

By Senator Bennett

21-00032-12

2012254__

1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; amending s. 316.066, F.S.;
4 revising provisions relating to the contents of
5 written reports of motor vehicle crashes; authorizing
6 the investigation officer to testify at trial or
7 provide an affidavit concerning the content of the
8 reports; amending s. 400.991, F.S.; requiring that an
9 application for licensure as a mobile clinic include a
10 statement regarding insurance fraud; amending s.
11 627.730, F.S.; conforming a cross-reference; amending
12 s. 627.731, F.S.; conforming provisions to changes
13 made by the act; reordering and amending s. 627.732,
14 F.S.; defining the term "no-fault law"; amending ss.
15 627.733 and 627.734, F.S.; conforming provisions to
16 changes made by the act; amending s. 627.736, F.S.;
17 conforming provisions to changes made by the act;
18 adding licensed acupuncturists to the list of
19 practitioners authorized to provide, supervise, order,
20 or prescribe services; providing that an insurer's
21 failure to send certain specification or explanation
22 waives other grounds for rejecting an invalid claim;
23 preempting local lien laws with respect to payment of
24 benefits to medical providers; providing that a
25 claimant that violates certain provisions is not
26 entitled to any payment, regardless of whether a
27 portion of the claim may be legitimate; revising the
28 insurer's reimbursement limitation; providing a limit
29 on the amount of reimbursement if the insurance policy

21-00032-12

2012254

30 includes a schedule of charges; deleting a provision
31 allowing charges for services provided before a
32 certain date; authorizing the insurer to deny a claim
33 if the provider does not submit a properly completed
34 statement or bill within a certain time; specifying
35 requirements for furnishing the insured with notice of
36 the amount of covered loss; deleting an obsolete
37 provision; requiring the provider to provide copies of
38 the patient log within a certain time if requested by
39 the insurer; providing that failure to maintain a
40 patient log renders the treatment unlawful and
41 noncompensable; revising requirements relating to
42 discovery; requiring that the provider authorize the
43 insurer to conduct a physical review of the treatment
44 location under certain circumstances; authorizing an
45 insurer to contract with a preferred provider;
46 authorizing an insurer to provide a premium discount
47 to an insured who selects a preferred provider;
48 providing that an insured forfeits the premium
49 discount if the insured uses nonemergency services
50 performed by a nonpreferred provider in specified
51 circumstances; authorizing an insurer to use a
52 preferred provider network; revising requirements
53 relating to demand letters in an action for benefits;
54 specifying when a demand letter is defective; deleting
55 obsolete provisions; authorizing a demand letter to be
56 used to request the production of claim documents or
57 other records from the insurer; amending ss. 627.737,
58 627.7405, and 627.7407, F.S.; conforming provisions to

21-00032-12

2012254__

59 changes made by the act; amending ss. 324.021,
60 627.7295, 628.909, and 817.234, F.S.; conforming
61 cross-references; providing an effective date.

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

64
65 Section 1. Subsection (1) of section 316.066, Florida
66 Statutes, is amended to read:

67 316.066 Written reports of crashes.—

68 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~
69 ~~required to~~ be completed and submitted to the department within
70 10 days after ~~completing~~ an investigation is completed by the
71 ~~every~~ law enforcement officer who in the regular course of duty
72 investigates a motor vehicle crash ~~that~~:

73 1. That resulted in death, or personal injury, or any
74 indication of complaints of pain or discomfort by any of the
75 parties or passengers involved in the crash;

76 2. That involved one or more passengers, other than the
77 drivers of the vehicles, in any of the vehicles involved in the
78 crash;

79 ~~3.2. That~~ involved a violation of s. 316.061(1) or s.
80 316.193; or

81 4. In which a vehicle was rendered inoperative to a degree
82 that required a wrecker to remove it from traffic, if the
83 investigating officer determines such action to be appropriate.

84 (b) In every crash for which a Florida Traffic Crash
85 Report, Long Form, is not required by this section, the law
86 enforcement officer may complete a short-form crash report or
87 provide a driver exchange-of-information form to be completed by

21-00032-12

2012254

88 each party involved in the crash. Short-form crash reports
89 prepared by the law enforcement officer shall be maintained by
90 the officer's agency.

91 (c) The long-form and the short-form report must include:

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

93 2. A description of the vehicles involved.

94 3. The names and addresses of the parties involved,
95 including all drivers and passengers.

96 4. The identification of all passengers and the vehicle in
97 which he or she was a passenger.

98 5.4. The names and addresses of witnesses.

99 6.5. The name, badge number, and law enforcement agency of
100 the officer investigating the crash.

101 7.6. The names of the insurance companies for the
102 respective parties involved in the crash.

103 (d) ~~(e)~~ Each party to the crash must provide the law
104 enforcement officer with proof of insurance, which must be
105 documented in the crash report. If a law enforcement officer
106 submits a report on the crash, proof of insurance must be
107 provided to the officer by each party involved in the crash. Any
108 party who fails to provide the required information commits a
109 noncriminal traffic infraction, punishable as a nonmoving
110 violation as provided in chapter 318, unless the officer
111 determines that due to injuries or other special circumstances
112 such insurance information cannot be provided immediately. If
113 the person provides the law enforcement agency, within 24 hours
114 after the crash, proof of insurance that was valid at the time
115 of the crash, the law enforcement agency may void the citation.

116 (e) ~~(d)~~ The driver of a vehicle that was in any manner

21-00032-12

2012254

117 involved in a crash resulting in damage to any vehicle or other
118 property in an amount of \$500 or more which was not investigated
119 by a law enforcement agency, shall, within 10 days after the
120 crash, submit a written report of the crash to the department.
121 The entity receiving the report may require witnesses of the
122 crash to render reports and may require any driver of a vehicle
123 involved in a crash of which a written report must be made to
124 file supplemental written reports if the original report is
125 deemed insufficient by the receiving entity.

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

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

131 Section 2. Subsection (6) is added to section 400.991,
132 Florida Statutes, to read:

133 400.991 License requirements; background screenings;
134 prohibitions.-

135 (6) All forms that constitute part of the application for
136 licensure or exemption from licensure under this part must
137 contain the following statement:

138
139 INSURANCE FRAUD NOTICE.-Submitting a false or
140 fraudulent application or other document when applying
141 for licensure as a health care clinic, when seeking an
142 exemption from licensure as a health care clinic, or
143 when demonstrating compliance with part X of chapter
144 400, Florida Statutes, is a fraudulent insurance act,
145 as defined in s. 626.989 or s. 817.234, Florida

21-00032-12

2012254__

146 Statutes, subject to investigation by the Division of
 147 Insurance Fraud, and is grounds for discipline by the
 148 appropriate licensing board of the Department of
 149 Health.

150 Section 3. Section 627.730, Florida Statutes, is amended to
 151 read:

152 627.730 Florida Motor Vehicle No-Fault Law.—Sections
 153 627.730-627.7407 ~~627.730-627.7405~~ may be cited ~~and known~~ as the
 154 “Florida Motor Vehicle No-Fault Law.”

155 Section 4. Section 627.731, Florida Statutes, is amended to
 156 read:

157 627.731 Purpose.—The purpose of the no-fault law ~~ss.~~
 158 ~~627.730-627.7405~~ is to provide for medical, surgical, funeral,
 159 and disability insurance benefits without regard to fault, and
 160 to require motor vehicle insurance securing such benefits, for
 161 motor vehicles required to be registered in this state and, with
 162 respect to motor vehicle accidents, a limitation on the right to
 163 claim damages for pain, suffering, mental anguish, and
 164 inconvenience.

165 Section 5. Section 627.732, Florida Statutes, is reordered
 166 and amended to read:

167 627.732 Definitions.—As used in the no-fault law ~~ss.~~
 168 ~~627.730-627.7405~~, the term:

169 (1) “Broker” means any person not possessing a license
 170 under chapter 395, chapter 400, chapter 429, chapter 458,
 171 chapter 459, chapter 460, chapter 461, or chapter 641 who
 172 charges or receives compensation for any use of medical
 173 equipment and is not the 100 percent ~~100-percent~~ owner or the
 174 100 percent ~~100-percent~~ lessee of such equipment. For purposes

21-00032-12

2012254__

175 of this section, such owner or lessee may be an individual, a
176 corporation, a partnership, or any other entity and any of its
177 100 percent-owned ~~100-percent-owned~~ affiliates and subsidiaries.
178 For purposes of this subsection, the term "lessee" means a long-
179 term lessee under a capital or operating lease, but does not
180 include a part-time lessee. The term "broker" does not include a
181 hospital or physician management company whose medical equipment
182 is ancillary to the practices managed, a debt collection agency,
183 or an entity that has contracted with the insurer to obtain a
184 discounted rate for such services; or ~~nor does the term include~~
185 a management company that has contracted to provide general
186 management services for a licensed physician or health care
187 facility and whose compensation is not materially affected by
188 the usage or frequency of usage of medical equipment or an
189 entity that is 100 percent ~~100-percent~~ owned by one or more
190 hospitals or physicians. The term "broker" does not include a
191 person or entity that certifies, upon request of an insurer,
192 that:

193 (a) It is a clinic licensed under ss. 400.990-400.995;

194 (b) It is a 100 percent ~~100-percent~~ owner of medical
195 equipment; and

196 (c) The owner's only part-time lease of medical equipment
197 for personal injury protection patients is on a temporary basis,
198 not to exceed 30 days in a 12-month period, and such lease is
199 solely for the purposes of necessary repair or maintenance of
200 the 100 percent-owned ~~100-percent-owned~~ medical equipment or
201 pending the arrival and installation of the newly purchased or a
202 replacement for the 100 percent-owned ~~100-percent-owned~~ medical
203 equipment, or for patients for whom, because of physical size or

21-00032-12

2012254__

204 claustrophobia, it is determined by the medical director or
 205 clinical director to be medically necessary that the test be
 206 performed in medical equipment that is open-style. The leased
 207 medical equipment may not ~~cannot~~ be used by patients who are not
 208 patients of the registered clinic ~~for medical treatment of~~
 209 ~~services~~. Any person or entity making a false certification
 210 under this subsection commits insurance fraud as defined in s.
 211 817.234. However, the 30-day period ~~provided in this paragraph~~
 212 may be extended for an additional 60 days as applicable to
 213 magnetic resonance imaging equipment if the owner certifies that
 214 the extension otherwise complies with this paragraph.

215 (8) ~~(2)~~ "Medically necessary" refers to a medical service or
 216 supply that a prudent physician would provide for the purpose of
 217 preventing, diagnosing, or treating an illness, injury, disease,
 218 or symptom in a manner that is:

219 (a) In accordance with generally accepted standards of
 220 medical practice;

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

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

225 (9) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
 226 with four or more wheels which is of a type both designed and
 227 required to be licensed for use on the highways of this state,
 228 and any trailer or semitrailer designed for use with such
 229 vehicle, and includes:

230 (a) A "private passenger motor vehicle," which is any motor
 231 vehicle that ~~which~~ is a sedan, station wagon, or jeep-type
 232 vehicle and, if not used primarily for occupational,

21-00032-12

2012254__

233 professional, or business purposes, a motor vehicle of the
234 pickup, panel, van, camper, or motor home type.

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

237
238 The term "~~motor vehicle~~" does not include a mobile home or any
239 motor vehicle that ~~which~~ is used in mass transit, other than
240 public school transportation, and designed to transport more
241 than five passengers exclusive of the operator of the motor
242 vehicle and that ~~which~~ is owned by a municipality, a transit
243 authority, or a political subdivision of the state.

244 (10)~~(4)~~ "Named insured" means a person, usually the owner
245 of a vehicle, identified in a policy by name as the insured
246 under the policy.

247 (11) "No-fault law" means the Florida Motor Vehicle No-
248 Fault Law codified at ss. 627.730-627.7407.

249 (12)~~(5)~~ "Owner" means a person who holds the legal title to
250 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
251 subject of a security agreement or lease with an option to
252 purchase with the debtor or lessee having the right to
253 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
254 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.

255 (14)~~(6)~~ "Relative residing in the same household" means a
256 relative of any degree by blood or by marriage who usually makes
257 her or his home in the same family unit, whether or not
258 temporarily living elsewhere.

259 (2)~~(7)~~ "Certify" means to swear or attest to being true or
260 represented in writing.

261 (4)~~(8)~~ "Immediate personal supervision," as it relates to

21-00032-12

2012254

262 the performance of medical services by nonphysicians not in a
263 hospital, means that an individual licensed to perform the
264 medical service or provide the medical supplies must be present
265 within the confines of the physical structure where the medical
266 services are performed or where the medical supplies are
267 provided such that the licensed individual can respond
268 immediately to any emergencies if needed.

269 (5)~~(9)~~ "Incident," with respect to services considered as
270 incident to a physician's professional service, for a physician
271 licensed under chapter 458, chapter 459, chapter 460, or chapter
272 461, if not furnished in a hospital, means ~~such~~ that
273 are ~~must be~~ an integral, even if incidental, part of a covered
274 physician's service.

275 (6)~~(10)~~ "Knowingly" means that a person, with respect to
276 information, has actual knowledge of the information, and acts in
277 deliberate ignorance of the truth or falsity of the
278 information, and or acts in reckless disregard of the information. and
279 ~~and~~ Proof of specific intent to defraud is not required.

280 (7)~~(11)~~ "Lawful" or "lawfully" means in substantial
281 compliance with all relevant applicable criminal, civil, and
282 administrative requirements of state and federal law related to
283 the provision of medical services or treatment.

284 (3)~~(12)~~ "Hospital" means a facility that, at the time
285 services or treatment was ~~were~~ rendered, was licensed under
286 chapter 395.

287 (13)~~(13)~~ "Properly completed" means providing truthful,
288 substantially complete, and substantially accurate responses ~~as~~
289 to all material elements of ~~to~~ each applicable request for
290 information or statement by a means that may lawfully be

21-00032-12

2012254__

291 provided and that complies with this section, or as agreed by
 292 the parties.

293 (16) ~~(14)~~ "Upcoding" means submitting ~~an action that submits~~
 294 a billing code that would result in payment greater in amount
 295 than would be paid using a billing code that accurately
 296 describes the services performed. The term does not include an
 297 otherwise lawful bill by a magnetic resonance imaging facility,
 298 which globally combines both technical and professional
 299 components, if the amount of the global bill is not more than
 300 the components if billed separately; however, payment of such a
 301 bill constitutes payment in full for all components of such
 302 service.

303 (15) "Unbundling" means submitting ~~an action that submits~~ a
 304 billing code that is properly billed under one billing code, but
 305 that has been separated into two or more billing codes, and
 306 would result in payment greater than the ~~in~~ amount that ~~than~~
 307 would be paid using one billing code.

308 Section 6. Subsections (3) and (4) of section 627.733,
 309 Florida Statutes, are amended to read:

310 627.733 Required security.—

311 (3) Such security shall be provided:

312 (a) By an insurance policy delivered or issued for delivery
 313 in this state by an authorized or eligible motor vehicle
 314 liability insurer which provides the benefits and exemptions
 315 contained under the no-fault law ~~in ss. 627.730-627.7405~~. Any
 316 policy of insurance represented or sold as providing the
 317 security required hereunder shall be deemed to provide insurance
 318 for the payment of the required benefits; or

319 (b) By any other method authorized by s. 324.031(2), (3),

21-00032-12

2012254__

320 or (4) and approved by the Department of Highway Safety and
321 Motor Vehicles as affording security equivalent to that afforded
322 by a policy of insurance or by self-insuring as authorized by s.
323 768.28(16). The person filing such security has ~~shall have~~ all
324 of the obligations and rights of an insurer under the no-fault
325 law ~~ss. 627.730-627.7405.~~

326 (4) An owner of a motor vehicle with respect to which
327 security is required by this section who fails to have such
328 security in effect at the time of an accident has ~~shall have~~ no
329 immunity from tort liability, but is ~~shall be~~ personally liable
330 for the payment of benefits under s. 627.736. With respect to
331 such benefits, such ~~an~~ owner has ~~shall have~~ all of the rights
332 and obligations of an insurer under the no-fault law ~~ss.~~
333 ~~627.730-627.7405.~~

334 Section 7. Section 627.734, Florida Statutes, is amended to
335 read:

336 627.734 Proof of security; security requirements;
337 penalties.—

338 (1) The provisions of chapter 324 which pertain to the
339 method of giving and maintaining proof of financial
340 responsibility and which govern and define a motor vehicle
341 liability policy ~~shall~~ apply to filing and maintaining proof of
342 security required under the no-fault law ~~by ss. 627.730-~~
343 ~~627.7405.~~

344 (2) Any person who:

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

21-00032-12

2012254__

349 (b) Forges or, without authority, signs any evidence of
350 proof of security; or

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

354

355 commits ~~is guilty of~~ a misdemeanor of the first degree,
356 punishable as provided in s. 775.082 or s. 775.083.

357 Section 8. Subsections (1), (4), and (5), paragraph (b) of
358 subsection (6), and subsections (8), (9), and (10) of section
359 627.736, Florida Statutes, are amended to read:

360 627.736 Required personal injury protection benefits;
361 exclusions; priority; claims.—

362 (1) REQUIRED BENEFITS.—Every insurance policy complying
363 with the security requirements of s. 627.733 must ~~shall~~ provide
364 personal injury protection to the named insured, relatives
365 residing in the same household, persons operating the insured
366 motor vehicle, passengers in such motor vehicle, and other
367 persons struck by such motor vehicle and suffering bodily injury
368 while not an occupant of a self-propelled vehicle, subject to
369 ~~the provisions of~~ subsection (2) and paragraph (4) (g) ~~(4) (e)~~, to
370 a limit of \$10,000 for loss sustained by ~~any~~ such person as a
371 result of bodily injury, sickness, disease, or death arising out
372 of the ownership, maintenance, or use of a motor vehicle as
373 follows:

374 (a) *Medical benefits.*—Eighty percent of all reasonable
375 expenses, charged pursuant to subsection (5) for medically
376 necessary medical, surgical, X-ray, dental, and rehabilitative
377 services, including prosthetic devices; for, ~~and~~ medically

21-00032-12

2012254__

378 necessary ambulance, hospital, and nursing services; and for
379 reasonable transportation services to such services. However,
380 the medical benefits ~~shall~~ provide reimbursement only for such
381 services and care that are lawfully provided, supervised,
382 ordered, or prescribed by a physician licensed under chapter 458
383 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a
384 chiropractic physician licensed under chapter 460, or an
385 acupuncturist licensed under chapter 457 pursuant to his or her
386 scope of practice, or that are provided by any of the following
387 ~~persons or entities:~~

388 1. A hospital or ambulatory surgical center licensed under
389 chapter 395.

390 2. A person or entity licensed under part III of chapter
391 401 which ss. ~~401.2101-401.45~~ that provides emergency
392 transportation and treatment.

393 3. An entity wholly owned by one or more physicians
394 licensed under chapter 458 or chapter 459, chiropractic
395 physicians licensed under chapter 460, or dentists licensed
396 under chapter 466 or by such ~~practitioner or~~ practitioners and
397 the spouse, parent, child, or sibling of such that practitioner
398 ~~or those~~ practitioners.

399 4. An entity wholly owned, directly or indirectly, by a
400 hospital or hospitals.

401 5. A health care clinic licensed under part X of chapter
402 400 which ss. ~~400.990-400.995~~ that is:

403 a. A health care clinic that is accredited by the Joint
404 Commission on Accreditation of Healthcare Organizations, the
405 American Osteopathic Association, the Commission on
406 Accreditation of Rehabilitation Facilities, or the Accreditation

21-00032-12

2012254

407 Association for Ambulatory Health Care, Inc.; or

408 b. A health care clinic that:

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

411 (II) Has been continuously licensed for more than 3 years
412 or is a publicly traded corporation that issues securities
413 traded on an exchange registered with the United States
414 Securities and Exchange Commission as a national securities
415 exchange; and

416 (III) Provides at least four of the following medical
417 specialties:

418 (A) General medicine.

419 (B) Radiography.

420 (C) Orthopedic medicine.

421 (D) Physical medicine.

422 (E) Physical therapy.

423 (F) Physical rehabilitation.

424 (G) Prescribing or dispensing outpatient prescription
425 medication.

426 (H) Laboratory services.

427
428 The Financial Services Commission shall adopt by rule the form
429 that must be used by an insurer and a health care provider
430 specified in subparagraph 3., subparagraph 4., or subparagraph
431 5. to document that the health care provider meets the criteria
432 of this paragraph, which rule must include a requirement for a
433 sworn statement or affidavit.

434 (b) *Disability benefits.*—Sixty percent of any loss of gross
435 income and loss of earning capacity per individual from

21-00032-12

2012254

436 inability to work proximately caused by the injury sustained by
437 the injured person, plus all expenses reasonably incurred in
438 obtaining from others ordinary and necessary services in lieu of
439 those that, but for the injury, the injured person would have
440 performed without income for the benefit of his or her
441 household. All disability benefits payable under this provision
442 must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.

443 (c) *Death benefits.*—Death benefits equal to the lesser of
444 \$5,000 or the remainder of unused personal injury protection
445 benefits per individual. The insurer may pay such benefits to
446 the executor or administrator of the deceased, to any of the
447 deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection~~
448 ~~by~~ marriage, or to any person appearing to the insurer to be
449 equitably entitled thereto.

450
451 Only insurers writing motor vehicle liability insurance in this
452 state may provide the required benefits of this section, and ~~no~~
453 such insurers may not ~~insurer shall~~ require the purchase of any
454 other motor vehicle coverage other than the purchase of property
455 damage liability coverage as required by s. 627.7275 as a
456 condition for providing such ~~required~~ benefits. Insurers may not
457 require that property damage liability insurance in an amount
458 greater than \$10,000 be purchased in conjunction with personal
459 injury protection. Such insurers shall make benefits and
460 required property damage liability insurance coverage available
461 through normal marketing channels. An ~~Any~~ insurer writing motor
462 vehicle liability insurance in this state who fails to comply
463 with such availability requirement as a general business
464 practice violates ~~shall be deemed to have violated~~ part IX of

21-00032-12

2012254__

465 chapter 626, and such violation constitutes ~~shall constitute~~ an
466 unfair method of competition or an unfair or deceptive act or
467 practice involving the business of insurance. An; ~~and any such~~
468 insurer committing such violation is ~~shall be~~ subject to the
469 penalties afforded in such part, as well as those that are ~~which~~
470 ~~may be~~ afforded elsewhere in the insurance code.

471 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
472 the no-fault law are ss. 627.730-627.7405 ~~shall be~~ primary,
473 except that benefits received under any workers' compensation
474 law shall be credited against the benefits provided by
475 subsection (1) and are ~~shall be~~ due and payable as loss accrues,
476 upon the receipt of reasonable proof of such loss and the amount
477 of expenses and loss incurred which are covered by the policy
478 issued under the no-fault law ss. 627.730-627.7405. If ~~When~~ the
479 Agency for Health Care Administration provides, pays, or becomes
480 liable for medical assistance under the Medicaid program related
481 to injury, sickness, disease, or death arising out of the
482 ownership, maintenance, or use of a motor vehicle, the benefits
483 are ~~under ss. 627.730-627.7405~~ ~~shall be~~ subject to the
484 provisions of the Medicaid program.

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

489 (b) Personal injury protection insurance benefits paid
490 pursuant to this section are ~~shall be~~ overdue if not paid within
491 30 days after the insurer is furnished written notice of the
492 fact of a covered loss and of the amount of same. If ~~such~~
493 written notice is not furnished to the insurer as to the entire

21-00032-12

2012254__

494 claim, any partial amount supported by written notice is overdue
495 if not paid within 30 days after the ~~such~~ written notice is
496 furnished to the insurer. Any part or all of the remainder of
497 the claim that is subsequently supported by written notice is
498 overdue if not paid within 30 days after ~~such~~ written notice is
499 furnished to the insurer. For the purpose of calculating the
500 extent to which benefits are overdue, payment shall be
501 considered made on the date a draft or other valid instrument
502 that is equivalent to payment is placed in the United States
503 mail in a properly addressed, postpaid envelope, or, if not so
504 posted, on the date of delivery.

505 (c) If ~~When~~ an insurer pays only a portion of a claim or
506 rejects a claim, the insurer shall provide at the time of the
507 partial payment or rejection an itemized specification of each
508 item that the insurer had reduced, omitted, or declined to pay
509 and any information that the insurer desires the claimant to
510 consider related to the medical necessity of the denied
511 treatment or to explain the reasonableness of the reduced
512 charge, if provided that this does shall not limit the
513 introduction of evidence at trial. ~~and~~ The insurer must shall
514 include the name and address of the person to whom the claimant
515 should respond, ~~and~~ a claim number to be referenced in future
516 correspondence, and a detailed description of the amount paid
517 for each date of service. The insurer's failure to include an
518 itemized specification or explanation of benefits waives other
519 grounds for rejecting an invalid claim.

520 (d) However, Notwithstanding the fact that written notice
521 has been furnished to the insurer, any payment is shall not be
522 ~~deemed~~ overdue if when the insurer has reasonable proof ~~to~~

21-00032-12

2012254__

523 establish that the insurer is not responsible for the payment.
524 ~~For the purpose of calculating the extent to which any benefits~~
525 ~~are overdue, payment shall be treated as being made on the date~~
526 ~~a draft or other valid instrument which is equivalent to payment~~
527 ~~was placed in the United States mail in a properly addressed,~~
528 ~~postpaid envelope or, if not so posted, on the date of delivery.~~
529 This paragraph does not preclude or limit the ability of the
530 insurer to assert that the claim was unrelated, was not
531 medically necessary, or was unreasonable, or that the amount of
532 the charge was in excess of that permitted under, or in
533 violation of, subsection (5). Such assertion by the insurer may
534 be made at any time, including after payment of the claim or
535 after the 30-day ~~time~~ period for payment set forth in ~~this~~
536 paragraph (b).

537 (e) ~~(e)~~ Notwithstanding any local lien law, upon receiving
538 notice of an accident that is potentially covered by personal
539 injury protection benefits, the insurer must reserve \$5,000 of
540 personal injury protection benefits for payment to physicians
541 licensed under chapter 458 or chapter 459 or dentists licensed
542 under chapter 466 who provide emergency services and care, as
543 defined in s. 395.002~~(9)~~, or who provide hospital inpatient
544 care. The amount required to be held in reserve may be used only
545 to pay claims from such physicians or dentists until 30 days
546 after the date the insurer receives notice of the accident.
547 After the 30-day period, any amount of the reserve for which the
548 insurer has not received notice of such a claim ~~from a physician~~
549 ~~or dentist who provided emergency services and care or who~~
550 ~~provided hospital inpatient care~~ may then be used by the insurer
551 to pay other claims. The time periods specified in paragraph (b)

21-00032-12

2012254

552 for ~~required~~ payment of personal injury protection benefits are
553 ~~shall be~~ tolled for the period of time that an insurer is
554 required ~~by this paragraph~~ to hold payment of a claim that is
555 not from a physician or dentist who provided emergency services
556 and care or who provided hospital inpatient care to the extent
557 that the personal injury protection benefits not held in reserve
558 are insufficient to pay the claim. This paragraph does not
559 require an insurer to establish a claim reserve for insurance
560 accounting purposes.

561 (f) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
562 the rate established under s. 55.03 or the rate established in
563 the insurance contract, whichever is greater, for the year in
564 which the payment became overdue, calculated from the date the
565 insurer was furnished with written notice of the amount of
566 covered loss. Interest is ~~shall be~~ due at the time payment of
567 the overdue claim is made.

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

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

574 2. Accidental bodily injury sustained outside this state,
575 but within the United States of America or its territories or
576 possessions or Canada, by the owner while occupying the owner's
577 motor vehicle.

578 3. Accidental bodily injury sustained by a relative of the
579 owner residing in the same household, under the circumstances
580 described in subparagraph 1. or subparagraph 2. if, ~~provided~~ the

21-00032-12

2012254__

581 relative at the time of the accident is domiciled in the owner's
582 household and is not ~~himself or herself~~ the owner of a motor
583 vehicle with respect to which security is required under the no-
584 fault law ss. ~~627.730-627.7405.~~

585 4. Accidental bodily injury sustained in this state by any
586 other person while occupying the owner's motor vehicle or, if a
587 resident of this state, while not an occupant of a self-
588 propelled vehicle, if the injury is caused by physical contact
589 with such motor vehicle and if, ~~provided~~ the injured person is
590 not ~~himself or herself~~:

591 a. The owner of a motor vehicle with respect to which
592 security is required under the no-fault law ss. ~~627.730-~~
593 ~~627.7405;~~ or

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

596 (h) ~~(f)~~ If two or more insurers are liable to pay personal
597 injury protection benefits for the same injury to any one
598 person, the maximum payable is ~~shall be~~ as specified in
599 subsection (1), and any insurer paying the benefits is ~~shall be~~
600 entitled to recover from each of the other insurers an equitable
601 pro rata share of the benefits paid and expenses incurred in
602 processing the claim.

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

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

21-00032-12

2012254

610 1. Submits a fraudulent statement, document, record, or
 611 bill;

612 2. Submits fraudulent information; or

613 3. Has otherwise committed or attempted to commit a
 614 fraudulent insurance act as defined in s. 626.989.

615

616 A claimant that violates this paragraph is not entitled to any
 617 personal injury protection benefit or payment for any bill and
 618 service, regardless of whether a portion of the claim may be
 619 legitimate. However, a claimant that does not violate this
 620 paragraph may not be denied benefits solely due to a violation
 621 by another claimant.

622 (k) A claimant has violated paragraph (j) committed, by a
 623 material act or omission, any insurance fraud relating to
 624 personal injury protection coverage under his or her policy, if
 625 the fraud is admitted to in a sworn statement by the insured or
 626 if it is established in a court of competent jurisdiction. Any
 627 insurance fraud voids shall void all coverage arising from the
 628 claim related to such fraud under the personal injury protection
 629 coverage of the claimant insured person who committed the fraud,
 630 irrespective of whether a portion of the insured person's claim
 631 may be legitimate, and any benefits paid before prior to the
 632 discovery of the insured person's insurance fraud is shall be
 633 recoverable in their entirety by the insurer from the claimant
 634 person who committed insurance fraud in their entirety. The
 635 prevailing party is entitled to its costs and attorney's fees in
 636 any action in which it prevails in an insurer's action to
 637 enforce its right of recovery under this paragraph.

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

21-00032-12

2012254

639 (a)~~1~~. Any physician, hospital, clinic, or other person or
 640 institution lawfully rendering treatment to an injured person
 641 for a bodily injury covered by personal injury protection
 642 insurance may charge the insurer and injured party only a
 643 reasonable amount pursuant to this section for the services and
 644 supplies rendered, and the insurer providing ~~such~~ coverage may
 645 pay for such charges directly to the ~~such~~ person or institution
 646 lawfully rendering such treatment~~7~~, if the insured receiving such
 647 treatment or his or her guardian has countersigned the properly
 648 completed invoice, bill, or claim form approved by the office
 649 upon which such charges are to be paid for as having actually
 650 been rendered, to the best knowledge of the insured or his or
 651 her guardian. ~~In no event,~~ However, ~~may~~ such charges may not
 652 exceed a charge be in excess of the amount the person or
 653 institution customarily charges for like services or supplies.
 654 In determining ~~With respect to a determination of~~ whether a
 655 charge for a particular service, treatment, or otherwise is
 656 reasonable, consideration may be given to evidence of usual and
 657 customary charges and payments accepted by the provider involved
 658 in the dispute, ~~and~~ reimbursement levels in the community, ~~and~~
 659 various federal and state medical fee schedules applicable to
 660 automobile and other insurance coverages, and other information
 661 relevant to the reasonableness of the reimbursement for the
 662 service, treatment, or supply.

663 1.2~~1~~. The insurer may limit reimbursement to not less than
 664 80 percent of the following schedule of maximum charges:

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

667 b. For emergency services and care provided by a hospital

21-00032-12

2012254

668 licensed under chapter 395, 75 percent of the hospital's usual
669 and customary charges.

670 c. For emergency services and care as defined by s.
671 395.002(9) provided in a facility licensed under chapter 395
672 rendered by a physician or dentist, and related hospital
673 inpatient services rendered by a physician or dentist, the usual
674 and customary charges in the community.

675 d. For hospital inpatient services, other than emergency
676 services and care, 200 percent of the Medicare Part A
677 prospective payment applicable to the specific hospital
678 providing the inpatient services.

679 e. For hospital outpatient services, other than emergency
680 services and care, 200 percent of the Medicare Part A Ambulatory
681 Payment Classification for the specific hospital providing the
682 outpatient services.

683 f. For all other medical services, ~~supplies, and care,~~ 200
684 percent of the allowable amount under the participating
685 physicians schedule of Medicare Part B. For all other supplies
686 and care, including durable medical equipment and care and
687 services rendered by ambulatory surgical centers and clinical
688 laboratories, 200 percent of the allowable amount under Medicare
689 Part B. However, if such services, supplies, or care is not
690 reimbursable under Medicare Part B, the insurer may limit
691 reimbursement to 80 percent of the maximum reimbursable
692 allowance under workers' compensation, as determined under s.
693 440.13 and rules adopted thereunder which are in effect at the
694 time such services, supplies, or care is provided. Services,
695 supplies, or care that is not reimbursable under Medicare or
696 workers' compensation is not required to be reimbursed by the

21-00032-12

2012254__

697 insurer.

698 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable fee
699 schedule or payment limitation under Medicare is the fee
700 schedule or payment limitation in effect at the time the
701 services, supplies, or care was rendered and for the area in
702 which such services were rendered, except that it may not be
703 less than the allowable amount under the participating
704 physicians schedule of Medicare Part B for 2007 for medical
705 services, supplies, and care subject to Medicare Part B.

706 ~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to apply
707 any limitation on the number of treatments or other utilization
708 limits that apply under Medicare or workers' compensation. An
709 insurer that applies the allowable payment limitations of
710 subparagraph 1. 2. must reimburse a provider who lawfully
711 provided care or treatment under the scope of his or her
712 license, regardless of whether such provider is ~~would be~~
713 entitled to reimbursement under Medicare due to restrictions or
714 limitations on the types or discipline of health care providers
715 who may be reimbursed for particular procedures or procedure
716 codes.

717 ~~4.5.~~ If an insurer limits payment as authorized by
718 subparagraph 1. 2., the person providing such services,
719 supplies, or care may not bill or attempt to collect from the
720 insured any amount in excess of such limits, except for amounts
721 that are not covered by the insured's personal injury protection
722 coverage due to the coinsurance amount or maximum policy limits.

723 5. Effective July 1, 2012, an insurer may limit
724 reimbursement pursuant to this paragraph only if the insurance
725 policy includes the schedule of charges specified in this

21-00032-12

2012254__

726 paragraph.727 (b)1. An insurer or insured is not required to pay a claim
728 or charges:729 a. Made by a broker or by a person making a claim on behalf
730 of a broker;731 b. For any service or treatment that was not lawful at the
732 time rendered;733 c. To any person who knowingly submits a false or
734 misleading statement relating to the claim or charges;735 d. With respect to a bill or statement that does not
736 substantially meet the ~~applicable~~ requirements of paragraphs
737 (c), paragraph (d), and (e);738 e. For any treatment or service that is upcoded, or that is
739 unbundled if ~~when~~ such treatment or services should be bundled,
740 in accordance with paragraph (d). To facilitate prompt payment
741 of lawful services, an insurer may change codes that it
742 determines to have been improperly or incorrectly upcoded or
743 unbundled, and may make payment based on the changed codes,
744 without affecting the right of the provider to dispute the
745 change by the insurer if, ~~provided that~~ before doing so, the
746 insurer contacts ~~must contact~~ the health care provider and
747 discusses ~~discuss~~ the reasons for the insurer's change and the
748 health care provider's reason for the coding, or makes ~~make~~ a
749 reasonable good faith effort to do so, as documented in the
750 insurer's file; or ~~and~~751 f. For medical services or treatment billed by a physician
752 and not provided in a hospital unless such services are rendered
753 by the physician or are incident to his or her professional
754 services and are included on the physician's bill, including

21-00032-12

2012254__

755 documentation verifying that the physician is responsible for
756 the medical services that were rendered and billed.

757 2. The Department of Health, in consultation with the
758 appropriate professional licensing boards, shall adopt, by rule,
759 a list of diagnostic tests deemed not to be medically necessary
760 for use in the treatment of persons sustaining bodily injury
761 covered by personal injury protection benefits under this
762 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
763 ~~and~~ shall be revised from time to time as determined by the
764 Department of Health, in consultation with the respective
765 professional licensing boards. Inclusion of a test on the list
766 must ~~of invalid diagnostic tests shall~~ be based on lack of
767 demonstrated medical value and a level of general acceptance by
768 the relevant provider community and may ~~shall~~ not be dependent
769 for results entirely upon subjective patient response.
770 Notwithstanding its inclusion on a fee schedule in this
771 subsection, an insurer or insured is not required to pay any
772 charges or reimburse claims for any invalid diagnostic test as
773 determined by the Department of Health.

774 (c)~~1~~. With respect to any treatment or service, other than
775 medical services billed by a hospital or other provider for
776 emergency services as defined in s. 395.002 or inpatient
777 services rendered at a hospital-owned facility, the statement of
778 charges must be furnished to the insurer by the provider and may
779 not include, and the insurer is not required to pay, charges for
780 treatment or services rendered more than 35 days before the
781 postmark date or electronic transmission date of the statement,
782 except for past due amounts previously billed on a timely basis
783 under this paragraph, ~~and except that, if the provider submits~~

21-00032-12

2012254__

784 ~~to the insurer a notice of initiation of treatment within 21~~
785 ~~days after its first examination or treatment of the claimant,~~
786 ~~the statement may include charges for treatment or services~~
787 ~~rendered up to, but not more than, 75 days before the postmark~~
788 ~~date of the statement. The injured party is not liable for, and~~
789 ~~the provider may ~~shall~~ not bill the injured party for, charges~~
790 ~~that are unpaid because of the provider's failure to comply with~~
791 ~~this paragraph. Any agreement requiring the injured person or~~
792 ~~insured to pay for such charges is unenforceable.~~

793 1.2. ~~If, however,~~ the insured fails to furnish the provider
794 with the correct name and address of the insured's personal
795 injury protection insurer, the provider has 35 days from the
796 date the provider obtains the correct information to furnish the
797 insurer with a statement of the charges. The insurer is not
798 required to pay for such charges unless the provider includes
799 with the statement documentary evidence that was provided by the
800 insured during the 35-day period demonstrating that the provider
801 reasonably relied on erroneous information from the insured and
802 either:

- 803 a. A denial letter from the incorrect insurer; or
804 b. Proof of mailing, which may include an affidavit under
805 penalty of perjury, reflecting timely mailing to the incorrect
806 address or insurer.

807 2.3. For emergency services and care as defined in s.
808 395.002 rendered in a hospital emergency department or for
809 transport and treatment rendered by an ambulance provider
810 licensed pursuant to part III of chapter 401, the provider is
811 not required to furnish the statement of charges within the time
812 periods established by this paragraph, ~~+~~ and the insurer is ~~shall~~

21-00032-12

2012254__

813 not ~~be~~ considered to have been furnished with notice of the
814 amount of covered loss for purposes of paragraph (4) (b) until it
815 receives a statement complying with paragraph (d), or copy
816 thereof, which specifically identifies the place of service to
817 be a hospital emergency department or an ambulance in accordance
818 with billing standards recognized by the Centers for Medicare
819 and Medicaid Services ~~Health Care Finance Administration~~.

820 3.4. Each notice of the insured's rights under s. 627.7401
821 must include the following statement in type no smaller than 12
822 points:

823
824 BILLING REQUIREMENTS.—Florida Statutes provide that
825 with respect to any treatment or services, other than
826 certain hospital and emergency services, the statement
827 of charges furnished to the insurer by the provider
828 may not include, and the insurer and the injured party
829 are not required to pay, charges for treatment or
830 services rendered more than 35 days before the
831 postmark date of the statement, except for past due
832 amounts previously billed on a timely basis, and
833 except that, if the provider submits to the insurer a
834 notice of initiation of treatment within 21 days after
835 its first examination or treatment of the claimant,
836 the first billing cycle statement may include charges
837 for treatment or services rendered up to, but not more
838 than, 75 days before the postmark date of the
839 statement.

840
841 (d) All statements and bills for medical services rendered

21-00032-12

2012254__

842 by any physician, hospital, clinic, or other person or
843 institution shall be submitted to the insurer on a properly
844 completed Centers for Medicare and Medicaid Services (CMS) 1500
845 form, UB 92 forms, or any other standard form approved by the
846 office or adopted by the commission for purposes of this
847 paragraph. All billings for such services rendered by providers
848 must ~~shall~~, to the extent applicable, follow the Physicians'
849 Current Procedural Terminology (CPT) or Healthcare Correct
850 Procedural Coding System (HCPCS), or ICD-9 in effect for the
851 year in which services are rendered and comply with the ~~Centers~~
852 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
853 and the American Medical Association Current Procedural
854 Terminology (CPT) Editorial Panel and Healthcare Correct
855 Procedural Coding System (HCPCS). All providers other than
856 hospitals shall include on the applicable claim form the
857 professional license number of the provider in the line or space
858 provided for "Signature of Physician or Supplier, Including
859 Degrees or Credentials." In determining compliance with
860 applicable CPT and HCPCS coding, guidance shall be provided by
861 the Physicians' Current Procedural Terminology (CPT) or the
862 Healthcare Correct Procedural Coding System (HCPCS) in effect
863 for the year in which services were rendered, the Office of the
864 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
865 other authoritative treatises designated by rule by the Agency
866 for Health Care Administration. A ~~No~~ statement of medical
867 services may not include charges for medical services of a
868 person or entity that performed such services without possessing
869 the valid licenses required to perform such services. For
870 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~

21-00032-12

2012254

871 considered to have been furnished with notice of the amount of
872 covered loss or medical bills due unless the statements or bills
873 comply with this paragraph, and unless the statements or bills
874 are properly completed in their entirety as to all
875 material provisions, with all relevant information being
876 provided therein. If an insurer denies a claim within 30 days
877 after receipt due to the provider's failure to submit a
878 substantially completed statement or bill, the insurer shall
879 notify the provider as to the provisions that were improperly
880 completed, and the provider shall have 120 days after the
881 receipt of such notice to submit a substantially completed
882 statement or bill. If the provider fails to comply with this
883 requirement, the insurer is not required to pay for the billed
884 services.

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

892 a. The insured, or his or her guardian, must countersign
893 the form attesting to the fact that the services set forth
894 therein were actually rendered. Listing common medical
895 abbreviations, commonly accepted CPT codes, or other common
896 coding on the disclosure and acknowledgment form satisfies this
897 requirement;

898 b. The insured, or his or her guardian, has both the right
899 and affirmative duty to confirm that the services were actually

21-00032-12

2012254

900 rendered;

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

903 d. The physician, other licensed professional, clinic, or
904 other medical institution rendering services for which payment
905 is being claimed explained the services to the insured or his or
906 her guardian; and

907 e. If the insured notifies the insurer in writing of a
908 billing error, the insured may be entitled to a certain
909 percentage of a reduction in the amounts paid by the insured's
910 motor vehicle insurer.

911 2. The physician, other licensed professional, clinic, or
912 other medical institution rendering services for which payment
913 is being claimed has the affirmative duty to explain the
914 services rendered to the insured, or his or her guardian, so
915 that the insured, or his or her guardian, countersigns the form
916 with informed consent.

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

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

924 5. An insurer is not considered to have been furnished with
925 notice of the amount of a covered loss or medical bills unless
926 the original completed disclosure and acknowledgment form is
927 ~~shall be~~ furnished to the insurer pursuant to paragraph (4) (b)
928 and sub-subparagraph 1.a. The disclosure and acknowledgement

21-00032-12

2012254

929 form may not be electronically furnished. A disclosure and
930 acknowledgement form that does not substantially meet the
931 minimum requirements of sub-subparagraph 1.a. does not provide
932 an insurer with notice of the amount of a covered loss or
933 medical bills due.

934 6. This disclosure and acknowledgment form is not required
935 for services billed by a provider for emergency services as
936 defined in s. 395.002, for emergency services and care as
937 defined in s. 395.002 rendered in a hospital emergency
938 department, or for transport and treatment rendered by an
939 ambulance provider licensed pursuant to part III of chapter 401.

940 7. The Financial Services Commission shall adopt, by rule,
941 a standard disclosure and acknowledgment form to that shall be
942 used to fulfill the requirements of this paragraph, effective 90
943 days after such form is adopted and becomes final. The
944 commission shall adopt a proposed rule by October 1, 2003. Until
945 the rule is final, the provider may use a form of its own which
946 otherwise complies with the requirements of this paragraph.

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

951 9. The requirements of this paragraph apply only with
952 respect to the initial treatment or service of the insured by a
953 provider. For subsequent treatments or service, the provider
954 must maintain a patient log signed by the patient, in
955 chronological order by date of service, that is consistent with
956 the services being rendered to the patient as claimed. Listing
957 commonly accepted CPT codes or other common coding on the

21-00032-12

2012254

958 patient log satisfies this requirement. The provider must
959 provide copies of the patient log to the insurer within 30 days
960 after receiving a written request from the insurer. Failure to
961 maintain a substantially complete patient log renders the
962 treatment unlawful and noncompensable. The requirements of this
963 ~~subparagraph~~ for maintaining a patient log signed by the patient
964 may be met by a hospital that maintains medical records as
965 required by s. 395.3025 and applicable rules and makes such
966 records available to the insurer upon request.

967 (f) Upon written notification by any person, an insurer
968 shall investigate any claim of improper billing by a physician
969 or other medical provider. The insurer shall determine if the
970 insured was properly billed for only those services and
971 treatments that the insured actually received. If the insurer
972 determines that the insured has been improperly billed, the
973 insurer shall notify the insured, the person making the written
974 notification, and the provider of its findings and ~~shall~~ reduce
975 the amount of payment to the provider by the amount determined
976 to be improperly billed. If a reduction is made due to a ~~such~~
977 written notification by any person, the insurer shall pay to the
978 person 20 percent of the amount of the reduction, up to \$500. If
979 the provider is arrested due to the improper billing, ~~then~~ the
980 insurer shall pay to the person 40 percent of the amount of the
981 reduction, up to \$500.

982 (g) An insurer may not systematically downcode with the
983 intent to deny reimbursement otherwise due. Such action
984 constitutes a material misrepresentation under s.
985 626.9541(1)(i)2.

986 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.-

21-00032-12

2012254

987 (b) Every physician, hospital, clinic, or other medical
988 institution providing, before or after bodily injury upon which
989 a claim for personal injury protection insurance benefits is
990 based, any products, services, or accommodations in relation to
991 that or any other injury, or in relation to a condition claimed
992 to be connected with that or any other injury, shall, if
993 requested to do so by the insurer against whom the claim has
994 been made, allow the insurer or the insurer's representative to
995 conduct an onsite physical review and examination of the
996 treatment location, treatment apparatuses, diagnostic devices,
997 and any other medical equipment used for the services rendered
998 within a reasonable time after the insurer's request, and
999 furnish ~~forthwith~~ a written report of the history, condition,
1000 treatment, dates, and costs of such treatment of the injured
1001 person and why the items identified by the insurer were
1002 reasonable in amount and medically necessary, together with a
1003 sworn statement that the treatment or services rendered were
1004 reasonable and necessary with respect to the bodily injury
1005 sustained and identifying which portion of the expenses for such
1006 treatment or services was incurred as a result of such bodily
1007 injury, and produce forthwith, and allow ~~permit~~ the inspection
1008 and copying of, his or her or its records regarding such
1009 history, condition, treatment, dates, and costs of treatment ~~if~~
1010 ~~provided that~~ this does ~~shall~~ not limit the introduction of
1011 evidence at trial. Such sworn statement must ~~shall~~ read as
1012 follows: "Under penalty of perjury, I declare that I have read
1013 the foregoing, and the facts alleged are true, to the best of my
1014 knowledge and belief." A ~~No~~ cause of action for violation of the
1015 physician-patient privilege or invasion of the right of privacy

21-00032-12

2012254

1016 may not be brought ~~shall be permitted~~ against any physician,
1017 hospital, clinic, or other medical institution complying with
1018 ~~the provisions of~~ this section. The person requesting such
1019 records and such sworn statement shall pay all reasonable costs
1020 connected therewith. If an insurer makes a written request for
1021 documentation or information under this paragraph within 30 days
1022 after having received notice of the amount of a covered loss
1023 under paragraph (4) (a), the amount or the partial amount that
1024 ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~
1025 overdue if the insurer does not pay in accordance with paragraph
1026 (4) (b) or within 10 days after the insurer's receipt of the
1027 requested documentation or information, whichever occurs later.
1028 As used in ~~For purposes of~~ this paragraph, the term "receipt"
1029 includes, but is not limited to, inspection and copying pursuant
1030 to this paragraph. An ~~Any~~ insurer that requests documentation or
1031 information pertaining to reasonableness of charges or medical
1032 necessity under this paragraph without a reasonable basis for
1033 such requests as a general business practice is engaging in an
1034 unfair trade practice under the insurance code.

1035 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—
1036 With respect to any dispute ~~under the provisions of ss. 627.730-~~
1037 ~~627.7405~~ between the insured and the insurer under the no-fault
1038 law, or between an assignee of an insured's rights and the
1039 insurer, the provisions of s. 627.428 ~~shall~~ apply, except as
1040 provided in subsections (10) and (15).

1041 (9) PREFERRED PROVIDERS.—An insurer may negotiate and enter
1042 into contracts with preferred ~~licensed health care~~ providers for
1043 the benefits described in this section, ~~referred to in this~~
1044 ~~section as "preferred providers,"~~ which include ~~shall include~~

21-00032-12

2012254

1045 health care providers licensed under chapter 457, chapter
1046 ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter
1047 ~~and~~ 463.

1048 (a) The insurer may provide an option to an insured to use
1049 a preferred provider at the time of purchase of the policy for
1050 personal injury protection benefits, if the requirements of this
1051 subsection are met. If the insured elects to use a provider who
1052 is not a preferred provider, whether the insured purchased a
1053 preferred provider policy or a nonpreferred provider policy, the
1054 medical benefits provided by the insurer must ~~shall~~ be as
1055 required by this section.

1056 (b) If the insured elects the ~~to use a provider who is a~~
1057 preferred provider option, the insurer may pay medical benefits
1058 in excess of the benefits required by this section and may waive
1059 or lower the amount of any deductible that applies to such
1060 medical benefits. As an alternative, or in addition to such
1061 benefits, waiver, or reduction, the insurer may provide an
1062 actuarially appropriate premium discount as specified in an
1063 approved rate filing to an insured who selects the preferred
1064 provider option. If the preferred provider option provides a
1065 premium discount, the insured forfeits the premium discount
1066 effective on the date that the insured elects to use a provider
1067 who is not a preferred provider and who renders nonemergency
1068 services, unless there is no member of the preferred provider
1069 network located within 15 miles of the insured's place of
1070 residence whose scope of practice includes the required
1071 services, or unless the nonemergency services are rendered in
1072 the emergency room of a hospital licensed under chapter 395. ~~If~~
1073 ~~the insurer offers a preferred provider policy to a policyholder~~

21-00032-12

2012254

1074 ~~or applicant, it must also offer a nonpreferred provider policy.~~

1075 (c) The insurer shall provide each insured policyholder
1076 with a current roster of preferred providers in the county in
1077 which the insured resides at the time of purchasing purchase of
1078 such policy, and shall make such list available for public
1079 inspection during regular business hours at the insurer's
1080 principal office of the insurer within the state. The insurer
1081 may contract with a health insurer to use an existing preferred
1082 provider network to implement the preferred provider option. All
1083 providers and entities that are eligible to receive
1084 reimbursement pursuant to paragraph (1)(a) may provide services
1085 through a preferred provider network. Any other arrangement is
1086 subject to the approval of the Office of Insurance Regulation.

1087 (10) DEMAND LETTER.—

1088 (a) As a condition precedent to filing any action for
1089 benefits under this section, the claimant filing suit must
1090 provide the insurer must be provided with written notice of an
1091 intent to initiate litigation. Such notice may not be sent until
1092 the claim is overdue, including any additional time the insurer
1093 has to pay the claim pursuant to paragraph (4)(b). A premature
1094 demand letter is defective and cannot be cured unless the court
1095 first abates the action or the claimant first voluntarily
1096 dismisses the action.

1097 (b) The ~~notice~~ required notice must ~~shall~~ state that it is
1098 a "demand letter under s. 627.736(10)" and ~~shall~~ state with
1099 specificity:

1100 1. The name of the insured upon which such benefits are
1101 being sought, including a copy of the assignment giving rights
1102 to the claimant if the claimant is not the insured.

21-00032-12

2012254__

1103 2. The claim number or policy number upon which such claim
1104 was originally submitted to the insurer.

1105 3. To the extent applicable, the name of any medical
1106 provider who rendered to an insured the treatment, services,
1107 accommodations, or supplies that form the basis of such claim;
1108 and an itemized statement specifying each exact amount, the date
1109 of treatment, service, or accommodation, and the type of benefit
1110 claimed to be due. A completed form satisfying the requirements
1111 of paragraph (5) (d) or the lost-wage statement previously
1112 submitted may be used as the itemized statement. ~~To the extent~~
1113 ~~that the demand involves an insurer's withdrawal of payment~~
1114 ~~under paragraph (7) (a) for future treatment not yet rendered,~~
1115 ~~the claimant shall attach a copy of the insurer's notice~~
1116 ~~withdrawing such payment and an itemized statement of the type,~~
1117 ~~frequency, and duration of future treatment claimed to be~~
1118 ~~reasonable and medically necessary.~~

1119 (c) Each notice required by this subsection must be
1120 delivered to the insurer by United States certified or
1121 registered mail, return receipt requested. Such postal costs
1122 shall be reimbursed by the insurer if ~~so~~ requested by the
1123 claimant in the notice, when the insurer pays the claim. Such
1124 notice must be sent to the person and address specified by the
1125 insurer for the purposes of receiving notices under this
1126 subsection. Each licensed insurer, whether domestic, foreign, or
1127 alien, shall file with the office designation of the name and
1128 address of the person to whom notices must ~~pursuant to this~~
1129 ~~subsection shall~~ be sent which the office shall make available
1130 on its Internet website. The name and address on file with the
1131 office pursuant to s. 624.422 shall be deemed the authorized

21-00032-12

2012254

1132 representative to accept notice pursuant to this subsection if
1133 ~~in the event~~ no other designation has been made.

1134 (d) If, within 30 days after receipt of notice by the
1135 insurer, the overdue claim specified in the notice is paid by
1136 the insurer together with applicable interest and a penalty of
1137 10 percent of the overdue amount paid by the insurer, subject to
1138 a maximum penalty of \$250, no action may be brought against the
1139 insurer. ~~If the demand involves an insurer's withdrawal of
1140 payment under paragraph (7) (a) for future treatment not yet
1141 rendered, no action may be brought against the insurer if,
1142 within 30 days after its receipt of the notice, the insurer
1143 mails to the person filing the notice a written statement of the
1144 insurer's agreement to pay for such treatment in accordance with
1145 the notice and to pay a penalty of 10 percent, subject to a
1146 maximum penalty of \$250, when it pays for such future treatment
1147 in accordance with the requirements of this section. To the
1148 extent the insurer determines not to pay any amount demanded,
1149 the penalty is ~~shall~~ not be payable in any subsequent action.
1150 For purposes of this subsection, payment or the insurer's
1151 agreement is ~~shall be~~ treated as being made on the date a draft
1152 or other valid instrument that is equivalent to payment, or the
1153 insurer's written statement of agreement, is placed in the
1154 United States mail in a properly addressed, postpaid envelope,
1155 or if not so posted, on the date of delivery. The insurer is not
1156 obligated to pay any attorney's fees if the insurer pays the
1157 claim or mails its agreement to pay for future treatment within
1158 the time prescribed by this subsection.~~

1159 (e) The applicable statute of limitation for an action
1160 under this section shall be tolled for ~~a period of~~ 30 business

21-00032-12

2012254__

1161 days by the mailing of the notice required by this subsection.

1162 (f) A demand letter that does not substantially meet the
 1163 minimum requirements set forth in this subsection is defective.
 1164 A defective demand letter cannot be cured unless the court first
 1165 abates the action or the claimant first voluntarily dismisses
 1166 the action.

1167 (g) ~~(f)~~ An Any insurer making a general business practice of
 1168 not paying valid claims until receipt of the notice required by
 1169 this subsection is engaging in an unfair trade practice under
 1170 the insurance code.

1171 (h) A demand letter may be used to request the production
 1172 of claim documents or other records from the insurer. The
 1173 insurer's reply must be made within 30 days after receipt of
 1174 such request.

1175 Section 9. Section 627.737, Florida Statutes, is amended to
 1176 read:

1177 627.737 Tort exemption; limitation on right to damages;
 1178 punitive damages.—

1179 (1) Every owner, registrant, operator, or occupant of a
 1180 motor vehicle with respect to which security has been provided
 1181 as required under the no-fault law ~~by ss. 627.730-627.7405~~, and
 1182 every person or organization legally responsible for her or his
 1183 acts or omissions, is ~~hereby~~ exempted from tort liability for
 1184 damages because of bodily injury, sickness, or disease arising
 1185 out of the ownership, operation, maintenance, or use of such
 1186 motor vehicle in this state to the extent that the benefits
 1187 described in s. 627.736(1) are payable for such injury, or would
 1188 be payable but for any exclusion authorized by the no-fault law
 1189 ~~ss. 627.730-627.7405~~, under any insurance policy or other method

21-00032-12

2012254__

1190 of security complying with the requirements of s. 627.733, or by
1191 an owner personally liable under s. 627.733 for the payment of
1192 such benefits, unless a person is entitled to maintain an action
1193 for pain, suffering, mental anguish, and inconvenience for such
1194 injury under ~~the provisions of~~ subsection (2).

1195 (2) In any action of tort brought against the owner,
1196 registrant, operator, or occupant of a motor vehicle with
1197 respect to which security has been provided as required by the
1198 no-fault law ~~ss. 627.730-627.7405~~, or against any person or
1199 organization legally responsible for her or his acts or
1200 omissions, a plaintiff may recover damages in tort for pain,
1201 suffering, mental anguish, and inconvenience because of bodily
1202 injury, sickness, or disease arising out of the ownership,
1203 maintenance, operation, or use of such motor vehicle only if ~~in~~
1204 ~~the event that~~ the injury or disease consists in whole or in
1205 part of:

1206 (a) Significant and permanent loss of an important bodily
1207 function.

1208 (b) Permanent injury within a reasonable degree of medical
1209 probability, other than scarring or disfigurement.

1210 (c) Significant and permanent scarring or disfigurement.

1211 (d) Death.

1212 (3) If ~~When~~ a defendant, in a proceeding brought pursuant
1213 to the no-fault law ~~ss. 627.730-627.7405~~, questions whether the
1214 plaintiff has met the requirements of subsection (2), ~~then~~ the
1215 defendant may file an appropriate motion with the court, and the
1216 court shall, on a one-time basis only, 30 days before the date
1217 set for the trial or the pretrial hearing, whichever occurs ~~is~~
1218 first, by examining the pleadings and the evidence before it,

21-00032-12

2012254

1219 ascertain whether the plaintiff will be able to submit some
1220 evidence that the plaintiff will meet the requirements of
1221 subsection (2). If the court finds that the plaintiff will not
1222 be able to submit such evidence, ~~then~~ the court shall dismiss
1223 the plaintiff's claim without prejudice.

1224 (4) In any action brought against an automobile liability
1225 insurer for damages in excess of its policy limits, a ~~no~~ claim
1226 for punitive damages is not ~~shall be~~ allowed.

1227 Section 10. Section 627.7405, Florida Statutes, is amended
1228 to read:

1229 627.7405 Insurers' right of reimbursement.—Notwithstanding
1230 any other provisions of the no-fault law ~~ss. 627.730-627.7405~~,
1231 any insurer providing personal injury protection benefits on a
1232 private passenger motor vehicle ~~shall have~~, to the extent of any
1233 personal injury protection benefits paid to any person as a
1234 benefit arising out of such private passenger motor vehicle
1235 insurance, has a right of reimbursement against the owner or the
1236 insurer of the owner of a commercial motor vehicle, if the
1237 benefits paid result from such person having been an occupant of
1238 the commercial motor vehicle or having been struck by the
1239 commercial motor vehicle while not an occupant of any self-
1240 propelled vehicle.

1241 Section 11. Subsection (1) of section 627.7407, Florida
1242 Statutes, is amended to read:

1243 627.7407 Application of the Florida Motor Vehicle No-Fault
1244 Law.—

1245 (1) Any person subject to the requirements of ~~ss. 627.730-~~
1246 ~~627.7405~~, the Florida Motor Vehicle No-Fault Law, as revived and
1247 amended by chapter 2007-324, Laws of Florida ~~this act~~, must

21-00032-12

2012254

1248 maintain security for personal injury protection as required by
1249 the ~~Florida Motor Vehicle~~ no-fault law, as revived and amended
1250 by this act, beginning on January 1, 2008.

1251 Section 12. Subsection (1) of section 324.021, Florida
1252 Statutes, is amended to read:

1253 324.021 Definitions; minimum insurance required.—The
1254 following words and phrases when used in this chapter shall, for
1255 the purpose of this chapter, have the meanings respectively
1256 ascribed to them in this section, except in those instances
1257 where the context clearly indicates a different meaning:

1258 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
1259 is designed and required to be licensed for use upon a highway,
1260 including trailers and semitrailers designed for use with such
1261 vehicles, except traction engines, road rollers, farm tractors,
1262 power shovels, and well drillers, and every vehicle that ~~which~~
1263 is propelled by electric power obtained from overhead wires but
1264 not operated upon rails, but not including any bicycle or moped.
1265 However, the term does ~~“motor vehicle” shall~~ not include a ~~any~~
1266 motor vehicle as defined in s. 627.732 ~~if s. 627.732(3) when~~ the
1267 owner of such vehicle has complied with the Florida Motor
1268 Vehicle No-Fault Law ~~requirements of ss. 627.730-627.7405,~~
1269 ~~inclusive~~, unless the provisions of s. 324.051 apply; and, in
1270 such case, the applicable proof of insurance provisions of s.
1271 320.02 apply.

1272 Section 13. Subsection (7) of section 627.7295, Florida
1273 Statutes, is amended to read:

1274 627.7295 Motor vehicle insurance contracts.—

1275 (7) A policy of private passenger motor vehicle insurance
1276 or a binder for such a policy may be initially issued in this

21-00032-12

2012254__

1277 state only if, before the effective date of such binder or
1278 policy, the insurer or agent has collected from the insured an
1279 amount equal to 2 months' premium. An insurer, agent, or premium
1280 finance company may not, directly or indirectly, take any action
1281 resulting in the insured having paid from the insured's own
1282 funds an amount less than the 2 months' premium ~~required by this~~
1283 ~~subsection.~~

1284 (a) This subsection applies without regard to whether the
1285 premium is financed by a premium finance company or is paid
1286 pursuant to a periodic payment plan of an insurer or an
1287 insurance agent.

1288 (b) This subsection does not apply:

1289 1. If an insured or member of the insured's family is
1290 renewing or replacing a policy or a binder for such policy
1291 written by the same insurer or a member of the same insurer
1292 group;~~;~~

1293 ~~2. This subsection does not apply~~ To an insurer that issues
1294 private passenger motor vehicle coverage primarily to active
1295 duty or former military personnel or their dependents; ~~or~~

1296 ~~3. This subsection does not apply~~ If all policy payments
1297 are paid pursuant to a payroll deduction plan or an automatic
1298 electronic funds transfer payment plan from the policyholder.

1299 (c) This subsection and subsection (4) do not apply if:

1300 1. All policy payments to an insurer are paid pursuant to
1301 an automatic electronic funds transfer payment plan from an
1302 agent, a managing general agent, or a premium finance company
1303 and if the policy includes, at a minimum, personal injury
1304 protection pursuant to the Florida Motor Vehicle No-Fault Law
1305 ~~ss. 627.730-627.7405~~; motor vehicle property damage liability

21-00032-12

2012254__

1306 pursuant to s. 627.7275; and bodily injury liability in at least
 1307 the amount of \$10,000 because of bodily injury to, or death of,
 1308 one person in any one accident and in the amount of \$20,000
 1309 because of bodily injury to, or death of, two or more persons in
 1310 any one accident; or-

1311 2. ~~This subsection and subsection (4) do not apply if~~ An
 1312 insured has had a policy in effect for at least 6 months, the
 1313 insured's agent is terminated by the insurer that issued the
 1314 policy, and the insured obtains coverage on the policy's renewal
 1315 date with a new company through the terminated agent.

1316 Section 14. Paragraph (d) of subsection (3) of section
 1317 628.909, Florida Statutes, is amended to read:

1318 628.909 Applicability of other laws.-

1319 (3) The following provisions of the Florida Insurance Code
 1320 shall apply to industrial insured captive insurers to the extent
 1321 that such provisions are not inconsistent with this part:

1322 (d) Sections 627.730-627.7407 ~~if 627.730-627.7405 when no-~~
 1323 fault coverage is provided.

1324 Section 15. Paragraph (c) of subsection (7) of section
 1325 817.234, Florida Statutes, is amended to read:

1326 817.234 False and fraudulent insurance claims.-

1327 (7)

1328 (c) An insurer, or any person acting at the direction of or
 1329 on behalf of an insurer, may not change an opinion in a mental
 1330 or physical report prepared under s. 627.736(7) ~~627.736(8)~~ or
 1331 direct the physician preparing the report to change such
 1332 opinion; however, this provision does not preclude the insurer
 1333 from calling to the attention of the physician errors of fact in
 1334 the report based upon information in the claim file. Any person

21-00032-12

2012254__

1335 who violates this paragraph commits a felony of the third
1336 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1337 775.084.

1338 Section 16. This act shall take effect July 1, 2012.