

1 A bill to be entitled
2 An act relating to personal injury protection insurance;
3 amending s. 26.012, F.S.; providing that the circuit court
4 has exclusive original jurisdiction in actions involving
5 challenges to arbitration decisions under the Florida
6 Motor Vehicle No-Fault Law; amending s. 627.4137, F.S.;
7 requiring requests made to a self-insured corporation for
8 disclosure of certain information to be by certified mail;
9 creating s. 627.7311, F.S.; providing for the effect of
10 specified statutory provisions, schedules, and procedures
11 on insurance policies; amending s. 627.736, F.S.;
12 requiring an insured seeking benefits to comply with
13 policy terms as a condition precedent to receiving
14 benefits; revising a reference to Medicare Part B payments
15 as the schedule for an insurer's discretionary use when
16 limiting reimbursement of certain medical services,
17 supplies, and care; specifying the Medicare fee schedule
18 or payment limitation that is to be used by an insurer to
19 limit reimbursements for certain medical services,
20 supplies, and care; requiring that an insurer under
21 certain circumstances notify a provider of an improperly
22 completed form and provide an opportunity to submit a
23 completed form within a specified time; requiring any
24 assignee of benefits or payments to cooperate under the
25 terms of the policy; requiring a provider who is assigned
26 the benefits of an insured to submit to examination under
27 oath under certain circumstances; requiring a provider to
28 produce certain knowledgeable individuals for examination

29 | under oath under certain circumstances; requiring certain
30 | records be provided by claimants for inspection if
31 | requested by an insurer; authorizing methods for recording
32 | examinations under oath; providing that certain actions by
33 | an insurer constitute an unfair and deceptive trade
34 | practice; subjecting insurers to penalties for an unfair
35 | and deceptive trade practice; creating a presumption
36 | relating to failing to appear for an examination;
37 | specifying that submitting to an examination is a
38 | condition precedent to receiving benefits; providing for
39 | application relating to attorney's fees; limiting the
40 | amount of recoverable attorney's fees; prohibiting the use
41 | of a contingency risk multiplier when calculating
42 | attorney's fees; authorizing binding arbitration as a
43 | policy provision for dispute resolution; providing
44 | requirements and procedures relating to arbitration;
45 | providing for the recovery of specified attorney's fees
46 | and costs in arbitration; providing for a judicial
47 | challenge of an arbitration decision; providing for the
48 | scope of review relating to such challenge; providing that
49 | s. 627.428, F.S., relating to attorneys' fees, does not
50 | apply to a challenge of an arbitration decision;
51 | prohibiting the accrual of interest during litigation of
52 | such challenge under certain circumstances; providing an
53 | effective date.

54 |
55 | Be It Enacted by the Legislature of the State of Florida:
56 |

57 Section 1. Subsection (2) of section 26.012, Florida
 58 Statutes, is amended to read:

59 26.012 Jurisdiction of circuit court.—

60 (2) The circuit court ~~They~~ shall have exclusive original
 61 jurisdiction:

62 (a) In all actions at law not cognizable by the county
 63 courts. ~~†~~

64 (b) Of proceedings relating to the settlement of the
 65 estates of decedents and minors, the granting of letters
 66 testamentary, guardianship, involuntary hospitalization, the
 67 determination of incompetency, and other jurisdiction usually
 68 pertaining to courts of probate. ~~†~~

69 (c) In all cases in equity including all cases relating to
 70 juveniles except traffic offenses as provided in chapters 316
 71 and 985. ~~†~~

72 (d) Of all felonies and of all misdemeanors arising out of
 73 the same circumstances as a felony which is also charged. ~~†~~

74 (e) In all cases involving legality of any tax assessment
 75 or toll or denial of refund, except as provided in s. 72.011. ~~†~~

76 (f) In actions of ejectment. ~~† and~~

77 (g) In all actions involving the title and boundaries of
 78 real property.

79 (h) In all actions involving the Florida Motor Vehicle No-
 80 Fault Law, ss. 627.730-627.7405, where arbitration is initiated
 81 pursuant to s. 627.736(18) and the arbitration decision is
 82 challenged.

83 Section 2. Subsection (3) is added to section 627.4137,
 84 Florida Statutes, to read:

85 627.4137 Disclosure of certain information required.—

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

89 Section 3. Section 627.7311, Florida Statutes, is created
 90 to read:

91 627.7311 Effect of law on policies.—The provisions,
 92 schedules, and procedures authorized in ss. 627.730-627.7405
 93 shall be implemented by the insurers offering policies pursuant
 94 to the Florida Motor Vehicle No-Fault Law. These provisions,
 95 schedules, and procedures have full force and effect regardless
 96 of their express inclusion in an insurance policy, and an
 97 insurer is not required to amend its policy to implement and
 98 apply such provisions, schedules, or procedures.

99 Section 4. Paragraph (i) is added to subsection (4) of
 100 section 627.736, Florida Statutes, paragraphs (a) and (d) of
 101 subsection (5), paragraph (b) of subsection (6), paragraph (b)
 102 of subsection (7), and subsection (8) of that section are
 103 amended, and subsections (17) and (18) are added to that
 104 section, to read:

105 627.736 Required personal injury protection benefits;
 106 exclusions; priority; claims.—

107 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
 108 ss. 627.730-627.7405 shall be primary, except that benefits
 109 received under any workers' compensation law shall be credited
 110 against the benefits provided by subsection (1) and shall be due
 111 and payable as loss accrues, upon receipt of reasonable proof of
 112 such loss and the amount of expenses and loss incurred which are

113 covered by the policy issued under ss. 627.730-627.7405. When
 114 the Agency for Health Care Administration provides, pays, or
 115 becomes liable for medical assistance under the Medicaid program
 116 related to injury, sickness, disease, or death arising out of
 117 the ownership, maintenance, or use of a motor vehicle, benefits
 118 under ss. 627.730-627.7405 shall be subject to the provisions of
 119 the Medicaid program.

120 (i) In all circumstances, an insured seeking benefits
 121 under ss. 627.730-627.7405 must comply with the terms of the
 122 policy, which includes, but is not limited to, submitting to
 123 examinations under oath. Compliance with this paragraph is a
 124 condition precedent to receiving benefits.

125 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

126 (a)~~1.~~ Any physician, hospital, clinic, or other person or
 127 institution lawfully rendering treatment to an injured person
 128 for a bodily injury covered by personal injury protection
 129 insurance may charge the insurer and injured party only a
 130 reasonable amount pursuant to this section for the services and
 131 supplies rendered, and the insurer providing such coverage may
 132 pay for such charges directly to such person or institution
 133 lawfully rendering such treatment, if the insured receiving such
 134 treatment or his or her guardian has countersigned the properly
 135 completed invoice, bill, or claim form approved by the office
 136 upon which such charges are to be paid for as having actually
 137 been rendered, to the best knowledge of the insured or his or
 138 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
 139 exceed ~~be in excess of~~ the amount the person or institution
 140 customarily charges for like services or supplies. When

141 determining ~~With respect to a determination of~~ whether a charge
 142 for a particular service, treatment, or otherwise is reasonable,
 143 consideration may be given to evidence of usual and customary
 144 charges and payments accepted by the provider involved in the
 145 dispute, and reimbursement levels in the community and various
 146 federal and state medical fee schedules applicable to automobile
 147 and other insurance coverages, and other information relevant to
 148 the reasonableness of the reimbursement for the service,
 149 treatment, or supply.

150 1.2. The insurer may limit reimbursement to 80 percent of
 151 the following schedule of maximum charges:

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

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

157 c. For emergency services and care as defined by s.
 158 395.002(9) provided in a facility licensed under chapter 395
 159 rendered by a physician or dentist, and related hospital
 160 inpatient services rendered by a physician or dentist, the usual
 161 and customary charges in the community.

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

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

169 outpatient services.

170 f. For all other medical services, supplies, and care,
171 including durable medical equipment, care, and services rendered
172 by a clinical laboratory, 200 percent of the allowable amount
173 under the participating physicians schedule of Medicare Part B.
174 However, if such services, supplies, or care is not reimbursable
175 under Medicare Part B, or if the care and services are rendered
176 in an ambulatory surgical center, the insurer may limit
177 reimbursement to 80 percent of the maximum reimbursable
178 allowance under workers' compensation, as determined under s.
179 440.13 and rules adopted thereunder which are in effect at the
180 time such services, supplies, or care is provided. Services,
181 supplies, or care that is not reimbursable under Medicare or
182 workers' compensation is not required to be reimbursed by the
183 insurer.

184 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable
185 fee schedule or payment limitation under Medicare is the fee
186 schedule or payment limitation in effect on January 1 of the
187 year in which ~~at the time~~ the services, supplies, or care was
188 rendered and for the area in which such services were rendered,
189 and shall apply throughout the remainder of the year,
190 notwithstanding any subsequent changes made to such fee schedule
191 or payment limitation, except that it may not be less than the
192 allowable amount under the participating physicians schedule of
193 Medicare Part B for 2007 for medical services, supplies, and
194 care subject to Medicare Part B.

195 ~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to
196 apply any limitation on the number of treatments or other

197 utilization limits that apply under Medicare or workers'
198 compensation. An insurer that applies the allowable payment
199 limitations of subparagraph 1. 2- must reimburse a provider who
200 lawfully provided care or treatment under the scope of his or
201 her license, regardless of whether such provider is ~~would be~~
202 entitled to reimbursement under Medicare due to restrictions or
203 limitations on the types or discipline of health care providers
204 who may be reimbursed for particular procedures or procedure
205 codes.

206 ~~4.5-~~ If an insurer limits payment as authorized by
207 subparagraph 1. 2-, the person providing such services,
208 supplies, or care may not bill or attempt to collect from the
209 insured any amount in excess of such limits, except for amounts
210 that are not covered by the insured's personal injury protection
211 coverage due to the coinsurance amount or maximum policy limits.

212 (d) All statements and bills for medical services rendered
213 by any physician, hospital, clinic, or other person or
214 institution shall be submitted to the insurer on a properly
215 completed Centers for Medicare and Medicaid Services (CMS) 1500
216 form, UB 92 forms, or any other standard form approved by the
217 office or adopted by the commission for purposes of this
218 paragraph. All billings for such services rendered by providers
219 shall, to the extent applicable, follow the Physicians' Current
220 Procedural Terminology (CPT) or Healthcare Correct Procedural
221 Coding System (HCPCS), or ICD-9 in effect for the year in which
222 services are rendered and comply with the Centers for Medicare
223 and Medicaid Services (CMS) 1500 form instructions and the
224 American Medical Association Current Procedural Terminology

225 (CPT) Editorial Panel and Healthcare Correct Procedural Coding
 226 System (HCPCS). All providers other than hospitals shall include
 227 on the applicable claim form the professional license number of
 228 the provider in the line or space provided for "Signature of
 229 Physician or Supplier, Including Degrees or Credentials." In
 230 determining compliance with applicable CPT and HCPCS coding,
 231 guidance shall be provided by the Physicians' Current Procedural
 232 Terminology (CPT) or the Healthcare Correct Procedural Coding
 233 System (HCPCS) in effect for the year in which services were
 234 rendered, the Office of the Inspector General (OIG), Physicians
 235 Compliance Guidelines, and other authoritative treatises
 236 designated by rule by the Agency for Health Care Administration.
 237 A ~~No~~ statement of medical services may not include charges for
 238 medical services of a person or entity that performed such
 239 services without possessing the valid licenses required to
 240 perform such services. For purposes of paragraph (4) (b), an
 241 insurer is ~~shall~~ not ~~be~~ considered to have been furnished with
 242 notice of the amount of covered loss or medical bills due unless
 243 the statements or bills comply with this paragraph, and unless
 244 the statements or bills are properly completed in their entirety
 245 as to all material provisions, with all relevant information
 246 being provided therein. If an insurer denies a claim under this
 247 section due to the failure of a provider to provide a properly
 248 completed form required by this paragraph, the insurer shall
 249 notify the provider as to the provisions that were improperly
 250 completed and shall give the provider 15 days to submit a
 251 completed form.

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

253 (b) Every physician, hospital, clinic, or other medical
 254 institution providing, before or after bodily injury upon which
 255 a claim for personal injury protection insurance benefits is
 256 based, any products, services, or accommodations in relation to
 257 that or any other injury, or in relation to a condition claimed
 258 to be connected with that or any other injury, shall, if
 259 requested to do so by the insurer against whom the claim has
 260 been made, furnish ~~forthwith~~ a written report of the history,
 261 condition, treatment, dates, and costs of such treatment of the
 262 injured person and why the items identified by the insurer were
 263 reasonable in amount and medically necessary, together with a
 264 sworn statement that the treatment or services rendered were
 265 reasonable and necessary with respect to the bodily injury
 266 sustained and identifying which portion of the expenses for such
 267 treatment or services was incurred as a result of such bodily
 268 injury, and produce forthwith, and permit the inspection and
 269 copying of, his or her or its records regarding such history,
 270 condition, treatment, dates, and costs of treatment if; ~~provided~~
 271 ~~that~~ this does ~~shall~~ not limit the introduction of evidence at
 272 trial. Such sworn statement must ~~shall~~ read as follows: "Under
 273 penalty of perjury, I declare that I have read the foregoing,
 274 and the facts alleged are true, to the best of my knowledge and
 275 belief." A ~~No~~ cause of action for violation of the physician-
 276 patient privilege or invasion of the right of privacy may not be
 277 brought ~~shall be permitted~~ against any physician, hospital,
 278 clinic, or other medical institution complying with ~~the~~
 279 ~~provisions~~ of this section. The person requesting such records
 280 and such sworn statement shall pay all reasonable costs

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

296 1. If an insured seeking to recover benefits under ss.
 297 627.730-627.7405 assigns the contractual right to those benefits
 298 or the payment of those benefits to any person or entity, the
 299 assignee shall comply with the terms of the policy. In all
 300 circumstances, the assignee shall be obligated to cooperate
 301 under the policy, which includes, but is not limited to,
 302 participation in an examination under oath. For time spent in an
 303 examination under oath, the assignee is entitled to reasonable
 304 compensation from the insurer. Compliance with this paragraph is
 305 a condition precedent to the recovery of benefits under ss.
 306 627.730-627.7405. If an insurer requests an examination under
 307 oath of a medical provider, the provider must produce those
 308 individuals with the most knowledge of the issues identified by

309 the insurer in the request for examination under oath. All
310 claimants must produce and provide for inspection all documents
311 requested by the insurer that are reasonably obtainable by the
312 claimant. Examinations under oath may be recorded by audio,
313 video, court reporter, or any combination thereof.

314 2. Prior to requesting that an assignee participate in an
315 examination under oath, the insurer must provide a written
316 request of the assignee for all information that the insurer
317 believes is necessary to the processing of the claim, including
318 the information contemplated in subparagraph 1. An assignee is
319 not relieved from the provisions of this subparagraph simply by
320 providing the information contemplated in subparagraph 1.

321 3. Any insurer that, as a general practice, requests
322 examinations under oath without a reasonable basis is engaging
323 in an unfair and deceptive trade practice.

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

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

CS/HB 967

2011

337 examination so ordered, or by taking the deposition of the
 338 examiner, the person examined waives any privilege he or she may
 339 have, in relation to the claim for benefits, regarding the
 340 testimony of every other person who has examined, or may
 341 thereafter examine, him or her in respect to the same mental or
 342 physical condition. If a person unreasonably refuses to submit
 343 to an examination, the personal injury protection carrier is no
 344 longer liable for ~~subsequent~~ personal injury protection benefits
 345 incurred after the date of the requested examination. Failure to
 346 appear for an examination raises a rebuttable presumption that
 347 such failure was unreasonable. Submission to an examination is a
 348 condition precedent to receiving benefits.

349 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 350 FEES.—With respect to any dispute under the provisions of ss.
 351 627.730-627.7405 between the insured and the insurer, or between
 352 an assignee of an insured's rights and the insurer, the
 353 provisions of s. 627.428 ~~shall~~ apply, except as provided in
 354 subsections (10) and (15) and except that any attorney's fees
 355 recovered are limited to the lesser of \$10,000 or three times
 356 any disputed amount recovered by the attorney under ss. 627.730-
 357 627.7405. Attorney's fees in a class action under ss. 627.730-
 358 627.7405 are limited to the lesser of \$50,000 or three times the
 359 total of any disputed amount recovered in the class action
 360 proceeding.

361 (17) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the
 362 attorney's fees recovered under ss. 627.730-627.7405 shall be
 363 calculated without regard to any contingency risk multiplier.

364 (18) ARBITRATION.—In order to provide for an expedited,

CS/HB 967

2011

365 cost-effective, and fair resolution of disputes arising from
366 contracts for personal injury protection benefits, an insurer
367 may offer a policy that requires or allows the insurer or
368 claimant to demand arbitration of any claims dispute involving
369 personal injury protection benefits prior to filing a lawsuit
370 and in lieu of litigation. Arbitration is subject to the Florida
371 Arbitration Code, except as otherwise provided in this section.

372 In addition:

373 (a) A demand for arbitration must be made in writing by
374 certified mail, and the arbitration must be held within 60 days
375 after the receipt of a request for arbitration. The 60-day
376 period may not be tolled for discovery of documents pursuant to
377 paragraph (d).

378 (b) Arbitration shall take place in the county in which
379 the treatment was rendered. If treatment was rendered outside
380 the state, arbitration shall take place in the county in which
381 the insured resides unless the parties agree to another
382 location.

383 (c) The arbitration shall be conducted by a single
384 arbitrator selected by the chief judge of the judicial circuit
385 in which the arbitration is being held.

386 (d)1. The claimant shall make available for inspection or
387 copying the medical and other records on which the claimant
388 intends to rely at arbitration, upon written request by the
389 insurer or his or her attorney, within 15 days after receipt of
390 such request.

391 2. The insurer shall make available for inspection or
392 copying all documents, records, or information upon which it is

CS/HB 967

2011

393 relying in adjusting or rejecting the claim, upon written
394 request by the claimant or his or her attorney, within 10 days
395 after receipt of such request.

396 3. Discovery of insurer documents, records, or information
397 shall be limited to those relating to insurance coverage. The
398 insurer is not required to produce claims-privileged items,
399 underwriting files, or documents that it does not intend to rely
400 on at arbitration.

401 4. There shall be no discovery relating to general claims-
402 handling practices.

403 (e) The decision of the arbitrator shall be set forth in
404 writing and furnished to each party within 30 days after the
405 arbitration. The decision shall be binding on each party unless
406 challenged pursuant to paragraph (g). An arbitration award may
407 not exceed the applicable limits of coverage remaining on the
408 policy.

409 (f) The claimant is entitled to reimbursement of
410 attorney's fees directly associated with the arbitration,
411 subject to subsection (8). The award of fees must be set forth
412 in the arbitration decision. The insurer shall bear all
413 reasonable costs directly associated with the arbitration
414 process.

415 (g)1. A party may challenge the arbitration decision by
416 filing a complaint in circuit court within 20 days after the
417 receipt of the arbitration decision.

418 2. Review of the arbitration shall be de novo.

419 3. Section 627.428 does not apply, and interest on the
420 amount in dispute may not accrue during the course of

CS/HB 967

2011

421 | litigation, if the insurer has tendered payment of the amount of
422 | the arbitration award to the claimant.

423 | Section 5. This act shall take effect July 1, 2011.