. The agency may impose a fine and,
21 in the case of an owner-operated clinic, revoke or deny a
22 clinic's license when a clinic medical director or clinic
23 director fraudulently misrepresents actions taken to correct a
24 violation.
25 (4) For fines that are upheld following administrative
26 or judicial review, the violator shall pay the fine, plus
27 interest at the rate as specified in s. 55.03, for each day
28 beyond the date set by the agency for payment of the fine.
29 (5) Any unlicensed clinic that continues to operate
30 after agency notification is subject to a $1,000 fine per day.
31

1 (6) Any licensed clinic whose owner, medical director,
2 or clinic director concurrently operates an unlicensed clinic
3 shall be subject to an administrative fine of $5,000 per day.
4 (7) Any clinic whose owner fails to apply for a
5 change-of-ownership license in accordance with s. 400.909 and
6 operates the clinic under the new ownership is subject to a
7 fine of $5,000.
8 (8) The agency, as an alternative to or in conjunction
9 with an administrative action against a clinic for violations
10 of this part and adopted rules, shall make a reasonable
11 attempt to discuss each violation and recommended corrective
12 action with the owner, medical director, or clinic director of
13 the clinic, prior to written notification. The agency, instead
14 of fixing a period within which the clinic shall enter into
15 compliance with standards, may request a plan of corrective
16 action from the clinic which demonstrates a good-faith effort
17 to remedy each violation by a specific date, subject to the
18 approval of the agency.
19 (9) Administrative fines paid by any clinic under this
20 section shall be deposited into the Health Care Trust Fund.
21 Section 5. Paragraph (b) of subsection (1) of section
22 456.0375, Florida Statutes, is amended to read:
23 456.0375 Registration of certain clinics;
24 requirements; discipline; exemptions.--
25 (1)
26 (b) For purposes of this section, the term "clinic"
27 does not include and the registration requirements herein do
28 not apply to:
29 1. Entities licensed or registered by the state
30 pursuant to chapter 390, chapter 394, chapter 395, chapter
31

1 397, chapter 400, chapter 463, chapter 465, chapter 466,
2 chapter 478, chapter 480, ~~or~~ chapter 484, or chapter 651.
3 2. Entities that own, directly or indirectly, entities
4 licensed or registered by the state pursuant to chapter 390,
5 chapter 394, chapter 395, chapter 397, chapter 400, chapter
6 463, chapter 465, chapter 466, chapter 478, chapter 480,
7 chapter 484, or chapter 651.
8 3. Entities that are owned, directly or indirectly, by
9 an entity licensed or registered by the state pursuant to
10 chapter 390, chapter 394, chapter 395, chapter 397, chapter
11 400, chapter 463, chapter 465, chapter 466, chapter 478,
12 chapter 480, chapter 484, or chapter 651.
13 4. Entities that are under common ownership, directly
14 or indirectly, with an entity licensed or registered by the
15 state pursuant to chapter 390, chapter 394, chapter 395,
16 chapter 397, chapter 400, chapter 463, chapter 465, chapter
17 466, chapter 478, chapter 480, chapter 484, or chapter 651.
18 5.~~2.~~ Entities exempt from federal taxation under 26
19 U.S.C. s. 501(c)(3) and community college and university
20 clinics.
21 6.~~3.~~ Sole proprietorships, group practices,
22 partnerships, or corporations that provide health care
23 services by licensed health care practitioners pursuant to
24 chapters 457, 458, 459, 460, 461, 462, 463, 466, 467, 484,
25 486, 490, 491, or part I, part III, part X, part XIII, or part
26 XIV of chapter 468, or s. 464.012, which are wholly owned by
27 licensed health care practitioners or the licensed health care
28 practitioner and the spouse, parent, or child of a licensed
29 health care practitioner, so long as one of the owners who is
30 a licensed health care practitioner is supervising the
31 services performed therein and is legally responsible for the



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1 entity's compliance with all federal and state laws. However,
2 no health care practitioner may supervise services beyond the
3 scope of the practitioner's license.
4 7. Clinical facilities affiliated with an accredited
5 medical school at which training is provided for medical
6 students, residents, or fellows.
7 Section 6. Paragraphs (dd) and (ee) are added to
8 subsection (1) of section 456.072, Florida Statutes, to read:
9 456.072 Grounds for discipline; penalties;
10 enforcement.--
11 (1) The following acts shall constitute grounds for
12 which the disciplinary actions specified in subsection (2) may
13 be taken:
14 (dd) With respect to making a personal injury
15 protection claim as required by s. 627.736, intentionally
16 submitting a claim statement, or bill that has been "upcoded"
17 as defined in s. 627.732.
18 (ee) With respect to making a personal injury
19 protection claim as required by s. 627.736, intentionally
20 submitting a claim, statement, or bill for payment of services
21 that were not rendered.
22 Section 7. Subsection (11) of section 626.7451,
23 Florida Statutes, is amended to read:
24 626.7451 Managing general agents; required contract
25 provisions.--No person acting in the capacity of a managing
26 general agent shall place business with an insurer unless
27 there is in force a written contract between the parties which
28 sets forth the responsibility for a particular function,
29 specifies the division of responsibilities, and contains the
30 following minimum provisions:
31



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(11) A licensed managing general agent, when placing business with an insurer under this code, may charge a per-policy fee not to exceed $40~~$25~~. In no instance shall the aggregate of per-policy fees for a placement of business authorized under this section, when combined with any other per-policy fee charged by the insurer, result in per-policy fees which exceed the aggregate amount of $40~~$25~~. The per-policy fee shall be a component of the insurer's rate filing and shall be fully earned. A managing general agent that collects a per-policy fee shall remit a minimum of $5 per policy to the Division of Insurance Fraud of the Department of Financial Services, which shall be dedicated to the prevention and detection of motor vehicle insurance fraud, and an additional $5 per policy, 95 percent of which shall be remitted to the Justice Administration Commission, which shall distribute the collected fees to the state attorneys of the 20 judicial circuits for investigating and prosecuting cases of motor vehicle insurance fraud. The state attorneys must adopt an allocation formula that ensures equitable distribution among the 20 circuits which includes, but is not limited to, the population area served. The remaining 5 percent shall be remitted to the Office of Statewide Prosecution for investigating and prosecuting cases of motor vehicle insurance fraud. An insurer that writes directly without a managing general agent and that charges a per-policy fee shall charge an additional policy fee of $5 per policy to be remitted to the Division of Insurance Fraud of the Department of Financial Services, which shall be dedicated to the prevention and detection of motor vehicle insurance fraud, and an additional per-policy fee of $5, 95 percent of which is to be remitted to the Justice Administration Commission, to be distributed as

1 provided in this subsection. The remaining 5 percent shall be
2 remitted to the Office of Statewide Prosecution for
3 investigating and prosecuting cases of motor vehicle insurance
4 fraud. No later than July 1, 2005, the state attorneys and the
5 Office of Statewide Prosecutor must provide a report to the
6 President of the Senate and the Speaker of the House of
7 Representatives evaluating the effectiveness of the
8 investigation, detection, and prosecution of motor vehicle
9 insurance fraud as it related to the moneys generated by the
10 per-policy fee.
11
12 For the purposes of this section and ss. 626.7453 and
13 626.7454, the term "controlling person" or "controlling" has
14 the meaning set forth in s. 625.012(5)(b)1., and the term
15 "controlled person" or "controlled" has the meaning set forth
16 in s. 625.012(5)(b)2.
17 Section 8. Subsection (1) of section 627.732, Florida
18 Statutes, is amended, and subsections (8) through (19) are
19 added to that section, to read:
20 627.732 Definitions.--As used in ss. 627.730-627.7405,
21 the term:
22 (1) "Broker" means any person not possessing a license
23 under chapter 395, chapter 400, chapter 458, chapter 459,
24 chapter 460, chapter 461, or chapter 641 who charges or
25 receives compensation for any use of medical equipment and is
26 not the 100-percent owner or the 100-percent lessee of such
27 equipment. For purposes of this section, such owner or lessee
28 may be an individual, a corporation, a partnership, or any
29 other entity and any of its 100-percent-owned affiliates and
30 subsidiaries. For purposes of this subsection, the term
31 "lessee" means a long-term lessee under a capital or operating



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1 lease, but does not include a part-time lessee. The term
2 "broker" does not include a hospital or physician management
3 company whose medical equipment is ancillary to the practices
4 managed, a debt collection agency, or an entity that has
5 contracted with the insurer to obtain a discounted rate for
6 such services; nor does the term include a management company
7 that has contracted to provide general management services for
8 a licensed physician or health care facility and whose
9 compensation is not materially affected by the usage or
10 frequency of usage of medical equipment or an entity that is
11 100-percent owned by one or more hospitals or physicians. The
12 term "broker" does not include a person or entity that
13 certifies, upon request of an insurer, that:
14 (a) It is a clinic registered under s. 456.0375 or
15 licensed under ss. 400.901-400.921;
16 (b) It is a 100-percent owner of medical equipment;
17 and
18 (c) The owner's only part-time lease of medical
19 equipment for personal injury protection patients is on a
20 temporary basis not to exceed 30 days in a 12-month period,
21 and such lease is solely for the purposes of necessary repair
22 or maintenance of the 100-percent-owned medical equipment or
23 pending the arrival and installation of the newly purchased or
24 a replacement for the 100-percent-owned medical equipment, or
25 for patients for whom, because of physical size or
26 claustrophobia, it is determined by the medical director or
27 clinical director to be medically necessary that the test be
28 performed in medical equipment that is open-style. The leased
29 medical equipment cannot be used by patients who are not
30 patients of the registered clinic for medical treatment of
31 services. Any person or entity making a false certification

1 under this subsection commits insurance fraud as defined in s.
2 817.234. However, the 30-day period provided in this paragraph
3 may be extended for an additional 60 days as applicable to
4 magnetic resonance imaging equipment if the owner certifies
5 that the extension otherwise complies with this paragraph.
6 (8) "Certify" means to swear or attest to being true
7 or represented in writing.
8 (9) "Immediate personal supervision," as it relates to
9 the performance of medical services by nonphysicians not in a
10 hospital, means that an individual licensed to perform the
11 medical service or provide the medical supplies must be
12 present within the confines of the physical structure where
13 the medical services are performed or where the medical
14 supplies are provided such that the licensed individual can
15 respond immediately to any emergencies if needed.
16 (10) "Incident," with respect to services considered
17 as incident to a physician's professional service, for a
18 physician licensed under chapter 458, chapter 459, chapter
19 460, or chapter 461, if not furnished in a hospital, means
20 such services must be an integral, even if incidental, part of
21 a covered physician's service.
22 (11) "Knowingly" means that a person, with respect to
23 information, has actual knowledge of the information; acts in
24 deliberate ignorance of the truth or falsity of the
25 information; or acts in reckless disregard of the information,
26 and proof of specific intent to defraud is not required.
27 (12) "Lawful" or "lawfully" means in substantial
28 compliance with all relevant applicable criminal, civil, and
29 administrative requirements of state and federal law related
30 to the provision of medical services or treatment.
31



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1 (13) "Hospital" means a facility that, at the time
2 services or treatment were rendered, was licensed under
3 chapter 395.
4 (14) "Properly completed" means providing truthful,
5 substantially complete, and substantially accurate responses
6 as to all material elements to each applicable request for
7 information or statement by a means that may lawfully be
8 provided and that complies with this section, or as agreed by
9 the parties.
10 (15) "Upcoding" means an action that submits a billing
11 code that would result in payment greater in amount than would
12 be paid using a billing code that accurately describes the
13 services performed. The term does not include an otherwise
14 lawful bill by a magnetic resonance imaging facility, which
15 globally combines both technical and professional components
16 for services listed in that definition, if the amount of the
17 global bill is not more than the components if billed
18 separately; however, payment of such a bill constitutes
19 payment in full for all components of such service.
20 (16) "Unbundling" means an action that submits a
21 billing code that is properly billed under one billing code,
22 but that has been separated into two or more billing codes,
23 and would result in payment greater in amount than would be
24 paid using one billing code.
25 Section 9. Subsections (3), (4), (5), (6), (7), (8),
26 (10), (11), and (12) of section 627.736, Florida Statutes, are
27 amended, present subsection (13) of that section is
28 redesignated as subsection (14), and amended, and a new
29 subsection (13) is added to that section, to read:
30 627.736 Required personal injury protection benefits;
31 exclusions; priority; claims.--



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1 (3) INSERED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
2 TORT CLAIMS.--No insurer shall have a lien on any recovery in
3 tort by judgment, settlement, or otherwise for personal injury
4 protection benefits, whether suit has been filed or settlement
5 has been reached without suit. An injured party who is
6 entitled to bring suit under the provisions of ss.
7 627.730-627.7405, or his or her legal representative, shall
8 have no right to recover any damages for which personal injury
9 protection benefits are paid or payable. The plaintiff may
10 prove all of his or her special damages notwithstanding this
11 limitation, but if special damages are introduced in evidence,
12 the trier of facts, whether judge or jury, shall not award
13 damages for personal injury protection benefits paid or
14 payable. In all cases in which a jury is required to fix
15 damages, the court shall instruct the jury that the plaintiff
16 shall not recover such special damages for personal injury
17 protection benefits paid or payable.
18 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer
19 under ss. 627.730-627.7405 shall be primary, except that
20 benefits received under any workers' compensation law shall be
21 credited against the benefits provided by subsection (1) and
22 shall be due and payable as loss accrues, upon receipt of
23 reasonable proof of such loss and the amount of expenses and
24 loss incurred which are covered by the policy issued under ss.
25 627.730-627.7405. When the Agency for Health Care
26 Administration provides, pays, or becomes liable for medical
27 assistance under the Medicaid program related to injury,
28 sickness, disease, or death arising out of the ownership,
29 maintenance, or use of a motor vehicle, benefits under ss.
30 627.730-627.7405 shall be subject to the provisions of the
31 Medicaid program.

1 (a) An insurer may require written notice to be given
2 as soon as practicable after an accident involving a motor
3 vehicle with respect to which the policy affords the security
4 required by ss. 627.730-627.7405.
5 (b) Personal injury protection insurance benefits paid
6 pursuant to this section shall be overdue if not paid within
7 30 days after the insurer is furnished written notice of the
8 fact of a covered loss and of the amount of same. If such
9 written notice is not furnished to the insurer as to the
10 entire claim, any partial amount supported by written notice
11 is overdue if not paid within 30 days after such written
12 notice is furnished to the insurer. Any part or all of the
13 remainder of the claim that is subsequently supported by
14 written notice is overdue if not paid within 30 days after
15 such written notice is furnished to the insurer. When an
16 insurer pays only a portion of a claim or rejects a claim, the
17 insurer shall provide at the time of the partial payment or
18 rejection an itemized specification of each item that the
19 insurer had reduced, omitted, or declined to pay and any
20 information that the insurer desires the claimant to consider
21 related to the medical necessity of the denied treatment or to
22 explain the reasonableness of the reduced charge, provided
23 that this shall not limit the introduction of evidence at
24 trial; and the insurer shall include the name and address of
25 the person to whom the claimant should respond and a claim
26 number to be referenced in future correspondence. However,
27 notwithstanding the fact that written notice has been
28 furnished to the insurer, any payment shall not be deemed
29 overdue when the insurer has reasonable proof to establish
30 that the insurer is not responsible for the payment. For the
31 purpose of calculating the extent to which any benefits are

1 overdue, payment shall be treated as being made on the date a
2 draft or other valid instrument which is equivalent to payment
3 was placed in the United States mail in a properly addressed,
4 postpaid envelope or, if not so posted, on the date of
5 delivery. This paragraph does not preclude or limit the
6 ability of the insurer to assert that the claim was unrelated,
7 was not medically necessary, or was unreasonable or that the
8 amount of the charge was in excess of that permitted under, or
9 in violation of, subsection (5). Such assertion by the insurer
10 may be made at any time, including after payment of the claim
11 or after the 30-day time period for payment set forth in this
12 paragraph.
13 (c) All overdue payments shall bear simple interest at
14 the rate established ~~by the Comptroller~~ under s. 55.03 or the
15 rate established in the insurance contract, whichever is
16 greater, for the year in which the payment became overdue,
17 calculated from the date the insurer was furnished with
18 written notice of the amount of covered loss. Interest shall
19 be due at the time payment of the overdue claim is made.
20 (d) The insurer of the owner of a motor vehicle shall
21 pay personal injury protection benefits for:
22 1. Accidental bodily injury sustained in this state by
23 the owner while occupying a motor vehicle, or while not an
24 occupant of a self-propelled vehicle if the injury is caused
25 by physical contact with a motor vehicle.
26 2. Accidental bodily injury sustained outside this
27 state, but within the United States of America or its
28 territories or possessions or Canada, by the owner while
29 occupying the owner's motor vehicle.
30 3. Accidental bodily injury sustained by a relative of
31 the owner residing in the same household, under the

1 circumstances described in subparagraph 1. or subparagraph 2.,
2 provided the relative at the time of the accident is domiciled
3 in the owner's household and is not himself or herself the
4 owner of a motor vehicle with respect to which security is
5 required under ss. 627.730-627.7405.
6 4. Accidental bodily injury sustained in this state by
7 any other person while occupying the owner's motor vehicle or,
8 if a resident of this state, while not an occupant of a
9 self-propelled vehicle, if the injury is caused by physical
10 contact with such motor vehicle, provided the injured person
11 is not himself or herself:
12 a. The owner of a motor vehicle with respect to which
13 security is required under ss. 627.730-627.7405; or
14 b. Entitled to personal injury benefits from the
15 insurer of the owner or owners of such a motor vehicle.
16 (e) If two or more insurers are liable to pay personal
17 injury protection benefits for the same injury to any one
18 person, the maximum payable shall be as specified in
19 subsection (1), and any insurer paying the benefits shall be
20 entitled to recover from each of the other insurers an
21 equitable pro rata share of the benefits paid and expenses
22 incurred in processing the claim.
23 (f) It is a violation of the insurance code for an
24 insurer to fail to timely provide benefits as required by this
25 section with such frequency as to constitute a general
26 business practice.
27 (g) Benefits shall not be due or payable to or on the
28 behalf of an insured person if that person has committed, by a
29 material act or omission, any insurance fraud relating to
30 personal injury protection coverage under his or her policy,
31 if the fraud is admitted to in a sworn statement by the

1 insured or if it is established in a court of competent
2 jurisdiction. Any insurance fraud shall void all coverage
3 arising from the claim related to such fraud under the
4 personal injury protection coverage of the insured person who
5 committed the fraud, irrespective of whether a portion of the
6 insured person's claim may be legitimate, and any benefits
7 paid prior to the discovery of the insured person's insurance
8 fraud shall be recoverable by the insurer from the person who
9 committed insurance fraud in their entirety. The prevailing
10 party is entitled to its costs and attorney's fees in any
11 action in which it prevails in an insurer's action to enforce
12 its right of recovery under this paragraph.
13 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--
14 (a) Any physician, hospital, clinic, or other person
15 or institution lawfully rendering treatment to an injured
16 person for a bodily injury covered by personal injury
17 protection insurance may charge the insurer and injured party
18 only a reasonable amount pursuant to this section for the
19 services and supplies rendered, and the insurer providing such
20 coverage may pay for such charges directly to such person or
21 institution lawfully rendering such treatment, if the insured
22 receiving such treatment or his or her guardian has
23 countersigned the properly completed invoice, bill, or claim
24 form approved by the Department of Insurance upon which such
25 charges are to be paid for as having actually been rendered,
26 to the best knowledge of the insured or his or her guardian.
27 In no event, however, may such a charge be in excess of the
28 amount the person or institution customarily charges for like
29 services or supplies in cases involving no insurance. With
30 respect to a determination of whether a charge for a
31 particular service, treatment, or otherwise is reasonable,

1 consideration may be given to evidence of usual and customary
2 charges and payments accepted by the provider involved in the
3 dispute, and reimbursement levels in the community and various
4 federal and state medical fee schedules applicable to
5 automobile and other insurance coverages, and other
6 information relevant to the reasonableness of the
7 reimbursement for the service, treatment or supply.
8 (b)1. An insurer or insured is not required to pay a
9 claim or charges:
10 a. Made by a broker or by a person making a claim on
11 behalf of a broker;.
12 b. For any service or treatment that was not lawful at
13 the time rendered;
14 c. To any person who knowingly submits a false or
15 misleading statement relating to the claim or charges;
16 d. With respect to a bill or statement that does not
17 substantially meet the applicable requirements of paragraph
18 (d);
19 e. For any treatment or service that is upcoded, or
20 that is unbundled when such treatment or services should be
21 bundled, in accordance with paragraph (d). To facilitate
22 prompt payment of lawful services, an insurer may change codes
23 that it determines to have been improperly or incorrectly
24 upcoded or unbundled, and may make payment based on the
25 changed codes, without affecting the right of the provider to
26 dispute the change by the insurer, provided that before doing
27 so, the insurer must contact the health care provider and
28 discuss the reasons for the insurer's change and the health
29 care provider's reason for the coding, or make a reasonable
30 good-faith effort to do so, as documented in the insurer's
31 file; and

1 f. For medical services or treatment billed by a
2 physician and not provided in a hospital unless such services
3 are rendered by the physician or are incident to his or her
4 professional services and are included on the physician's
5 bill, including documentation verifying that the physician is
6 responsible for the medical services that were rendered and
7 billed.
8 2. Charges for medically necessary cephalic
9 thermograms, peripheral thermograms, spinal ultrasounds,
10 extremity ultrasounds, video fluoroscopy, and surface
11 electromyography shall not exceed the maximum reimbursement
12 allowance for such procedures as set forth in the applicable
13 fee schedule or other payment methodology established pursuant
14 to s. 440.13.
15 3. Allowable amounts that may be charged to a personal
16 injury protection insurance insurer and insured for medically
17 necessary nerve conduction testing when done in conjunction
18 with a needle electromyography procedure and both are
19 performed and billed solely by a physician licensed under
20 chapter 458, chapter 459, chapter 460, or chapter 461 who is
21 also certified by the American Board of Electrodiagnostic
22 Medicine or by a board recognized by the American Board of
23 Medical Specialties or the American Osteopathic Association or
24 who holds diplomate status with the American Chiropractic
25 Neurology Board or its predecessors shall not exceed 200
26 percent of the allowable amount under the participating
27 physician fee schedule of Medicare Part B for year 2001, for
28 the area in which the treatment was rendered, adjusted
29 annually on July 1 to reflect the prior calendar year's
30 changes in the annual Medical Care Item of the Consumer Price
31 Index for All Urban Consumers in the South Region as

determined by the Bureau of Labor Statistics of the United States Department of Labor ~~by an additional amount equal to the medical Consumer Price Index for Florida~~.

4. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing that does not meet the requirements of subparagraph 3. shall not exceed the applicable fee schedule or other payment methodology established pursuant to s. 440.13.

5. Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually to reflect the changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor for the 12-month period ending June 30 of that year ~~by an additional amount equal to the medical Consumer Price Index for Florida~~, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations shall



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not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually to reflect the changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor for the 12-month period ending June 30 of that year ~~by an additional amount equal to the medical Consumer Price Index for Florida~~. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395.

6. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not 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 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 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 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 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.

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.~~1.~~ A denial letter from the incorrect insurer; or

b.~~2.~~ Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

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 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) ~~(e)~~, 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 Health Care Finance Administration.

4. Each notice of 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 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) Every insurer shall include a provision in its policy for personal injury protection benefits for binding arbitration of any claims dispute involving medical benefits arising between the insurer and any person providing medical services or supplies if that person has agreed to accept assignment of personal injury protection benefits. The provision shall specify that the provisions of chapter 682 relating to arbitration shall apply. The prevailing party shall be entitled to attorney's fees and costs. For purposes of the award of attorney's fees and costs, the prevailing party shall be determined as follows:~~

~~1. When the amount of personal injury protection benefits determined by arbitration exceeds the sum of the amount offered by the insurer at arbitration plus 50 percent of the difference between the amount of the claim asserted by the claimant at arbitration and the amount offered by the insurer at arbitration, the claimant is the prevailing party.~~

~~2. When the amount of personal injury protection benefits determined by arbitration is less than the sum of the amount offered by the insurer at arbitration plus 50 percent of the difference between the amount of the claim asserted by the claimant at arbitration and the amount offered by the insurer at arbitration, the insurer is the prevailing party.~~

~~3. When neither subparagraph 1. nor subparagraph 2. applies, there is no prevailing party. For purposes of this paragraph, the amount of the offer or claim at arbitration is~~

~~the amount of the last written offer or claim made at least 30 days prior to the arbitration.~~

~~4. In the demand for arbitration, the party requesting arbitration must include a statement specifically identifying the issues for arbitration for each examination or treatment in dispute. The other party must subsequently issue a statement specifying any other examinations or treatment and any other issues that it intends to raise in the arbitration. The parties may amend their statements up to 30 days prior to arbitration, provided that arbitration shall be limited to those identified issues and neither party may add additional issues during arbitration.~~

(d)~~(e)~~ 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) ~~Health Care Finance Administration~~ 1500 form, UB 92 forms, or any other standard form approved by the department for purposes of this paragraph. All billings for such services rendered by providers 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

1 determining compliance with applicable CPT and HCPCS coding,
2 guidance shall be provided by the Physicians' Current
3 Procedural Terminology (CPT) or the Healthcare Correct
4 Procedural Coding System (HCPCS) in effect for the year in
5 which services were rendered, the Office of the Inspector
6 General (OIG), Physicians Compliance Guidelines, and other
7 authoritative treatises designated by rule by the Agency for
8 Health Care Administration. No statement of medical services
9 may include charges for medical services of a person or entity
10 that performed such services without possessing the valid
11 licenses required to perform such services. For purposes of
12 paragraph (4)(b), an insurer shall not be considered to have
13 been furnished with notice of the amount of covered loss or
14 medical bills due unless the statements or bills comply with
15 this paragraph, and unless the statements or bills are
16 properly completed in their entirety as to all material
17 provisions, with all relevant information being provided
18 therein.
19 (e)1. At the initial treatment or service provided,
20 each physician, other licensed professional, clinic, or other
21 medical institution providing medical services upon which a
22 claim for personal injury protection benefits is based shall
23 require an insured person, or his or her guardian, to execute
24 a disclosure and acknowledgment form, which reflects at a
25 minimum that:
26 a. The insured, or his or her guardian, must
27 countersign the form attesting to the fact that the services
28 set forth therein were actually rendered;
29 b. The insured, or his or her guardian, has both the
30 right and affirmative duty to confirm that the services were
31 actually rendered;

1 c. The insured, or his or her guardian, was not
2 solicited by any person to seek any services from the medical
3 provider;
4 d. That the physician, other licensed professional,
5 clinic, or other medical institution rendering services for
6 which payment is being claimed explained the services to the
7 insured or his or her guardian; and
8 e. If the insured notifies the insurer in writing of a
9 billing error, the insured may be entitled to a certain
10 percentage of a reduction in the amounts paid by the insured's
11 motor vehicle insurer.
12 2. The physician, other licensed professional, clinic,
13 or other medical institution rendering services for which
14 payment is being claimed has the affirmative duty to explain
15 the services rendered to the insured, or his or her guardian,
16 so that the insured, or his or her guardian, countersigns the
17 form with informed consent.
18 3. Countersignature by the insured, or his or her
19 guardian, is not required for the reading of diagnostic tests
20 or other services that are of such a nature that they are not
21 required to be performed in the presence of the insured.
22 4. The licensed medical professional rendering
23 treatment for which payment is being claimed must sign, by his
24 or her own hand, the form complying with this paragraph.
25 5. The original completed disclosure and
26 acknowledgement form shall be furnished to the insurer
27 pursuant to paragraph (4)(b) and may not be electronically
28 furnished.
29 6. This disclosure and acknowledgement form is not
30 required for services billed by a provider for emergency
31 services as defined in s. 395.002, for emergency services and

1 care as defined in s. 395.002 rendered in a hospital emergency
2 department, or for transport and treatment rendered by an
3 ambulance provider licensed pursuant to part III of chapter
4 401.
5 7. The Financial Services Commission shall adopt, by
6 rule, a standard disclosure and acknowledgment form that shall
7 be used to fulfill the requirements of this paragraph,
8 effective 90 days after such form is adopted and becomes
9 final. The commission shall adopt a proposed rule by October
10 1, 2003. Until the rule is final, the provider may use a form
11 of its own which otherwise complies with the requirements of
12 this paragraph.
13 8. As used in this paragraph, "countersigned" means a
14 second or verifying signature, as on a previously signed
15 document, and is not satisfied by the statement "signature on
16 file" or any similar statement.
17 9. The requirements of this paragraph apply only with
18 respect to the initial treatment or service of the insured by
19 a provider. For subsequent treatments or service, the provider
20 must maintain a patient log signed by the patient, in
21 chronological order by date of service, that is consistent
22 with the services being rendered to the patient as claimed.
23 (f) Upon written notification by any person, an
24 insurer shall investigate any claim of improper billing by a
25 physician or other medical provider. The insurer shall
26 determine if the insured was properly billed for only those
27 services and treatments that the insured actually received. If
28 the insurer determines that the insured has been improperly
29 billed, the insurer shall notify the insured, the person
30 making the written notification and the provider of its
31 findings and shall reduce the amount of payment to the



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1 provider by the amount determined to be improperly billed. If
2 a reduction is made due to such written notification by any
3 person, the insurer shall pay to the person 20 percent of the
4 amount of the reduction, up to $500. If the provider is
5 arrested due to the improper billing, then the insurer shall
6 pay to the person 40 percent of the amount of the reduction,
7 up to $500.
8 (h) An insurer may not systematically downcode with
9 the intent to deny reimbursement otherwise due. Such action
10 constitutes a material misrepresentation under s.
11 626.9541(1)(i)2.
12 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
13 DISPUTES.--
14 (a) Every employer shall, if a request is made by an
15 insurer providing personal injury protection benefits under
16 ss. 627.730-627.7405 against whom a claim has been made,
17 furnish forthwith, in a form approved by the department, a
18 sworn statement of the earnings, since the time of the bodily
19 injury and for a reasonable period before the injury, of the
20 person upon whose injury the claim is based.
21 (b) Every physician, hospital, clinic, or other
22 medical institution providing, before or after bodily injury
23 upon which a claim for personal injury protection insurance
24 benefits is based, any products, services, or accommodations
25 in relation to that or any other injury, or in relation to a
26 condition claimed to be connected with that or any other
27 injury, shall, if requested to do so by the insurer against
28 whom the claim has been made, furnish forthwith a written
29 report of the history, condition, treatment, dates, and costs
30 of such treatment of the injured person and why the items
31 identified by the insurer were reasonable in amount and

1 medically necessary, together with a sworn statement that the
2 treatment or services rendered were reasonable and necessary
3 with respect to the bodily injury sustained and identifying
4 which portion of the expenses for such treatment or services
5 was incurred as a result of such bodily injury, and produce
6 forthwith, and permit the inspection and copying of, his or
7 her or its records regarding such history, condition,
8 treatment, dates, and costs of treatment; provided that this
9 shall not limit the introduction of evidence at trial. Such
10 sworn statement shall read as follows: "Under penalty of
11 perjury, I declare that I have read the foregoing, and the
12 facts alleged are true, to the best of my knowledge and
13 belief." No cause of action for violation of the
14 physician-patient privilege or invasion of the right of
15 privacy shall be permitted against any physician, hospital,
16 clinic, or other medical institution complying with the
17 provisions of this section. The person requesting such records
18 and such sworn statement shall pay all reasonable costs
19 connected therewith. If an insurer makes a written request for
20 documentation or information under this paragraph within 30
21 days after having received notice of the amount of a covered
22 loss under paragraph (4)(a), the amount or the partial amount
23 which is the subject of the insurer's inquiry shall become
24 overdue if the insurer does not pay in accordance with
25 paragraph (4)(b) or within 10 days after the insurer's receipt
26 of the requested documentation or information, whichever
27 occurs later. For purposes of this paragraph, the term
28 "receipt" includes, but is not limited to, inspection and
29 copying pursuant to this paragraph. Any insurer that requests
30 documentation or information pertaining to reasonableness of
31 charges or medical necessity under this paragraph without a



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reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section ~~about an injured person's earnings or about his or her history, condition, or treatment, or the dates and costs of such treatment~~, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

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

(a) 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 personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental

1 or physical examination by a physician or physicians. The
2 costs of any examinations requested by an insurer shall be
3 borne entirely by the insurer. Such examination shall be
4 conducted within the municipality where the insured is
5 receiving treatment, or in a location reasonably accessible to
6 the insured, which, for purposes of this paragraph, means any
7 location within the municipality in which the insured resides,
8 or any location within 10 miles by road of the insured's
9 residence, provided such location is within the county in
10 which the insured resides. If the examination is to be
11 conducted in a location reasonably accessible to the insured,
12 and if there is no qualified physician to conduct the
13 examination in a location reasonably accessible to the
14 insured, then such examination shall be conducted in an area
15 of the closest proximity to the insured's residence. Personal
16 protection insurers are authorized to include reasonable
17 provisions in personal injury protection insurance policies
18 for mental and physical examination of those claiming personal
19 injury protection insurance benefits. An insurer may not
20 withdraw payment of a treating physician without the consent
21 of the injured person covered by the personal injury
22 protection, unless the insurer first obtains a valid report by
23 a Florida physician licensed under the same chapter as the
24 treating physician whose treatment authorization is sought to
25 be withdrawn, stating that treatment was not reasonable,
26 related, or necessary. A valid report is one that is prepared
27 and signed by the physician examining the injured person or
28 reviewing the treatment records of the injured person and is
29 factually supported by the examination and treatment records
30 if reviewed and that has not been modified by anyone other
31 than the physician. The physician preparing the report must be

1 in active practice, unless the physician is physically
2 disabled. Active practice means that during the 3 years
3 immediately preceding the date of the physical examination or
4 review of the treatment records the physician must have
5 devoted professional time to the active clinical practice of
6 evaluation, diagnosis, or treatment of medical conditions or
7 to the instruction of students in an accredited health
8 professional school or accredited residency program or a
9 clinical research program that is affiliated with an
10 accredited health professional school or teaching hospital or
11 accredited residency program. The physician preparing a report
12 at the request of an insurer and physicians rendering expert
13 opinions on behalf of persons claiming medical benefits for
14 personal injury protection, or on behalf of an insured through
15 an attorney or another entity, shall maintain, for at least 3
16 years, copies of all examination reports as medical records
17 and shall maintain, for at least 3 years, records of all
18 payments for the examinations and reports. Neither an insurer
19 nor any person acting at the direction of or on behalf of an
20 insurer may materially change an opinion in a report prepared
21 under this paragraph or direct the physician preparing the
22 report to change such opinion. The denial of a payment as the
23 result of such a changed opinion constitutes a material
24 misrepresentation under s. 626.9541(1)(i)2.; however, this
25 provision does not preclude the insurer from calling to the
26 attention of the physician errors of fact in the report based
27 upon information in the claim file.
28 (b) If requested by the person examined, a party
29 causing an examination to be made shall deliver to him or her
30 a copy of every written report concerning the examination
31 rendered by an examining physician, at least one of which

1 reports must set out the examining physician's findings and
2 conclusions in detail. After such request and delivery, the
3 party causing the examination to be made is entitled, upon
4 request, to receive from the person examined every written
5 report available to him or her or his or her representative
6 concerning any examination, previously or thereafter made, of
7 the same mental or physical condition. By requesting and
8 obtaining a report of the examination so ordered, or by taking
9 the deposition of the examiner, the person examined waives any
10 privilege he or she may have, in relation to the claim for
11 benefits, regarding the testimony of every other person who
12 has examined, or may thereafter examine, him or her in respect
13 to the same mental or physical condition. If a person
14 unreasonably refuses to submit to an examination, the personal
15 injury protection carrier is no longer liable for subsequent
16 personal injury protection benefits.
17 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
18 FEES.--With respect to any dispute under the provisions of ss.
19 627.730-627.7405 between the insured and the insurer, or
20 between an assignee of an insured's rights and the insurer,
21 the provisions of s. 627.428 shall apply, except as provided
22 in subsection (11).
23 (10) An insurer may negotiate and enter into contracts
24 with licensed health care providers for the benefits described
25 in this section, referred to in this section as "preferred
26 providers," which shall include health care providers licensed
27 under chapters 458, 459, 460, 461, and 463. The insurer may
28 provide an option to an insured to use a preferred provider at
29 the time of purchase of the policy for personal injury
30 protection benefits, if the requirements of this subsection
31 are met. If the insured elects to use a provider who is not a



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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. If the insured elects to use a provider who is a preferred provider, 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. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(11) DEMAND LETTER.--

(a) As a condition precedent to filing any action for ~~an overdue claim for~~ benefits under this section ~~paragraph (4)(b)~~, the insurer must be provided with written notice of an intent to initiate litigation~~; provided, however, that, except with regard to a claim or amended claim or judgment for interest only which was not paid or was incorrectly calculated, such notice is not required for an overdue claim that the insurer has denied or reduced, nor is such notice required if the insurer has been provided documentation or information at the insurer's request pursuant to subsection (6)~~. 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).



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(b) The notice required shall state that it is a "demand letter under s. 627.736(11)" 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 (5)(d) or the lost-wage statement previously submitted ~~Health Care Finance Administration 1500 form, UB 92, or successor forms approved by the Secretary of the United States Department of Health and Human Services~~ 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 ~~section~~ 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 ~~provider~~ in the notice, when the insurer pays the ~~overdue~~ claim. Such notice must be sent to the person and

address specified by the insurer for the purposes of receiving notices under this subsection ~~section, on the document denying or reducing the amount asserted by the filer to be overdue~~. Each licensed insurer, whether domestic, foreign, or alien, shall ~~may~~ file with the office ~~department~~ designation of the name and address of the person to whom notices pursuant to this subsection ~~section~~ shall be sent which the office shall make available on its Internet website ~~when such document does not specify the name and address to whom the notices under this section are to be sent or when there is no such document~~. The name and address on file with the office ~~department~~ pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection ~~section~~ in the event no other designation has been made.

(d) If, within 15 ~~7 business~~ 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 ~~for nonpayment or late payment~~ 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 15 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 ~~the overdue~~ amount demanded, the penalty shall not be payable

1 in any subsequent action ~~for nonpayment or late payment~~. For
2 purposes of this subsection, payment or the insurer's
3 agreement shall be treated as being made on the date a draft
4 or other valid instrument that is equivalent to payment, or
5 the insurer's written statement of agreement, is placed in the
6 United States mail in a properly addressed, postpaid envelope,
7 or if not so posted, on the date of delivery. The insurer
8 shall not be obligated to pay any attorney's fees if the
9 insurer pays the claim or mails its agreement to pay for
10 future treatment within the time prescribed by this
11 subsection.
12 (e) The applicable statute of limitation for an action
13 under this section shall be tolled for a period of 15 business
14 days by the mailing of the notice required by this subsection.
15 (f) Any insurer making a general business practice of
16 not paying valid claims until receipt of the notice required
17 by this subsection ~~section~~ is engaging in an unfair trade
18 practice under the insurance code.
19 (12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer
20 shall have a cause of action against any person convicted of,
21 or who, regardless of adjudication of guilt, pleads guilty or
22 nolo contendere to insurance fraud under s. 817.234, patient
23 brokering under s. 817.505, or kickbacks under s. 456.054,
24 associated with a claim for personal injury protection
25 benefits in accordance with this section. An insurer
26 prevailing in an action brought under this subsection may
27 recover compensatory, consequential, and punitive damages
28 subject to the requirements and limitations of part II of
29 chapter 768, and attorney's fees and costs incurred in
30 litigating a cause of action against any person convicted of,
31 or who, regardless of adjudication of guilt, pleads guilty or

nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

Section 10. Subsections (1) and (2) of section 627.739, Florida Statutes, are amended to read:

627.739 Personal injury protection; optional limitations; deductibles.--

(1) The named insured may elect a deductible or modified coverage or combination thereof to apply to the named insured alone or to the named insured and dependent relatives residing in the same household, but may not elect a deductible or modified coverage to apply to any other person covered under the policy. ~~Any person electing a deductible or modified coverage, or a combination thereof, or subject to such deductible or modified coverage as a result of the named insured's election, shall have no right to claim or to recover any amount so deducted from any owner, registrant, operator, or occupant of a vehicle or any person or organization legally responsible for any such person's acts or omissions who is made exempt from tort liability by ss. 627.730-627.7405.~~

(2) Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, and $1,000~~, and $2,000~~. The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736. After the deductible is met, each insured is eligible to receive up to $10,000 in total benefits described in s. 627.736(1).~~, such amount to be deducted from the benefits otherwise due each person subject to the deduction.~~However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

Section 11. Subsections (7), (8), and (9) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.--

(7)(a) It shall constitute a material omission and insurance fraud for any physician or other provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the patient or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge.

(b) The provisions of this section shall also apply as to any insurer or adjusting firm or its agents or representatives who, with intent, injure, defraud, or deceive any claimant with regard to any claim. The claimant shall have the right to recover the damages provided in this section.

(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

1 <u>opinion; however, this provision does not preclude the insurer</u>
2 <u>from calling to the attention of the physician errors of fact</u>
3 <u>in the report based upon information in the claim file. Any</u>
4 <u>person who violates this paragraph commits a felony of the</u>
5 <u>third degree, punishable as provided in s. 775.082, s.</u>
6 <u>775.083, or s. 775.084.</u>
7 (8)<u>(a)</u> It is unlawful for any person <u>intending to</u>
8 <u>defraud any other person</u>~~, in his or her individual capacity or~~
9 ~~in his or her capacity as a public or private employee, or for~~
10 ~~any firm, corporation, partnership, or association,~~to solicit
11 or cause to be solicited any business from a person involved
12 in a motor vehicle accident ~~by any means of communication~~
13 ~~other than advertising directed to the public~~ for the purpose
14 of making<u>, adjusting, or settling</u> motor vehicle tort claims or
15 claims for personal injury protection benefits required by s.
16 627.736. ~~Charges for any services rendered by a health care~~
17 ~~provider or attorney who violates this subsection in regard to~~
18 ~~the person for whom such services were rendered are~~
19 ~~noncompensable and unenforceable as a matter of law.~~Any
20 person who violates the provisions of this <u>paragraph</u>
21 ~~subsection~~ commits a felony of the <u>second</u> ~~third~~ degree,
22 punishable as provided in s. 775.082, s. 775.083, or s.
23 775.084. <u>A person who is convicted of a violation of this</u>
24 <u>subsection shall be sentenced to a minimum term of</u>
25 <u>imprisonment of 2 years.</u>
26 <u>(b) A person may not solicit or cause to be solicited</u>
27 <u>any business from a person involved in a motor vehicle</u>
28 <u>accident by any means of communication other than advertising</u>
29 <u>directed to the public for the purpose of making motor vehicle</u>
30 <u>tort claims or claims for personal injury protection benefits</u>
31 <u>required by s. 627.736, within 60 days after the occurrence of</u>

1 the motor vehicle accident. Any person who violates this
2 paragraph commits a felony of the third degree, punishable as
3 provided in s. 775.082, s. 775.083, or s. 775.084.
4 (c) A lawyer, health care practitioner as defined in
5 s. 456.001, or owner or medical director of a clinic required
6 to be licensed pursuant to s. 400.903 may not, at any time
7 after 60 days have elapsed from the occurrence of a motor
8 vehicle accident, solicit or cause to be solicited any
9 business from a person involved in a motor vehicle accident by
10 means of in-person or telephone contact at the person's
11 residence, for the purpose of making motor vehicle tort claims
12 or claims for personal injury protection benefits required by
13 s. 627.736. Any person who violates this paragraph commits a
14 felony of the third degree, punishable as provided in s.
15 775.082, s. 775.083, or s. 775.084.
16 (d) Charges for any services rendered by any person
17 who violates this subsection in regard to the person for whom
18 such services were rendered are noncompensable and
19 unenforceable as a matter of law.
20 (9) A person may not organize, plan, or knowingly
21 participate in an intentional motor vehicle crash for the
22 purpose of making motor vehicle tort claims or claims for
23 personal injury protection benefits as required by s. 627.736.
24 ~~It is unlawful for any attorney to solicit any business~~
25 ~~relating to the representation of a person involved in a motor~~
26 ~~vehicle accident for the purpose of filing a motor vehicle~~
27 ~~tort claim or a claim for personal injury protection benefits~~
28 ~~required by s. 627.736. The solicitation by advertising of~~
29 ~~any business by an attorney relating to the representation of~~
30 ~~a person injured in a specific motor vehicle accident is~~
31 ~~prohibited by this section.~~Any person ~~attorney~~ who violates

~~the provisions of~~ this paragraph ~~subsection~~ commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.~~Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney is guilty of a violation of this section, such committee shall forward to the appropriate state attorney a copy of the finding of probable cause and the report being filed in the matter. This section shall not be interpreted to prohibit advertising by attorneys which does not entail a solicitation as described in this subsection and which is permitted by the rules regulating The Florida Bar as promulgated by the Florida Supreme Court.~~

Section 12. Section 817.236, Florida Statutes, is amended to read:

817.236 False and fraudulent motor vehicle insurance application.--Any person who, with intent to injure, defraud, or deceive any motor vehicle insurer, including any statutorily created underwriting association or pool of motor vehicle insurers, presents or causes to be presented any written application, or written statement in support thereof, for motor vehicle insurance knowing that the application or statement contains any false, incomplete, or misleading information concerning any fact or matter material to the application commits a felony ~~misdemeanor~~ of the third ~~first~~ degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084.

Section 13. Section 817.2361, Florida Statutes, is created to read:



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 817.2361 False or fraudulent motor vehicle insurance
2 card.--Any person who, with intent to deceive any other
3 person, creates, markets, or presents a false or fraudulent
4 motor vehicle insurance card commits a felony of the third
5 degree, punishable as provided in s. 775.082, s. 775.083, or
6 s. 775.084.
7 Section 14. Effective October 1, 2003, paragraphs (c)
8 and (g) of subsection (3) of section 921.0022, Florida
9 Statutes, are amended to read:
10 921.0022 Criminal Punishment Code; offense severity
11 ranking chart.--
12 (3) OFFENSE SEVERITY RANKING CHART
13

| | Florida Statute | Felony Degree | Description |
|---|---|---|---|
| 14–15 | Florida Statute | Felony Degree | Description |
| 16 | | | |
| 17 | | | |
| 18 | | | (c) LEVEL 3 |
| 19–20 | 119.10(3) | 3rd | Unlawful use of confidential information from police reports. |
| 21–22 | 316.066(3)(d)-(f) | 3rd | Unlawfully obtaining or using confidential crash reports. |
| 23 | 316.193(2)(b) | 3rd | Felony DUI, 3rd conviction. |
| 24–27 | 316.1935(2) | 3rd | Fleeing or attempting to elude law enforcement officer in marked patrol vehicle with siren and lights activated. |
| 28–30 | 319.30(4) | 3rd | Possession by junkyard of motor vehicle with identification number plate removed. |
| 31 | | | |



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

| | | | |
|---|---|---|---|
| 1 | 319.33(1)(a) | 3rd | Alter or forge any certificate of |
| 2 | | | title to a motor vehicle or |
| 3 | | | mobile home. |
| 4 | 319.33(1)(c) | 3rd | Procure or pass title on stolen |
| 5 | | | vehicle. |
| 6 | 319.33(4) | 3rd | With intent to defraud, possess, |
| 7 | | | sell, etc., a blank, forged, or |
| 8 | | | unlawfully obtained title or |
| 9 | | | registration. |
| 10 | 327.35(2)(b) | 3rd | Felony BUI. |
| 11 | 328.05(2) | 3rd | Possess, sell, or counterfeit |
| 12 | | | fictitious, stolen, or fraudulent |
| 13 | | | titles or bills of sale of |
| 14 | | | vessels. |
| 15 | 328.07(4) | 3rd | Manufacture, exchange, or possess |
| 16 | | | vessel with counterfeit or wrong |
| 17 | | | ID number. |
| 18 | 376.302(5) | 3rd | Fraud related to reimbursement |
| 19 | | | for cleanup expenses under the |
| 20 | | | Inland Protection Trust Fund. |
| 21 | 400.903(3) | 3rd | Operating a clinic without a |
| 22 | | | license or filing false license |
| 23 | | | application or other required |
| 24 | | | information. |
| 25 | 501.001(2)(b) | 2nd | Tampers with a consumer product |
| 26 | | | or the container using materially |
| 27 | | | false/misleading information. |
| 28 | 697.08 | 3rd | Equity skimming. |
| 29 | 790.15(3) | 3rd | Person directs another to |
| 30 | | | discharge firearm from a vehicle. |
| 31 | 796.05(1) | 3rd | Live on earnings of a prostitute. |



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| | | |
|---|---|---|
| 806.10(1) | 3rd | Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting. |
| 806.10(2) | 3rd | Interferes with or assaults firefighter in performance of duty. |
| 810.09(2)(c) | 3rd | Trespass on property other than structure or conveyance armed with firearm or dangerous weapon. |
| 812.014(2)(c)2. | 3rd | Grand theft; $5,000 or more but less than $10,000. |
| 812.0145(2)(c) | 3rd | Theft from person 65 years of age or older; $300 or more but less than $10,000. |
| 815.04(4)(b) | 2nd | Computer offense devised to defraud or obtain property. |
| 817.034(4)(a)3. | 3rd | Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000. |
| 817.233 | 3rd | Burning to defraud insurer. |
| 817.234(8)(b)-(c)~~&(9)~~ | 3rd | Unlawful solicitation of persons involved in motor vehicle accidents. |
| 817.234(11)(a) | 3rd | Insurance fraud; property value less than $20,000. |
| 817.236 | 3rd | Filing a false motor vehicle insurance application. |



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

| | | | |
|---|---|---|---|
| 1 | 817.2361 | 3rd | Creating, marketing, or |
| 2 | | | presenting a false or fraudulent |
| 3 | | | motor vehicle insurance card. |
| 4 | 817.505(4) | 3rd | Patient brokering. |
| 5 | 828.12(2) | 3rd | Tortures any animal with intent |
| 6 | | | to inflict intense pain, serious |
| 7 | | | physical injury, or death. |
| 8 | 831.28(2)(a) | 3rd | Counterfeiting a payment |
| 9 | | | instrument with intent to defraud |
| 10 | | | or possessing a counterfeit |
| 11 | | | payment instrument. |
| 12 | 831.29 | 2nd | Possession of instruments for |
| 13 | | | counterfeiting drivers' licenses |
| 14 | | | or identification cards. |
| 15 | 838.021(3)(b) | 3rd | Threatens unlawful harm to public |
| 16 | | | servant. |
| 17 | 843.19 | 3rd | Injure, disable, or kill police |
| 18 | | | dog or horse. |
| 19 | 870.01(2) | 3rd | Riot; inciting or encouraging. |
| 20 | 893.13(1)(a)2. | 3rd | Sell, manufacture, or deliver |
| 21 | | | cannabis (or other s. |
| 22 | | | 893.03(1)(c), (2)(c)1., (2)(c)2., |
| 23 | | | (2)(c)3., (2)(c)5., (2)(c)6., |
| 24 | | | (2)(c)7., (2)(c)8., (2)(c)9., |
| 25 | | | (3), or (4) drugs). |
| 26 | 893.13(1)(d)2. | 2nd | Sell, manufacture, or deliver s. |
| 27 | | | 893.03(1)(c), (2)(c)1., (2)(c)2., |
| 28 | | | (2)(c)3., (2)(c)5., (2)(c)6., |
| 29 | | | (2)(c)7., (2)(c)8., (2)(c)9., |
| 30 | | | (3), or (4) drugs within 200 feet |
| 31 | | | of university or public park. |

| | | | |
|---|---|---|---|
| 1 | 893.13(1)(f)2. | 2nd | Sell, manufacture, or deliver s. |
| 2 | | | 893.03(1)(c), (2)(c)1., (2)(c)2., |
| 3 | | | (2)(c)3., (2)(c)5., (2)(c)6., |
| 4 | | | (2)(c)7., (2)(c)8., (2)(c)9., |
| 5 | | | (3), or (4) drugs within 200 feet |
| 6 | | | of public housing facility. |
| 7 | 893.13(6)(a) | 3rd | Possession of any controlled |
| 8 | | | substance other than felony |
| 9 | | | possession of cannabis. |
| 10 | 893.13(7)(a)8. | 3rd | Withhold information from |
| 11 | | | practitioner regarding previous |
| 12 | | | receipt of or prescription for a |
| 13 | | | controlled substance. |
| 14 | 893.13(7)(a)9. | 3rd | Obtain or attempt to obtain |
| 15 | | | controlled substance by fraud, |
| 16 | | | forgery, misrepresentation, etc. |
| 17 | 893.13(7)(a)10. | 3rd | Affix false or forged label to |
| 18 | | | package of controlled substance. |
| 19 | 893.13(7)(a)11. | 3rd | Furnish false or fraudulent |
| 20 | | | material information on any |
| 21 | | | document or record required by |
| 22 | | | chapter 893. |
| 23 | 893.13(8)(a)1. | 3rd | Knowingly assist a patient, other |
| 24 | | | person, or owner of an animal in |
| 25 | | | obtaining a controlled substance |
| 26 | | | through deceptive, untrue, or |
| 27 | | | fraudulent representations in or |
| 28 | | | related to the practitioner's |
| 29 | | | practice. |
| 30 | | | |
| 31 | | | |



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

| Line | Statute | Degree | Description |
|---|---|---|---|
| 1 | 893.13(8)(a)2. | 3rd | Employ a trick or scheme in the |
| 2 | | | practitioner's practice to assist |
| 3 | | | a patient, other person, or owner |
| 4 | | | of an animal in obtaining a |
| 5 | | | controlled substance. |
| 6 | 893.13(8)(a)3. | 3rd | Knowingly write a prescription |
| 7 | | | for a controlled substance for a |
| 8 | | | fictitious person. |
| 9 | 893.13(8)(a)4. | 3rd | Write a prescription for a |
| 10 | | | controlled substance for a |
| 11 | | | patient, other person, or an |
| 12 | | | animal if the sole purpose of |
| 13 | | | writing the prescription is a |
| 14 | | | monetary benefit for the |
| 15 | | | practitioner. |
| 16 | 918.13(1)(a) | 3rd | Alter, destroy, or conceal |
| 17 | | | investigation evidence. |
| 18 | 944.47 | | |
| 19 | (1)(a)1.-2. | 3rd | Introduce contraband to |
| 20 | | | correctional facility. |
| 21 | 944.47(1)(c) | 2nd | Possess contraband while upon the |
| 22 | | | grounds of a correctional |
| 23 | | | institution. |
| 24 | 985.3141 | 3rd | Escapes from a juvenile facility |
| 25 | | | (secure detention or residential |
| 26 | | | commitment facility). |
| 27 | | | (g) LEVEL 7 |
| 28 | 316.193(3)(c)2. | 3rd | DUI resulting in serious bodily |
| 29 | | | injury. |
| 30 | 327.35(3)(c)2. | 3rd | Vessel BUI resulting in serious |
| 31 | | | bodily injury. |



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| | | | |
|---|---|---|---|
| 1 | 402.319(2) | 2nd | Misrepresentation and negligence |
| 2 | | | or intentional act resulting in |
| 3 | | | great bodily harm, permanent |
| 4 | | | disfiguration, permanent |
| 5 | | | disability, or death. |
| 6 | 409.920(2) | 3rd | Medicaid provider fraud. |
| 7 | 456.065(2) | 3rd | Practicing a health care |
| 8 | | | profession without a license. |
| 9 | 456.065(2) | 2nd | Practicing a health care |
| 10 | | | profession without a license |
| 11 | | | which results in serious bodily |
| 12 | | | injury. |
| 13 | 458.327(1) | 3rd | Practicing medicine without a |
| 14 | | | license. |
| 15 | 459.013(1) | 3rd | Practicing osteopathic medicine |
| 16 | | | without a license. |
| 17 | 460.411(1) | 3rd | Practicing chiropractic medicine |
| 18 | | | without a license. |
| 19 | 461.012(1) | 3rd | Practicing podiatric medicine |
| 20 | | | without a license. |
| 21 | 462.17 | 3rd | Practicing naturopathy without a |
| 22 | | | license. |
| 23 | 463.015(1) | 3rd | Practicing optometry without a |
| 24 | | | license. |
| 25 | 464.016(1) | 3rd | Practicing nursing without a |
| 26 | | | license. |
| 27 | 465.015(2) | 3rd | Practicing pharmacy without a |
| 28 | | | license. |
| 29 | 466.026(1) | 3rd | Practicing dentistry or dental |
| 30 | | | hygiene without a license. |
| 31 | | | |



**CODING:**Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

| | | | |
|---|---|---|---|
| 1 | 467.201 | 3rd | Practicing midwifery without a |
| 2 | | | license. |
| 3 | 468.366 | 3rd | Delivering respiratory care |
| 4 | | | services without a license. |
| 5 | 483.828(1) | 3rd | Practicing as clinical laboratory |
| 6 | | | personnel without a license. |
| 7 | 483.901(9) | 3rd | Practicing medical physics |
| 8 | | | without a license. |
| 9 | 484.013(1)(c) | 3rd | Preparing or dispensing optical |
| 10 | | | devices without a prescription. |
| 11 | 484.053 | 3rd | Dispensing hearing aids without a |
| 12 | | | license. |
| 13 | 494.0018(2) | 1st | Conviction of any violation of |
| 14 | | | ss. 494.001-494.0077 in which the |
| 15 | | | total money and property |
| 16 | | | unlawfully obtained exceeded |
| 17 | | | $50,000 and there were five or |
| 18 | | | more victims. |
| 19 | 560.123(8)(b)1. | 3rd | Failure to report currency or |
| 20 | | | payment instruments exceeding |
| 21 | | | $300 but less than $20,000 by |
| 22 | | | money transmitter. |
| 23 | 560.125(5)(a) | 3rd | Money transmitter business by |
| 24 | | | unauthorized person, currency or |
| 25 | | | payment instruments exceeding |
| 26 | | | $300 but less than $20,000. |
| 27 | 655.50(10)(b)1. | 3rd | Failure to report financial |
| 28 | | | transactions exceeding $300 but |
| 29 | | | less than $20,000 by financial |
| 30 | | | institution. |
| 31 | | | |



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

| | | |
|---|---|---|
| 782.051(3) | 2nd | Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony. |
| 782.07(1) | 2nd | Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter). |
| 782.071 | 2nd | Killing of human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide). |
| 782.072 | 2nd | Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide). |
| 784.045(1)(a)1. | 2nd | Aggravated battery; intentionally causing great bodily harm or disfigurement. |
| 784.045(1)(a)2. | 2nd | Aggravated battery; using deadly weapon. |
| 784.045(1)(b) | 2nd | Aggravated battery; perpetrator aware victim pregnant. |
| 784.048(4) | 3rd | Aggravated stalking; violation of injunction or court order. |
| 784.07(2)(d) | 1st | Aggravated battery on law enforcement officer. |
| 784.074(1)(a) | 1st | Aggravated battery on sexually violent predators facility staff. |
| 784.08(2)(a) | 1st | Aggravated battery on a person 65 years of age or older. |

| | | | |
|---|---|---|---|
| 1<br>2 | 784.081(1) | 1st | Aggravated battery on specified official or employee. |
| 3<br>4<br>5 | 784.082(1) | 1st | Aggravated battery by detained person on visitor or other detainee. |
| 6<br>7 | 784.083(1) | 1st | Aggravated battery on code inspector. |
| 8<br>9<br>10 | 790.07(4) | 1st | Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2). |
| 11<br>12 | 790.16(1) | 1st | Discharge of a machine gun under specified circumstances. |
| 13<br>14 | 790.165(2) | 2nd | Manufacture, sell, possess, or deliver hoax bomb. |
| 15<br>16<br>17<br>18 | 790.165(3) | 2nd | Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony. |
| 19<br>20<br>21 | 790.166(3) | 2nd | Possessing, selling, using, or attempting to use a hoax weapon of mass destruction. |
| 22<br>23<br>24<br>25<br>26 | 790.166(4) | 2nd | Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony. |
| 27<br>28 | 796.03 | 2nd | Procuring any person under 16 years for prostitution. |
| 29<br>30<br>31 | 800.04(5)(c)1. | 2nd | Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years. |



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| | | | |
|---|---|---|---|
| 1 | 800.04(5)(c)2. | 2nd | Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older. |
| 5 | 806.01(2) | 2nd | Maliciously damage structure by fire or explosive. |
| 7 | 810.02(3)(a) | 2nd | Burglary of occupied dwelling; unarmed; no assault or battery. |
| 9 | 810.02(3)(b) | 2nd | Burglary of unoccupied dwelling; unarmed; no assault or battery. |
| 11 | 810.02(3)(d) | 2nd | Burglary of occupied conveyance; unarmed; no assault or battery. |
| 13 | 812.014(2)(a) | 1st | Property stolen, valued at $100,000 or more; cargo stolen valued at $50,000 or more; property stolen while causing other property damage; 1st degree grand theft. |
| 19 | 812.014(2)(b)3. | 2nd | Property stolen, emergency medical equipment; 2nd degree grand theft. |
| 22 | 812.0145(2)(a) | 1st | Theft from person 65 years of age or older; $50,000 or more. |
| 24 | 812.019(2) | 1st | Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property. |
| 28 | 812.131(2)(a) | 2nd | Robbery by sudden snatching. |
| 29 | 812.133(2)(b) | 1st | Carjacking; no firearm, deadly weapon, or other weapon. |
| 31 | | | |

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|---|---|---|---|
| 1-3 | 817.234(8)(a) | 2nd | Solicitation of motor vehicle accident victims with intent to defraud. |
| 4-6 | 817.234(9) | 2nd | Organizing, planning, or participating in an intentional motor vehicle collision. |
| 7-8 | 817.234(11)(c) | 1st | Insurance fraud; property value $100,000 or more. |
| 9-12 | 825.102(3)(b) | 2nd | Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement. |
| 13-16 | 825.103(2)(b) | 2nd | Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000. |
| 17-19 | 827.03(3)(b) | 2nd | Neglect of a child causing great bodily harm, disability, or disfigurement. |
| 20-22 | 827.04(3) | 3rd | Impregnation of a child under 16 years of age by person 21 years of age or older. |
| 23-25 | 837.05(2) | 3rd | Giving false information about alleged capital felony to a law enforcement officer. |
| 26 | 872.06 | 2nd | Abuse of a dead human body. |

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|---|---|---|
| 893.13(1)(c)1. | 1st | Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility or school. |
| 893.13(1)(e)1. | 1st | Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site. |
| 893.13(4)(a) | 1st | Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs). |
| 893.135(1)(a)1. | 1st | Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs. |
| 893.135 (1)(b)1.a. | 1st | Trafficking in cocaine, more than 28 grams, less than 200 grams. |
| 893.135 (1)(c)1.a. | 1st | Trafficking in illegal drugs, more than 4 grams, less than 14 grams. |



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|---|---|---|
| 893.135 (1)(d)1. | 1st | Trafficking in phencyclidine, more than 28 grams, less than 200 grams. |
| 893.135(1)(e)1. | 1st | Trafficking in methaqualone, more than 200 grams, less than 5 kilograms. |
| 893.135(1)(f)1. | 1st | Trafficking in amphetamine, more than 14 grams, less than 28 grams. |
| 893.135 (1)(g)1.a. | 1st | Trafficking in flunitrazepam, 4 grams or more, less than 14 grams. |
| 893.135 (1)(h)1.a. | 1st | Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms. |
| 893.135 (1)(j)1.a. | 1st | Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms. |
| 893.135 (1)(k)2.a. | 1st | Trafficking in Phenethylamines, 10 grams or more, less than 200 grams. |
| 896.101(5)(a) | 3rd | Money laundering, financial transactions exceeding $300 but less than $20,000. |

1 896.104(4)(a)1. 3rd Structuring transactions to evade
2 reporting or registration
3 requirements, financial
4 transactions exceeding $300 but
5 less than $20,000.
6 Section 15. The amendment made by this act to section
7 456.0375(1)(b), Florida Statutes, is intended to clarify the
8 legislative intent of this provision as it existed at the time
9 the provision initially took effect. Accordingly, section
10 456.0375(1)(b), Florida Statutes, as amended by this act shall
11 operate retroactively to October 1, 2001.
12 Section 16. Effective March 1, 2004, section 456.0375,
13 Florida Statutes, is repealed.
14 Section 17. (1) On or before January 1, 2004, every
15 insurer writing with a managing general agent and having a
16 per-policy fee in its rate filing shall make a rate filing
17 under section 627.062 or section 627.0651, Florida Statutes,
18 to conform its per-policy fee to the requirements of this act.
19 (2) Any increase in benefits approved by the Financial
20 Services Commission under subsection (12) of section 627.736,
21 Florida Statutes, as added by this act, shall apply to new and
22 renewal policies that are effective 120 days after the order
23 issued by the commission becomes final. Subsection (2) of
24 section 627.739, Florida Statutes, as amended by this act,
25 shall apply to new and renewal policies issued on or after
26 October 1, 2003.
27 (3) Subsection (11) of section 627.736, Florida
28 Statutes, as amended by this act, shall apply to actions filed
29 on and after the effective date of this act.
30 (4) Paragraph (7)(a) of section 627.736, Florida
31 Statutes, as amended by this act, and paragraph (7)(c) of

1 section 817.234, Florida Statutes, as amended by this act,
2 shall apply to examinations conducted on and after October 1,
3 2003.
4 Section 18. By December 31, 2004, the Department of
5 Financial Services, the Department of Health, and the Agency
6 for Health Care Administration each shall submit a report on
7 the implementation of this act and recommendations, if any, to
8 further improve the automobile insurance market, reduce
9 automobile insurance costs, and reduce automobile insurance
10 fraud and abuse to the President of the Senate and the Speaker
11 of the House of Representatives. The report by the Department
12 of Financial Services shall include a study of the medical and
13 legal costs associated with personal injury protection
14 insurance claims.
15 Section 19. There is appropriated $2.5 million from
16 the Health Care Trust Fund, and 51 full-time equivalent
17 positions are authorized, for the Agency for Health Care
18 Administration to implement the provisions of this act.
19 Section 20. (1) Effective October 1, 2007, sections
20 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737,
21 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes,
22 constituting the Florida Motor Vehicle No-Fault Law, are
23 repealed, unless reenacted by the Legislature during the 2006
24 Regular Session and such reenactment becomes law to take
25 effect for policies issued or renewed on or after October 1,
26 2006.
27 (2) Insurers are authorized to provide, in all
28 policies issues or renewed after October 1, 2006, that such
29 policies may terminate on or after October 1, 2007, as
30 provided in subsection (1).
31

Section 21. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2003.



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