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

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

57 a health insurer in specified circumstances; amending
58 ss. 324.021, 456.057, 627.7295, 627.733, 627.734,
59 627.737, 627.7401, 627.7405, 627.7407, and 628.909,
60 F.S.; conforming cross-references; reenacting s.
61 817.234(7)(c), F.S., relating to false and fraudulent
62 insurance claims, to incorporate the amendment of s.
63 627.736, F.S., in a reference thereto; providing an
64 effective date.
65
66 Be It Enacted by the Legislature of the State of Florida:
67
68 Section 1. (1) SHORT TITLE.—This act may be cited as the
69 "Comprehensive Insurance Fraud Investigation and Prevention
70 Act."
71 (2) FINDINGS AND INTENT.—The Legislature intends to
72 balance the insured's interest in prompt payment of valid claims
73 for insurance benefits under the no-fault law with the public's
74 interest in reducing fraud, abuse, and overuse of the no-fault
75 system. To that end, the Legislature intends that the
76 investigation and prevention of fraudulent insurance acts in
77 this state be enhanced, that additional sanctions for such acts
78 be imposed, and that the no-fault law be revised to remove
79 incentives for fraudulent insurance acts. The Legislature
80 intends that the no-fault law be construed according to the
81 plain language of the statutory provisions, which are designed
82 to meet these goals.
83 (a) The Legislature finds that:
84 1. Motor vehicle insurance fraud remains a major problem

85 for state consumers and insurers. According to the National
86 Insurance Crime Bureau, in recent years this state has been
87 among those states that have the highest number of fraudulent
88 and questionable claims.
89 2. The current regulatory process for health care clinics
90 under part X of chapter 400, Florida Statutes, which was
91 originally enacted to reduce motor vehicle insurance fraud, is
92 not adequately preventing fraudulent insurance acts with respect
93 to licensure exemptions and compliance with that part.
94 (b) The Legislature intends that:
95 1. Insurers properly investigate claims, and as such, this
96 act clarifies that insurers are allowed to obtain examinations
97 under oath and sworn statements from any claimant seeking no-
98 fault insurance benefits and to request mental and physical
99 examinations of persons seeking personal injury protection
100 coverage or benefits.
101 2. Any false, misleading, or otherwise fraudulent activity
102 associated with a claim render the entire claim invalid. An
103 insurer must be able to raise fraud as a defense to a claim for
104 no-fault insurance benefits irrespective of any prior
105 adjudication of guilt or determination of fraud by the
106 Department of Financial Services.
107 3. Insurers toll the payment or denial of a claim with
108 respect to any portion of a claim for which the insurer has a
109 reasonable belief that a fraudulent insurance act, as defined in
110 s. 626.989 or s. 817.234, Florida Statutes, has been committed.
111 4. Insurers discover the names of all passengers involved
112 in a motor vehicle crash before paying claims or benefits

113 pursuant to an insurance policy governed by the no-fault law. A
114 rebuttable presumption must be established that a person was not
115 involved in the event giving rise to the claim if that person's
116 name does not appear on the police report.
117 Section 2. Subsection (1) of section 316.066, Florida
118 Statutes, is amended to read:
119 316.066 Written reports of crashes.—
120 (1)(a) A Florida Traffic Crash Report, Long Form must ~~is~~
121 ~~required to~~ be completed and submitted to the department within
122 10 days after ~~completing~~ an investigation is completed by the
123 ~~every~~ law enforcement officer who in the regular course of duty
124 investigates a motor vehicle crash that:
125 1. Resulted in death of, ~~or~~ personal injury to, or any
126 indication of complaints of pain or discomfort by any of the
127 parties or passengers involved in the crash;
128 2. Involved one or more passengers, other than the drivers
129 of the vehicles, in any of the vehicles involved in the crash;
130 or~~.~~
131 3.~~2.~~ Involved a violation of s. 316.061(1) or s. 316.193.
132 (b) The long form must include:
133 1. The date, time, and location of the crash.
134 2. A description of the vehicles involved.
135 3. The names and addresses of the parties involved,
136 including all drivers and passengers.
137 4. The names and addresses of witnesses.
138 5. The name, badge number, and law enforcement agency of
139 the officer investigating the crash.
140 6. The names of the insurance companies for the respective

141 parties involved in the crash.
142 7. The names and addresses of all passengers in all
143 vehicles involved in the crash, each clearly identified as being
144 a passenger, including the identification of the vehicle in
145 which each was a passenger.
146 (c)(b) In every crash for which a Florida Traffic Crash
147 Report, Long Form is not required by this section, the law
148 enforcement officer may complete a short-form crash report or
149 provide a driver exchange-of-information form to be completed by
150 each party involved in the crash. The short-form report must
151 include all of the items listed in subparagraphs (b)1.-6. Short-
152 form crash reports prepared by the law enforcement officer shall
153 be maintained by the officer's agency.:
154 1. The date, time, and location of the crash.
155 2. A description of the vehicles involved.
156 3. The names and addresses of the parties involved,
157 including all drivers and passengers.
158 4. The names and addresses of witnesses.
159 5. The name, badge number, and law enforcement agency of
160 the officer investigating the crash.
161 6. The names of the insurance companies for the respective
162 parties involved in the crash.
163 (d)(c) Each party to the crash must provide the law
164 enforcement officer with proof of insurance, which must be
165 documented in the crash report. If a law enforcement officer
166 submits a report on the crash, proof of insurance must be
167 provided to the officer by each party involved in the crash. Any
168 party who fails to provide the required information commits a

169 noncriminal traffic infraction, punishable as a nonmoving
170 violation as provided in chapter 318, unless the officer
171 determines that due to injuries or other special circumstances
172 such insurance information cannot be provided immediately. If
173 the person provides the law enforcement agency, within 24 hours
174 after the crash, proof of insurance that was valid at the time
175 of the crash, the law enforcement agency may void the citation.
176 (e) ~~(d)~~ The driver of a vehicle that was in any manner
177 involved in a crash resulting in damage to any vehicle or other
178 property in an amount of $500 or more which was not investigated
179 by a law enforcement agency~~,~~ shall, within 10 days after the
180 crash, submit a written report of the crash to the department.
181 The entity receiving the report may require witnesses of the
182 crash to render reports and may require any driver of a vehicle
183 involved in a crash of which a written report must be made to
184 file supplemental written reports if the original report is
185 deemed insufficient by the receiving entity.
186 (f) The investigating law enforcement officer may testify
187 at trial or provide a signed affidavit to confirm or supplement
188 the information included on the long-form or short-form report.
189 ~~(e) Short-form crash reports prepared by law enforcement~~
190 ~~shall be maintained by the law enforcement officer's agency.~~
191 Section 3. Subsection (6) is added to section 400.991,
192 Florida Statutes, to read:
193 400.991 License requirements; background screenings;
194 prohibitions.—
195 (6) All forms that constitute part of the application for
196 licensure or exemption from licensure under this part must

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197 contain the following statement:

198

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

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

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

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

218 627.731 Purpose; legislative intent.—

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

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225 damages for pain, suffering, mental anguish, and inconvenience.
226 (2) The Legislature intends that the provisions,
227 schedules, and procedures authorized under the no-fault law be
228 implemented by the insurers offering policies pursuant to the
229 no-fault law. These provisions, schedules, and procedures have
230 full force and effect regardless of their express inclusion in
231 an insurance policy, and an insurer is not required to amend its
232 policy to implement and apply such provisions, schedules, or
233 procedures.
234 Section 6. Section 627.732, Florida Statutes, is amended
235 to read:
236 627.732 Definitions.—As used in the no-fault law ~~ss.~~
237 ~~627.730-627.7405~~, the term:
238 (1) "Broker" means any person not possessing a license
239 under chapter 395, chapter 400, chapter 429, chapter 458,
240 chapter 459, chapter 460, chapter 461, or chapter 641 who
241 charges or receives compensation for any use of medical
242 equipment and is not the 100-percent owner or the 100-percent
243 lessee of such equipment. For purposes of this section, such
244 owner or lessee may be an individual, a corporation, a
245 partnership, or any other entity and any of its 100-percent-
246 owned affiliates and subsidiaries. For purposes of this
247 subsection, the term "lessee" means a long-term lessee under a
248 capital or operating lease, but does not include a part-time
249 lessee. The term "broker" does not include a hospital or
250 physician management company whose medical equipment is
251 ancillary to the practices managed, a debt collection agency, or
252 an entity that has contracted with the insurer to obtain a

253 discounted rate for such services; or ~~nor does the term include~~
254 a management company that has contracted to provide general
255 management services for a licensed physician or health care
256 facility and whose compensation is not materially affected by
257 the usage or frequency of usage of medical equipment or an
258 entity that is 100-percent owned by one or more hospitals or
259 physicians. The term "broker" does not include a person or
260 entity that certifies, upon request of an insurer, that:
261 (a) It is a clinic licensed under ss. 400.990-400.995;
262 (b) It is a 100-percent owner of medical equipment; and
263 (c) The owner's only part-time lease of medical equipment
264 for personal injury protection patients is on a temporary basis,
265 not to exceed 30 days in a 12-month period, and such lease is
266 solely for the purposes of necessary repair or maintenance of
267 the 100-percent-owned medical equipment or pending the arrival
268 and installation of the newly purchased or a replacement for the
269 100-percent-owned medical equipment, or for patients for whom,
270 because of physical size or claustrophobia, it is determined by
271 the medical director or clinical director to be medically
272 necessary that the test be performed in medical equipment that
273 is open-style. The leased medical equipment may not ~~cannot~~ be
274 used by patients who are not patients of the registered clinic
275 ~~for medical treatment of services~~. Any person or entity making a
276 false certification under this subsection commits insurance
277 fraud as defined in s. 817.234. However, the 30-day period
278 ~~provided in this paragraph~~ may be extended for an additional 60
279 days as applicable to magnetic resonance imaging equipment if
280 the owner certifies that the extension otherwise complies with

281 this paragraph.
282 (2) ~~(7)~~ "Certify" means to swear or attest to being true or
283 represented in writing.
284 (3) "Claimant" means the person, organization, or entity
285 seeking benefits, including all assignees.
286 (4) ~~(12)~~ "Hospital" means a facility that, at the time
287 services or treatment were rendered, was licensed under chapter
288 395.
289 (5) ~~(8)~~ "Immediate personal supervision," as it relates to
290 the performance of medical services by nonphysicians not in a
291 hospital, means that an individual licensed to perform the
292 medical service or provide the medical supplies must be present
293 within the confines of the physical structure where the medical
294 services are performed or where the medical supplies are
295 provided such that the licensed individual can respond
296 immediately to any emergencies if needed.
297 (6) ~~(9)~~ "Incident," with respect to services considered as
298 incident to a physician's professional service, for a physician
299 licensed under chapter 458, chapter 459, chapter 460, or chapter
300 461, if not furnished in a hospital, means ~~such~~ services that
301 are ~~must be~~ an integral, even if incidental, part of a covered
302 physician's service.
303 (7) ~~(10)~~ "Knowingly" means that a person, with respect to
304 information, has actual knowledge of the information, ~~;~~ acts in
305 deliberate ignorance of the truth or falsity of the
306 information, ~~;~~ or acts in reckless disregard of the information. ~~,~~
307 ~~and~~ Proof of specific intent to defraud is not required.
308 (8) ~~(11)~~ "Lawful" or "lawfully" means in substantial

309 compliance with all relevant applicable criminal, civil, and
310 administrative requirements of state and federal law related to
311 the provision of medical services or treatment.
312 (9) ~~(2)~~ "Medically necessary" refers to a medical service
313 or supply that a prudent physician would provide for the purpose
314 of preventing, diagnosing, or treating an illness, injury,
315 disease, or symptom in a manner that is:
316 (a) In accordance with generally accepted standards of
317 medical practice;
318 (b) Clinically appropriate in terms of type, frequency,
319 extent, site, and duration; and
320 (c) Not primarily for the convenience of the patient,
321 physician, or other health care provider.
322 (10) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
323 with four or more wheels that ~~which~~ is of a type both designed
324 and required to be licensed for use on the highways of this
325 state, and any trailer or semitrailer designed for use with such
326 vehicle, and includes:
327 (a) A "private passenger motor vehicle," which is any
328 motor vehicle that ~~which~~ is a sedan, station wagon, or jeep-type
329 vehicle and, if not used primarily for occupational,
330 professional, or business purposes, a motor vehicle of the
331 pickup, panel, van, camper, or motor home type.
332 (b) A "commercial motor vehicle," which is any motor
333 vehicle that ~~which~~ is not a private passenger motor vehicle.
334
335 The term "motor vehicle" does not include a mobile home or any
336 motor vehicle that ~~which~~ is used in mass transit, other than

337 public school transportation, and designed to transport more
338 than five passengers exclusive of the operator of the motor
339 vehicle and that ~~which~~ is owned by a municipality, a transit
340 authority, or a political subdivision of the state.
341 (11) ~~(4)~~ "Named insured" means a person, usually the owner
342 of a vehicle, identified in a policy by name as the insured
343 under the policy.
344 (12) "No-fault law" means the Florida Motor Vehicle No-
345 Fault Law, ss. 627.730-627.7407.
346 (13) ~~(5)~~ "Owner" means a person who holds the legal title
347 to a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
348 subject of a security agreement or lease with an option to
349 purchase with the debtor or lessee having the right to
350 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
351 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.
352 (14) ~~(13)~~ "Properly completed" means providing truthful,
353 substantially complete, and substantially accurate responses ~~as~~
354 to all material elements of ~~to~~ each applicable request for
355 information or statement by a means that may lawfully be
356 provided and that complies with this section, or as agreed by
357 the parties.
358 (15) ~~(6)~~ "Relative residing in the same household" means a
359 relative of any degree by blood or by marriage who usually makes
360 her or his home in the same family unit, whether or not
361 temporarily living elsewhere.
362 (16) ~~(15)~~ "Unbundling" means submitting ~~an action that~~
363 ~~submits~~ a billing code that is properly billed under one billing
364 code~~,~~ but that has been separated into two or more billing

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365 codes~~,~~ and would result in payment greater than the ~~in~~ amount
366 that ~~than~~ would be paid using one billing code.
367 (17)~~(14)~~ "Upcoding" means submitting ~~an action that~~
368 ~~submits~~ a billing code that would result in payment greater than
369 the ~~in~~ amount that ~~than~~ would be paid using a billing code that
370 accurately describes the services performed. The term does not
371 include an otherwise lawful bill by a magnetic resonance imaging
372 facility, which globally combines both technical and
373 professional components, if the amount of the global bill is not
374 more than the components if billed separately; however, payment
375 of such a bill constitutes payment in full for all components of
376 such service.
377 Section 7. Subsections (1), (3), and (4) of section
378 627.736, Florida Statutes, are amended, subsections (5) through
379 (16) of that section are renumbered as subsections (6) through
380 (17), respectively, a new subsection (5) is added to that
381 section, and present subsections (5), (6), (8), and (9),
382 paragraph (b) of present subsection (7), and present subsection
383 (16) of that section are amended, to read:
384 627.736 Required personal injury protection benefits;
385 exclusions; priority; claims.—
386 (1) REQUIRED BENEFITS.—Every insurance policy complying
387 with the security requirements of s. 627.733 must ~~shall~~ provide
388 personal injury protection to the named insured, relatives
389 residing in the same household, persons operating the insured
390 motor vehicle, passengers in such motor vehicle, and other
391 persons struck by such motor vehicle and suffering bodily injury
392 while not an occupant of a self-propelled vehicle, subject to

393 ~~the provisions of~~ subsection (2) and paragraph (4)(g) ~~(4)(e)~~, to
394 a limit of $10,000 for loss sustained by ~~any~~ such person as a
395 result of bodily injury, sickness, disease, or death arising out
396 of the ownership, maintenance, or use of a motor vehicle as
397 follows:
398 (a) Medical benefits.—Eighty percent of ~~all reasonable~~
399 expenses for medically necessary medical, surgical, X-ray,
400 dental, and rehabilitative services, including prosthetic
401 devices, and for medically necessary ambulance, hospital, and
402 nursing services. However, the medical benefits ~~shall~~ provide
403 reimbursement only for such services and care that are lawfully
404 provided, supervised, ordered, or prescribed by a physician
405 licensed under chapter 458 or chapter 459, a dentist licensed
406 under chapter 466, or a chiropractic physician licensed under
407 chapter 460 or that are provided by any of the following ~~persons~~
408 ~~or entities~~:
409 1. A hospital or ambulatory surgical center licensed under
410 chapter 395.
411 2. A person or entity licensed under part III of chapter
412 401 that ~~ss. 401.2101-401.45 that~~ provides emergency
413 transportation and treatment.
414 3. An entity wholly owned by one or more physicians
415 licensed under chapter 458 or chapter 459, chiropractic
416 physicians licensed under chapter 460, or dentists licensed
417 under chapter 466 or by such ~~practitioner or~~ practitioners and
418 the spouses, parents, children, or siblings ~~spouse, parent,~~
419 ~~child, or sibling~~ of such ~~that practitioner or those~~
420 practitioners.

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421 4. An entity wholly owned, directly or indirectly, by a
422 hospital or hospitals.
423 5. A health care clinic licensed under part X of chapter
424 400 ~~ss. 400.990-400.995~~ that is:
425 a. Accredited by the Joint Commission on Accreditation of
426 Healthcare Organizations, the American Osteopathic Association,
427 the Commission on Accreditation of Rehabilitation Facilities, or
428 the Accreditation Association for Ambulatory Health Care, Inc.;
429 or
430 b. A health care clinic that:
431 (I) Has a medical director licensed under chapter 458,
432 chapter 459, or chapter 460;
433 (II) Has been continuously licensed for more than 3 years
434 or is a publicly traded corporation that issues securities
435 traded on an exchange registered with the United States
436 Securities and Exchange Commission as a national securities
437 exchange; and
438 (III) Provides at least four of the following medical
439 specialties:
440 (A) General medicine.
441 (B) Radiography.
442 (C) Orthopedic medicine.
443 (D) Physical medicine.
444 (E) Physical therapy.
445 (F) Physical rehabilitation.
446 (G) Prescribing or dispensing outpatient prescription
447 medication.
448 (H) Laboratory services.

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449

450 If any services under this paragraph are provided by an entity
451 or clinic described in subparagraph 3., subparagraph 4., or
452 subparagraph 5., the entity or clinic must provide the insurer
453 at the initial submission of the claim with a form adopted by
454 the Department of Financial Services that documents that the
455 entity or clinic meets applicable criteria for such entity or
456 clinic and includes a sworn statement or affidavit to that
457 effect. Any change in ownership requires the filing of a new
458 form within 10 days after the date of the change in ownership.
459 ~~The Financial Services Commission shall adopt by rule the form~~
460 ~~that must be used by an insurer and a health care provider~~
461 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
462 ~~5. to document that the health care provider meets the criteria~~
463 ~~of this paragraph, which rule must include a requirement for a~~
464 ~~sworn statement or affidavit.~~
465 (b) Disability benefits.—Sixty percent of any loss of
466 gross income and loss of earning capacity per individual from
467 inability to work proximately caused by the injury sustained by
468 the injured person, plus all expenses reasonably incurred in
469 obtaining from others ordinary and necessary services in lieu of
470 those that, but for the injury, the injured person would have
471 performed without income for the benefit of his or her
472 household. All disability benefits payable under this paragraph
473 must ~~provision shall~~ be paid at least ~~not less than~~ every 2
474 weeks.
475 (c) Death benefits.—Death benefits equal to the lesser of
476 $5,000 or the remainder of unused personal injury protection

477 benefits per individual. The insurer may pay such benefits to
478 the executor or administrator of the deceased, to any of the
479 deceased's relatives by blood, or legal adoption, or connection
480 by marriage, or to any person appearing to the insurer to be
481 equitably entitled thereto.
482
483 Only insurers writing motor vehicle liability insurance in this
484 state may provide the required benefits of this section, and no
485 such insurers may not insurer shall require the purchase of any
486 other motor vehicle coverage other than the purchase of property
487 damage liability coverage as required by s. 627.7275 as a
488 condition for providing such required benefits. Insurers may not
489 require that property damage liability insurance in an amount
490 greater than $10,000 be purchased in conjunction with personal
491 injury protection. Such insurers shall make benefits and
492 required property damage liability insurance coverage available
493 through normal marketing channels. An Any insurer writing motor
494 vehicle liability insurance in this state who fails to comply
495 with such availability requirement as a general business
496 practice violates shall be deemed to have violated part IX of
497 chapter 626, and such violation constitutes shall constitute an
498 unfair method of competition or an unfair or deceptive act or
499 practice involving the business of insurance. An; and any such
500 insurer committing such violation is shall be subject to the
501 penalties afforded in such part, as well as those that are which
502 may be afforded elsewhere in the insurance code.
503 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
504 TORT CLAIMS.—An No insurer shall not have a lien on any recovery

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505 in tort by judgment, settlement, or otherwise for personal
506 injury protection benefits, whether suit has been filed or
507 settlement has been reached without suit. An injured party who
508 is entitled to bring suit under the no-fault law ~~provisions of~~
509 ~~ss. 627.730-627.7405~~, or his or her legal representative, shall
510 have no right to recover any damages for which personal injury
511 protection benefits are paid or payable. The plaintiff may prove
512 all of his or her special damages notwithstanding this
513 limitation, but if special damages are introduced in evidence,
514 the trier of facts, whether judge or jury, shall not award
515 damages for personal injury protection benefits paid or payable.
516 In all cases in which a jury is required to fix damages, the
517 court shall instruct the jury that the plaintiff shall not
518 recover such special damages for personal injury protection
519 benefits paid or payable.
520 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
521 the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary,
522 except that benefits received under any workers' compensation
523 law shall be credited against the benefits provided by
524 subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~
525 upon the receipt of reasonable proof of such loss and the amount
526 of expenses and loss incurred that ~~which~~ are covered by the
527 policy issued under the no-fault law ~~ss. 627.730-627.7405~~. If
528 ~~When~~ the Agency for Health Care Administration provides, pays,
529 or becomes liable for medical assistance under the Medicaid
530 program related to injury, sickness, disease, or death arising
531 out of the ownership, maintenance, or use of a motor vehicle,
532 the benefits are ~~under ss. 627.730-627.7405 shall be~~ subject to

533 the provisions of the Medicaid program.
534 (a) An insurer may require written notice to be given as
535 soon as practicable after an accident involving a motor vehicle
536 with respect to which the policy affords the security required
537 by the no-fault law ~~ss. 627.730-627.7405~~.
538 (b) Personal injury protection insurance benefits paid
539 pursuant to this section are ~~shall be~~ overdue if not paid within
540 30 days after the insurer is furnished written notice of the
541 fact of a covered loss and of the amount of same. If such
542 written notice is not furnished to the insurer as to the entire
543 claim, any partial amount supported by written notice is overdue
544 if not paid within 30 days after such written notice is
545 furnished to the insurer. Any part or all of the remainder of
546 the claim that is subsequently supported by written notice is
547 overdue if not paid within 30 days after such written notice is
548 furnished to the insurer.
549 (c) If ~~When~~ an insurer pays only a portion of a claim or
550 rejects a claim, the insurer shall provide at the time of the
551 partial payment or rejection an itemized specification of each
552 item that the insurer had reduced, omitted, or declined to pay
553 and any information that the insurer desires the claimant to
554 consider related to the medical necessity of the denied
555 treatment or to explain the reasonableness of the reduced
556 charge, provided that this does ~~shall~~ not limit the introduction
557 of evidence at trial.~~; and~~ The insurer must ~~shall~~ include the
558 name and address of the person to whom the claimant should
559 respond and a claim number to be referenced in future
560 correspondence.

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

589 potentially covered by personal injury protection benefits, the
590 insurer must reserve $5,000 of personal injury protection
591 benefits for payment to physicians licensed under chapter 458 or
592 chapter 459 or dentists licensed under chapter 466 who provide
593 emergency services and care, as defined in s. 395.002~~(9)~~, or who
594 provide hospital inpatient care. The amount required to be held
595 in reserve may be used only to pay claims from such physicians
596 or dentists until 30 days after the date the insurer receives
597 notice of the accident. After the 30-day period, any amount of
598 the reserve for which the insurer has not received notice of
599 such ~~a~~ claim ~~from a physician or dentist who provided emergency~~
600 ~~services and care or who provided hospital inpatient care~~ may
601 ~~then~~ be used by the insurer to pay other claims. The time
602 periods specified in paragraph (b) for ~~required~~ payment of
603 personal injury protection benefits are ~~shall be~~ tolled for the
604 period of time that an insurer is required ~~by this paragraph~~ to
605 hold payment of a claim that is not from a physician or dentist
606 who provided emergency services and care or who provided
607 hospital inpatient care to the extent that the personal injury
608 protection benefits not held in reserve are insufficient to pay
609 the claim. This paragraph does not require an insurer to
610 establish a claim reserve for insurance accounting purposes.
611 (f)~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
612 the rate established under s. 55.03 or the rate established in
613 the insurance contract, whichever is greater, for the year in
614 which the payment became overdue, calculated from the date the
615 insurer was furnished with written notice of the amount of
616 covered loss. Interest is ~~shall be~~ due at the time payment of

617 the overdue claim is made.

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

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

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

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

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

641 a. The owner of a motor vehicle with respect to which
642 security is required under the no-fault law ~~ss. 627.730-~~
643 ~~627.7405~~; or

644 b. Entitled to personal injury benefits from the insurer

645 of the owner ~~or owners~~ of such a motor vehicle.
646 (h) ~~(f)~~ If two or more insurers are liable to pay personal
647 injury protection benefits for the same injury to any one
648 person, the maximum payable is ~~shall be~~ as specified in
649 subsection (1), and any insurer paying the benefits is ~~shall be~~
650 entitled to recover from each of the other insurers an equitable
651 pro rata share of the benefits paid and expenses incurred in
652 processing the claim.
653 (i) ~~(g)~~ It is a violation of the insurance code for an
654 insurer to fail to timely provide benefits as required by this
655 section with such frequency as to constitute a general business
656 practice.
657 (j) ~~(h)~~ Benefits are ~~shall~~ not ~~be~~ due or payable to or on
658 the behalf of a claimant who: ~~an insured person if that person~~
659 ~~has~~
660 1. Submits a false or misleading statement, document,
661 record, or bill;
662 2. Submits any other false or misleading information; or
663 3. Has otherwise committed or attempted to commit a
664 fraudulent insurance act as defined in s. 626.989.
665
666 A claimant who violates this paragraph is not entitled to any
667 personal injury protection benefits or payment for any bills and
668 services, regardless of whether a portion of the claim may be
669 legitimate.
670 (k) Notwithstanding any remedies afforded by law, the
671 insurer may recover from a claimant who has violated paragraph
672 (j) any sums previously paid to the claimant and may bring any

673 available common law and statutory causes of action ~~committed,~~
674 ~~by a material act or omission, any insurance fraud relating to~~
675 ~~personal injury protection coverage under his or her policy, if~~
676 ~~the fraud is admitted to in a sworn statement by the insured or~~
677 ~~if it is established in a court of competent jurisdiction~~. If a
678 physician, hospital, clinic, or other medical institution
679 violates paragraph (j), the injured party is not liable for, and
680 the physician, hospital, clinic, or other medical institution
681 may not bill the insured for, charges that are unpaid because of
682 failure to comply with paragraph (j). Any agreement requiring
683 the injured person or insured to pay for such charges is
684 unenforceable. ~~Any insurance fraud shall void all coverage~~
685 ~~arising from the claim related to such fraud under the personal~~
686 ~~injury protection coverage of the insured person who committed~~
687 ~~the fraud, irrespective of whether a portion of the insured~~
688 ~~person's claim may be legitimate, and any benefits paid prior to~~
689 ~~the discovery of the insured person's insurance fraud shall be~~
690 ~~recoverable by the insurer from the person who committed~~
691 ~~insurance fraud in their entirety. The prevailing party is~~
692 ~~entitled to its costs and attorney's fees in any action in which~~
693 ~~it prevails in an insurer's action to enforce its right of~~
694 ~~recovery under this paragraph.~~
695 (5) INSURER INVESTIGATIONS.—An insurer has the right and
696 duty to conduct a reasonable investigation of a claim. In the
697 course of the investigation, the insurer may require the
698 insured, claimant, or medical provider to provide copies of the
699 treatment and examination records so that the insurer can
700 provide such records to a physician for a records review. A

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701 records review need not be based on a physical examination and
702 may be obtained at any time, including after reduction or denial
703 of the claim. The 30-day period for payment under paragraph
704 (4)(b) is tolled from the date the insurer sends its request for
705 treatment records to the date that the insurer receives the
706 treatment records. The claim may be denied or reduced if the
707 medical provider fails to keep adequate records such that the
708 insurer is unable to obtain a records review.
709 (6) ~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.—
710 (a) ~~1.~~ Any physician, hospital, clinic, or other person or
711 institution lawfully rendering treatment to an injured person
712 for a bodily injury covered by personal injury protection
713 insurance may charge the insurer and injured party only an ~~a~~
714 ~~reasonable~~ amount pursuant to this section for the services and
715 supplies rendered, and the insurer providing such coverage may
716 pay for such charges directly to such person or institution
717 lawfully rendering such treatment~~,~~ if the insured receiving such
718 treatment or his or her guardian has countersigned the properly
719 completed invoice, bill, or claim form approved by the office
720 upon which such charges are to be paid for as having actually
721 been rendered, to the best knowledge of the insured or his or
722 her guardian. ~~In no event,~~ However, ~~may~~ such ~~a~~ charge may not
723 exceed ~~be in excess of~~ the amount the person or institution
724 customarily charges for like services or supplies. When
725 determining ~~With respect to a determination of~~ whether a charge
726 for a particular service, treatment, or otherwise is reasonable,
727 consideration may be given to evidence of usual and customary
728 charges and payments accepted by the provider involved in the

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729 dispute, ~~and~~ reimbursement levels in the community and various
730 federal and state medical fee schedules applicable to automobile
731 and other insurance coverages, and other information relevant to
732 the reasonableness of the reimbursement for the service,
733 treatment, or supply.
734 1.~~2.~~ The insurer may limit reimbursement to 80 percent of
735 the following schedule of maximum charges:
736 a. For emergency transport and treatment by providers
737 licensed under chapter 401, 200 percent of Medicare.
738 b. For emergency services and care provided by a hospital
739 licensed under chapter 395, 75 percent of the hospital's usual
740 and customary charges.
741 c. For emergency services and care as defined by s.
742 395.002~~(9)~~ provided in a facility licensed under chapter 395
743 rendered by a physician or dentist, and related hospital
744 inpatient services rendered by a physician or dentist, the usual
745 and customary charges in the community.
746 d. For hospital inpatient services, other than emergency
747 services and care, 200 percent of the Medicare Part A
748 prospective payment applicable to the specific hospital
749 providing the inpatient services.
750 e. For hospital outpatient services, other than emergency
751 services and care, 200 percent of the Medicare Part A Ambulatory
752 Payment Classification for the specific hospital providing the
753 outpatient services.
754 f. For all other medical services, supplies, and care, 200
755 percent of the allowable amount under the participating
756 physicians schedule of Medicare Part B. However, if such

757 services, supplies, or care is not reimbursable under Medicare
758 Part B, the insurer may limit reimbursement to 80 percent of the
759 maximum reimbursable allowance under workers' compensation, as
760 determined under s. 440.13 and rules adopted thereunder which
761 are in effect at the time such services, supplies, or care is
762 provided. Services, supplies, or care that is not reimbursable
763 under Medicare or workers' compensation is not required to be
764 reimbursed by the insurer.
765 2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable
766 fee schedule or payment limitation under Medicare is the fee
767 schedule or payment limitation in effect on January 1 of the
768 year in which ~~at the time~~ the services, supplies, or care was
769 rendered and for the area in which such services were rendered,
770 notwithstanding any subsequent changes made to such fee schedule
771 or payment limitation, except that it may not be less than the
772 allowable amount under the participating physicians schedule of
773 Medicare Part B for 2007 for medical services, supplies, and
774 care subject to Medicare Part B.
775 3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to
776 apply any limitation on the number of treatments or other
777 utilization limits that apply under Medicare or workers'
778 compensation. An insurer that applies the allowable payment
779 limitations of subparagraph 1. ~~2.~~ must reimburse a provider who
780 lawfully provided care or treatment under the scope of his or
781 her license~~,~~ regardless of whether such provider is ~~would be~~
782 entitled to reimbursement under Medicare due to restrictions or
783 limitations on the types or discipline of health care providers
784 who may be reimbursed for particular procedures or procedure

785 codes.
786 4.5. If an insurer limits payment as authorized by
787 subparagraph 1. 2., the person providing such services,
788 supplies, or care may not bill or attempt to collect from the
789 insured any amount in excess of such limits, except for amounts
790 that are not covered by the insured's personal injury protection
791 coverage due to the coinsurance amount or maximum policy limits.
792 (b)1. An insurer or insured is not required to pay a claim
793 or charges:
794 a. Made by a broker or by a person making a claim on
795 behalf of a broker;
796 b. For any service or treatment that was not lawful at the
797 time rendered;
798 c. To any person who knowingly submits a false or
799 misleading statement relating to the claim or charges;
800 d. With respect to a bill or statement that does not
801 substantially meet the applicable requirements of paragraphs (c)
802 and paragraph (d);
803 e. For any treatment or service that is upcoded, or that
804 is unbundled if when such treatment or services should be
805 bundled, in accordance with paragraph (d). To facilitate prompt
806 payment of lawful services, an insurer may change codes that it
807 determines to have been improperly or incorrectly upcoded or
808 unbundled, and may make payment based on the changed codes,
809 without affecting the right of the provider to dispute the
810 change by the insurer if, provided that before doing so, the
811 insurer contacts must contact the health care provider and
812 discusses discuss the reasons for the insurer's change and the

813 health care provider's reason for the coding, or makes ~~make~~ a
814 reasonable good faith effort to do so, as documented in the
815 insurer's file; and
816 f. For medical services or treatment billed by a physician
817 and not provided in a hospital unless such services are rendered
818 by the physician or are incident to his or her professional
819 services and are included on the physician's bill, including
820 documentation verifying that the physician is responsible for
821 the medical services that were rendered and billed.
822 2. The Department of Health, in consultation with the
823 appropriate professional licensing boards, shall adopt, by rule,
824 a list of diagnostic tests deemed not to be medically necessary
825 for use in the treatment of persons sustaining bodily injury
826 covered by personal injury protection benefits under this
827 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
828 ~~and~~ shall be revised from time to time as determined by the
829 Department of Health~~,~~ in consultation with the respective
830 professional licensing boards. Inclusion of a test on the list
831 must ~~of invalid diagnostic tests shall~~ be based on lack of
832 demonstrated medical value and a level of general acceptance by
833 the relevant provider community and may ~~shall~~ not be dependent
834 for results entirely upon subjective patient response.
835 Notwithstanding its inclusion on a fee schedule in this
836 subsection, an insurer or insured is not required to pay any
837 charges or reimburse claims for any invalid diagnostic test as
838 determined by the Department of Health.
839 (c)~~1.~~ With respect to any treatment or service, other than
840 medical services billed by a hospital or other provider for

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841 emergency services as defined in s. 395.002 or inpatient
842 services rendered at a hospital-owned facility, the statement of
843 charges must be furnished to the insurer by the provider and may
844 not include, and the insurer is not required to pay, charges for
845 treatment or services rendered more than 35 days before the
846 postmark date or electronic transmission date of the statement,
847 except for past due amounts previously billed on a timely basis
848 under this paragraph, and except that, if the provider submits
849 to the insurer a notice of initiation of treatment within 21
850 days after its first examination or treatment of the claimant,
851 the statement may include charges for treatment or services
852 rendered up to, but not more than, 75 days before the postmark
853 date of the statement. The injured party is not liable for, and
854 the provider may ~~shall~~ not bill the injured party for, charges
855 that are unpaid because of the provider's failure to comply with
856 this paragraph. Any agreement requiring the injured person or
857 insured to pay for such charges is unenforceable.
858 1.~~2.~~ If~~, however,~~ the insured fails to furnish the
859 provider with the correct name and address of the insured's
860 personal injury protection insurer, the provider has 35 days
861 from the date the provider obtains the correct information to
862 furnish the insurer with a statement of the charges. The insurer
863 is not required to pay for such charges unless the provider
864 includes with the statement documentary evidence that was
865 provided by the insured during the 35-day period demonstrating
866 that the provider reasonably relied on erroneous information
867 from the insured and either:
868 a. A denial letter from the incorrect insurer; or

869 b. Proof of mailing, which may include an affidavit under
870 penalty of perjury, reflecting timely mailing to the incorrect
871 address or insurer.
872 2.~~3.~~ For emergency services and care as defined in s.
873 395.002 rendered in a hospital emergency department or for
874 transport and treatment rendered by an ambulance provider
875 licensed pursuant to part III of chapter 401, the provider is
876 not required to furnish the statement of charges within the time
877 periods established by this paragraph,~~;~~ and the insurer is ~~shall~~
878 not ~~be~~ considered to have been furnished with notice of the
879 amount of covered loss for purposes of paragraph (4)(b) until it
880 receives a statement complying with paragraph (d), or copy
881 thereof, which specifically identifies the place of service to
882 be a hospital emergency department or an ambulance in accordance
883 with billing standards recognized by the Centers for Medicare
884 and Medicaid Services (CMS) ~~Health Care Finance Administration~~.
885 3.~~4.~~ Each notice of the insured's rights under s. 627.7401
886 must include the following statement in type no smaller than 12
887 points:
888
889 BILLING REQUIREMENTS.—Florida Statutes provide that
890 with respect to any treatment or services, other than
891 certain hospital and emergency services, the statement
892 of charges furnished to the insurer by the provider
893 may not include, and the insurer and the injured party
894 are not required to pay, charges for treatment or
895 services rendered more than 35 days before the
896 postmark date of the statement, except for past due

897 amounts previously billed on a timely basis, and
898 except that, if the provider submits to the insurer a
899 notice of initiation of treatment within 21 days after
900 its first examination or treatment of the claimant,
901 the first billing cycle statement may include charges
902 for treatment or services rendered up to, but not more
903 than, 75 days before the postmark date of the
904 statement.
905
906 (d) All statements and bills for medical services rendered
907 by any physician, hospital, clinic, or other person or
908 institution shall be submitted to the insurer on a properly
909 completed Centers for Medicare and Medicaid Services (CMS) 1500
910 form, UB 92 forms, or any other standard form approved by the
911 office or adopted by the commission for purposes of this
912 paragraph. All billings for such services rendered by providers
913 must ~~shall~~, to the extent applicable, follow the Physicians'
914 Current Procedural Terminology (CPT) or Healthcare Correct
915 Procedural Coding System (HCPCS), or ICD-9 in effect for the
916 year in which services are rendered and comply with the ~~Centers~~
917 ~~for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions
918 and the American Medical Association Current Procedural
919 Terminology (CPT) Editorial Panel and Healthcare Correct
920 Procedural Coding System (HCPCS). All providers other than
921 hospitals shall include on the applicable claim form the
922 professional license number of the provider in the line or space
923 provided for "Signature of Physician or Supplier, Including
924 Degrees or Credentials." In determining compliance with

925 applicable CPT and HCPCS coding, guidance shall be provided by
926 the Physicians' Current Procedural Terminology (CPT) or the
927 Healthcare Correct Procedural Coding System (HCPCS) in effect
928 for the year in which services were rendered, the Office of the
929 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
930 other authoritative treatises designated by rule by the Agency
931 for Health Care Administration. A ~~No~~ statement of medical
932 services may not include charges for medical services of a
933 person or entity that performed such services without possessing
934 the valid licenses required to perform such services. For
935 purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~
936 considered to have been furnished with notice of the amount of
937 covered loss or medical bills due unless the statements or bills
938 comply with this paragraph, and unless the statements or bills
939 are properly completed in their entirety as to all material
940 provisions, with all relevant information ~~being~~ provided
941 ~~therein~~.
942 (e)1. At the initial treatment or service provided, each
943 physician, other licensed professional, clinic, or other medical
944 institution providing medical services upon which a claim for
945 personal injury protection benefits is based shall require an
946 insured person, or his or her guardian, to execute a disclosure
947 and acknowledgment form, which reflects at a minimum that:
948 a. The insured, or his or her guardian, must countersign
949 the form attesting to the fact that the services set forth
950 therein were actually rendered;
951 b. The insured, or his or her guardian, has both the right
952 and affirmative duty to confirm that the services were actually

953 rendered;
954 c. The insured, or his or her guardian, was not solicited
955 by any person to seek any services from the medical provider;
956 d. The physician, other licensed professional, clinic, or
957 other medical institution rendering services for which payment
958 is being claimed explained the services to the insured or his or
959 her guardian; and
960 e. If the insured notifies the insurer in writing of a
961 billing error, the insured may be entitled to a certain
962 percentage of a reduction in the amounts paid by the insured's
963 motor vehicle insurer.
964 2. The physician, other licensed professional, clinic, or
965 other medical institution rendering services for which payment
966 is being claimed has the affirmative duty to explain the
967 services rendered to the insured, or his or her guardian, so
968 that the insured, or his or her guardian, countersigns the form
969 with informed consent.
970 3. Countersignature by the insured, or his or her
971 guardian, is not required for the reading of diagnostic tests or
972 other services that are of such a nature that they are not
973 required to be performed in the presence of the insured.
974 4. The licensed medical professional rendering treatment
975 for which payment is being claimed must sign, by his or her own
976 hand, the form complying with this paragraph.
977 5. The original completed disclosure and acknowledgment
978 form <u>is</u> ~~shall be~~ furnished to the insurer pursuant to paragraph
979 (4)(b) and may not be electronically furnished.
980 6. This disclosure and acknowledgment form is not required

981 for services billed by a provider for emergency services as
982 defined in s. 395.002, for emergency services and care as
983 defined in s. 395.002 rendered in a hospital emergency
984 department, or for transport and treatment rendered by an
985 ambulance provider licensed pursuant to part III of chapter 401.
986 7. The Financial Services Commission shall adopt~~,~~ by rule~~,~~
987 a standard disclosure and acknowledgment form to ~~that shall~~ be
988 used to fulfill the requirements of this paragraph~~, effective 90~~
989 ~~days after such form is adopted and becomes final~~. ~~The~~
990 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
991 ~~the rule is final, the provider may use a form of its own which~~
992 ~~otherwise complies with the requirements of this paragraph.~~
993 8. As used in this paragraph, the term "countersigned" or
994 "countersignature" means a second or verifying signature, as on
995 a previously signed document, and is not satisfied by the
996 statement "signature on file" or any similar statement.
997 9. The requirements of this paragraph apply only with
998 respect to the initial treatment or service of the insured by a
999 provider. For subsequent treatments or service, the provider
1000 must maintain a patient log signed by the patient, in
1001 chronological order by date of service, that is consistent with
1002 the services being rendered to the patient as claimed. The
1003 requirements ~~of this subparagraph~~ for maintaining a patient log
1004 signed by the patient may be met by a hospital that maintains
1005 medical records as required by s. 395.3025 and applicable rules
1006 and makes such records available to the insurer upon request.
1007 (f) Upon written notification by any person, an insurer
1008 shall investigate any claim of improper billing by a physician

1009 or other medical provider. The insurer shall determine if the
1010 insured was properly billed for only those services and
1011 treatments that the insured actually received. If the insurer
1012 determines that the insured has been improperly billed, the
1013 insurer shall notify the insured, the person making the written
1014 notification, and the provider of its findings and ~~shall~~ reduce
1015 the amount of payment to the provider by the amount determined
1016 to be improperly billed. If a reduction is made due to such
1017 written notification by any person, the insurer shall pay to the
1018 person 20 percent of the amount of the reduction, up to $500. If
1019 the provider is arrested due to the improper billing, ~~then~~ the
1020 insurer shall pay to the person 40 percent of the amount of the
1021 reduction, up to $500.

1022 (g) An insurer may not systematically downcode with the
1023 intent to deny reimbursement otherwise due. Such action
1024 constitutes a material misrepresentation under s.
1025 626.9541(1)(i)2.

1026 (7) ~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1027 DISPUTES.—

1028 (a) An insurer may require a claimant to submit to an
1029 examination under oath or sworn statement as often as reasonably
1030 requested by an insurer and at any reasonable location
1031 designated by the insurer. Submission to an examination under
1032 oath or sworn statement is a condition precedent to recovery or
1033 filing suit. The insurer is not liable for benefits under the
1034 no-fault law if the claimant fails to fully and truthfully
1035 answer all questions asked or violates any provision of
1036 paragraph (4)(j).

1037 1. The insurer may conduct the examination outside the
1038 presence of any other person seeking coverage.
1039 2. If an insurer requests an examination of a claimant
1040 that is in a hospital, clinic, or other medical institution,
1041 such claimant shall produce the persons with the most knowledge
1042 relating to the issues set forth by the insurer in the notice of
1043 examination.
1044 3. The claimant must provide the insurer at the
1045 examination with all documents, papers, receipts, invoices,
1046 bills, records, or other tangible items requested by the
1047 insurer.
1048 4. The examination may be recorded by audio, video, or
1049 court report or any combination thereof. The claimant may record
1050 the examination at the claimant's expense.
1051 5. The claimant may have an attorney present at the
1052 examination at the claimant's expense.
1053 6. An insurer that unreasonably requests an examination
1054 without a reasonable basis as a general business practice is
1055 engaging in an unfair insurance trade practice pursuant to s.
1056 626.9541.
1057 ~~(a) Every employer shall, if a request is made by an~~
1058 ~~insurer providing personal injury protection benefits under ss.~~
1059 ~~627.730-627.7405 against whom a claim has been made, furnish~~
1060 ~~forthwith, in a form approved by the office, a sworn statement~~
1061 ~~of the earnings, since the time of the bodily injury and for a~~
1062 ~~reasonable period before the injury, of the person upon whose~~
1063 ~~injury the claim is based.~~
1064 (b) Every physician, hospital, clinic, or other medical

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

1093 ~~permitted~~ against any physician, hospital, clinic, or other
1094 medical institution complying with ~~the provisions of~~ this
1095 section. The person requesting such records and such sworn
1096 statement shall pay all reasonable costs connected therewith. If
1097 an insurer makes a written request for documentation or
1098 information under this paragraph within 30 days after having
1099 received notice of the amount of a covered loss under paragraph
1100 (4)(a), the amount or the partial amount <u>that</u> ~~which~~ is the
1101 subject of the insurer's inquiry <u>is</u> ~~shall become~~ overdue if the
1102 insurer does not pay in accordance with paragraph (4)(b) or
1103 within 10 days after the insurer's receipt of the requested
1104 documentation or information, whichever occurs later. For
1105 purposes of this paragraph, the term "receipt" includes, but is
1106 not limited to, inspection and copying pursuant to this
1107 paragraph. <u>An</u> ~~Any~~ insurer that requests documentation or
1108 information pertaining to reasonableness of charges or medical
1109 necessity under this paragraph without a reasonable basis for
1110 such requests as a general business practice is engaging in an
1111 unfair trade practice under the insurance code.
1112 <u>(c) If a request is made by an insurer, an employer must</u>
1113 <u>furnish, in a form approved by the office, a sworn statement of</u>
1114 <u>the earnings of the person upon whose injury a claim is based</u>
1115 <u>since the time of the bodily injury and for a reasonable period</u>
1116 <u>before the injury.</u>
1117 <u>(d)</u>~~(c)~~ <u>If there is a</u> ~~In the event of any~~ dispute regarding
1118 an insurer's right to discovery of facts under this section, the
1119 insurer may petition <u>the</u> ~~a~~ court ~~of competent jurisdiction~~ to
1120 enter an order permitting such discovery. The order may be made

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1121 only on motion for good cause shown and upon notice to all
1122 persons having an interest~~,~~ and must ~~it shall~~ specify the time,
1123 place, manner, conditions, and scope of the discovery. The ~~Such~~
1124 court may, in order to protect against annoyance, embarrassment,
1125 or oppression, as justice requires, enter an order refusing
1126 discovery or specifying conditions of discovery and ~~may~~ order
1127 payments of costs and expenses of the proceeding, including
1128 reasonable fees for the appearance of attorneys at the
1129 proceedings, as justice requires.
1130 (8) ~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1131 REPORTS.—
1132 (b) If requested by the person examined, a party causing
1133 an examination to be made shall deliver to him or her a copy of
1134 every written report concerning the examination rendered by an
1135 examining physician, at least one of which reports must set out
1136 the examining physician's findings and conclusions in detail.
1137 After such request and delivery, the party causing the
1138 examination to be made is entitled, upon request, to receive
1139 from the person examined every written report available to him
1140 or her or his or her representative concerning any examination,
1141 previously or thereafter made, of the same mental or physical
1142 condition. By requesting and obtaining a report of the
1143 examination so ordered, or by taking the deposition of the
1144 examiner, the person examined waives any privilege he or she may
1145 have, in relation to the claim for benefits, regarding the
1146 testimony of every other person who has examined, or may
1147 thereafter examine, him or her in respect to the same mental or
1148 physical condition. If a person unreasonably refuses to submit

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1149 to an examination, the personal injury protection carrier is no
1150 longer liable for ~~subsequent~~ personal injury protection benefits
1151 incurred after the date of the first request for examination.
1152 Failure to appear for an examination raises a rebuttable
1153 presumption that such failure was unreasonable. Submission to an
1154 examination is a condition precedent to the recovery of
1155 benefits.
1156 (9) ~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
1157 FEES.—With respect to any dispute ~~under the provisions of ss.~~
1158 ~~627.730-627.7405~~ between the insured and the insurer under the
1159 no-fault law~~,~~ or between an assignee of an insured's rights and
1160 the insurer, ~~the provisions of~~ s. 627.428 applies ~~shall apply~~,
1161 except as provided in subsections (11) and (16) ~~(10) and (15)~~.
1162 (10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and
1163 enter into contracts with preferred ~~licensed health care~~
1164 providers for the benefits described in this section, ~~referred~~
1165 ~~to in this section as "preferred providers,"~~ which ~~shall~~ include
1166 health care providers licensed under chapter ~~chapters~~ 458,
1167 chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.
1168 (a) The insurer may provide an option to an insured to use
1169 a preferred provider at the time of purchase of the policy for
1170 personal injury protection benefits~~,~~ if the requirements of this
1171 subsection are met. However, if the insurer offers a preferred
1172 provider option, it must also offer a nonpreferred provider
1173 policy. ~~If the insured elects to use a provider who is not a~~
1174 ~~preferred provider, whether the insured purchased a preferred~~
1175 ~~provider policy or a nonpreferred provider policy, the medical~~
1176 ~~benefits provided by the insurer shall be as required by this~~

1177 ~~section.~~

1178 (b) If the insured elects the ~~to use a provider who is a~~
1179 preferred provider option, the insurer may pay medical benefits
1180 in excess of the benefits required by this section and may waive
1181 or lower the amount of any deductible that applies to such
1182 medical benefits. As an alternative, or in addition to such
1183 benefits, waiver, or reduction, the insurer may provide an
1184 actuarially appropriate premium discount as specified in an
1185 approved rate filing to an insured who selects the preferred
1186 provider option. If the preferred provider option provides a
1187 premium discount, the policy may provide that charges for
1188 nonemergency services provided within this state are payable
1189 only if performed by members of the preferred provider network
1190 unless there is no member of the preferred provider network
1191 located within 15 miles of the insured's place of residence
1192 whose scope of practice includes the required services. ~~If the~~
1193 ~~insurer offers a preferred provider policy to a policyholder or~~
1194 ~~applicant, it must also offer a nonpreferred provider policy.~~

1195 (c) The insurer shall provide each insured ~~policyholder~~
1196 with a current roster of preferred providers in the county in
1197 which the insured resides at the time of purchasing ~~purchase of~~
1198 such policy~~,~~ and ~~shall~~ make such list available for public
1199 inspection during regular business hours at the insurer's
1200 principal office ~~of the insurer~~ within the state. The insurer
1201 may contract with another health insurer for the right to use an
1202 existing preferred provider network to implement the preferred
1203 provider option. Any other arrangement is subject to the
1204 approval of the Office of Insurance Regulation.

1205 (17) ~~(16)~~ SECURE ELECTRONIC DATA TRANSFER.—If all parties
1206 mutually and expressly agree, a notice, documentation,
1207 transmission, or communication of any kind required or
1208 authorized under the no-fault law ~~ss. 627.730-627.7405~~ may be
1209 transmitted electronically if it is transmitted by secure
1210 electronic data transfer that is consistent with state and
1211 federal privacy and security laws.
1212 Section 8. Subsection (1) of section 324.021, Florida
1213 Statutes, is amended to read:
1214 324.021 Definitions; minimum insurance required.—The
1215 following words and phrases when used in this chapter shall, for
1216 the purpose of this chapter, have the meanings respectively
1217 ascribed to them in this section, except in those instances
1218 where the context clearly indicates a different meaning:
1219 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
1220 is designed and required to be licensed for use upon a highway,
1221 including trailers and semitrailers designed for use with such
1222 vehicles, except traction engines, road rollers, farm tractors,
1223 power shovels, and well drillers, and every vehicle that ~~which~~
1224 is propelled by electric power obtained from overhead wires but
1225 not operated upon rails, but not including any bicycle or moped.
1226 However, the term does ~~"motor vehicle" shall~~ not include a ~~any~~
1227 motor vehicle as defined in s. 627.732 ~~(3)~~ if ~~when~~ the owner of
1228 such vehicle has complied with the no-fault law ~~requirements of~~
1229 ~~ss. 627.730-627.7405, inclusive~~, unless the provisions of s.
1230 324.051 apply; and, in such case, the applicable proof of
1231 insurance provisions of s. 320.02 apply.
1232 Section 9. Paragraph (k) of subsection (2) of section

1233 456.057, Florida Statutes, is amended to read:
1234 456.057 Ownership and control of patient records; report
1235 or copies of records to be furnished.—
1236 (2) As used in this section, the terms "records owner,"
1237 "health care practitioner," and "health care practitioner's
1238 employer" do not include any of the following persons or
1239 entities; furthermore, the following persons or entities are not
1240 authorized to acquire or own medical records, but are authorized
1241 under the confidentiality and disclosure requirements of this
1242 section to maintain those documents required by the part or
1243 chapter under which they are licensed or regulated:
1244 (k) Persons or entities practicing under s. 627.736(8)
1245 ~~627.736(7)~~.
1246 Section 10. Subsection (7) of section 627.7295, Florida
1247 Statutes, is amended to read:
1248 627.7295 Motor vehicle insurance contracts.—
1249 (7) A policy of private passenger motor vehicle insurance
1250 or a binder for such a policy may be initially issued in this
1251 state only if, before the effective date of such binder or
1252 policy, the insurer or agent has collected from the insured an
1253 amount equal to 2 months' premium. An insurer, agent, or premium
1254 finance company may not, directly or indirectly, take any action
1255 resulting in the insured having paid from the insured's own
1256 funds an amount less than the 2 months' premium required by this
1257 subsection. This subsection applies without regard to whether
1258 the premium is financed by a premium finance company or is paid
1259 pursuant to a periodic payment plan of an insurer or an
1260 insurance agent. This subsection does not apply if an insured or

1261 member of the insured's family is renewing or replacing a policy
1262 or a binder for such policy written by the same insurer or a
1263 member of the same insurer group. This subsection does not apply
1264 to an insurer that issues private passenger motor vehicle
1265 coverage primarily to active duty or former military personnel
1266 or their dependents. This subsection does not apply if all
1267 policy payments are paid pursuant to a payroll deduction plan or
1268 an automatic electronic funds transfer payment plan from the
1269 policyholder. This subsection and subsection (4) do not apply if
1270 all policy payments to an insurer are paid pursuant to an
1271 automatic electronic funds transfer payment plan from an agent,
1272 a managing general agent, or a premium finance company and if
1273 the policy includes, at a minimum, personal injury protection
1274 pursuant to ss. 627.730-627.7407 ~~627.730-627.7405~~; motor vehicle
1275 property damage liability pursuant to s. 627.7275; and bodily
1276 injury liability in at least the amount of $10,000 because of
1277 bodily injury to, or death of, one person in any one accident
1278 and in the amount of $20,000 because of bodily injury to, or
1279 death of, two or more persons in any one accident. This
1280 subsection and subsection (4) do not apply if an insured has had
1281 a policy in effect for at least 6 months, the insured's agent is
1282 terminated by the insurer that issued the policy, and the
1283 insured obtains coverage on the policy's renewal date with a new
1284 company through the terminated agent.
1285 Section 11. Subsections (3) and (4) of section 627.733,
1286 Florida Statutes, are amended to read:
1287 627.733 Required security.—
1288 (3) Such security shall be provided:

1289 (a) By an insurance policy delivered or issued for
1290 delivery in this state by an authorized or eligible motor
1291 vehicle liability insurer which provides the benefits and
1292 exemptions contained in the no-fault law ~~ss. 627.730-627.7405~~.
1293 Any policy of insurance represented or sold as providing the
1294 security required hereunder shall be deemed to provide insurance
1295 for the payment of the required benefits; or
1296 (b) By any other method authorized by s. 324.031(2), (3),
1297 or (4) and approved by the Department of Highway Safety and
1298 Motor Vehicles as affording security equivalent to that afforded
1299 by a policy of insurance or by self-insuring as authorized by s.
1300 768.28(16). The person filing such security shall have all of
1301 the obligations and rights of an insurer under the no-fault law
1302 ~~ss. 627.730-627.7405~~.
1303 (4) An owner of a motor vehicle with respect to which
1304 security is required by this section who fails to have such
1305 security in effect at the time of an accident shall have no
1306 immunity from tort liability, but shall be personally liable for
1307 the payment of benefits under s. 627.736. With respect to such
1308 benefits, such an owner shall have all of the rights and
1309 obligations of an insurer under the no-fault law ~~ss. 627.730-~~
1310 ~~627.7405~~.
1311 Section 12. Section 627.734, Florida Statutes, is amended
1312 to read:
1313 627.734 Proof of security; security requirements;
1314 penalties.—
1315 (1) The provisions of chapter 324 that ~~which~~ pertain to
1316 the method of giving and maintaining proof of financial

1317 responsibility and that ~~which~~ govern and define a motor vehicle
1318 liability policy shall apply to filing and maintaining proof of
1319 security required by the no-fault law ~~ss. 627.730-627.7405~~.
1320 (2) Any person who:
1321 (a) Gives information required in a report or otherwise as
1322 provided for in the no-fault law ~~ss. 627.730-627.7405~~, knowing
1323 or having reason to believe that such information is false;
1324 (b) Forges or, without authority, signs any evidence of
1325 proof of security; or
1326 (c) Files, or offers for filing, any such evidence of
1327 proof, knowing or having reason to believe that it is forged or
1328 signed without authority,
1329
1330 commits ~~is guilty of~~ a misdemeanor of the first degree,
1331 punishable as provided in s. 775.082 or s. 775.083.
1332 Section 13. Subsections (1), (2), and (3) of section
1333 627.737, Florida Statutes, are amended to read:
1334 627.737 Tort exemption; limitation on right to damages;
1335 punitive damages.—
1336 (1) Every owner, registrant, operator, or occupant of a
1337 motor vehicle with respect to which security has been provided
1338 as required by the no-fault law ~~ss. 627.730-627.7405~~, and every
1339 person or organization legally responsible for her or his acts
1340 or omissions, is hereby exempted from tort liability for damages
1341 because of bodily injury, sickness, or disease arising out of
1342 the ownership, operation, maintenance, or use of such motor
1343 vehicle in this state to the extent that the benefits described
1344 in s. 627.736(1) are payable for such injury, or would be

1345 payable but for any exclusion authorized by the no-fault law ~~ss.~~
1346 ~~627.730-627.7405~~, under any insurance policy or other method of
1347 security complying with the requirements of s. 627.733, or by an
1348 owner personally liable under s. 627.733 for the payment of such
1349 benefits, unless a person is entitled to maintain an action for
1350 pain, suffering, mental anguish, and inconvenience for such
1351 injury under ~~the provisions of~~ subsection (2).
1352 (2) In any action of tort brought against the owner,
1353 registrant, operator, or occupant of a motor vehicle with
1354 respect to which security has been provided as required by the
1355 no-fault law ~~ss. 627.730-627.7405~~, or against any person or
1356 organization legally responsible for her or his acts or
1357 omissions, a plaintiff may recover damages in tort for pain,
1358 suffering, mental anguish, and inconvenience because of bodily
1359 injury, sickness, or disease arising out of the ownership,
1360 maintenance, operation, or use of such motor vehicle only in the
1361 event that the injury or disease consists in whole or in part
1362 of:
1363 (a) Significant and permanent loss of an important bodily
1364 function.
1365 (b) Permanent injury within a reasonable degree of medical
1366 probability, other than scarring or disfigurement.
1367 (c) Significant and permanent scarring or disfigurement.
1368 (d) Death.
1369 (3) When a defendant, in a proceeding brought pursuant to
1370 the no-fault law ~~ss. 627.730-627.7405~~, questions whether the
1371 plaintiff has met the requirements of subsection (2), ~~then~~ the
1372 defendant may file an appropriate motion with the court, and the

1373 court shall, on a one-time basis only, 30 days before the date
1374 set for the trial or the pretrial hearing, whichever is first,
1375 by examining the pleadings and the evidence before it, ascertain
1376 whether the plaintiff will be able to submit some evidence that
1377 the plaintiff will meet the requirements of subsection (2). If
1378 the court finds that the plaintiff will not be able to submit
1379 such evidence, ~~then~~ the court shall dismiss the plaintiff's
1380 claim without prejudice.
1381 Section 14. Subsection (1) of section 627.7401, Florida
1382 Statutes, is amended to read:
1383 627.7401 Notification of insured's rights.—
1384 (1) The commission, by rule, shall adopt a form for the
1385 notification of insureds of their right to receive personal
1386 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1387 fault law. Such notice shall include:
1388 (a) A description of the benefits provided by personal
1389 injury protection, including, but not limited to, the specific
1390 types of services for which medical benefits are paid,
1391 disability benefits, death benefits, significant exclusions from
1392 and limitations on personal injury protection benefits, when
1393 payments are due, how benefits are coordinated with other
1394 insurance benefits that the insured may have, penalties and
1395 interest that may be imposed on insurers for failure to make
1396 timely payments of benefits, and rights of parties regarding
1397 disputes as to benefits.
1398 (b) An advisory informing insureds that:
1399 1. Pursuant to s. 626.9892, the Department of Financial
1400 Services may pay rewards of up to $25,000 to persons providing

1401 information leading to the arrest and conviction of persons
1402 committing crimes investigated by the Division of Insurance
1403 Fraud arising from violations of s. 440.105, s. 624.15, s.
1404 626.9541, s. 626.989, or s. 817.234.
1405 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
1406 insured notifies the insurer of a billing error, the insured may
1407 be entitled to a certain percentage of a reduction in the amount
1408 paid by the insured's motor vehicle insurer.
1409 (c) A notice that solicitation of a person injured in a
1410 motor vehicle crash for purposes of filing personal injury
1411 protection or tort claims could be a violation of s. 817.234, s
1412 817.505, or the rules regulating The Florida Bar and should be
1413 immediately reported to the Division of Insurance Fraud if such
1414 conduct has taken place.
1415 Section 15. Section 627.7405, Florida Statutes, is amended
1416 to read:
1417 627.7405 Insurers' right of reimbursement.—Notwithstanding
1418 any other provisions of the no-fault law ~~ss. 627.730-627.7405~~,
1419 any insurer providing personal injury protection benefits on a
1420 private passenger motor vehicle has ~~shall have~~, to the extent of
1421 any personal injury protection benefits paid to any person as a
1422 benefit arising out of such private passenger motor vehicle
1423 insurance, a right of reimbursement against the owner or the
1424 insurer of the owner of a commercial motor vehicle~~,~~ if the
1425 benefits paid result from such person having been an occupant of
1426 the commercial motor vehicle or having been struck by the
1427 commercial motor vehicle while not an occupant of any self-
1428 propelled vehicle.

1429 Section 16. Subsection (1) of section 627.7407, Florida
1430 Statutes, is amended to read:
1431 627.7407 Application of the Florida Motor Vehicle No-Fault
1432 Law.—
1433 (1) Any person subject to the requirements of ~~ss. 627.730-~~
1434 ~~627.7405,~~ the Florida Motor Vehicle No-Fault Law, as revived and
1435 amended by this act, must maintain security for personal injury
1436 protection as required by the Florida Motor Vehicle No-Fault
1437 Law, as revived and amended by this act, beginning on January 1,
1438 2008.
1439 Section 17. Paragraph (d) of subsection (2) and paragraph
1440 (d) of subsection (3) of section 628.909, Florida Statutes, are
1441 amended to read:
1442 628.909 Applicability of other laws.—
1443 (2) The following provisions of the Florida Insurance Code
1444 shall apply to captive insurers who are not industrial insured
1445 captive insurers to the extent that such provisions are not
1446 inconsistent with this part:
1447 (d) Sections <u>627.730-627.7407</u> ~~627.730-627.7405~~, when no-
1448 fault coverage is provided.
1449 (3) The following provisions of the Florida Insurance Code
1450 shall apply to industrial insured captive insurers to the extent
1451 that such provisions are not inconsistent with this part:
1452 (d) Sections <u>627.730-627.7407</u> ~~627.730-627.7405~~ when no-
1453 fault coverage is provided.
1454 Section 18. For the purpose of incorporating the amendment
1455 made by this act to section 627.736, Florida Statutes, in a
1456 reference thereto, paragraph (c) of subsection (7) of section

1457 817.234, Florida Statutes, is reenacted to read:
1458 817.234 False and fraudulent insurance claims.—
1459 (7)
1460 (c) An insurer, or any person acting at the direction of
1461 or on behalf of an insurer, may not change an opinion in a
1462 mental or physical report prepared under s. 627.736(8) or direct
1463 the physician preparing the report to change such opinion;
1464 however, this provision does not preclude the insurer from
1465 calling to the attention of the physician errors of fact in the
1466 report based upon information in the claim file. Any person who
1467 violates this paragraph commits a felony of the third degree,
1468 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
1469 Section 19. This act shall take effect July 1, 2012.