

1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; providing a short title; providing
4 legislative intent; amending s. 316.066, F.S.; revising
5 provisions relating to the contents of written reports of
6 motor vehicle crashes; authorizing the investigating
7 officer to testify at trial or provide an affidavit
8 concerning the content of the reports; amending s.
9 400.991, F.S.; requiring that an application for licensure
10 as a mobile clinic include a statement regarding insurance
11 fraud; amending s. 627.730, F.S.; conforming a cross-
12 reference; amending s. 627.731, F.S.; providing
13 legislative intent with respect to the Florida Motor
14 Vehicle No-Fault Law; amending s. 627.732, F.S.; defining
15 the terms "claimant" and "no-fault law"; amending s.
16 627.736, F.S.; conforming a cross-reference; requiring
17 certain entities providing medical services to document
18 that they meet required criteria; revising requirements
19 relating to the form that must be submitted by providers;
20 requiring an entity or clinic to file a new form within a
21 specified period after the date of a change of ownership;
22 revising provisions relating to when payment for a benefit
23 is due; providing that the time period for paying or
24 denying a claim is tolled during the investigation of a
25 fraudulent insurance act; specifying when benefits are not
26 payable; providing that a claimant that violates certain
27 provisions is not entitled to any payment, regardless of
28 whether a portion of the claim may be legitimate;

29 | authorizing an insurer to recover payments and bring a
30 | cause of action to recover payments; forbidding a
31 | physician, hospital, clinic, or other medical institution
32 | that fails to comply with certain provisions from billing
33 | the injured person or the insured; providing that an
34 | insurer has a right to conduct reasonable investigations
35 | of claims; authorizing an insurer to require a claimant to
36 | provide certain records; revising the insurer's
37 | reimbursement limitation; deleting an obsolete provision;
38 | revising requirements relating to discovery; authorizing
39 | an insurer to conduct examinations of claimants under oath
40 | or sworn statement; requiring the provider to produce
41 | persons having the most knowledge in specified
42 | circumstances; providing that an insurer that requests an
43 | examination under oath without a reasonable basis is
44 | engaging in an unfair and deceptive trade practice;
45 | authorizing the insurer to conduct a physical review of
46 | the treatment location; authorizing an insurer to contract
47 | with a preferred provider network; authorizing an insurer
48 | to provide a premium discount to an insured who selects a
49 | preferred provider; authorizing an insurance policy not to
50 | pay for nonemergency services performed by a nonpreferred
51 | provider in specified circumstances; authorizing an
52 | insurer to contract with a health insurer in specified
53 | circumstances; amending s. 817.234, F.S.; conforming a
54 | cross-reference; providing civil penalties for criminal
55 | acts that result in the unlawful receipt of insurance
56 | proceeds from a motor vehicle insurance contract; amending

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57 ss. 324.021, 456.057, 627.7295, 627.733, 627.734, 627.737,
58 627.7401, 627.7405, 627.7407, and 628.909, F.S.;
59 conforming cross-references; providing an effective date.
60

61 Be It Enacted by the Legislature of the State of Florida:
62

63 Section 1. (1) SHORT TITLE.—This act may be cited as the
64 "Comprehensive Insurance Fraud Investigation and Prevention
65 Act."

66 (2) FINDINGS AND INTENT.—The Legislature intends to
67 balance the insured's interest in prompt payment of valid claims
68 for insurance benefits under the no-fault law with the public's
69 interest in reducing fraud, abuse, and overuse of the no-fault
70 system. To that end, the Legislature intends that the
71 investigation and prevention of fraudulent insurance acts in
72 this state be enhanced, that additional sanctions for such acts
73 be imposed, and that the no-fault law be revised to remove
74 incentives for fraudulent insurance acts. The Legislature
75 intends that the no-fault law be construed according to the
76 plain language of the statutory provisions, which are designed
77 to meet these goals.

78 (a) The Legislature finds that:

79 1. Motor vehicle insurance fraud remains a major problem
80 for state consumers and insurers. According to the National
81 Insurance Crime Bureau, in recent years this state has been
82 among those states that have the highest number of fraudulent
83 and questionable claims.

84 2. The current regulatory process for health care clinics

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85 under part X of chapter 400, Florida Statutes, which was
86 originally enacted to reduce motor vehicle insurance fraud, is
87 not adequately preventing fraudulent insurance acts with respect
88 to licensure exemptions and compliance with that part.

89 (b) The Legislature intends that:

90 1. Insurers properly investigate claims, and as such, this
91 act clarifies that insurers are allowed to obtain examinations
92 under oath and sworn statements from any claimant seeking no-
93 fault insurance benefits and to request mental and physical
94 examinations of persons seeking personal injury protection
95 coverage or benefits.

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

102 3. Insurers toll the payment or denial of a claim with
103 respect to any portion of a claim for which the insurer has a
104 reasonable belief that a fraudulent insurance act, as defined in
105 s. 626.989 or s. 817.234, Florida Statutes, has been committed.

106 4. Insurers discover the names of all passengers involved
107 in a motor vehicle crash before paying claims or benefits
108 pursuant to an insurance policy governed by the no-fault law. A
109 rebuttable presumption must be established that a person was not
110 involved in the event giving rise to the claim if that person's
111 name does not appear on the police report.

112 Section 2. Subsection (1) of section 316.066, Florida

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113 Statutes, is amended to read:

114 316.066 Written reports of crashes.—

115 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~
116 ~~required to~~ be completed and submitted to the department within
117 10 days after ~~completing~~ an investigation is completed by the
118 ~~every~~ law enforcement officer who in the regular course of duty
119 investigates a motor vehicle crash:

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

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

126 ~~3.2.~~ That involved a violation of s. 316.061(1) or s.
127 316.193; or—

128 ~~4.3.~~ In which a vehicle was rendered inoperative to a
129 degree that required a wrecker to remove it from traffic, if
130 such action is appropriate, in the officer's discretion.

131 (b) The long form must include:

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

133 2. A description of the vehicles involved.

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

135 4. The names and addresses of witnesses.

136 5. The name, badge number, and law enforcement agency of
137 the officer investigating the crash.

138 6. The names of the insurance companies for the respective
139 parties involved in the crash.

140 7. The names and addresses of all passengers in all

141 vehicles involved in the crash, each clearly identified as being
 142 a passenger, including the identification of the vehicle in
 143 which each was a passenger.

144 (c)~~(b)~~ In every crash for which a Florida Traffic Crash
 145 Report, Long Form, is not required by this section, the law
 146 enforcement officer may complete a short-form crash report or
 147 provide a short-form crash report to be completed by each party
 148 involved in the crash. The short-form report must include all of
 149 the items listed in subparagraphs (b)1.-6. Short-form crash
 150 reports prepared by the law enforcement officer shall be
 151 maintained by the officer's agency.÷

- 152 ~~1. The date, time, and location of the crash.~~
- 153 ~~2. A description of the vehicles involved.~~
- 154 ~~3. The names and addresses of the parties involved.~~
- 155 ~~4. The names and addresses of witnesses.~~
- 156 ~~5. The name, badge number, and law enforcement agency of~~
 157 ~~the officer investigating the crash.~~
- 158 ~~6. The names of the insurance companies for the respective~~
 159 ~~parties involved in the crash.~~

160 (d)~~(e)~~ Each party to the crash must ~~shall~~ provide the law
 161 enforcement officer with proof of insurance, which must ~~to~~ be
 162 included in the crash report. If a law enforcement officer
 163 submits a report on the accident, proof of insurance must be
 164 provided to the officer by each party involved in the crash. Any
 165 party who fails to provide the required information commits a
 166 noncriminal traffic infraction, punishable as a nonmoving
 167 violation as provided in chapter 318, unless the officer
 168 determines that due to injuries or other special circumstances

169 such insurance information cannot be provided immediately. If
 170 the person provides the law enforcement agency, within 24 hours
 171 after the crash, proof of insurance that was valid at the time
 172 of the crash, the law enforcement agency may void the citation.

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

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

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

190 Section 3. Subsection (6) is added to section 400.991,
 191 Florida Statutes, to read:

192 400.991 License requirements; background screenings;
 193 prohibitions.—

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

197
 198 INSURANCE FRAUD NOTICE.—Submitting a false,
 199 misleading, or fraudulent application or other
 200 document when applying for licensure as a health care
 201 clinic, when seeking an exemption from licensure as a
 202 health care clinic, or when demonstrating compliance
 203 with part X of chapter 400, Florida Statutes, is a
 204 criminal act under s. 817.234, Florida Statutes, or a
 205 fraudulent insurance act as defined in s. 626.989,
 206 Florida Statutes, subject to investigation by the
 207 Division of Insurance Fraud, and is grounds for
 208 discipline by the appropriate licensing board of the
 209 Florida Department of Health.

210 Section 4. Section 627.730, Florida Statutes, is amended
 211 to read:

212 627.730 Florida Motor Vehicle No-Fault Law.—Sections
 213 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the
 214 "Florida Motor Vehicle No-Fault Law."

215 Section 5. Section 627.731, Florida Statutes, is amended
 216 to read:

217 627.731 Purpose; legislative intent.—

218 (1) The purpose of the no-fault law ~~ss. 627.730-627.7405~~
 219 is to provide for medical, surgical, funeral, and disability
 220 insurance benefits without regard to fault, and to require motor
 221 vehicle insurance securing such benefits, for motor vehicles
 222 required to be registered in this state and, with respect to
 223 motor vehicle accidents, a limitation on the right to claim
 224 damages for pain, suffering, mental anguish, and inconvenience.

225 (2) The Legislature intends that the provisions,
 226 schedules, and procedures authorized under the no-fault law be
 227 implemented by the insurers offering policies pursuant to the
 228 no-fault law. These provisions, schedules, and procedures have
 229 full force and effect regardless of their express inclusion in
 230 an insurance policy, and an insurer is not required to amend its
 231 policy to implement and apply such provisions, schedules, or
 232 procedures.

233 Section 6. Section 627.732, Florida Statutes, is amended
 234 to read:

235 627.732 Definitions.—As used in the no-fault law ~~ss.~~
 236 ~~627.730-627.7405~~, the term:

237 (1) "Broker" means any person not possessing a license
 238 under chapter 395, chapter 400, chapter 429, chapter 458,
 239 chapter 459, chapter 460, chapter 461, or chapter 641 who
 240 charges or receives compensation for any use of medical
 241 equipment and is not the 100-percent owner or the 100-percent
 242 lessee of such equipment. For purposes of this section, such
 243 owner or lessee may be an individual, a corporation, a
 244 partnership, or any other entity and any of its 100-percent-
 245 owned affiliates and subsidiaries. For purposes of this
 246 subsection, the term "lessee" means a long-term lessee under a
 247 capital or operating lease, but does not include a part-time
 248 lessee. The term "broker" does not include a hospital or
 249 physician management company whose medical equipment is
 250 ancillary to the practices managed, a debt collection agency, or
 251 an entity that has contracted with the insurer to obtain a
 252 discounted rate for such services; or ~~nor does the term include~~

253 a management company that has contracted to provide general
 254 management services for a licensed physician or health care
 255 facility and whose compensation is not materially affected by
 256 the usage or frequency of usage of medical equipment or an
 257 entity that is 100-percent owned by one or more hospitals or
 258 physicians. The term "broker" does not include a person or
 259 entity that certifies, upon request of an insurer, that:

- 260 (a) It is a clinic licensed under ss. 400.990-400.995;
- 261 (b) It is a 100-percent owner of medical equipment; and
- 262 (c) The owner's only part-time lease of medical equipment
 263 for personal injury protection patients is on a temporary basis,l
 264 not to exceed 30 days in a 12-month period, and such lease is
 265 solely for the purposes of necessary repair or maintenance of
 266 the 100-percent-owned medical equipment or pending the arrival
 267 and installation of the newly purchased or a replacement for the
 268 100-percent-owned medical equipment, or for patients for whom,
 269 because of physical size or claustrophobia, it is determined by
 270 the medical director or clinical director to be medically
 271 necessary that the test be performed in medical equipment that
 272 is open-style. The leased medical equipment may not ~~cannot~~ be
 273 used by patients who are not patients of the registered clinic
 274 ~~for medical treatment of services~~. Any person or entity making a
 275 false certification under this subsection commits insurance
 276 fraud as defined in s. 817.234. However, the 30-day period
 277 ~~provided in this paragraph~~ may be extended for an additional 60
 278 days as applicable to magnetic resonance imaging equipment if
 279 the owner certifies that the extension otherwise complies with
 280 this paragraph.

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281 (2)~~(7)~~ "Certify" means to swear or attest to being true or
 282 represented in writing.

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

285 (4)~~(12)~~ "Hospital" means a facility that, at the time
 286 services or treatment were rendered, was licensed under chapter
 287 395.

288 (5)~~(8)~~ "Immediate personal supervision," as it relates to
 289 the performance of medical services by nonphysicians not in a
 290 hospital, means that an individual licensed to perform the
 291 medical service or provide the medical supplies must be present
 292 within the confines of the physical structure where the medical
 293 services are performed or where the medical supplies are
 294 provided such that the licensed individual can respond
 295 immediately to any emergencies if needed.

296 (6)~~(9)~~ "Incident," with respect to services considered as
 297 incident to a physician's professional service, for a physician
 298 licensed under chapter 458, chapter 459, chapter 460, or chapter
 299 461, if not furnished in a hospital, means ~~such~~ services that
 300 are ~~must be~~ an integral, even if incidental, part of a covered
 301 physician's service.

302 (7)~~(10)~~ "Knowingly" means that a person, with respect to
 303 information, has actual knowledge of the information, and acts in
 304 deliberate ignorance of the truth or falsity of the
 305 information, and or acts in reckless disregard of the information, and
 306 ~~and~~ Proof of specific intent to defraud is not required.

307 (8)~~(11)~~ "Lawful" or "lawfully" means in substantial
 308 compliance with all relevant applicable criminal, civil, and

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309 administrative requirements of state and federal law related to
 310 the provision of medical services or treatment.

311 (9)~~(2)~~ "Medically necessary" refers to a medical service
 312 or supply that a prudent physician would provide for the purpose
 313 of preventing, diagnosing, or treating an illness, injury,
 314 disease, or symptom in a manner that is:

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

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

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

321 (10)~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
 322 with four or more wheels that ~~which~~ is of a type both designed
 323 and required to be licensed for use on the highways of this
 324 state, and any trailer or semitrailer designed for use with such
 325 vehicle, and includes:

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

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

333
 334 The term "motor vehicle" does not include a mobile home or any
 335 motor vehicle that ~~which~~ is used in mass transit, other than
 336 public school transportation, and designed to transport more

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

340 (11)~~(4)~~ "Named insured" means a person, usually the owner
 341 of a vehicle, identified in a policy by name as the insured
 342 under the policy.

343 (12) "No-fault law" means the Florida Motor Vehicle No-
 344 Fault Law, ss. 627.730-627.7407.

345 (13)~~(5)~~ "Owner" means a person who holds the legal title
 346 to a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
 347 subject of a security agreement or lease with an option to
 348 purchase with the debtor or lessee having the right to
 349 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
 350 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405.~~

351 (14)~~(13)~~ "Properly completed" means providing truthful,
 352 substantially complete, and substantially accurate responses ~~as~~
 353 to all material elements of ~~to~~ each applicable request for
 354 information or statement by a means that may lawfully be
 355 provided and that complies with this section, or as agreed by
 356 the parties.

357 (15)~~(6)~~ "Relative residing in the same household" means a
 358 relative of any degree by blood or by marriage who usually makes
 359 her or his home in the same family unit, whether or not
 360 temporarily living elsewhere.

361 (16)~~(15)~~ "Unbundling" means submitting ~~an action that~~
 362 ~~submits~~ a billing code that is properly billed under one billing
 363 code, but that has been separated into two or more billing
 364 codes, and would result in payment greater than the ~~in~~ amount

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365 that ~~than~~ would be paid using one billing code.

366 (17)~~(14)~~ "Upcoding" means submitting ~~an action that~~
 367 ~~submits~~ a billing code that would result in payment greater than
 368 the ~~in~~ amount that ~~than~~ would be paid using a billing code that
 369 accurately describes the services performed. The term does not
 370 include an otherwise lawful bill by a magnetic resonance imaging
 371 facility, which globally combines both technical and
 372 professional components, if the amount of the global bill is not
 373 more than the components if billed separately; however, payment
 374 of such a bill constitutes payment in full for all components of
 375 such service.

376 Section 7. Subsections (1), (3), and (4) of section
 377 627.736, Florida Statutes, are amended, subsections (5) through
 378 (16) of that section are renumbered as subsections (6) through
 379 (17), respectively, a new subsection (5) is added to that
 380 section, and present subsections (5), (6), (8), and (9),
 381 paragraph (b) of present subsection (7), and present subsection
 382 (16) of that section are amended, to read:

383 627.736 Required personal injury protection benefits;
 384 exclusions; priority; claims.—

385 (1) REQUIRED BENEFITS.—Every insurance policy complying
 386 with the security requirements of s. 627.733 must ~~shall~~ provide
 387 personal injury protection to the named insured, relatives
 388 residing in the same household, persons operating the insured
 389 motor vehicle, passengers in such motor vehicle, and other
 390 persons struck by such motor vehicle and suffering bodily injury
 391 while not an occupant of a self-propelled vehicle, subject to
 392 ~~the provisions of~~ subsection (2) and paragraph (4) (g) ~~(4) (e)~~, to

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393 a limit of \$10,000 for loss sustained by ~~any~~ such person as a
 394 result of bodily injury, sickness, disease, or death arising out
 395 of the ownership, maintenance, or use of a motor vehicle as
 396 follows:

397 (a) Medical benefits.—Eighty percent of ~~all reasonable~~
 398 expenses for medically necessary medical, surgical, X-ray,
 399 dental, and rehabilitative services, including prosthetic
 400 devices, and for medically necessary ambulance, hospital, and
 401 nursing services. However, the medical benefits ~~shall~~ provide
 402 reimbursement only for such services and care that are lawfully
 403 provided, supervised, ordered, or prescribed by a physician
 404 licensed under chapter 458 or chapter 459, a dentist licensed
 405 under chapter 466, or a chiropractic physician licensed under
 406 chapter 460 or that are provided by any of the following ~~persons~~
 407 ~~or entities~~:

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

410 2. A person or entity licensed under part III of chapter
 411 401 that ss. 401.2101-401.45 that provides emergency
 412 transportation and treatment.

413 3. An entity wholly owned by one or more physicians
 414 licensed under chapter 458 or chapter 459, chiropractic
 415 physicians licensed under chapter 460, or dentists licensed
 416 under chapter 466 or by such ~~practitioner or practitioners and~~
 417 the spouses, parents, children, or siblings ~~spouse, parent,~~
 418 ~~child, or sibling~~ of such ~~that practitioner or those~~
 419 practitioners.

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

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421 hospital or hospitals.

422 5. A health care clinic licensed under part X of chapter
 423 400 ~~ss. 400.990-400.995~~ that is:

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

429 b. A health care clinic that:

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

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

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

439 (A) General medicine.

440 (B) Radiography.

441 (C) Orthopedic medicine.

442 (D) Physical medicine.

443 (E) Physical therapy.

444 (F) Physical rehabilitation.

445 (G) Prescribing or dispensing outpatient prescription
 446 medication.

447 (H) Laboratory services.

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449 If any services under this paragraph are provided by an entity
450 or clinic described in subparagraph 3., subparagraph 4., or
451 subparagraph 5., the entity or clinic must provide the insurer
452 at the initial submission of the claim with a form adopted by
453 the Department of Financial Services that documents that the
454 entity or clinic meets applicable criteria for such entity or
455 clinic and includes a sworn statement or affidavit to that
456 effect. Any change in ownership requires the filing of a new
457 form within 10 days after the date of the change in ownership.
458 ~~The Financial Services Commission shall adopt by rule the form~~
459 ~~that must be used by an insurer and a health care provider~~
460 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
461 ~~5. to document that the health care provider meets the criteria~~
462 ~~of this paragraph, which rule must include a requirement for a~~
463 ~~sworn statement or affidavit.~~

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

474 (c) Death benefits.—Death benefits equal to the lesser of
475 \$5,000 or the remainder of unused personal injury protection
476 benefits per individual. The insurer may pay such benefits to

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477 the executor or administrator of the deceased, to any of the
 478 deceased's relatives by blood, ~~or~~ legal adoption, ~~or connection~~
 479 ~~by~~ marriage, or to any person appearing to the insurer to be
 480 equitably entitled thereto.

481
 482 Only insurers writing motor vehicle liability insurance in this
 483 state may provide the required benefits of this section, and ~~no~~
 484 such insurers may not ~~insurer shall~~ require the purchase of any
 485 other motor vehicle coverage other than the purchase of property
 486 damage liability coverage as required by s. 627.7275 as a
 487 condition for providing such ~~required~~ benefits. Insurers may not
 488 require that property damage liability insurance in an amount
 489 greater than \$10,000 be purchased in conjunction with personal
 490 injury protection. Such insurers shall make benefits and
 491 required property damage liability insurance coverage available
 492 through normal marketing channels. An ~~Any~~ insurer writing motor
 493 vehicle liability insurance in this state who fails to comply
 494 with such availability requirement as a general business
 495 practice violates ~~shall be deemed to have violated~~ part IX of
 496 chapter 626, and such violation constitutes ~~shall constitute~~ an
 497 unfair method of competition or an unfair or deceptive act or
 498 practice involving the business of insurance. An; ~~and any such~~
 499 insurer committing such violation is ~~shall be~~ subject to the
 500 penalties afforded in such part, as well as those that are ~~which~~
 501 ~~may be~~ afforded elsewhere in the insurance code.

502 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
 503 TORT CLAIMS.—An ~~No~~ insurer shall not have a lien on any recovery
 504 in tort by judgment, settlement, or otherwise for personal

505 injury protection benefits, whether suit has been filed or
 506 settlement has been reached without suit. An injured party who
 507 is entitled to bring suit under the no-fault law ~~provisions of~~
 508 ~~ss. 627.730-627.7405~~, or his or her legal representative, shall
 509 have no right to recover any damages for which personal injury
 510 protection benefits are paid or payable. The plaintiff may prove
 511 all of his or her special damages notwithstanding this
 512 limitation, but if special damages are introduced in evidence,
 513 the trier of facts, whether judge or jury, shall not award
 514 damages for personal injury protection benefits paid or payable.
 515 In all cases in which a jury is required to fix damages, the
 516 court shall instruct the jury that the plaintiff shall not
 517 recover such special damages for personal injury protection
 518 benefits paid or payable.

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

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

537 (b) Personal injury protection insurance benefits paid
 538 pursuant to this section are ~~shall be~~ overdue if not paid within
 539 30 days after the insurer is furnished written notice of the
 540 fact of a covered loss and of the amount of same. If such
 541 written notice is not furnished to the insurer as to the entire
 542 claim, any partial amount supported by written notice is overdue
 543 if not paid within 30 days after such written notice is
 544 furnished to the insurer. Any part or all of the remainder of
 545 the claim that is subsequently supported by written notice is
 546 overdue if not paid within 30 days after such written notice is
 547 furnished to the insurer.

548 (c) ~~If when~~ an insurer pays only a portion of a claim or
 549 rejects a claim, the insurer shall provide at the time of the
 550 partial payment or rejection an itemized specification of each
 551 item that the insurer had reduced, omitted, or declined to pay
 552 and any information that the insurer desires the claimant to
 553 consider related to the medical necessity of the denied
 554 treatment or to explain the reasonableness of the reduced
 555 charge, provided that this does ~~shall~~ not limit the introduction
 556 of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the
 557 name and address of the person to whom the claimant should
 558 respond and a claim number to be referenced in future
 559 correspondence.

560 (d) ~~A However, notwithstanding the fact that written~~

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561 ~~notice has been furnished to the insurer, Any payment is shall~~
 562 ~~not be deemed~~ overdue if ~~when~~ the insurer has reasonable proof
 563 ~~to establish~~ that the insurer is not responsible for ~~the~~
 564 payment. For the purpose of calculating the extent to which any
 565 benefits are overdue, payment shall be treated as being made on
 566 the date a draft or other valid instrument ~~which is~~ equivalent
 567 to payment was placed in the United States mail in a properly
 568 addressed, postpaid envelope or, if not so posted, on the date
 569 of delivery. This paragraph does not preclude or limit the
 570 ability of the insurer to assert that the claim is ~~was~~
 571 unrelated, ~~was~~ not medically necessary, ~~or was~~ unreasonable, or
 572 submitted ~~that the amount of the charge was in excess of that~~
 573 ~~permitted under, or in violation of,~~ subsection (6) ~~(5)~~. Such
 574 ~~assertion by the insurer may be made~~ at any time, including
 575 after payment of the claim or after the 30-day ~~time~~ period for
 576 payment set forth in ~~this~~ paragraph (b). The 30-day period for
 577 payment or denial is tolled with respect to any portion of a
 578 claim for which the insurer has a reasonable belief that a
 579 fraudulent insurance act as defined in s. 626.989 has been
 580 committed while the insurer investigates such act. The insurer
 581 must notify the claimant in writing that it is investigating a
 582 fraudulent insurance act within 30 days after the date it has a
 583 reasonable belief that such act has been committed. The insurer
 584 must pay or deny the claim, in full or in part, within 120 days
 585 after the date the written notice of the fact of a covered loss
 586 and of the amount of the loss was provided to the insurer.

587 (e) ~~(e)~~ Upon receiving notice of an accident that is
 588 potentially covered by personal injury protection benefits, the

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589 insurer must reserve \$5,000 of personal injury protection
590 benefits for payment to physicians licensed under chapter 458 or
591 chapter 459 or dentists licensed under chapter 466 who provide
592 emergency services and care, as defined in s. 395.002~~(9)~~, or who
593 provide hospital inpatient care. The amount required to be held
594 in reserve may be used only to pay claims from such physicians
595 or dentists until 30 days after the date the insurer receives
596 notice of the accident. After the 30-day period, any amount of
597 the reserve for which the insurer has not received notice of
598 such a claim ~~from a physician or dentist who provided emergency~~
599 ~~services and care or who provided hospital inpatient care~~ may
600 ~~then~~ be used by the insurer to pay other claims. The time
601 periods specified in paragraph (b) for ~~required~~ payment of
602 personal injury protection benefits are ~~shall be~~ tolled for the
603 period of time that an insurer is required ~~by this paragraph~~ to
604 hold payment of a claim that is not from a physician or dentist
605 who provided emergency services and care or who provided
606 hospital inpatient care to the extent that the personal injury
607 protection benefits not held in reserve are insufficient to pay
608 the claim. This paragraph does not require an insurer to
609 establish a claim reserve for insurance accounting purposes.

610 (f)~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
611 the rate established under s. 55.03 or the rate established in
612 the insurance contract, whichever is greater, for the year in
613 which the payment became overdue, calculated from the date the
614 insurer was furnished with written notice of the amount of
615 covered loss. Interest is ~~shall be~~ due at the time payment of
616 the overdue claim is made.

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

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

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

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

634 4. Accidental bodily injury sustained in this state by any
 635 other person while occupying the owner's motor vehicle or, if a
 636 resident of this state, while not an occupant of a self-
 637 propelled vehicle, if the injury is caused by physical contact
 638 with such motor vehicle and if~~, provided~~ the injured person is
 639 not ~~himself or herself~~:

640 a. The owner of a motor vehicle with respect to which
 641 security is required under the no-fault law ~~ss. 627.730-~~
 642 ~~627.7405~~; or

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

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

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

656 (j)~~(h)~~ Benefits are ~~shall~~ not be due or payable to or on
 657 the behalf of a claimant who: ~~an insured person if that person~~
 658 ~~has~~

- 659 1. Submits a false or misleading statement, document,
- 660 record, or bill;
- 661 2. Submits any other false or misleading information; or
- 662 3. Has otherwise committed or attempted to commit a
- 663 fraudulent insurance act as defined in s. 626.989.

664
 665 A claimant who violates this paragraph is not entitled to any
 666 personal injury protection benefits or payment for any bills and
 667 services, regardless of whether a portion of the claim may be
 668 legitimate.

669 (k) Notwithstanding any remedies afforded by law, the
 670 insurer may recover from a claimant who has violated paragraph
 671 (j) any sums previously paid to the claimant and may bring any
 672 available common law and statutory causes of action ~~committed,~~

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673 ~~by a material act or omission, any insurance fraud relating to~~
674 ~~personal injury protection coverage under his or her policy, if~~
675 ~~the fraud is admitted to in a sworn statement by the insured or~~
676 ~~if it is established in a court of competent jurisdiction. If a~~
677 ~~physician, hospital, clinic, or other medical institution~~
678 ~~violates paragraph (j), the injured party is not liable for, and~~
679 ~~the physician, hospital, clinic, or other medical institution~~
680 ~~may not bill the insured for, charges that are unpaid because of~~
681 ~~failure to comply with paragraph (j). Any agreement requiring~~
682 ~~the injured person or insured to pay for such charges is~~
683 ~~unenforceable. Any insurance fraud shall void all coverage~~
684 ~~arising from the claim related to such fraud under the personal~~
685 ~~injury protection coverage of the insured person who committed~~
686 ~~the fraud, irrespective of whether a portion of the insured~~
687 ~~person's claim may be legitimate, and any benefits paid prior to~~
688 ~~the discovery of the insured person's insurance fraud shall be~~
689 ~~recoverable by the insurer from the person who committed~~
690 ~~insurance fraud in their entirety. The prevailing party is~~
691 ~~entitled to its costs and attorney's fees in any action in which~~
692 ~~it prevails in an insurer's action to enforce its right of~~
693 ~~recovery under this paragraph.~~

694 (5) INSURER INVESTIGATIONS.—An insurer has the right and
695 duty to conduct a reasonable investigation of a claim. In the
696 course of the investigation, the insurer may require the
697 insured, claimant, or medical provider to provide copies of the
698 treatment and examination records so that the insurer can
699 provide such records to a physician for a records review. A
700 records review need not be based on a physical examination and

701 may be obtained at any time, including after reduction or denial
 702 of the claim. The 30-day period for payment under paragraph
 703 (4) (b) is tolled from the date the insurer sends its request for
 704 treatment records to the date that the insurer receives the
 705 treatment records. The claim may be denied or reduced if the
 706 medical provider fails to keep adequate records such that the
 707 insurer is unable to obtain a records review.

708 (6)~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.—

709 (a)~~1.~~ Any physician, hospital, clinic, or other person or
 710 institution lawfully rendering treatment to an injured person
 711 for a bodily injury covered by personal injury protection
 712 insurance may charge the insurer and injured party only an a
 713 ~~reasonable~~ amount pursuant to this section for the services and
 714 supplies rendered, and the insurer providing such coverage may
 715 pay for such charges directly to such person or institution
 716 lawfully rendering such treatment, if the insured receiving such
 717 treatment or his or her guardian has countersigned the properly
 718 completed invoice, bill, or claim form approved by the office
 719 upon which such charges are to be paid for as having actually
 720 been rendered, to the best knowledge of the insured or his or
 721 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
 722 exceed ~~be in excess of~~ the amount the person or institution
 723 customarily charges for like services or supplies. When
 724 determining ~~With respect to a determination of~~ whether a charge
 725 for a particular service, treatment, or otherwise is reasonable,
 726 consideration may be given to evidence of usual and customary
 727 charges and payments accepted by the provider involved in the
 728 dispute, ~~and~~ reimbursement levels in the community and various

729 federal and state medical fee schedules applicable to automobile
 730 and other insurance coverages, and other information relevant to
 731 the reasonableness of the reimbursement for the service,
 732 treatment, or supply.

733 1.2- The insurer may limit reimbursement to 80 percent of
 734 the following schedule of maximum charges:

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

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

740 c. For emergency services and care as defined by s.
 741 395.002~~(9)~~ provided in a facility licensed under chapter 395
 742 rendered by a physician or dentist, and related hospital
 743 inpatient services rendered by a physician or dentist, the usual
 744 and customary charges in the community.

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

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

753 f. For all other medical services, supplies, and care, 200
 754 percent of the allowable amount under the participating
 755 physicians schedule of Medicare Part B. However, if such
 756 services, supplies, or care is not reimbursable under Medicare

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757 Part B, the insurer may limit reimbursement to 80 percent of the
758 maximum reimbursable allowance under workers' compensation, as
759 determined under s. 440.13 and rules adopted thereunder which
760 are in effect at the time such services, supplies, or care is
761 provided. Services, supplies, or care that is not reimbursable
762 under Medicare or workers' compensation is not required to be
763 reimbursed by the insurer.

764 ~~2.3.~~ For purposes of subparagraph ~~1. 2.~~, the applicable
765 fee schedule or payment limitation under Medicare is the fee
766 schedule or payment limitation in effect on January 1 of the
767 year in which ~~at the time~~ the services, supplies, or care was
768 rendered and for the area in which such services were rendered,
769 notwithstanding any subsequent changes made to such fee schedule
770 or payment limitation, except that it may not be less than the
771 allowable amount under the participating physicians schedule of
772 Medicare Part B for 2007 for medical services, supplies, and
773 care subject to Medicare Part B.

774 ~~3.4.~~ Subparagraph ~~1. 2.~~ does not allow the insurer to
775 apply any limitation on the number of treatments or other
776 utilization limits that apply under Medicare or workers'
777 compensation. An insurer that applies the allowable payment
778 limitations of subparagraph ~~1. 2.~~ must reimburse a provider who
779 lawfully provided care or treatment under the scope of his or
780 her license, ~~regardless of whether such provider is~~ would be
781 entitled to reimbursement under Medicare due to restrictions or
782 limitations on the types or discipline of health care providers
783 who may be reimbursed for particular procedures or procedure
784 codes.

785 ~~4.5.~~ If an insurer limits payment as authorized by
 786 subparagraph 1. 2., the person providing such services,
 787 supplies, or care may not bill or attempt to collect from the
 788 insured any amount in excess of such limits, except for amounts
 789 that are not covered by the insured's personal injury protection
 790 coverage due to the coinsurance amount or maximum policy limits.

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

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

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

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

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

802 e. For any treatment or service that is upcoded, or that
 803 is unbundled if ~~when~~ such treatment or services should be
 804 bundled, in accordance with paragraph (d). To facilitate prompt
 805 payment of lawful services, an insurer may change codes that it
 806 determines to have been improperly or incorrectly upcoded or
 807 unbundled, and may make payment based on the changed codes,
 808 without affecting the right of the provider to dispute the
 809 change by the insurer if, ~~provided that~~ before doing so, the
 810 insurer contacts ~~must contact~~ the health care provider and
 811 discusses ~~discuss~~ the reasons for the insurer's change and the
 812 health care provider's reason for the coding, or makes ~~make~~ a

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813 reasonable good faith effort to do so, as documented in the
 814 insurer's file; and

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

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

838 (c)~~1~~. With respect to any treatment or service, other than
 839 medical services billed by a hospital or other provider for
 840 emergency services as defined in s. 395.002 or inpatient

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841 services rendered at a hospital-owned facility, the statement of
842 charges must be furnished to the insurer by the provider and may
843 not include, and the insurer is not required to pay, charges for
844 treatment or services rendered more than 35 days before the
845 postmark date or electronic transmission date of the statement,
846 except for past due amounts previously billed on a timely basis
847 under this paragraph, and except that, if the provider submits
848 to the insurer a notice of initiation of treatment within 21
849 days after its first examination or treatment of the claimant,
850 the statement may include charges for treatment or services
851 rendered up to, but not more than, 75 days before the postmark
852 date of the statement. The injured party is not liable for, and
853 the provider may ~~shall~~ not bill the injured party for, charges
854 that are unpaid because of the provider's failure to comply with
855 this paragraph. Any agreement requiring the injured person or
856 insured to pay for such charges is unenforceable.

857 1.2. ~~If, however,~~ the insured fails to furnish the
858 provider with the correct name and address of the insured's
859 personal injury protection insurer, the provider has 35 days
860 from the date the provider obtains the correct information to
861 furnish the insurer with a statement of the charges. The insurer
862 is not required to pay for such charges unless the provider
863 includes with the statement documentary evidence that was
864 provided by the insured during the 35-day period demonstrating
865 that the provider reasonably relied on erroneous information
866 from the insured and either:

- 867 a. A denial letter from the incorrect insurer; or
868 b. Proof of mailing, which may include an affidavit under

869 penalty of perjury, reflecting timely mailing to the incorrect
 870 address or insurer.

871 ~~2.3.~~ For emergency services and care as defined in s.
 872 395.002 rendered in a hospital emergency department or for
 873 transport and treatment rendered by an ambulance provider
 874 licensed pursuant to part III of chapter 401, the provider is
 875 not required to furnish the statement of charges within the time
 876 periods established by this paragraph, ~~and~~ and the insurer ~~is shall~~
 877 not ~~be~~ considered to have been furnished with notice of the
 878 amount of covered loss for purposes of paragraph (4) (b) until it
 879 receives a statement complying with paragraph (d), or copy
 880 thereof, which specifically identifies the place of service to
 881 be a hospital emergency department or an ambulance in accordance
 882 with billing standards recognized by the Centers for Medicare
 883 and Medicaid Services (CMS) Health Care Finance Administration.

884 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
 885 must include the following statement in type no smaller than 12
 886 points:

887
 888 BILLING REQUIREMENTS.—Florida Statutes provide that
 889 with respect to any treatment or services, other than
 890 certain hospital and emergency services, the statement
 891 of charges furnished to the insurer by the provider
 892 may not include, and the insurer and the injured party
 893 are not required to pay, charges for treatment or
 894 services rendered more than 35 days before the
 895 postmark date of the statement, except for past due
 896 amounts previously billed on a timely basis, and

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897 except that, if the provider submits to the insurer a
898 notice of initiation of treatment within 21 days after
899 its first examination or treatment of the claimant,
900 the first billing cycle statement may include charges
901 for treatment or services rendered up to, but not more
902 than, 75 days before the postmark date of the
903 statement.

904
905 (d) All statements and bills for medical services rendered
906 by any physician, hospital, clinic, or other person or
907 institution shall be submitted to the insurer on a properly
908 completed Centers for Medicare and Medicaid Services (CMS) 1500
909 form, UB 92 forms, or any other standard form approved by the
910 office or adopted by the commission for purposes of this
911 paragraph. All billings for such services rendered by providers
912 must ~~shall~~, to the extent applicable, follow the Physicians'
913 Current Procedural Terminology (CPT) or Healthcare Correct
914 Procedural Coding System (HCPCS), or ICD-9 in effect for the
915 year in which services are rendered and comply with the ~~Centers~~
916 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
917 and the American Medical Association Current Procedural
918 Terminology (CPT) Editorial Panel and Healthcare Correct
919 Procedural Coding System (HCPCS). All providers other than
920 hospitals shall include on the applicable claim form the
921 professional license number of the provider in the line or space
922 provided for "Signature of Physician or Supplier, Including
923 Degrees or Credentials." In determining compliance with
924 applicable CPT and HCPCS coding, guidance shall be provided by

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925 | the Physicians' Current Procedural Terminology (CPT) or the
 926 | Healthcare Correct Procedural Coding System (HCPCS) in effect
 927 | for the year in which services were rendered, the Office of the
 928 | Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
 929 | other authoritative treatises designated by rule by the Agency
 930 | for Health Care Administration. A ~~No~~ statement of medical
 931 | services may not include charges for medical services of a
 932 | person or entity that performed such services without possessing
 933 | the valid licenses required to perform such services. For
 934 | purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
 935 | considered to have been furnished with notice of the amount of
 936 | covered loss or medical bills due unless the statements or bills
 937 | comply with this paragraph, and unless the statements or bills
 938 | are properly completed in their entirety as to all material
 939 | provisions, with all relevant information ~~being~~ provided
 940 | ~~therein~~.

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

947 | a. The insured, or his or her guardian, must countersign
 948 | the form attesting to the fact that the services set forth
 949 | therein were actually rendered;

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

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

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

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

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

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

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

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

976 5. The original completed disclosure and acknowledgment
 977 form is ~~shall be~~ furnished to the insurer pursuant to paragraph
 978 (4) (b) and may not be electronically furnished.

979 6. This disclosure and acknowledgment form is not required
 980 for services billed by a provider for emergency services as

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

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

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

996 9. The requirements of this paragraph apply only with
 997 respect to the initial treatment or service of the insured by a
 998 provider. For subsequent treatments or service, the provider
 999 must maintain a patient log signed by the patient, in
 1000 chronological order by date of service, that is consistent with
 1001 the services being rendered to the patient as claimed. The
 1002 requirements ~~of this subparagraph~~ for maintaining a patient log
 1003 signed by the patient may be met by a hospital that maintains
 1004 medical records as required by s. 395.3025 and applicable rules
 1005 and makes such records available to the insurer upon request.

1006 (f) Upon written notification by any person, an insurer
 1007 shall investigate any claim of improper billing by a physician
 1008 or other medical provider. The insurer shall determine if the

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1009 insured was properly billed for only those services and
 1010 treatments that the insured actually received. If the insurer
 1011 determines that the insured has been improperly billed, the
 1012 insurer shall notify the insured, the person making the written
 1013 notification, and the provider of its findings and shall reduce
 1014 the amount of payment to the provider by the amount determined
 1015 to be improperly billed. If a reduction is made due to such
 1016 written notification by any person, the insurer shall pay to the
 1017 person 20 percent of the amount of the reduction, up to \$500. If
 1018 the provider is arrested due to the improper billing, ~~then~~ the
 1019 insurer shall pay to the person 40 percent of the amount of the
 1020 reduction, up to \$500.

1021 (g) An insurer may not systematically downcode with the
 1022 intent to deny reimbursement otherwise due. Such action
 1023 constitutes a material misrepresentation under s.
 1024 626.9541(1)(i)2.

1025 (7) ~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
 1026 DISPUTES.—

1027 (a) An insurer may require a claimant to submit to an
 1028 examination under oath or sworn statement as often as reasonably
 1029 requested by an insurer and at any reasonable location
 1030 designated by the insurer. Submission to an examination under
 1031 oath or sworn statement is a condition precedent to recovery or
 1032 filing suit. The insurer is not liable for benefits under the
 1033 no-fault law if the claimant fails to fully and truthfully
 1034 answer all questions asked or violates any provision of
 1035 paragraph (4)(j).

1036 1. The insurer may conduct the examination outside the

1037 presence of any other person seeking coverage.

1038 2. If an insurer requests an examination of a claimant
 1039 that is in a hospital, clinic, or other medical institution,
 1040 such claimant shall produce the persons with the most knowledge
 1041 relating to the issues set forth by the insurer in the notice of
 1042 examination.

1043 3. The claimant must provide the insurer at the
 1044 examination with all documents, papers, receipts, invoices,
 1045 bills, records, or other tangible items requested by the
 1046 insurer.

1047 4. The examination may be recorded by audio, video, or
 1048 court report or any combination thereof. The claimant may record
 1049 the examination at the claimant's expense.

1050 5. The claimant may have an attorney present at the
 1051 examination at the claimant's expense.

1052 6. An insurer that unreasonably requests an examination
 1053 without a reasonable basis as a general business practice is
 1054 engaging in an unfair insurance trade practice pursuant to s.
 1055 626.9541.

1056 ~~(a) Every employer shall, if a request is made by an~~
 1057 ~~insurer providing personal injury protection benefits under ss.~~
 1058 ~~627.730-627.7405 against whom a claim has been made, furnish~~
 1059 ~~forthwith, in a form approved by the office, a sworn statement~~
 1060 ~~of the earnings, since the time of the bodily injury and for a~~
 1061 ~~reasonable period before the injury, of the person upon whose~~
 1062 ~~injury the claim is based.~~

1063 (b) Every physician, hospital, clinic, or other medical
 1064 institution providing, before or after bodily injury upon which

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1065 a claim for personal injury protection insurance benefits is
 1066 based, any products, services, or accommodations in relation to
 1067 that or any other injury, or in relation to a condition claimed
 1068 to be connected with that or any other injury, shall, if
 1069 requested to do so by the insurer against whom the claim has
 1070 been made, permit the insurer or the insurer's representative to
 1071 conduct an onsite physical review and examination of the
 1072 treatment location, treatment apparatuses, diagnostic devices,
 1073 and any other medical equipment used for the services rendered
 1074 within 10 days after the insurer's request and furnish forthwith
 1075 a written report of the history, condition, treatment, dates,
 1076 and costs of such treatment of the injured person and why the
 1077 items identified by the insurer were reasonable in amount and
 1078 medically necessary, together with a sworn statement that the
 1079 treatment or services rendered were reasonable and necessary
 1080 with respect to the bodily injury sustained and identifying
 1081 which portion of the expenses for such treatment or services was
 1082 incurred as a result of such bodily injury, and produce
 1083 ~~forthwith,~~ and permit the inspection and copying of, his or her
 1084 or its records regarding such history, condition, treatment,
 1085 dates, and costs of treatment ~~if; provided that this does shall~~
 1086 not limit the introduction of evidence at trial. Such sworn
 1087 statement must shall read as follows: "Under penalty of perjury,
 1088 I declare that I have read the foregoing, and the facts alleged
 1089 are true, to the best of my knowledge and belief." A ~~No~~ cause of
 1090 action for violation of the physician-patient privilege or
 1091 invasion of the right of privacy may not be brought shall be
 1092 ~~permitted~~ against any physician, hospital, clinic, or other

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1093 | medical institution complying with ~~the provisions of~~ this
 1094 | section. The person requesting such records and such sworn
 1095 | statement shall pay all reasonable costs connected therewith. If
 1096 | an insurer makes a written request for documentation or
 1097 | information under this paragraph within 30 days after having
 1098 | received notice of the amount of a covered loss under paragraph
 1099 | (4) (a), the amount or the partial amount that ~~which~~ is the
 1100 | subject of the insurer's inquiry is ~~shall become~~ overdue if the
 1101 | insurer does not pay in accordance with paragraph (4) (b) or
 1102 | within 10 days after the insurer's receipt of the requested
 1103 | documentation or information, whichever occurs later. For
 1104 | purposes of this paragraph, the term "receipt" includes, but is
 1105 | not limited to, inspection and copying pursuant to this
 1106 | paragraph. An ~~Any~~ insurer that requests documentation or
 1107 | information pertaining to reasonableness of charges or medical
 1108 | necessity under this paragraph without a reasonable basis for
 1109 | such requests as a general business practice is engaging in an
 1110 | unfair trade practice under the insurance code.

1111 | (c) If a request is made by an insurer, an employer must
 1112 | furnish, in a form approved by the office, a sworn statement of
 1113 | the earnings of the person upon whose injury a claim is based
 1114 | since the time of the bodily injury and for a reasonable period
 1115 | before the injury.

1116 | (d) (e) If there is a ~~In the event of any~~ dispute regarding
 1117 | an insurer's right to discovery of facts under this section, the
 1118 | insurer may petition the ~~a court of competent jurisdiction~~ to
 1119 | enter an order permitting such discovery. The order may be made
 1120 | only on motion for good cause shown and upon notice to all

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1121 persons having an interest, and must ~~it shall~~ specify the time,
 1122 place, manner, conditions, and scope of the discovery. The ~~Such~~
 1123 court may, in order to protect against annoyance, embarrassment,
 1124 or oppression, as justice requires, enter an order refusing
 1125 discovery or specifying conditions of discovery and ~~may~~ order
 1126 payments of costs and expenses of the proceeding, including
 1127 reasonable fees for the appearance of attorneys at the
 1128 proceedings, as justice requires.

1129 (8) ~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
 1130 REPORTS.—

1131 (b) If requested by the person examined, a party causing
 1132 an examination to be made shall deliver to him or her a copy of
 1133 every written report concerning the examination rendered by an
 1134 examining physician, at least one of which reports must set out
 1135 the examining physician's findings and conclusions in detail.
 1136 After such request and delivery, the party causing the
 1137 examination to be made is entitled, upon request, to receive
 1138 from the person examined every written report available to him
 1139 or her or his or her representative concerning any examination,
 1140 previously or thereafter made, of the same mental or physical
 1141 condition. By requesting and obtaining a report of the
 1142 examination so ordered, or by taking the deposition of the
 1143 examiner, the person examined waives any privilege he or she may
 1144 have, in relation to the claim for benefits, regarding the
 1145 testimony of every other person who has examined, or may
 1146 thereafter examine, him or her in respect to the same mental or
 1147 physical condition. If a person unreasonably refuses to submit
 1148 to an examination, the personal injury protection carrier is no

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1149 longer liable for ~~subsequent~~ personal injury protection benefits
 1150 incurred after the date of the first request for examination.
 1151 Failure to appear for an examination raises a rebuttable
 1152 presumption that such failure was unreasonable. Submission to an
 1153 examination is a condition precedent to the recovery of
 1154 benefits.

1155 (9)~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 1156 FEES.—With respect to any dispute ~~under the provisions of ss.~~
 1157 ~~627.730–627.7405~~ between the insured and the insurer under the
 1158 no-fault law~~7~~ or between an assignee of an insured's rights and
 1159 the insurer, ~~the provisions of s. 627.428 applies shall apply,~~
 1160 except as provided in subsections (11) and (16) ~~(10) and (15)~~.

1161 (10)~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and
 1162 enter into contracts with preferred ~~licensed health care~~
 1163 providers for the benefits described in this section, ~~referred~~
 1164 ~~to in this section as "preferred providers,"~~ which shall include
 1165 health care providers licensed under chapter ~~chapters~~ 458,
 1166 chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

1167 (a) The insurer may provide an option to an insured to use
 1168 a preferred provider at the time of purchase of the policy for
 1169 personal injury protection benefits~~7~~, if the requirements of this
 1170 subsection are met. However, if the insurer offers a preferred
 1171 provider option, it must also offer a nonpreferred provider
 1172 policy. ~~If the insured elects to use a provider who is not a~~
 1173 ~~preferred provider, whether the insured purchased a preferred~~
 1174 ~~provider policy or a nonpreferred provider policy, the medical~~
 1175 ~~benefits provided by the insurer shall be as required by this~~
 1176 ~~section.~~

1177 **(b)** If the insured elects the ~~to use a provider who is a~~
 1178 preferred provider option, the insurer may pay medical benefits
 1179 in excess of the benefits required by this section and may waive
 1180 or lower the amount of any deductible that applies to such
 1181 medical benefits. As an alternative, or in addition to such
 1182 benefits, waiver, or reduction, the insurer may provide an
 1183 actuarially appropriate premium discount as specified in an
 1184 approved rate filing to an insured who selects the preferred
 1185 provider option. If the preferred provider option provides a
 1186 premium discount, the policy may provide that charges for
 1187 nonemergency services provided within this state are payable
 1188 only if performed by members of the preferred provider network
 1189 unless there is no member of the preferred provider network
 1190 located within 15 miles of the insured's place of residence
 1191 whose scope of practice includes the required services. ~~If the~~
 1192 ~~insurer offers a preferred provider policy to a policyholder or~~
 1193 ~~applicant, it must also offer a nonpreferred provider policy.~~

1194 **(c)** The insurer shall provide each insured ~~policyholder~~
 1195 with a current roster of preferred providers in the county in
 1196 which the insured resides at the time of purchasing ~~purchase of~~
 1197 such policy, ~~and shall~~ make such list available for public
 1198 inspection during regular business hours at the insurer's
 1199 principal office ~~of the insurer~~ within the state. The insurer
 1200 may contract with another health insurer for the right to use an
 1201 existing preferred provider network to implement the preferred
 1202 provider option. Any other arrangement is subject to the
 1203 approval of the Office of Insurance Regulation.

1204 **(17)-(16)** SECURE ELECTRONIC DATA TRANSFER.—If all parties

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1205 mutually and expressly agree, a notice, documentation,
 1206 transmission, or communication of any kind required or
 1207 authorized under the no-fault law ss. ~~627.730-627.7405~~ may be
 1208 transmitted electronically if it is transmitted by secure
 1209 electronic data transfer that is consistent with state and
 1210 federal privacy and security laws.

1211 Section 8. Paragraph (c) of subsection (7) of section
 1212 817.234, Florida Statutes, is amended, present subsection (12)
 1213 of that section is renumbered as subsection (13), and a new
 1214 subsection (12) is added to that section, to read:

1215 817.234 False and fraudulent insurance claims.—

1216 (7)

1217 (c) An insurer, or any person acting at the direction of
 1218 or on behalf of an insurer, may not change an opinion in a
 1219 mental or physical report prepared under s. 627.736(8)
 1220 ~~627.736(7)~~ or direct the physician preparing the report to
 1221 change such opinion; however, this provision does not preclude
 1222 the insurer from calling to the attention of the physician
 1223 errors of fact in the report based upon information in the claim
 1224 file. Any person who violates this paragraph commits a felony of
 1225 the third degree, punishable as provided in s. 775.082, s.
 1226 775.083, or s. 775.084.

1227 (12) In addition to any criminal liability, a person
 1228 convicted of violating any provision of this section for the
 1229 purpose of receiving insurance proceeds from a motor vehicle
 1230 insurance contract is subject to a civil penalty.

1231 (a) Except for a violation of subsection (9), the civil
 1232 penalty shall be:

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- 1233 1. A fine up to \$5,000 for a first offense.
- 1234 2. A fine greater than \$5,000, but not to exceed \$10,000,
 1235 for a second offense.
- 1236 3. A fine greater than \$10,000, but not to exceed \$15,000,
 1237 for a third or subsequent offense.
- 1238 (b) The civil penalty for a violation of subsection
 1239 (9) must be at least \$15,000 but may not exceed \$50,000.
- 1240 (c) The civil penalty shall be paid to the Insurance
 1241 Regulatory Trust Fund within the Department of Financial
 1242 Services and used by the department for the investigation and
 1243 prosecution of insurance fraud.
- 1244 (d) This subsection does not prohibit a state attorney
 1245 from entering into a written agreement in which the person
 1246 charged with the violation does not admit to or deny the charges
 1247 but consents to payment of the civil penalty.

1248 Section 9. Subsection (1) of section 324.021, Florida
 1249 Statutes, is amended to read:

1250 324.021 Definitions; minimum insurance required.—The
 1251 following words and phrases when used in this chapter shall, for
 1252 the purpose of this chapter, have the meanings respectively
 1253 ascribed to them in this section, except in those instances
 1254 where the context clearly indicates a different meaning:

1255 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
 1256 is designed and required to be licensed for use upon a highway,
 1257 including trailers and semitrailers designed for use with such
 1258 vehicles, except traction engines, road rollers, farm tractors,
 1259 power shovels, and well drillers, and every vehicle that ~~which~~
 1260 is propelled by electric power obtained from overhead wires but

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1261 not operated upon rails, but not including any bicycle or moped.
 1262 However, the term does ~~"motor vehicle"~~ shall not include a any
 1263 motor vehicle as defined in s. 627.732(3) if ~~when~~ the owner of
 1264 such vehicle has complied with the no-fault law ~~requirements of~~
 1265 ~~ss. 627.730-627.7405, inclusive,~~ unless the provisions of s.
 1266 324.051 apply; and, in such case, the applicable proof of
 1267 insurance provisions of s. 320.02 apply.

1268 Section 10. Paragraph (k) of subsection (2) of section
 1269 456.057, Florida Statutes, is amended to read:

1270 456.057 Ownership and control of patient records; report
 1271 or copies of records to be furnished.—

1272 (2) As used in this section, the terms "records owner,"
 1273 "health care practitioner," and "health care practitioner's
 1274 employer" do not include any of the following persons or
 1275 entities; furthermore, the following persons or entities are not
 1276 authorized to acquire or own medical records, but are authorized
 1277 under the confidentiality and disclosure requirements of this
 1278 section to maintain those documents required by the part or
 1279 chapter under which they are licensed or regulated:

1280 (k) Persons or entities practicing under s. 627.736(8)
 1281 ~~627.736(7)~~.

1282 Section 11. Subsection (7) of section 627.7295, Florida
 1283 Statutes, is amended to read:

1284 627.7295 Motor vehicle insurance contracts.—

1285 (7) A policy of private passenger motor vehicle insurance
 1286 or a binder for such a policy may be initially issued in this
 1287 state only if the insurer or agent has collected from the
 1288 insured an amount equal to 2 months' premium. An insurer, agent,

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1289 | or premium finance company may not, directly or indirectly, take
 1290 | any action resulting in the insured having paid from the
 1291 | insured's own funds an amount less than the 2 months' premium
 1292 | required by this subsection. This subsection applies without
 1293 | regard to whether the premium is financed by a premium finance
 1294 | company or is paid pursuant to a periodic payment plan of an
 1295 | insurer or an insurance agent. This subsection does not apply if
 1296 | an insured or member of the insured's family is renewing or
 1297 | replacing a policy or a binder for such policy written by the
 1298 | same insurer or a member of the same insurer group. This
 1299 | subsection does not apply to an insurer that issues private
 1300 | passenger motor vehicle coverage primarily to active duty or
 1301 | former military personnel or their dependents. This subsection
 1302 | does not apply if all policy payments are paid pursuant to a
 1303 | payroll deduction plan or an automatic electronic funds transfer
 1304 | payment plan from the policyholder, provided that the first
 1305 | policy payment is made by cash, cashier's check, check, or a
 1306 | money order. This subsection and subsection (4) do not apply if
 1307 | all policy payments to an insurer are paid pursuant to an
 1308 | automatic electronic funds transfer payment plan from an agent,
 1309 | a managing general agent, or a premium finance company and if
 1310 | the policy includes, at a minimum, personal injury protection
 1311 | pursuant to ss. 627.730-627.7407 ~~627.730-627.7405~~; motor vehicle
 1312 | property damage liability pursuant to s. 627.7275; and bodily
 1313 | injury liability in at least the amount of \$10,000 because of
 1314 | bodily injury to, or death of, one person in any one accident
 1315 | and in the amount of \$20,000 because of bodily injury to, or
 1316 | death of, two or more persons in any one accident. This

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1317 subsection and subsection (4) do not apply if an insured has had
 1318 a policy in effect for at least 6 months, the insured's agent is
 1319 terminated by the insurer that issued the policy, and the
 1320 insured obtains coverage on the policy's renewal date with a new
 1321 company through the terminated agent.

1322 Section 12. Subsections (3) and (4) of section 627.733,
 1323 Florida Statutes, are amended to read:

1324 627.733 Required security.—

1325 (3) Such security shall be provided:

1326 (a) By an insurance policy delivered or issued for
 1327 delivery in this state by an authorized or eligible motor
 1328 vehicle liability insurer which provides the benefits and
 1329 exemptions contained in the no-fault law ~~ss. 627.730-627.7405~~.

1330 Any policy of insurance represented or sold as providing the
 1331 security required hereunder shall be deemed to provide insurance
 1332 for the payment of the required benefits; or

1333 (b) By any other method authorized by s. 324.031(2), (3),
 1334 or (4) and approved by the Department of Highway Safety and
 1335 Motor Vehicles as affording security equivalent to that afforded
 1336 by a policy of insurance or by self-insuring as authorized by s.
 1337 768.28(16). The person filing such security shall have all of
 1338 the obligations and rights of an insurer under the no-fault law
 1339 ~~ss. 627.730-627.7405~~.

1340 (4) An owner of a motor vehicle with respect to which
 1341 security is required by this section who fails to have such
 1342 security in effect at the time of an accident shall have no
 1343 immunity from tort liability, but shall be personally liable for
 1344 the payment of benefits under s. 627.736. With respect to such

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1345 benefits, such an owner shall have all of the rights and
 1346 obligations of an insurer under the no-fault law ~~ss. 627.730-~~
 1347 ~~627.7405.~~

1348 Section 13. Section 627.734, Florida Statutes, is amended
 1349 to read:

1350 627.734 Proof of security; security requirements;
 1351 penalties.—

1352 (1) The provisions of chapter 324 that ~~which~~ pertain to
 1353 the method of giving and maintaining proof of financial
 1354 responsibility and that ~~which~~ govern and define a motor vehicle
 1355 liability policy shall apply to filing and maintaining proof of
 1356 security required by the no-fault law ~~ss. 627.730-627.7405.~~

1357 (2) Any person who:

1358 (a) Gives information required in a report or otherwise as
 1359 provided for in the no-fault law ~~ss. 627.730-627.7405~~, knowing
 1360 or having reason to believe that such information is false;

1361 (b) Forges or, without authority, signs any evidence of
 1362 proof of security; or

1363 (c) Files, or offers for filing, any such evidence of
 1364 proof, knowing or having reason to believe that it is forged or
 1365 signed without authority,

1366
 1367 commits is guilty of a misdemeanor of the first degree,
 1368 punishable as provided in s. 775.082 or s. 775.083.

1369 Section 14. Subsections (1), (2), and (3) of section
 1370 627.737, Florida Statutes, are amended to read:

1371 627.737 Tort exemption; limitation on right to damages;
 1372 punitive damages.—

1373 (1) Every owner, registrant, operator, or occupant of a
 1374 motor vehicle with respect to which security has been provided
 1375 as required by the no-fault law ~~ss. 627.730-627.7405~~, and every
 1376 person or organization legally responsible for her or his acts
 1377 or omissions, is hereby exempted from tort liability for damages
 1378 because of bodily injury, sickness, or disease arising out of
 1379 the ownership, operation, maintenance, or use of such motor
 1380 vehicle in this state to the extent that the benefits described
 1381 in s. 627.736(1) are payable for such injury, or would be
 1382 payable but for any exclusion authorized by the no-fault law ~~ss.~~
 1383 ~~627.730-627.7405~~, under any insurance policy or other method of
 1384 security complying with the requirements of s. 627.733, or by an
 1385 owner personally liable under s. 627.733 for the payment of such
 1386 benefits, unless a person is entitled to maintain an action for
 1387 pain, suffering, mental anguish, and inconvenience for such
 1388 injury under ~~the provisions of~~ subsection (2).

1389 (2) In any action of tort brought against the owner,
 1390 registrant, operator, or occupant of a motor vehicle with
 1391 respect to which security has been provided as required by the
 1392 no-fault law ~~ss. 627.730-627.7405~~, or against any person or
 1393 organization legally responsible for her or his acts or
 1394 omissions, a plaintiff may recover damages in tort for pain,
 1395 suffering, mental anguish, and inconvenience because of bodily
 1396 injury, sickness, or disease arising out of the ownership,
 1397 maintenance, operation, or use of such motor vehicle only in the
 1398 event that the injury or disease consists in whole or in part
 1399 of:

1400 (a) Significant and permanent loss of an important bodily

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1401 function.

1402 (b) Permanent injury within a reasonable degree of medical
1403 probability, other than scarring or disfigurement.

1404 (c) Significant and permanent scarring or disfigurement.

1405 (d) Death.

1406 (3) When a defendant, in a proceeding brought pursuant to
1407 the no-fault law ~~ss. 627.730-627.7405~~, questions whether the
1408 plaintiff has met the requirements of subsection (2), ~~then~~ the
1409 defendant may file an appropriate motion with the court, and the
1410 court shall, on a one-time basis only, 30 days before the date
1411 set for the trial or the pretrial hearing, whichever is first,
1412 by examining the pleadings and the evidence before it, ascertain
1413 whether the plaintiff will be able to submit some evidence that
1414 the plaintiff will meet the requirements of subsection (2). If
1415 the court finds that the plaintiff will not be able to submit
1416 such evidence, ~~then~~ the court shall dismiss the plaintiff's
1417 claim without prejudice.

1418 Section 15. Subsection (1) of section 627.7401, Florida
1419 Statutes, is amended to read:

1420 627.7401 Notification of insured's rights.—

1421 (1) The commission, by rule, shall adopt a form for the
1422 notification of insureds of their right to receive personal
1423 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1424 fault law. Such notice shall include:

1425 (a) A description of the benefits provided by personal
1426 injury protection, including, but not limited to, the specific
1427 types of services for which medical benefits are paid,
1428 disability benefits, death benefits, significant exclusions from

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1429 and limitations on personal injury protection benefits, when
 1430 payments are due, how benefits are coordinated with other
 1431 insurance benefits that the insured may have, penalties and
 1432 interest that may be imposed on insurers for failure to make
 1433 timely payments of benefits, and rights of parties regarding
 1434 disputes as to benefits.

1435 (b) An advisory informing insureds that:

1436 1. Pursuant to s. 626.9892, the Department of Financial
 1437 Services may pay rewards of up to \$25,000 to persons providing
 1438 information leading to the arrest and conviction of persons
 1439 committing crimes investigated by the Division of Insurance
 1440 Fraud arising from violations of s. 440.105, s. 624.15, s.
 1441 626.9541, s. 626.989, or s. 817.234.

1442 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
 1443 insured notifies the insurer of a billing error, the insured may
 1444 be entitled to a certain percentage of a reduction in the amount
 1445 paid by the insured's motor vehicle insurer.

1446 (c) A notice that solicitation of a person injured in a
 1447 motor vehicle crash for purposes of filing personal injury
 1448 protection or tort claims could be a violation of s. 817.234, s
 1449 817.505, or the rules regulating The Florida Bar and should be
 1450 immediately reported to the Division of Insurance Fraud if such
 1451 conduct has taken place.

1452 Section 16. Section 627.7405, Florida Statutes, is amended
 1453 to read:

1454 627.7405 Insurers' right of reimbursement.—Notwithstanding
 1455 any other provisions of the no-fault law ~~ss. 627.730–627.7405,~~
 1456 any insurer providing personal injury protection benefits on a

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1457 private passenger motor vehicle has ~~shall have~~, to the extent of
 1458 any personal injury protection benefits paid to any person as a
 1459 benefit arising out of such private passenger motor vehicle
 1460 insurance, a right of reimbursement against the owner or the
 1461 insurer of the owner of a commercial motor vehicle, if the
 1462 benefits paid result from such person having been an occupant of
 1463 the commercial motor vehicle or having been struck by the
 1464 commercial motor vehicle while not an occupant of any self-
 1465 propelled vehicle.

1466 Section 17. Subsection (1) of section 627.7407, Florida
 1467 Statutes, is amended to read:

1468 627.7407 Application of the Florida Motor Vehicle No-Fault
 1469 Law.—

1470 (1) Any person subject to the requirements of ~~ss. 627.730-~~
 1471 ~~627.7405~~, the Florida Motor Vehicle No-Fault Law, as revived and
 1472 amended by this act, must maintain security for personal injury
 1473 protection as required by the Florida Motor Vehicle No-Fault
 1474 Law, as revived and amended by this act, beginning on January 1,
 1475 2008.

1476 Section 18. Paragraph (d) of subsection (2) and paragraph
 1477 (d) of subsection (3) of section 628.909, Florida Statutes, are
 1478 amended to read:

1479 628.909 Applicability of other laws.—

1480 (2) The following provisions of the Florida Insurance Code
 1481 shall apply to captive insurers who are not industrial insured
 1482 captive insurers to the extent that such provisions are not
 1483 inconsistent with this part:

1484 (d) Sections 627.730-627.7407 ~~627.730-627.7405~~, when no-

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1485 | fault coverage is provided.

1486 | (3) The following provisions of the Florida Insurance Code
 1487 | shall apply to industrial insured captive insurers to the extent
 1488 | that such provisions are not inconsistent with this part:

1489 | (d) Sections 627.730-627.7407 ~~627.730-627.7405~~ when no-
 1490 | fault coverage is provided.

1491 | Section 19. This act shall take effect July 1, 2011.