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 the responsibility for payment of costs in
47 arbitration; providing for a judicial challenge of an
48 arbitration decision; providing for the scope of review
49 relating to such challenge; providing that s. 627.428,
50 F.S., relating to attorneys' fees, does not apply to a
51 challenge of an arbitration decision; prohibiting the
52 accrual of interest during litigation of such challenge
53 under certain circumstances; providing an 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(19) 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), (18), and (19) 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

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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,~~ 200
171 percent of the allowable amount under the participating
172 physicians schedule of Medicare Part B. <u>For all other supplies</u>
173 <u>and care, including durable medical equipment and care and</u>
174 <u>services rendered by ambulatory surgical centers and clinical</u>
175 <u>laboratories, 200 percent of the allowable amount under Medicare</u>
176 <u>Part B.</u> However, if such services, supplies, or care is not
177 reimbursable under Medicare Part B, the insurer may limit
178 reimbursement to 80 percent of the maximum reimbursable
179 allowance under workers' compensation, as determined under s.
180 440.13 and rules adopted thereunder which are in effect at the
181 time such services, supplies, or care is provided. Services,
182 supplies, or care that is not reimbursable under Medicare or
183 workers' compensation is not required to be reimbursed by the
184 insurer.
185 <u>2.</u>~~3.~~ For purposes of subparagraph <u>1.</u> ~~2.~~, the applicable
186 fee schedule or payment limitation under Medicare is the fee
187 schedule or payment limitation in effect <u>on January 1 of the</u>
188 <u>year in which</u> ~~at the time~~ the services, supplies, or care was
189 rendered and for the area in which such services were rendered,
190 <u>and shall apply throughout the remainder of the year,</u>
191 <u>notwithstanding any subsequent changes made to such fee schedule</u>
192 <u>or payment limitation,</u> except that it may not be less than the
193 allowable amount under the participating physicians schedule of
194 Medicare Part B for 2007 for medical services, supplies, and
195 care subject to Medicare Part B.
196 <u>3.</u>~~4.~~ Subparagraph <u>1.</u> ~~2.~~ does not allow the insurer to

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

207 4.~~5.~~ If an insurer limits payment as authorized by
208 subparagraph 1. ~~2.~~, the person providing such services,
209 supplies, or care may not bill or attempt to collect from the
210 insured any amount in excess of such limits, except for amounts
211 that are not covered by the insured's personal injury protection
212 coverage due to the coinsurance amount or maximum policy limits.

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

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

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

281 and such sworn statement shall pay all reasonable costs
282 connected therewith. If an insurer makes a written request for
283 documentation or information under this paragraph within 30 days
284 after having received notice of the amount of a covered loss
285 under paragraph (4)(a), the amount or the partial amount that
286 ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~
287 overdue if the insurer does not pay in accordance with paragraph
288 (4)(b) or within 10 days after the insurer's receipt of the
289 requested documentation or information, whichever occurs later.
290 For purposes of this paragraph, the term "receipt" includes, but
291 is not limited to, inspection and copying pursuant to this
292 paragraph. An ~~Any~~ insurer that requests documentation or
293 information pertaining to reasonableness of charges or medical
294 necessity under this paragraph without a reasonable basis for
295 such requests as a general business practice is engaging in an
296 unfair trade practice under the insurance code.
297 1. If an insured seeking to recover benefits under ss.
298 627.730-627.7405 assigns the contractual right to those benefits
299 or the payment of those benefits to any person or entity, the
300 assignee shall comply with the terms of the policy. In all
301 circumstances, the assignee shall be obligated to cooperate
302 under the policy, which includes, but is not limited to,
303 participation in an examination under oath. For time spent in an
304 examination under oath, the assignee is entitled to reasonable
305 compensation from the insurer. Compliance with this paragraph is
306 a condition precedent to the recovery of benefits under ss.
307 627.730-627.7405. If an insurer requests an examination under
308 oath of a medical provider, the provider must produce those

309 individuals with the most knowledge of the issues identified by
310 the insurer in the request for examination under oath. All
311 claimants must produce and provide for inspection all documents
312 requested by the insurer that are reasonably obtainable by the
313 claimant. Examinations under oath may be recorded by audio,
314 video, court reporter, or any combination thereof.
315 2. Prior to requesting that an assignee participate in an
316 examination under oath, the insurer must provide a written
317 request of the assignee for all information that the insurer
318 believes is necessary to the processing of the claim, including
319 the information contemplated in subparagraph 1. An assignee is
320 not relieved from the provisions of this subparagraph simply by
321 providing the information contemplated in subparagraph 1.
322 3. Any insurer that, as a general practice, requests
323 examinations under oath without a reasonable basis is engaging
324 in an unfair and deceptive trade practice.
325 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
326 REPORTS.—
327 (b) If requested by the person examined, a party causing
328 an examination to be made shall deliver to him or her a copy of
329 every written report concerning the examination rendered by an
330 examining physician, at least one of which reports must set out
331 the examining physician's findings and conclusions in detail.
332 After such request and delivery, the party causing the
333 examination to be made is entitled, upon request, to receive
334 from the person examined every written report available to him
335 or her or his or her representative concerning any examination,
336 previously or thereafter made, of the same mental or physical

337 condition. By requesting and obtaining a report of the
338 examination so ordered, or by taking the deposition of the
339 examiner, the person examined waives any privilege he or she may
340 have, in relation to the claim for benefits, regarding the
341 testimony of every other person who has examined, or may
342 thereafter examine, him or her in respect to the same mental or
343 physical condition. If a person unreasonably refuses to submit
344 to an examination, the personal injury protection carrier is no
345 longer liable for ~~subsequent~~ personal injury protection benefits
346 incurred after the date of the requested examination. Failure to
347 appear for an examination raises a rebuttable presumption that
348 such failure was unreasonable. Submission to an examination is a
349 condition precedent to receiving benefits.
350 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
351 FEES.—With respect to any dispute under the provisions of ss.
352 627.730-627.7405 between the insured and the insurer, or between
353 an assignee of an insured's rights and the insurer, the
354 provisions of s. 627.428 ~~shall~~ apply, except as provided in
355 subsections (10) and (15) and except that any attorney's fees
356 recovered are limited to the lesser of $200 per billable hour
357 or:
358 (a) For any disputed amount of less than $500, 15 times
359 any disputed amount recovered by the attorney under ss. 627.730-
360 627.7405, limited to a total of $5,000;
361 (b) For any disputed amount of $500 or more and less than
362 $5,000, 10 times any disputed amount recovered by the attorney
363 under ss. 627.730-627.7405, limited to a total of $10,000; or
364 (c) For any disputed amount of $5,000 or more and up to

365 $10,000, 5 times any disputed amount recovered by the attorney
366 under ss. 627.730-627.7405, limited to a total of $15,000.
367 (17) CLASS ACTIONS.—Attorney's fees in a class action
368 under ss. 627.730-627.7405 are limited to the lesser of $50,000
369 or three times the total of any disputed amount recovered in the
370 class action proceeding.
371 (18) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the
372 attorney's fees recovered under ss. 627.730-627.7405 shall be
373 calculated without regard to any contingency risk multiplier.
374 (19) ARBITRATION.—In order to provide for an expedited,
375 cost-effective, and fair resolution of disputes arising from
376 contracts for personal injury protection benefits, an insurer
377 may offer a policy that requires or allows the insurer or
378 claimant to demand arbitration of any claims dispute involving
379 personal injury protection benefits prior to filing a lawsuit
380 and in lieu of litigation. Arbitration is subject to the Florida
381 Arbitration Code, except as otherwise provided in this section.
382 In addition:
383 (a) A demand for arbitration must be made in writing by
384 certified mail, and the arbitration must be held within 60 days
385 after the receipt of a request for arbitration. The 60-day
386 period may not be tolled for discovery of documents pursuant to
387 paragraph (d).
388 (b) Arbitration shall take place in the county in which
389 the treatment was rendered. If treatment was rendered outside
390 the state, arbitration shall take place in the county in which
391 the insured resides unless the parties agree to another
392 location.

393 (c) The arbitration shall be conducted by a single
394 arbitrator. The Department of Financial Services shall adopt by
395 rule procedures to implement this arbitration program including:
396 1. Reasonable requirements for the processing and
397 scheduling of requests for arbitration;
398 2. Qualifications of arbitrators;
399 3. Selection of arbitrators;
400 4. Fees charged by arbitrators; and
401 5. Criteria for the conduct of arbitration.
402 (d)1. The claimant shall make available for inspection or
403 copying the medical and other records on which the claimant
404 intends to rely at arbitration, upon written request by the
405 insurer or his or her attorney, within 15 days after receipt of
406 such request.
407 2. The insurer shall make available for inspection or
408 copying all documents, records, or information upon which it is
409 relying in adjusting or rejecting the claim, upon written
410 request by the claimant or his or her attorney, within 10 days
411 after receipt of such request.
412 3. Discovery of insurer documents, records, or information
413 shall be limited to those relating to insurance coverage. The
414 insurer is not required to produce claims-privileged items,
415 underwriting files, or documents that it does not intend to rely
416 on at arbitration.
417 4. There shall be no discovery relating to general claims-
418 handling practices.
419 (e) The decision of the arbitrator shall be set forth in
420 writing and furnished to each party within 30 days after the

421 arbitration. The decision shall be binding on each party unless
422 challenged pursuant to paragraph (g). An arbitration award may
423 not exceed the applicable limits of coverage remaining on the
424 policy.
425 (f) The claimant is entitled to reimbursement of
426 attorney's fees directly associated with the arbitration,
427 subject to subsection (8). The award of fees must be set forth
428 in the arbitration decision. The insurer is responsible for
429 payment of the arbitrator fees and expenses, court reporter
430 fees, and any facility fees associated with the arbitration
431 proceedings. All costs and other expenses incurred during the
432 preparation, discovery, and arbitration proceedings shall be
433 paid by the parties incurring the expenses.
434 (g)1. A party may challenge the arbitration decision by
435 filing a complaint in circuit court within 20 days after the
436 receipt of the arbitration decision.
437 2. Review of the arbitration shall be de novo.
438 3. Section 627.428 does not apply, and interest on the
439 amount in dispute may not accrue during the course of
440 litigation, if the insurer has tendered payment of the amount of
441 the arbitration award to the claimant.
442 Section 5. This act shall take effect July 1, 2011.