By the Committee on Banking and Insurance; and Senator Negron

597-02844-12 20121860c1

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 the conditions for completing the long-form
5 traffic crash report; revising the information
6 contained in the long-form and the short-form reports;
7 limiting the inclusion of telephone numbers in crash
8 reports; authorizing an investigating officer to
9 testify at trial or provide an affidavit regarding a
10 crash; amending s. 400.9905, F.S.; providing that
11 certain entities exempt from licensure as a health
12 care clinic must nonetheless be licensed in order to
13 receive reimbursement for the provision of personal
14 injury protection benefits; amending s. 400.991, F.S.;
15 requiring that an application for licensure, or
16 exemption from licensure, as a health care clinic
17 include a statement regarding insurance fraud;
18 amending s. 626.989, F.S.; providing that knowingly
19 submitting false, misleading, or fraudulent documents
20 relating to licensure as a health care clinic, or
21 submitting a claim for personal injury protection
22 relating to clinic licensure documents, is a
23 fraudulent insurance act under certain conditions;
24 amending s. 626.9894, F.S.; conforming provisions to
25 changes made by act; creating s. 626.9895, F.S.;
26 providing definitions; authorizing the Division of
27 Insurance Fraud of the Department of Financial
28 Services to establish a direct-support organization
29 for the purpose of prosecuting, investigating, and

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30 preventing motor vehicle insurance fraud; providing
31 requirements for, and duties of, the organization;
32 requiring that the organization operate pursuant to a
33 contract with the division; providing for the
34 requirements of the contract; providing for a board of
35 directors; authorizing the organization to use the
36 division’s property and facilities subject to certain
37 requirements; requiring that the department adopt
38 rules relating to procedures for the organization’s
39 governance and relating to conditions for the use of
40 the division’s property or facilities; authorizing
41 contributions from insurers; authorizing any moneys
42 received by the organization to be held in a separate
43 depository account in the name of the organization;
44 requiring that the division deposit certain proceeds
45 into the Insurance Regulatory Trust Fund; amending s.
46 627.736, F.S.; excluding massage and acupuncture from
47 medical benefits that may be reimbursed under the
48 motor vehicle no-fault law; requiring that an insurer
49 give priority to the payment of death benefits under
50 certain conditions; requiring that an insurer repay
51 any benefits covered by the Medicaid program;
52 requiring that an insurer provide a claimant an
53 opportunity to revise claims that contain errors;
54 including hospitals within a requirement for insurers
55 to reserve a portion of personal injury protection
56 benefits; requiring that an insurer create and
57 maintain a log of personal injury protection benefits
58 paid and that the insurer provide to the insured or an

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59 assignee of the insured, upon request, a copy of the
60 log; revising the Medicare fee schedules that an
61 insurer may use as a basis for limiting reimbursement
62 of personal injury protection benefits; providing that
63 the Medicare fee schedule in effect on a specific date
64 applies for purposes of limiting such reimbursement;
65 authorizing insurers to apply certain Medicare coding
66 policies and payment methodologies; requiring that an
67 insurer that limits payments based on the statutory
68 fee schedule include a notice in insurance policies at
69 the time of issuance or renewal; deleting obsolete
70 provisions; providing that certain entities exempt
71 from licensure as a clinic must nonetheless be
72 licensed to receive reimbursement for the provision of
73 personal injury protection benefits; providing
74 exceptions; requiring that an insurer notify parties
75 in disputes over personal injury protection claims
76 when policy limits are reached; consolidating
77 provisions relating to unfair or deceptive practices
78 under certain conditions; eliminating a requirement
79 that all parties mutually and expressly agree for the
80 use of electronic transmission of data; amending s.
81 817.234, F.S.; providing that it is insurance fraud to
82 present a claim for personal injury protection
83 benefits payable to a person or entity that knowingly
84 submitted false, misleading, or fraudulent documents
85 relating to licensure as a health care clinic;
86 providing that a licensed health care practitioner
87 guilty of certain insurance fraud loses his or her

88 license and may not receive personal injury protection
89 benefits for a specified period; defining the term
90 “insurer”; amending s. 316.065, F.S.; conforming a
91 cross-reference; requiring that the Office of
92 Insurance Regulation perform a data call relating to
93 personal injury protection; prescribing required
94 elements of the data call; providing for severability;
95 providing effective dates.
96
97 Be It Enacted by the Legislature of the State of Florida:
98
99 Section 1. Subsection (1) of section 316.066, Florida
100 Statutes, is amended to read:
101 316.066 Written reports of crashes.—
102 (1)(a) A Florida Traffic Crash Report, Long Form, must ~~is~~
103 ~~required to~~ be completed and submitted to the department within
104 10 days after ~~completing~~ an investigation is completed by the
105 ~~every~~ law enforcement officer who in the regular course of duty
106 investigates a motor vehicle crash that:
107 1. Resulted in death, ~~or~~ personal injury, or any complaint
108 of pain or discomfort by any of the parties or passengers
109 involved in the crash;~~.~~
110 2. Involved one or more passengers in any vehicle involved
111 in the crash, other than the driver of the vehicle; or
112 3.~~2.~~ Involved a violation of s. 316.061(1) or s. 316.193.
113 (b) In any ~~every~~ crash for which a Florida Traffic Crash
114 Report, Long Form, is not required ~~by this section~~, the law
115 enforcement officer may complete a short-form crash report or
116 provide a driver exchange-of-information form to be completed by

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117 each party involved in the crash. The agency that employs the
118 law enforcement officer who prepares the short-form crash report
119 shall maintain the report.
120 (c) The long-form and the short-form reports ~~report~~ must
121 include:
122 1. The date, time, and location of the crash.
123 2. A description of the vehicles involved.
124 3. The names and addresses of the parties involved,
125 including all drivers and passengers, with each party clearly
126 identified as a driver or passenger and the vehicle that he or
127 she occupied.
128 4. The names and addresses of witnesses.
129 5. The name, badge number, and law enforcement agency of
130 the officer investigating the crash.
131 6. The names of the insurance companies for the respective
132 parties involved in the crash.
133
134 Except for a crash in which a party is charged with a criminal
135 traffic offense, a long-form or short-form crash report may not
136 include the telephone number of a party involved in the crash.
137 (d) ~~(c)~~ Each party to the crash must provide the law
138 enforcement officer with proof of insurance, which must be
139 documented in the crash report. If a law enforcement officer
140 submits a report on the crash, proof of insurance must be
141 provided to the officer by each party involved in the crash. Any
142 party who fails to provide the required information commits a
143 noncriminal traffic infraction, punishable as a nonmoving
144 violation as provided in chapter 318, unless the officer
145 determines that due to injuries or other special circumstances

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146 such insurance information cannot be provided immediately. If,
147 within 24 hours after the crash, the person provides the law
148 enforcement agency with~~, within 24 hours after the crash,~~ proof
149 of insurance that was valid at the time of the crash, the law
150 enforcement agency may void the citation.
151 (e)~~(d)~~ The driver of a vehicle that was in any manner
152 involved in a crash resulting in damage to any vehicle or other
153 property in an amount of $500 or more which was not investigated
154 by a law enforcement agency, shall, within 10 days after the
155 crash, submit a written report of the crash to the department.
156 The entity receiving the report may require witnesses of the
157 crash to render reports and may require the ~~any~~ driver of a
158 vehicle involved in a crash of which a written report must be
159 made to file supplemental written reports if the original report
160 is deemed insufficient by the receiving entity.
161 (f) The law enforcement officer who investigates a crash
162 may testify at trial, provide a deposition for use at trial, or
163 provide a signed affidavit to confirm or supplement information
164 included in the long-form or short-form crash report.
165 ~~(e) Short-form crash reports prepared by law enforcement~~
166 ~~shall be maintained by the law enforcement officer's agency.~~
167 Section 2. Subsection (4) of section 400.9905, Florida
168 Statutes, is amended to read:
169 400.9905 Definitions.—
170 (4) "Clinic" means an entity where ~~at which~~ health care
171 services are provided to individuals and which tenders charges
172 for reimbursement for such services, including a mobile clinic
173 and a portable equipment provider. As used in ~~For purposes of~~
174 this part, the term does not include and the licensure

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175 requirements of this part do not apply to:
176 (a) Entities licensed or registered by the state under
177 chapter 395; ~~or~~ entities licensed or registered by the state and
178 providing only health care services within the scope of services
179 authorized under their respective licenses ~~granted~~ under ss.
180 383.30-383.335, chapter 390, chapter 394, chapter 397, this
181 chapter except part X, chapter 429, chapter 463, chapter 465,
182 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
183 chapter 651; end-stage renal disease providers authorized under
184 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
185 C.F.R. part 485, subpart B or subpart H; or any entity that
186 provides neonatal or pediatric hospital-based health care
187 services or other health care services by licensed practitioners
188 solely within a hospital licensed under chapter 395.
189 (b) Entities that own, directly or indirectly, entities
190 licensed or registered by the state pursuant to chapter 395; ~~or~~
191 entities that own, directly or indirectly, entities licensed or
192 registered by the state and providing only health care services
193 within the scope of services authorized pursuant to their
194 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
195 390, chapter 394, chapter 397, this chapter except part X,
196 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
197 part I of chapter 483, chapter 484, chapter 651; end-stage renal
198 disease providers authorized under 42 C.F.R. part 405, subpart
199 U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or
200 subpart H; or any entity that provides neonatal or pediatric
201 hospital-based health care services by licensed practitioners
202 solely within a hospital licensed under chapter 395.
203 (c) Entities that are owned, directly or indirectly, by an

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204 entity licensed or registered by the state pursuant to chapter
205 395; ~~or~~ entities that are owned, directly or indirectly, by an
206 entity licensed or registered by the state and providing only
207 health care services within the scope of services authorized
208 pursuant to their respective licenses ~~granted~~ under ss. 383.30-
209 383.335, chapter 390, chapter 394, chapter 397, this chapter
210 except part X, chapter 429, chapter 463, chapter 465, chapter
211 466, chapter 478, part I of chapter 483, chapter 484, or chapter
212 651; end-stage renal disease providers authorized under 42
213 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
214 C.F.R. part 485, subpart B or subpart H; or any entity that
215 provides neonatal or pediatric hospital-based health care
216 services by licensed practitioners solely within a hospital
217 under chapter 395.
218 (d) Entities that are under common ownership, directly or
219 indirectly, with an entity licensed or registered by the state
220 pursuant to chapter 395; ~~or~~ entities that are under common
221 ownership, directly or indirectly, with an entity licensed or
222 registered by the state and providing only health care services
223 within the scope of services authorized pursuant to their
224 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
225 390, chapter 394, chapter 397, this chapter except part X,
226 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
227 part I of chapter 483, chapter 484, or chapter 651; end-stage
228 renal disease providers authorized under 42 C.F.R. part 405,
229 subpart U; ~~or~~ providers certified under 42 C.F.R. part 485,
230 subpart B or subpart H; or any entity that provides neonatal or
231 pediatric hospital-based health care services by licensed
232 practitioners solely within a hospital licensed under chapter

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233 395.
234 (e) An entity that is exempt from federal taxation under 26
235 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
236 under 26 U.S.C. s. 409 that has a board of trustees at least ~~not~~
237 ~~less than~~ two-thirds of which are Florida-licensed health care
238 practitioners and provides only physical therapy services under
239 physician orders, any community college or university clinic,
240 and any entity owned or operated by the federal or state
241 government, including agencies, subdivisions, or municipalities
242 thereof.
243 (f) A sole proprietorship, group practice, partnership, or
244 corporation that provides health care services by physicians
245 covered by s. 627.419, that is directly supervised by one or
246 more of such physicians, and that is wholly owned by one or more
247 of those physicians or by a physician and the spouse, parent,
248 child, or sibling of that physician.
249 (g) A sole proprietorship, group practice, partnership, or
250 corporation that provides health care services by licensed
251 health care practitioners under chapter 457, chapter 458,
252 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
253 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
254 chapter 490, chapter 491, or part I, part III, part X, part
255 XIII, or part XIV of chapter 468, or s. 464.012, and that is
256 ~~which are~~ wholly owned by one or more licensed health care
257 practitioners, or the licensed health care practitioners set
258 forth in this paragraph and the spouse, parent, child, or
259 sibling of a licensed health care practitioner if~~, so long as~~
260 one of the owners who is a licensed health care practitioner is
261 supervising the business activities and is legally responsible

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262 for the entity’s compliance with all federal and state laws.
263 However, a health care practitioner may not supervise services
264 beyond the scope of the practitioner’s license, except that, for
265 the purposes of this part, a clinic owned by a licensee in s.
266 456.053(3)(b) which ~~that~~ provides only services authorized
267 pursuant to s. 456.053(3)(b) may be supervised by a licensee
268 specified in s. 456.053(3)(b).
269 (h) Clinical facilities affiliated with an accredited
270 medical school at which training is provided for medical
271 students, residents, or fellows.
272 (i) Entities that provide only oncology or radiation
273 therapy services by physicians licensed under chapter 458 or
274 chapter 459 or entities that provide oncology or radiation
275 therapy services by physicians licensed under chapter 458 or
276 chapter 459 which are owned by a corporation whose shares are
277 publicly traded on a recognized stock exchange.
278 (j) Clinical facilities affiliated with a college of
279 chiropractic accredited by the Council on Chiropractic Education
280 at which training is provided for chiropractic students.
281 (k) Entities that provide licensed practitioners to staff
282 emergency departments or to deliver anesthesia services in
283 facilities licensed under chapter 395 and that derive at least
284 90 percent of their gross annual revenues from the provision of
285 such services. Entities claiming an exemption from licensure
286 under this paragraph must provide documentation demonstrating
287 compliance.
288 (l) Orthotic or prosthetic clinical facilities that are a
289 publicly traded corporation or that are wholly owned, directly
290 or indirectly, by a publicly traded corporation. As used in this

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291 paragraph, a publicly traded corporation is a corporation that
292 issues securities traded on an exchange registered with the
293 United States Securities and Exchange Commission as a national
294 securities exchange.
295
296 Notwithstanding this subsection, an entity shall be deemed a
297 clinic and must be licensed under this part in order to receive
298 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
299 627.730-627.7405, unless exempted under s. 627.736(5)(h).
300 Section 3. Subsection (6) is added to section 400.991,
301 Florida Statutes, to read:
302 400.991 License requirements; background screenings;
303 prohibitions.—
304 (6) All agency forms for licensure application or exemption
305 from licensure under this part must contain the following
306 statement:
307
308 INSURANCE FRAUD NOTICE.—A person who knowingly submits
309 a false, misleading, or fraudulent application or
310 other document when applying for licensure as a health
311 care clinic, seeking an exemption from licensure as a
312 health care clinic, or demonstrating compliance with
313 part X of chapter 400, Florida Statutes, with the
314 intent to use the license, exemption from licensure,
315 or demonstration of compliance to provide services or
316 seek reimbursement under the Florida Motor Vehicle No-
317 Fault Law, commits a fraudulent insurance act, as
318 defined in s. 626.989, Florida Statutes. A person who
319 presents a claim for personal injury protection

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320 benefits knowing that the payee knowingly submitted
321 such health care clinic application or document,
322 commits insurance fraud, as defined in s. 817.234,
323 Florida Statutes.
324 Section 4. Subsection (1) of section 626.989, Florida
325 Statutes, is amended to read:
326 626.989 Investigation by department or Division of
327 Insurance Fraud; compliance; immunity; confidential information;
328 reports to division; division investigator’s power of arrest.—
329 (1) For the purposes of this section:~~,~~
330 (a) A person commits a “fraudulent insurance act” if the
331 person:
332 1. Knowingly and with intent to defraud presents, causes to
333 be presented, or prepares with knowledge or belief that it will
334 be presented, to or by an insurer, self-insurer, self-insurance
335 fund, servicing corporation, purported insurer, broker, or any
336 agent thereof, any written statement as part of, or in support
337 of, an application for the issuance of, or the rating of, any
338 insurance policy, or a claim for payment or other benefit
339 pursuant to any insurance policy, which the person knows to
340 contain materially false information concerning any fact
341 material thereto or if the person conceals, for the purpose of
342 misleading another, information concerning any fact material
343 thereto.
344 2. Knowingly submits:
345 a. A false, misleading, or fraudulent application or other
346 document when applying for licensure as a health care clinic,
347 seeking an exemption from licensure as a health care clinic, or
348 demonstrating compliance with part X of chapter 400 with an

349 intent to use the license, exemption from licensure, or
350 demonstration of compliance to provide services or seek
351 reimbursement under the Florida Motor Vehicle No-Fault Law.
352 b. A claim for payment or other benefit pursuant to a
353 personal injury protection insurance policy under the Florida
354 Motor Vehicle No-Fault Law if the person knows that the payee
355 knowingly submitted a false, misleading, or fraudulent
356 application or other document when applying for licensure as a
357 health care clinic, seeking an exemption from licensure as a
358 health care clinic, or demonstrating compliance with part X of
359 chapter 400. ~~For the purposes of this section,~~
360 (b) The term "insurer" also includes a ~~any~~ health
361 maintenance organization, and the term "insurance policy" also
362 includes a health maintenance organization subscriber contract.
363 Section 5. Subsection (5) of section 626.9894, Florida
364 Statutes, is amended to read:
365 626.9894 Gifts and grants.—
366 (5) Notwithstanding ~~the provisions of~~ s. 216.301 and
367 pursuant to s. 216.351, any balance of moneys deposited into the
368 Insurance Regulatory Trust Fund pursuant to this section or s.
369 626.9895 remaining at the end of any fiscal year is ~~shall be~~
370 available for carrying out the duties and responsibilities of
371 the division. The department may request annual appropriations
372 from the grants and donations received pursuant to this section
373 or s. 626.9895 and cash balances in the Insurance Regulatory
374 Trust Fund for the purpose of carrying out its duties and
375 responsibilities related to the division's anti-fraud efforts,
376 including the funding of dedicated prosecutors and related
377 personnel.

378 Section 6. Section 626.9895, Florida Statutes, is created
379 to read:
380 626.9895 Motor vehicle insurance fraud direct-support
381 organization.—
382 (1) DEFINITIONS.—As used in this section, the term:
383 (a) "Division" means the Division of Insurance Fraud of the
384 Department of Financial Services.
385 (b) "Motor vehicle insurance fraud" means any act defined
386 as a "fraudulent insurance act" under s. 626.989, which relates
387 to the coverage of motor vehicle insurance as described in part
388 XI of chapter 627.
389 (c) "Organization" means the direct-support organization
390 established under this section.
391 (2) ORGANIZATION ESTABLISHED.—The division may establish a
392 direct-support organization, to be known as the "Automobile
393 Insurance Fraud Strike Force," whose sole purpose is to support
394 the prosecution, investigation, and prevention of motor vehicle
395 insurance fraud. The organization shall:
396 (a) Be a not-for-profit corporation incorporated under
397 chapter 617 and approved by the Department of State.
398 (b) Be organized and operated to conduct programs and
399 activities; raise funds; request and receive grants, gifts, and
400 bequests of money; acquire, receive, hold, invest, and
401 administer, in its own name, securities, funds, objects of
402 value, or other property, real or personal; and make grants and
403 expenditures to or for the direct or indirect benefit of the
404 division, state attorneys' offices, the statewide prosecutor,
405 the Agency for Health Care Administration, and the Department of
406 Health to the extent that such grants and expenditures are used

407 exclusively to advance the prosecution, investigation, or
408 prevention of motor vehicle insurance fraud. Grants and
409 expenditures may include the cost of salaries or benefits of
410 motor vehicle insurance fraud investigators, prosecutors, or
411 support personnel if such grants and expenditures do not
412 interfere with prosecutorial independence or otherwise create
413 conflicts of interest which threaten the success of
414 prosecutions.
415 (c) Be determined by the division to operate in a manner
416 that promotes the goals of laws relating to motor vehicle
417 insurance fraud, that is in the best interest of the state, and
418 that is in accordance with the adopted goals and mission of the
419 division.
420 (d) Use all of its grants and expenditures solely for the
421 purpose of preventing and decreasing motor vehicle insurance
422 fraud, and not for the purpose of lobbying as defined in s.
423 11.045.
424 (e) Be subject to an annual financial audit in accordance
425 with s. 215.981.
426 (3) CONTRACT.—The organization shall operate under written
427 contract with the division. The contract must provide for:
428 (a) Approval of the articles of incorporation and bylaws of
429 the organization by the division.
430 (b) Submission of an annual budget for approval of the
431 division. The budget must require the organization to minimize
432 costs to the division and its members at all times by using
433 existing personnel and property and allowing for telephonic
434 meetings if appropriate.
435 (c) Certification by the division that the organization is

436 complying with the terms of the contract and in a manner
437 consistent with the goals and purposes of the department and in
438 the best interest of the state. Such certification must be made
439 annually and reported in the official minutes of a meeting of
440 the organization.
441 (d) Allocation of funds to address motor vehicle insurance
442 fraud.
443 (e) Reversion of moneys and property held in trust by the
444 organization for motor vehicle insurance fraud prosecution,
445 investigation, and prevention to the division if the
446 organization is no longer approved to operate for the department
447 or if the organization ceases to exist, or to the state if the
448 division ceases to exist.
449 (f) Specific criteria to be used by the organization's
450 board of directors to evaluate the effectiveness of funding used
451 to combat motor vehicle insurance fraud.
452 (g) The fiscal year of the organization, which begins July
453 1 of each year and ends June 30 of the following year.
454 (h) Disclosure of the material provisions of the contract,
455 and distinguishing between the department and the organization
456 to donors of gifts, contributions, or bequests, including
457 providing such disclosure on all promotional and fundraising
458 publications.
459 (4) BOARD OF DIRECTORS.—
460 (a) The board of directors of the organization shall
461 consist of the following eleven members:
462 1. The Chief Financial Officer, or designee, who shall
463 serve as chair.
464 2. Two state attorneys, one of whom shall be appointed by

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465 the Chief Financial Officer and one of whom shall be appointed
466 by the Attorney General.
467 3. Two representatives of motor vehicle insurers appointed
468 by the Chief Financial Officer.
469 4. Two representatives of local law enforcement agencies,
470 one of whom shall be appointed by the Chief Financial Officer
471 and one of whom shall be appointed by the Attorney General.
472 5. Two representatives of the types of health care
473 providers who regularly make claims for benefits under ss.
474 627.730-627.7405, one of whom shall be appointed by the
475 President of the Senate and one of whom shall be appointed by
476 the Speaker of the House of Representatives. The appointees may
477 not represent the same type of health care provider.
478 6. A private attorney that has experience in representing
479 claimants in actions for benefits under ss. 627.730-627.7405,
480 who shall be appointed by the President of the Senate.
481 7. A private attorney who has experience in representing
482 insurers in actions for benefits under ss. 627.730-627.7405, who
483 shall be appointed by the Speaker of the House of
484 Representatives.
485 (b) The officer who appointed a member of the board may
486 remove that member for cause. The term of office of an appointed
487 member expires at the same time as the term of the officer who
488 appointed him or her or at such earlier time as the person
489 ceases to be qualified.
490 (5) USE OF PROPERTY.—The department may authorize, without
491 charge, appropriate use of fixed property and facilities of the
492 division by the organization, subject to this subsection.
493 (a) The department may prescribe any condition with which

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494 the organization must comply in order to use the division’s
495 property or facilities.
496 (b) The department may not authorize the use of the
497 division’s property or facilities if the organization does not
498 provide equal membership and employment opportunities to all
499 persons regardless of race, religion, sex, age, or national
500 origin.
501 (c) The department shall adopt rules prescribing the
502 procedures by which the organization is governed and any
503 conditions with which the organization must comply to use the
504 division’s property or facilities.
505 (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an
506 insurer to the organization shall be allowed as an appropriate
507 business expense of the insurer for all regulatory purposes.
508 (7) DEPOSITORY ACCOUNT.—Any moneys received by the
509 organization may be held in a separate depository account in the
510 name of the organization and subject to the contract with the
511 division.
512 (8) DIVISION’S RECEIPT OF PROCEEDS.—Proceeds received by
513 the division from the organization shall be deposited into the
514 Insurance Regulatory Trust Fund.
515 Section 7. Subsections (1), (4), (5), (6), (8), (9), (10),
516 and (11) of section 627.736, Florida Statutes, are amended to
517 read:
518 627.736 Required personal injury protection benefits;
519 exclusions; priority; claims.—
520 (1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy complying
521 with the security requirements of s. 627.733 must ~~shall~~ provide
522 personal injury protection to the named insured, relatives

523 residing in the same household, persons operating the insured
524 motor vehicle, passengers in the ~~such~~ motor vehicle, and other
525 persons struck by the ~~such~~ motor vehicle and suffering bodily
526 injury while not an occupant of a self-propelled vehicle,
527 subject to ~~the provisions of~~ subsection (2) and paragraph
528 (4)(e), to a limit of $10,000 for loss sustained by ~~any~~ such
529 person as a result of bodily injury, sickness, disease, or death
530 arising out of the ownership, maintenance, or use of a motor
531 vehicle as follows:
532 (a) *Medical benefits.*—Eighty percent of all reasonable
533 expenses for medically necessary medical, surgical, X-ray,
534 dental, and rehabilitative services, including prosthetic
535 devices~~,~~ and medically necessary ambulance, hospital, and
536 nursing services. Medical benefits do not include massage as
537 defined in s. 480.033 or acupuncture as defined in s. 457.102.
538 ~~However,~~ The medical benefits ~~shall~~ provide reimbursement only
539 for ~~such~~ services and care that are lawfully provided,
540 supervised, ordered, or prescribed by a physician licensed under
541 chapter 458 or chapter 459, a dentist licensed under chapter
542 466, or a chiropractic physician licensed under chapter 460 or
543 that are provided by any of the following ~~persons or entities~~:
544 1. A hospital or ambulatory surgical center licensed under
545 chapter 395.
546 2. A person or entity licensed under part III of chapter
547 401 which ~~ss. 401.2101-401.45 that~~ provides emergency
548 transportation and treatment.
549 3. An entity wholly owned by one or more physicians
550 licensed under chapter 458 or chapter 459, chiropractic
551 physicians licensed under chapter 460, or dentists licensed

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552 under chapter 466 or by such ~~practitioner or~~ practitioners and
553 the spouse, parent, child, or sibling of such ~~that practitioner~~
554 ~~or those~~ practitioners.
555 4. An entity wholly owned, directly or indirectly, by a
556 hospital or hospitals.
557 5. A health care clinic licensed under part X of chapter
558 400 which ~~ss. 400.990-400.995 that~~ is:
559 a. A health care clinic accredited by the Joint Commission
560 on Accreditation of Healthcare Organizations, the American
561 Osteopathic Association, the Commission on Accreditation of
562 Rehabilitation Facilities, or the Accreditation Association for
563 Ambulatory Health Care, Inc.; or
564 b. A health care clinic that:
565 (I) Has a medical director licensed under chapter 458,
566 chapter 459, or chapter 460;
567 (II) Has been continuously licensed for more than 3 years
568 or is a publicly traded corporation that issues securities
569 traded on an exchange registered with the United States
570 Securities and Exchange Commission as a national securities
571 exchange; and
572 (III) Provides at least four of the following medical
573 specialties:
574 (A) General medicine.
575 (B) Radiography.
576 (C) Orthopedic medicine.
577 (D) Physical medicine.
578 (E) Physical therapy.
579 (F) Physical rehabilitation.
580 (G) Prescribing or dispensing outpatient prescription

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581 medication.
582 (H) Laboratory services.
583
584 The Financial Services Commission shall adopt by rule the form
585 that must be used by an insurer and a health care provider
586 specified in subparagraph 3., subparagraph 4., or subparagraph
587 5. to document that the health care provider meets the criteria
588 of this paragraph, which rule must include a requirement for a
589 sworn statement or affidavit.
590 (b) *Disability benefits.*—Sixty percent of any loss of gross
591 income and loss of earning capacity per individual from
592 inability to work proximately caused by the injury sustained by
593 the injured person, plus all expenses reasonably incurred in
594 obtaining from others ordinary and necessary services in lieu of
595 those that, but for the injury, the injured person would have
596 performed without income for the benefit of his or her
597 household. All disability benefits payable under this provision
598 <u>must</u> ~~shall~~ be paid <u>at least</u> ~~not less than~~ every 2 weeks.
599 (c) *Death benefits.*—Death benefits equal to the lesser of
600 $5,000 or the remainder of unused personal injury protection
601 benefits per individual. <u>The insurer shall give priority to the</u>
602 <u>payment of death benefits over the payment of other benefits of</u>
603 <u>the deceased and, upon learning of the death of the individual,</u>
604 <u>stop paying the other benefits until the death benefits are</u>
605 <u>paid.</u> The insurer may pay <u>death</u> ~~such~~ benefits to the executor or
606 administrator of the deceased, to any of the deceased’s
607 relatives by blood<u>,</u> ~~or~~ legal adoption<u>,</u> or ~~connection by~~
608 marriage, or to any person appearing to the insurer to be
609 equitably entitled ~~thereto~~.

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610

611 Only insurers writing motor vehicle liability insurance in this
612 state may provide the required benefits of this section, and no
613 such insurer may not shall require the purchase of any other
614 motor vehicle coverage other than the purchase of property
615 damage liability coverage as required by s. 627.7275 as a
616 condition for providing such required benefits. Insurers may not
617 require that property damage liability insurance in an amount
618 greater than $10,000 be purchased in conjunction with personal
619 injury protection. Such insurers shall make benefits and
620 required property damage liability insurance coverage available
621 through normal marketing channels. An Any insurer writing motor
622 vehicle liability insurance in this state who fails to comply
623 with such availability requirement as a general business
624 practice violates shall be deemed to have violated part IX of
625 chapter 626, and such violation constitutes shall constitute an
626 unfair method of competition or an unfair or deceptive act or
627 practice involving the business of insurance. An; and any such
628 insurer committing such violation is shall be subject to the
629 penalties provided under that afforded in such part, as well as
630 those provided which may be afforded elsewhere in the insurance
631 code.
632 (4) PAYMENT OF BENEFITS; WHEN DUE.—Benefits due from an
633 insurer under ss. 627.730-627.7405 are shall be primary, except
634 that benefits received under any workers' compensation law must
635 shall be credited against the benefits provided by subsection
636 (1) and are shall be due and payable as loss accrues, upon
637 receipt of reasonable proof of such loss and the amount of
638 expenses and loss incurred which are covered by the policy

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639 issued under ss. 627.730-627.7405. If ~~When~~ the Agency for Health
640 Care Administration provides, pays, or becomes liable for
641 medical assistance under the Medicaid program related to injury,
642 sickness, disease, or death arising out of the ownership,
643 maintenance, or use of a motor vehicle, the benefits under ss.
644 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of~~ the
645 Medicaid program. However, within 30 days after receiving notice
646 that the Medicaid program paid such benefits, the insurer shall
647 repay the full amount of the benefits to the Medicaid program.
648 (a) An insurer may require written notice to be given as
649 soon as practicable after an accident involving a motor vehicle
650 with respect to which the policy affords the security required
651 by ss. 627.730-627.7405.
652 (b) Personal injury protection insurance benefits paid
653 pursuant to this section are ~~shall be~~ overdue if not paid within
654 30 days after the insurer is furnished written notice of the
655 fact of a covered loss and of the amount of same. However:
656 1. If ~~such~~ written notice of the entire claim is not
657 furnished to the insurer ~~as to the entire claim~~, any partial
658 amount supported by written notice is overdue if not paid within
659 30 days after ~~such~~ written notice is furnished to the insurer.
660 Any part or all of the remainder of the claim that is
661 subsequently supported by written notice is overdue if not paid
662 within 30 days after ~~such~~ written notice is furnished to the
663 insurer.
664 2. If ~~When~~ an insurer pays only a portion of a claim or
665 rejects a claim, the insurer shall provide at the time of the
666 partial payment or rejection an itemized specification of each
667 item that the insurer had reduced, omitted, or declined to pay

668 and any information that the insurer desires the claimant to
669 consider related to the medical necessity of the denied
670 treatment or to explain the reasonableness of the reduced charge
671 if~~, provided that~~ this does ~~shall~~ not limit the introduction of
672 evidence at trial.~~; and~~ The insurer must also ~~shall~~ include the
673 name and address of the person to whom the claimant should
674 respond and a claim number to be referenced in future
675 correspondence.

676 3. If an insurer pays only a portion of a claim or rejects
677 a claim due to an alleged error in the claim, the insurer shall
678 provide at the time of the partial payment or rejection an
679 itemized specification or explanation of benefits of the
680 specified error. Upon receiving the specification or
681 explanation, the person making the claim has, at the person's
682 option and without waiving any other legal remedy for payment,
683 15 days to submit a revised claim, and the revised claim shall
684 be considered a timely submission of written notice of a claim.

685 4. ~~However,~~ Notwithstanding the fact that written notice
686 has been furnished to the insurer, ~~any~~ payment is ~~shall~~ not ~~be~~
687 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~
688 ~~establish~~ that the insurer is not responsible for the payment.

689 5. For the purpose of calculating the extent to which ~~any~~
690 benefits are overdue, payment shall be treated as being made on
691 the date a draft or other valid instrument that ~~which~~ is
692 equivalent to payment was placed in the United States mail in a
693 properly addressed, postpaid envelope or, if not so posted, on
694 the date of delivery.

695 6. This paragraph does not preclude or limit the ability of
696 the insurer to assert that the claim was unrelated, was not

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697 medically necessary, or was unreasonable or that the amount of
698 the charge was in excess of that permitted under, or in
699 violation of, subsection (5). Such assertion ~~by the insurer~~ may
700 be made at any time, including after payment of the claim or
701 after the 30-day ~~time~~ period for payment set forth in this
702 paragraph.
703 (c) Upon receiving notice of an accident that is
704 potentially covered by personal injury protection benefits, the
705 insurer must reserve $5,000 of personal injury protection
706 benefits for payment to:
707 1. Physicians licensed under chapter 458 or chapter 459 or
708 dentists licensed under chapter 466 who provide emergency
709 services and care, as defined in s. 395.002~~(9)~~, or who provide
710 hospital inpatient care.
711 2. Hospitals licensed under chapter 395.
712
713 The amount required to be held in reserve may be used only to
714 pay claims from such physicians, ~~or~~ dentists, or hospitals until
715 30 days after the date the insurer receives notice of the
716 accident. After the 30-day period, any amount of the reserve for
717 which the insurer has not received notice of such claims ~~a claim~~
718 ~~from a physician or dentist who provided emergency services and~~
719 ~~care or who provided hospital inpatient care~~ may ~~then~~ be used by
720 the insurer to pay other claims. The time periods specified in
721 paragraph (b) for ~~required~~ payment of personal injury protection
722 benefits are ~~shall be~~ tolled for the period of time that an
723 insurer is required ~~by this paragraph~~ to hold payment of a claim
724 that is not from such ~~a~~ physician, ~~or~~ dentist, or hospital ~~who~~
725 ~~provided emergency services and care or who provided hospital~~

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726 ~~inpatient care~~ to the extent that the personal injury protection
727 benefits not held in reserve are insufficient to pay the claim.
728 This paragraph does not require an insurer to establish a claim
729 reserve for insurance accounting purposes.
730 (d) All overdue payments ~~shall~~ bear simple interest at the
731 rate established under s. 55.03 or the rate established in the
732 insurance contract, whichever is greater, for the year in which
733 the payment became overdue, calculated from the date the insurer
734 was furnished with written notice of the amount of covered loss.
735 Interest is ~~shall be~~ due at the time payment of the overdue
736 claim is made.
737 (e) The insurer of the owner of a motor vehicle shall pay
738 personal injury protection benefits for:
739 1. Accidental bodily injury sustained in this state by the
740 owner while occupying a motor vehicle, or while not an occupant
741 of a self-propelled vehicle if the injury is caused by physical
742 contact with a motor vehicle.
743 2. Accidental bodily injury sustained outside this state,
744 but within the United States of America or its territories or
745 possessions or Canada, by the owner while occupying the owner's
746 motor vehicle.
747 3. Accidental bodily injury sustained by a relative of the
748 owner residing in the same household, under the circumstances
749 described in subparagraph 1. or subparagraph 2., if ~~provided~~ the
750 relative at the time of the accident is domiciled in the owner's
751 household and is not ~~himself or herself~~ the owner of a motor
752 vehicle with respect to which security is required under ss.
753 627.730-627.7405.
754 4. Accidental bodily injury sustained in this state by any

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755 other person while occupying the owner’s motor vehicle or, if a
756 resident of this state, while not an occupant of a self-
757 propelled vehicle~~,~~ if the injury is caused by physical contact
758 with such motor vehicle, if ~~provided~~ the injured person is not
759 ~~himself or herself~~:
760 a. The owner of a motor vehicle with respect to which
761 security is required under ss. 627.730-627.7405; or
762 b. Entitled to personal injury benefits from the insurer of
763 the owner ~~or owners~~ of such a motor vehicle.
764 (f) If two or more insurers are liable for paying ~~to pay~~
765 personal injury protection benefits for the same injury to any
766 one person, the maximum payable is ~~shall be~~ as specified in
767 subsection (1), and the ~~any~~ insurer paying the benefits is ~~shall~~
768 ~~be~~ entitled to recover from each of the other insurers an
769 equitable pro rata share of the benefits paid and expenses
770 incurred in processing the claim.
771 (g) It is a violation of the insurance code for an insurer
772 to fail to timely provide benefits as required by this section
773 with such frequency as to constitute a general business
774 practice.
775 (h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the
776 behalf of an insured person if that person has committed, by a
777 material act or omission, ~~any~~ insurance fraud relating to
778 personal injury protection coverage under his or her policy, if
779 the fraud is admitted to in a sworn statement by the insured or
780 ~~if it is~~ established in a court of competent jurisdiction. Any
781 insurance fraud voids ~~shall void~~ all coverage arising from the
782 claim related to such fraud under the personal injury protection
783 coverage of the insured person who committed the fraud,

784 irrespective of whether a portion of the insured person’s claim
785 may be legitimate, and any benefits paid before ~~prior to~~ the
786 discovery of the ~~insured person’s insurance~~ fraud is ~~shall be~~
787 recoverable by the insurer in its entirety from the person who
788 committed insurance fraud ~~in their entirety~~. The prevailing
789 party is entitled to its costs and attorney ~~attorney’s~~ fees in
790 any action in which it prevails in an insurer’s action to
791 enforce its right of recovery under this paragraph.
792 (i) An insurer shall create and maintain for each insured a
793 log of personal injury protection benefits paid by the insurer
794 on behalf of the insured. The insurer shall provide to the
795 insured, or an assignee of the insured, a copy of the log within
796 30 days after receiving a request for the log from the insured
797 or the assignee.
798 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
799 (a)~~1.~~ A ~~Any~~ physician, hospital, clinic, or other person or
800 institution lawfully rendering treatment to an injured person
801 for a bodily injury covered by personal injury protection
802 insurance may charge the insurer and injured party only a
803 reasonable amount pursuant to this section for the services and
804 supplies rendered, and the insurer providing such coverage may
805 pay for such charges directly to such person or institution
806 lawfully rendering such treatment~~,~~ if the insured receiving such
807 treatment or his or her guardian has countersigned the properly
808 completed invoice, bill, or claim form approved by the office
809 upon which such charges are to be paid for as having actually
810 been rendered, to the best knowledge of the insured or his or
811 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
812 exceed ~~be in excess of~~ the amount the person or institution

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813 customarily charges for like services or supplies. In
814 determining ~~With respect to a determination of~~ whether a charge
815 for a particular service, treatment, or otherwise is reasonable,
816 consideration may be given to evidence of usual and customary
817 charges and payments accepted by the provider involved in the
818 dispute, ~~and~~ reimbursement levels in the community and various
819 federal and state medical fee schedules applicable to motor
820 vehicle ~~automobile~~ and other insurance coverages, and other
821 information relevant to the reasonableness of the reimbursement
822 for the service, treatment, or supply.
823 1.~~2.~~ The insurer may limit reimbursement to 80 percent of
824 the following schedule of maximum charges:
825 a. For emergency transport and treatment by providers
826 licensed under chapter 401, 200 percent of Medicare.
827 b. For emergency services and care provided by a hospital
828 licensed under chapter 395, 75 percent of the hospital’s usual
829 and customary charges.
830 c. For emergency services and care as defined by s.
831 395.002~~(9)~~ provided in a facility licensed under chapter 395
832 rendered by a physician or dentist, and related hospital
833 inpatient services rendered by a physician or dentist, the usual
834 and customary charges in the community.
835 d. For hospital inpatient services, other than emergency
836 services and care, 200 percent of the Medicare Part A
837 prospective payment applicable to the specific hospital
838 providing the inpatient services.
839 e. For hospital outpatient services, other than emergency
840 services and care, 200 percent of the Medicare Part A Ambulatory
841 Payment Classification for the specific hospital providing the

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842 outpatient services.

843 f. For all other medical services, supplies, and care, 200
844 percent of the allowable amount under:

845 (I) The participating physicians fee schedule of Medicare
846 Part B, except as provided in sub-sub-subparagraphs (II) and
847 (III).

848 (II) Medicare Part B, in the case of services, supplies,
849 and care provided by ambulatory surgical centers and clinical
850 laboratories.

851 (III) The Durable Medical Equipment Prosthetics/Orthotics
852 and Supplies fee schedule of Medicare Part B, in the case of
853 durable medical equipment.

854

855 However, if such services, supplies, or care is not reimbursable
856 under Medicare Part B, as provided in this sub-subparagraph, the
857 insurer may limit reimbursement to 80 percent of the maximum
858 reimbursable allowance under workers' compensation, as
859 determined under s. 440.13 and rules adopted thereunder which
860 are in effect at the time such services, supplies, or care is
861 provided. Services, supplies, or care that is not reimbursable
862 under Medicare or workers' compensation is not required to be
863 reimbursed by the insurer.

864 2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee
865 schedule or payment limitation under Medicare is the fee
866 schedule or payment limitation in effect on January 1 of the
867 year in which ~~at the time~~ the services, supplies, or care is ~~was~~
868 rendered and for the area in which such services, supplies, or
869 care is ~~were~~ rendered, and the applicable fee schedule or
870 payment limitation applies throughout the remainder of that

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871 year, notwithstanding any subsequent change made to the fee
872 schedule or payment limitation, except that it may not be less
873 than the allowable amount under the applicable ~~participating~~
874 ~~physicians~~ schedule of Medicare Part B for 2007 for medical
875 services, supplies, and care subject to Medicare Part B.
876 3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply
877 any limitation on the number of treatments or other utilization
878 limits that apply under Medicare or workers' compensation. An
879 insurer that applies the allowable payment limitations of
880 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully
881 provided care or treatment under the scope of his or her
882 license, regardless of whether such provider is ~~would be~~
883 entitled to reimbursement under Medicare due to restrictions or
884 limitations on the types or discipline of health care providers
885 who may be reimbursed for particular procedures or procedure
886 codes. However, subparagraph 1. does not prohibit an insurer
887 from using the Medicare coding policies and payment
888 methodologies of the federal Centers for Medicare and Medicaid
889 Services, including applicable modifiers, to determine the
890 appropriate amount of reimbursement for medical services,
891 supplies, or care if the coding policy or payment methodology
892 does not constitute a utilization limit.
893 4.~~5.~~ If an insurer limits payment as authorized by
894 subparagraph 1. ~~2.~~, the person providing such services,
895 supplies, or care may not bill or attempt to collect from the
896 insured any amount in excess of such limits, except for amounts
897 that are not covered by the insured's personal injury protection
898 coverage due to the coinsurance amount or maximum policy limits.
899 5. Effective July 1, 2012, an insurer may limit payment as

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900 authorized by this paragraph only if the insurance policy
901 includes a notice at the time of issuance or renewal that the
902 insurer may limit payment pursuant to the schedule of charges
903 specified in this paragraph. A policy form approved by the
904 office satisfies this requirement. If a provider submits a
905 charge for an amount less than the amount allowed under
906 subparagraph 1., the insurer may pay the amount of the charge
907 submitted.
908 (b)1. An insurer or insured is not required to pay a claim
909 or charges:
910 a. Made by a broker or by a person making a claim on behalf
911 of a broker;
912 b. For any service or treatment that was not lawful at the
913 time rendered;
914 c. To any person who knowingly submits a false or
915 misleading statement relating to the claim or charges;
916 d. With respect to a bill or statement that does not
917 substantially meet the applicable requirements of paragraph (d);
918 e. For any treatment or service that is upcoded, or that is
919 unbundled when such treatment or services should be bundled, in
920 accordance with paragraph (d). To facilitate prompt payment of
921 lawful services, an insurer may change codes that it determines
922 ~~to~~ have been improperly or incorrectly upcoded or unbundled~~,~~ and
923 may make payment based on the changed codes, without affecting
924 the right of the provider to dispute the change by the insurer,
925 if, ~~provided that~~ before doing so, the insurer contacts ~~must~~
926 ~~contact~~ the health care provider and discusses ~~discuss~~ the
927 reasons for the insurer's change and the health care provider's
928 reason for the coding, or makes ~~make~~ a reasonable good faith

929 effort to do so, as documented in the insurer’s file; and
930 f. For medical services or treatment billed by a physician
931 and not provided in a hospital unless such services are rendered
932 by the physician or are incident to his or her professional
933 services and are included on the physician’s bill, including
934 documentation verifying that the physician is responsible for
935 the medical services that were rendered and billed.
936 2. The Department of Health, in consultation with the
937 appropriate professional licensing boards, shall adopt, by rule,
938 a list of diagnostic tests deemed not to be medically necessary
939 for use in the treatment of persons sustaining bodily injury
940 covered by personal injury protection benefits under this
941 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
942 ~~and~~ shall be revised from time to time as determined by the
943 Department of Health, in consultation with the respective
944 professional licensing boards. Inclusion of a test on the list
945 ~~of invalid diagnostic tests~~ shall be based on lack of
946 demonstrated medical value and a level of general acceptance by
947 the relevant provider community and may ~~shall~~ not be dependent
948 for results entirely upon subjective patient response.
949 Notwithstanding its inclusion on a fee schedule in this
950 subsection, an insurer or insured is not required to pay any
951 charges or reimburse claims for an ~~any~~ invalid diagnostic test
952 as determined by the Department of Health.
953 (c)~~1.~~ With respect to any treatment or service, other than
954 medical services billed by a hospital or other provider for
955 emergency services and care as defined in s. 395.002 or
956 inpatient services rendered at a hospital-owned facility, the
957 statement of charges must be furnished to the insurer by the

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958 provider and may not include, and the insurer is not required to
959 pay, charges for treatment or services rendered more than 35
960 days before the postmark date or electronic transmission date of
961 the statement, except for past due amounts previously billed on
962 a timely basis under this paragraph, and except that, if the
963 provider submits to the insurer a notice of initiation of
964 treatment within 21 days after its first examination or
965 treatment of the claimant, the statement may include charges for
966 treatment or services rendered up to, but not more than, 75 days
967 before the postmark date of the statement. The injured party is
968 not liable for, and the provider may ~~shall~~ not bill the injured
969 party for, charges that are unpaid because of the provider's
970 failure to comply with this paragraph. Any agreement requiring
971 the injured person or insured to pay for such charges is
972 unenforceable.

973 1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider
974 with the correct name and address of the insured's personal
975 injury protection insurer, the provider has 35 days from the
976 date the provider obtains the correct information to furnish the
977 insurer with a statement of the charges. The insurer is not
978 required to pay for such charges unless the provider includes
979 with the statement documentary evidence that was provided by the
980 insured during the 35-day period demonstrating that the provider
981 reasonably relied on erroneous information from the insured and
982 either:

983 a. A denial letter from the incorrect insurer; or

984 b. Proof of mailing, which may include an affidavit under
985 penalty of perjury, reflecting timely mailing to the incorrect
986 address or insurer.

987 <u>2.</u>~~3.~~ For emergency services and care ~~as defined in s.~~
988 ~~395.002~~ rendered in a hospital emergency department or for
989 transport and treatment rendered by an ambulance provider
990 licensed pursuant to part III of chapter 401, the provider is
991 not required to furnish the statement of charges within the time
992 periods established by this paragraph<u>,</u>~~;~~ and the insurer <u>is</u> ~~shall~~
993 not ~~be~~ considered to have been furnished with notice of the
994 amount of covered loss for purposes of paragraph (4)(b) until it
995 receives a statement complying with paragraph (d), or copy
996 thereof, which specifically identifies the place of service to
997 be a hospital emergency department or an ambulance in accordance
998 with billing standards recognized by the <u>federal Centers for</u>
999 <u>Medicare and Medicaid Services</u> ~~Health Care Finance~~
1000 ~~Administration~~.
1001 <u>3.</u>~~4.~~ Each notice of <u>the</u> insured's rights under s. 627.7401
1002 must include the following statement <u>in at least 12-point type</u>
1003 ~~in type no smaller than 12 points~~:
1004
1005 BILLING REQUIREMENTS.—Florida <u>law provides</u> ~~Statutes~~
1006 ~~provide~~ that with respect to any treatment or
1007 services, other than certain hospital and emergency
1008 services, the statement of charges furnished to the
1009 insurer by the provider may not include, and the
1010 insurer and the injured party are not required to pay,
1011 charges for treatment or services rendered more than
1012 35 days before the postmark date of the statement,
1013 except for past due amounts previously billed on a
1014 timely basis, and except that, if the provider submits
1015 to the insurer a notice of initiation of treatment

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within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

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

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1045 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1046 other authoritative treatises designated by rule by the Agency
1047 for Health Care Administration. A ~~No~~ statement of medical
1048 services may not include charges for medical services of a
1049 person or entity that performed such services without possessing
1050 the valid licenses required to perform such services. For
1051 purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~
1052 considered to have been furnished with notice of the amount of
1053 covered loss or medical bills due unless the statements or bills
1054 comply with this paragraph~~,~~ and ~~unless the statements or bills~~
1055 are properly completed in their entirety as to all material
1056 provisions, with all relevant information being provided
1057 therein.
1058 (e)1. At the initial treatment or service provided, each
1059 physician, other licensed professional, clinic, or other medical
1060 institution providing medical services upon which a claim for
1061 personal injury protection benefits is based shall require an
1062 insured person, or his or her guardian, to execute a disclosure
1063 and acknowledgment form, which reflects at a minimum that:
1064 a. The insured, or his or her guardian, must countersign
1065 the form attesting to the fact that the services set forth
1066 therein were actually rendered;
1067 b. The insured, or his or her guardian, has both the right
1068 and affirmative duty to confirm that the services were actually
1069 rendered;
1070 c. The insured, or his or her guardian, was not solicited
1071 by any person to seek any services from the medical provider;
1072 d. The physician, other licensed professional, clinic, or
1073 other medical institution rendering services for which payment

1074 is being claimed explained the services to the insured or his or
1075 her guardian; and
1076 e. If the insured notifies the insurer in writing of a
1077 billing error, the insured may be entitled to a certain
1078 percentage of a reduction in the amounts paid by the insured’s
1079 motor vehicle insurer.
1080 2. The physician, other licensed professional, clinic, or
1081 other medical institution rendering services for which payment
1082 is being claimed has the affirmative duty to explain the
1083 services rendered to the insured, or his or her guardian, so
1084 that the insured, or his or her guardian, countersigns the form
1085 with informed consent.
1086 3. Countersignature by the insured, or his or her guardian,
1087 is not required for the reading of diagnostic tests or other
1088 services that are of such a nature that they are not required to
1089 be performed in the presence of the insured.
1090 4. The licensed medical professional rendering treatment
1091 for which payment is being claimed must sign, by his or her own
1092 hand, the form complying with this paragraph.
1093 5. The original completed disclosure and acknowledgment
1094 form shall be furnished to the insurer pursuant to paragraph
1095 (4)(b) and may not be electronically furnished.
1096 6. <u>The</u> ~~This~~ disclosure and acknowledgment form is not
1097 required for services billed by a provider ~~for emergency~~
1098 ~~services as defined in s. 395.002,~~ for emergency services and
1099 care as defined in s. 395.002 rendered in a hospital emergency
1100 department, or for transport and treatment rendered by an
1101 ambulance provider licensed pursuant to part III of chapter 401.
1102 7. The Financial Services Commission shall adopt, by rule,

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1103 a standard disclosure and acknowledgment form to ~~that shall~~ be
1104 used to fulfill the requirements of this paragraph~~, effective 90~~
1105 ~~days after such form is adopted and becomes final~~. ~~The~~
1106 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1107 ~~the rule is final, the provider may use a form of its own which~~
1108 ~~otherwise complies with the requirements of this paragraph.~~
1109 8. As used in this paragraph, the term "countersign" or
1110 "countersignature" ~~"countersigned"~~ means a second or verifying
1111 signature, as on a previously signed document, and is not
1112 satisfied by the statement "signature on file" or any similar
1113 statement.
1114 9. The requirements of this paragraph apply only with
1115 respect to the initial treatment or service of the insured by a
1116 provider. For subsequent treatments or service, the provider
1117 must maintain a patient log signed by the patient, in
1118 chronological order by date of service, which ~~that~~ is consistent
1119 with the services being rendered to the patient as claimed. The
1120 requirement to maintain ~~requirements of this subparagraph for~~
1121 ~~maintaining~~ a patient log signed by the patient may be met by a
1122 hospital that maintains medical records as required by s.
1123 395.3025 and applicable rules and makes such records available
1124 to the insurer upon request.
1125 (f) Upon written notification by any person, an insurer
1126 shall investigate any claim of improper billing by a physician
1127 or other medical provider. The insurer shall determine if the
1128 insured was properly billed for only those services and
1129 treatments that the insured actually received. If the insurer
1130 determines that the insured has been improperly billed, the
1131 insurer shall notify the insured, the person making the written

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1132 notification, and the provider of its findings and ~~shall~~ reduce
1133 the amount of payment to the provider by the amount determined
1134 to be improperly billed. If a reduction is made due to a ~~such~~
1135 written notification by any person, the insurer shall pay to the
1136 person 20 percent of the amount of the reduction, up to $500. If
1137 the provider is arrested due to the improper billing, ~~then~~ the
1138 insurer shall pay to the person 40 percent of the amount of the
1139 reduction, up to $500.
1140 (g) An insurer may not systematically downcode with the
1141 intent to deny reimbursement otherwise due. Such action
1142 constitutes a material misrepresentation under s.
1143 626.9541(1)(i)2.
1144 (h) As provided in s. 400.9905, an entity excluded from the
1145 definition of a clinic shall be deemed a clinic and must be
1146 licensed under part X of chapter 400 in order to receive
1147 reimbursement under ss. 627.730-627.7405. However, this
1148 licensing requirement does not apply to:
1149 1. An entity wholly owned by a physician licensed under
1150 chapter 458 or chapter 459, or by the physician and the spouse,
1151 parent, child, or sibling of the physician;
1152 2. An entity wholly owned by a dentist licensed under
1153 chapter 466, or by the dentist and the spouse, parent, child, or
1154 sibling of the dentist;
1155 3. An entity wholly owned by a chiropractic physician
1156 licensed under chapter 460, or by the chiropractic physician and
1157 the spouse, parent, child, or sibling of the chiropractic
1158 physician;
1159 4. A hospital or ambulatory surgical center licensed under
1160 chapter 395; or

1161 5. An entity wholly owned, directly or indirectly, by a
1162 hospital or hospitals licensed under chapter 395.
1163 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—
1164 (a) ~~Every employer shall,~~ If a request is made by an
1165 insurer providing personal injury protection benefits under ss.
1166 627.730-627.7405 against whom a claim has been made, an employer
1167 must furnish ~~forthwith~~, in a form approved by the office, a
1168 sworn statement of the earnings, since the time of the bodily
1169 injury and for a reasonable period before the injury, of the
1170 person upon whose injury the claim is based.
1171 (b) Every physician, hospital, clinic, or other medical
1172 institution providing, before or after bodily injury upon which
1173 a claim for personal injury protection insurance benefits is
1174 based, any products, services, or accommodations in relation to
1175 that or any other injury, or in relation to a condition claimed
1176 to be connected with that or any other injury, shall, if
1177 requested ~~to do so~~ by the insurer against whom the claim has
1178 been made, furnish ~~forthwith~~ a written report of the history,
1179 condition, treatment, dates, and costs of such treatment of the
1180 injured person and why the items identified by the insurer were
1181 reasonable in amount and medically necessary, together with a
1182 sworn statement that the treatment or services rendered were
1183 reasonable and necessary with respect to the bodily injury
1184 sustained and identifying which portion of the expenses for such
1185 treatment or services was incurred as a result of such bodily
1186 injury, and produce ~~forthwith~~, and allow ~~permit~~ the inspection
1187 and copying of, his or her or its records regarding such
1188 history, condition, treatment, dates, and costs of treatment if~~;~~
1189 ~~provided that~~ this does ~~shall~~ not limit the introduction of

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1190 evidence at trial. Such sworn statement <u>must</u> ~~shall~~ read as
1191 follows: “Under penalty of perjury, I declare that I have read
1192 the foregoing, and the facts alleged are true, to the best of my
1193 knowledge and belief.” <u>A</u> ~~No~~ cause of action for violation of the
1194 physician-patient privilege or invasion of the right of privacy
1195 <u>may not be brought</u> ~~shall be permitted~~ against any physician,
1196 hospital, clinic, or other medical institution complying with
1197 ~~the provisions of~~ this section. The person requesting such
1198 records and such sworn statement shall pay all reasonable costs
1199 connected therewith. If an insurer makes a written request for
1200 documentation or information under this paragraph within 30 days
1201 after having received notice of the amount of a covered loss
1202 under paragraph (4)(a), the amount or the partial amount <u>that</u>
1203 ~~which~~ is the subject of the insurer’s inquiry <u>is</u> ~~shall become~~
1204 overdue if the insurer does not pay in accordance with paragraph
1205 (4)(b) or within 10 days after the insurer’s receipt of the
1206 requested documentation or information, whichever occurs later.
1207 <u>As used in</u> ~~For purposes of~~ this paragraph, the term “receipt”
1208 includes, but is not limited to, inspection and copying pursuant
1209 to this paragraph. <u>An</u> ~~Any~~ insurer that requests documentation or
1210 information pertaining to reasonableness of charges or medical
1211 necessity under this paragraph without a reasonable basis for
1212 such requests as a general business practice is engaging in an
1213 unfair trade practice under the insurance code.
1214 (c) In the event of <u>a</u> ~~any~~ dispute regarding an insurer’s
1215 right to discovery of facts under this section, the insurer may
1216 petition a court of competent jurisdiction to enter an order
1217 permitting such discovery. The order may be made only on motion
1218 for good cause shown and upon notice to all persons having an

1219 interest, and must ~~it shall~~ specify the time, place, manner,
1220 conditions, and scope of the discovery. ~~Such court may,~~ In order
1221 to protect against annoyance, embarrassment, or oppression, as
1222 justice requires, the court may enter an order refusing
1223 discovery or specifying conditions of discovery and may order
1224 payments of costs and expenses of the proceeding, including
1225 reasonable fees for the appearance of attorneys at the
1226 proceedings, as justice requires.
1227 (d) The injured person shall be furnished, upon request, a
1228 copy of all information obtained by the insurer under ~~the~~
1229 ~~provisions of~~ this section, and ~~shall~~ pay a reasonable charge,
1230 if required by the insurer.
1231 (e) Notice to an insurer of the existence of a claim may
1232 ~~shall~~ not be unreasonably withheld by an insured.
1233 (f) In a dispute between the insured and the insurer, or
1234 between an assignee of the insured's rights and the insurer, the
1235 insurer must notify the insured or the assignee that the policy
1236 limits under this section have been reached within 15 days after
1237 the limits have been reached.
1238 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY
1239 ~~ATTORNEY'S~~ FEES.—With respect to any dispute under the
1240 provisions of ss. 627.730-627.7405 between the insured and the
1241 insurer, or between an assignee of an insured's rights and the
1242 insurer, the provisions of ss. ~~s.~~ 627.428 and 768.79 ~~shall~~
1243 apply, except as provided in subsections (10) and (15).
1244 (9) PREFERRED PROVIDERS.—An insurer may negotiate and
1245 contract ~~enter into contracts~~ with preferred ~~licensed health~~
1246 ~~care~~ providers for the benefits described in this section,
1247 ~~referred to in this section as "preferred providers,"~~ which

1248 ~~shall~~ include health care providers licensed under <u>chapter</u>
1249 ~~chapters~~ 458, <u>chapter</u> 459, <u>chapter</u> 460, <u>chapter</u> 461, <u>or chapter</u>
1250 ~~and~~ 463. The insurer may provide an option to an insured to use
1251 a preferred provider at the time of <u>purchasing</u> ~~purchase of~~ the
1252 policy for personal injury protection benefits, if the
1253 requirements of this subsection are met. If the insured elects
1254 to use a provider who is not a preferred provider, whether the
1255 insured purchased a preferred provider policy or a nonpreferred
1256 provider policy, the medical benefits provided by the insurer
1257 shall be as required by this section. If the insured elects to
1258 use a provider who is a preferred provider, the insurer may pay
1259 medical benefits in excess of the benefits required by this
1260 section and may waive or lower the amount of any deductible that
1261 applies to such medical benefits. If the insurer offers a
1262 preferred provider policy to a policyholder or applicant, it
1263 must also offer a nonpreferred provider policy. The insurer
1264 shall provide each <u>insured</u> ~~policyholder~~ with a current roster of
1265 preferred providers in the county in which the insured resides
1266 at the time of purchase of such policy, and shall make such list
1267 available for public inspection during regular business hours at
1268 the <u>insurer's</u> principal office ~~of the insurer~~ within the state.
1269 (10) DEMAND LETTER.—
1270 (a) As a condition precedent to filing any action for
1271 benefits under this section, ~~the insurer must be provided with~~
1272 written notice of an intent to initiate litigation <u>must be</u>
1273 <u>provided to the insurer</u>. Such notice may not be sent until the
1274 claim is overdue, including any additional time the insurer has
1275 to pay the claim pursuant to paragraph (4)(b).
1276 (b) The notice <u>must</u> ~~required shall~~ state that it is a

1277 “demand letter under s. 627.736~~(10)~~” and ~~shall~~ state with
1278 specificity:
1279 1. The name of the insured upon which such benefits are
1280 being sought, including a copy of the assignment giving rights
1281 to the claimant if the claimant is not the insured.
1282 2. The claim number or policy number upon which such claim
1283 was originally submitted to the insurer.
1284 3. To the extent applicable, the name of any medical
1285 provider who rendered to an insured the treatment, services,
1286 accommodations, or supplies that form the basis of such claim;
1287 and an itemized statement specifying each exact amount, the date
1288 of treatment, service, or accommodation, and the type of benefit
1289 claimed to be due. A completed form satisfying the requirements
1290 of paragraph (5)(d) or the lost-wage statement previously
1291 submitted may be used as the itemized statement. To the extent
1292 that the demand involves an insurer’s withdrawal of payment
1293 under paragraph (7)(a) for future treatment not yet rendered,
1294 the claimant shall attach a copy of the insurer’s notice
1295 withdrawing such payment and an itemized statement of the type,
1296 frequency, and duration of future treatment claimed to be
1297 reasonable and medically necessary.
1298 (c) Each notice required by this subsection must be
1299 delivered to the insurer by United States certified or
1300 registered mail, return receipt requested. Such postal costs
1301 shall be reimbursed by the insurer if ~~so~~ requested by the
1302 claimant in the notice, when the insurer pays the claim. Such
1303 notice must be sent to the person and address specified by the
1304 insurer for the purposes of receiving notices under this
1305 subsection. Each licensed insurer, whether domestic, foreign, or

1306 alien, shall file with the office designation of the name and
1307 address of the person to whom notices must ~~pursuant to this~~
1308 ~~subsection shall~~ be sent which the office shall make available
1309 on its Internet website. The name and address on file with the
1310 office pursuant to s. 624.422 are ~~shall be~~ deemed the authorized
1311 representative to accept notice pursuant to this subsection if
1312 ~~in the event~~ no other designation has been made.
1313 (d) If, within 30 days after receipt of notice by the
1314 insurer, the overdue claim specified in the notice is paid by
1315 the insurer together with applicable interest and a penalty of
1316 10 percent of the overdue amount paid by the insurer, subject to
1317 a maximum penalty of $250, no action may be brought against the
1318 insurer. If the demand involves an insurer’s withdrawal of
1319 payment under paragraph (7)(a) for future treatment not yet
1320 rendered, no action may be brought against the insurer if,
1321 within 30 days after its receipt of the notice, the insurer
1322 mails to the person filing the notice a written statement of the
1323 insurer’s agreement to pay for such treatment in accordance with
1324 the notice and to pay a penalty of 10 percent, subject to a
1325 maximum penalty of $250, when it pays for such future treatment
1326 in accordance with the requirements of this section. To the
1327 extent the insurer determines not to pay any amount demanded,
1328 the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action.
1329 For purposes of this subsection, payment or the insurer’s
1330 agreement shall be treated as being made on the date a draft or
1331 other valid instrument that is equivalent to payment, or the
1332 insurer’s written statement of agreement, is placed in the
1333 United States mail in a properly addressed, postpaid envelope,
1334 or if not so posted, on the date of delivery. The insurer is not

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1335 obligated to pay any attorney ~~attorney's~~ fees if the insurer
1336 pays the claim or mails its agreement to pay for future
1337 treatment within the time prescribed by this subsection.
1338 (e) The applicable statute of limitation for an action
1339 under this section shall be tolled for ~~a period of~~ 30 business
1340 days by the mailing of the notice required by this subsection.
1341 ~~(f) Any insurer making a general business practice of not~~
1342 ~~paying valid claims until receipt of the notice required by this~~
1343 ~~subsection is engaging in an unfair trade practice under the~~
1344 ~~insurance code.~~
1345 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
1346 PRACTICE.—
1347 (a) ~~If~~ An insurer ~~fails to pay valid claims for personal~~
1348 ~~injury protection with such frequency so as to indicate a~~
1349 ~~general business practice, the insurer~~ is engaging in a
1350 prohibited unfair or deceptive practice that is subject to the
1351 penalties provided in s. 626.9521 and the office has the powers
1352 and duties specified in ss. 626.9561-626.9601 if the insurer,
1353 with such frequency so as to indicate a general business
1354 practice: ~~with respect thereto~~
1355 1. Fails to pay valid claims for personal injury
1356 protection; or
1357 2. Fails to pay valid claims until receipt of the notice
1358 required by subsection (10).
1359 (b) Notwithstanding s. 501.212, the Department of Legal
1360 Affairs may investigate and initiate actions for a violation of
1361 this subsection, including, but not limited to, the powers and
1362 duties specified in part II of chapter 501.
1363 Section 8. Effective December 1, 2012, subsection (16) of

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1364 section 627.736, Florida Statutes, is amended to read:
1365 627.736 Required personal injury protection benefits;
1366 exclusions; priority; claims.—
1367 (16) SECURE ELECTRONIC DATA TRANSFER.~~—If all parties~~
1368 ~~mutually and expressly agree,~~ A notice, documentation,
1369 transmission, or communication of any kind required or
1370 authorized under ss. 627.730-627.7405 may be transmitted
1371 electronically if it is transmitted by secure electronic data
1372 transfer that is consistent with state and federal privacy and
1373 security laws.
1374 Section 9. Subsections (1), (10), and (13) of section
1375 817.234, Florida Statutes, are amended to read:
1376 817.234 False and fraudulent insurance claims.—
1377 (1)(a) A person commits insurance fraud punishable as
1378 provided in subsection (11) if that person, with the intent to
1379 injure, defraud, or deceive any insurer:
1380 1. Presents or causes to be presented any written or oral
1381 statement as part of, or in support of, a claim for payment or
1382 other benefit pursuant to an insurance policy or a health
1383 maintenance organization subscriber or provider contract,
1384 knowing that such statement contains any false, incomplete, or
1385 misleading information concerning any fact or thing material to
1386 such claim;
1387 2. Prepares or makes any written or oral statement that is
1388 intended to be presented to any insurer in connection with, or
1389 in support of, any claim for payment or other benefit pursuant
1390 to an insurance policy or a health maintenance organization
1391 subscriber or provider contract, knowing that such statement
1392 contains any false, incomplete, or misleading information

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1393 concerning any fact or thing material to such claim; ~~or~~
1394 3.a. Knowingly presents, causes to be presented, or
1395 prepares or makes with knowledge or belief that it will be
1396 presented to any insurer, purported insurer, servicing
1397 corporation, insurance broker, or insurance agent, or any
1398 employee or agent thereof, any false, incomplete, or misleading
1399 information or written or oral statement as part of, or in
1400 support of, an application for the issuance of, or the rating
1401 of, any insurance policy, or a health maintenance organization
1402 subscriber or provider contract; or
1403 b. ~~Who~~ Knowingly conceals information concerning any fact
1404 material to such application; or~~.~~
1405 4. Knowingly presents, causes to be presented, or prepares
1406 or makes with knowledge or belief that it will be presented to
1407 any insurer a claim for payment or other benefit under a
1408 personal injury protection insurance policy if the person knows
1409 that the payee knowingly submitted a false, misleading, or
1410 fraudulent application or other document when applying for
1411 licensure as a health care clinic, seeking an exemption from
1412 licensure as a health care clinic, or demonstrating compliance
1413 with part X of chapter 400.
1414 (b) All claims and application forms must ~~shall~~ contain a
1415 statement that is approved by the Office of Insurance Regulation
1416 of the Financial Services Commission which clearly states in
1417 substance the following: “Any person who knowingly and with
1418 intent to injure, defraud, or deceive any insurer files a
1419 statement of claim or an application containing any false,
1420 incomplete, or misleading information is guilty of a felony of
1421 the third degree.” This paragraph does ~~shall~~ not apply to

1422 reinsurance contracts, reinsurance agreements, or reinsurance
1423 claims transactions.
1424 (10) A licensed health care practitioner who is found
1425 guilty of insurance fraud under this section for an act relating
1426 to a personal injury protection insurance policy loses his or
1427 her license to practice for 5 years and may not receive
1428 reimbursement for personal injury protection benefits for 10
1429 years. ~~As used in this section, the term "insurer" means any~~
1430 ~~insurer, health maintenance organization, self-insurer, self-~~
1431 ~~insurance fund, or other similar entity or person regulated~~
1432 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~
1433 ~~Regulation under the Florida Insurance Code.~~
1434 (13) As used in this section, the term:
1435 (a) "Insurer" means any insurer, health maintenance
1436 organization, self-insurer, self-insurance fund, or similar
1437 entity or person regulated under chapter 440 or chapter 641 or
1438 by the Office of Insurance Regulation under the Florida
1439 Insurance Code.
1440 (b)~~(a)~~ "Property" means property as defined in s. 812.012.
1441 (c)~~(b)~~ "Value" means value as defined in s. 812.012.
1442 Section 10. Subsection (4) of section 316.065, Florida
1443 Statutes, is amended to read:
1444 316.065 Crashes; reports; penalties.—
1445 (4) Any person who knowingly repairs a motor vehicle
1446 without having made a report as required by subsection (3) is
1447 guilty of a misdemeanor of the first degree, punishable as
1448 provided in s. 775.082 or s. 775.083. The owner and driver of a
1449 vehicle involved in a crash who makes a report thereof in
1450 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable

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1451 under this section.
1452 Section 11. The Office of Insurance Regulation shall
1453 perform a comprehensive personal injury protection data call and
1454 publish the results by January 1, 2015. It is the intent of the
1455 Legislature that the office design the data call with the
1456 expectation that the Legislature will use the data to help
1457 evaluate market conditions relating to the Florida Motor Vehicle
1458 No-Fault Law and the impact on the market of reforms to the law
1459 made by this act. The elements of the data call must address,
1460 but need not be limited to, the following components of the
1461 Florida Motor Vehicle No-Fault Law:
1462 (1) Quantity of personal injury protection claims.
1463 (2) Type or nature of claimants.
1464 (3) Amount and type of personal injury protection benefits
1465 paid and expenses incurred.
1466 (4) Type and quantity of, and charges for, medical
1467 benefits.
1468 (5) Attorney fees related to bringing and defending actions
1469 for benefits.
1470 (6) Direct earned premiums for personal injury protection
1471 coverage, pure loss ratios, pure premiums, and other information
1472 related to premiums and losses.
1473 (7) Licensed drivers and accidents.
1474 (8) Fraud and enforcement.
1475 Section 12. If any provision of this act or its application
1476 to any person or circumstance is held invalid, the invalidity
1477 does not affect other provisions or applications of the act
1478 which can be given effect without the invalid provision or
1479 application, and to this end the provisions of this act are

1480 severable.

1481 Section 13. Except as otherwise expressly provided in this

1482 act, this act shall take effect July 1, 2012.