By the Committee on Banking and Insurance and Senator Diaz-Balart

311-1887E-98

A bill to be entitled

An act relating to insurance; amending s. 627.7295, F.S.; authorizing certain fees to be collected by general lines agents; amending s. 627.736, F.S.; prohibiting a provider's statement of charges from including certain charges for services covered by personal injury protection benefits; specifying which party is the prevailing party in arbitration of disputes relating to personal injury protection claims; specifying requirements for arbitration; prescribing forms for submission of medical services; specifying payment time limitations; specifying where an independent medical examination of a claimant may be conducted; providing an effective date.

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

Section 1. Subsection (5) of section 627.7295, Florida Statutes, is amended to read:

627.7295 Motor vehicle insurance contracts.--

(5)(a) A licensed general lines agent may charge a per-policy fee not to exceed $10 to cover the administrative costs of the agent associated with selling the motor vehicle insurance policy if the policy covers only personal injury protection coverage as provided by s. 627.736 and property damage liability coverage as provided by s. 627.7275 and if no other insurance is sold or issued in conjunction with or collateral to the policy. The per-policy fee must be a component of the insurer's rate filing and may not be charged

by an agent unless the fee is included in the filing. The fee is not considered part of the premium except for purposes of the department's review of expense factors in a filing made pursuant to s. 627.062.

(b) To the extent that a licensed general agent's cost of obtaining motor vehicle reports on applicants for motor vehicle insurance is not otherwise compensated, the agent may, in addition to any other fees authorized by law, charge an applicant for motor vehicle insurance a reasonable, nonrefundable fee to reimburse the agent the actual cost of obtaining the report for each licensed driver when the motor vehicle report is obtained by the agent simultaneously with the preparation of the application for use in the calculation of premium or in the proper placement of the risk. The amount of the fee may not exceed the agent's actual cost in obtaining the report which is not otherwise compensated. Actual cost is the cost of obtaining the report on an individual driver basis when so obtained or the pro rata cost per driver when the report is obtained on more than one driver; however, in no case may actual cost include subscription or access fees associated with obtaining motor vehicle reports on-line though any electronic transmissions program.

Section 2. Subsection (5), paragraph (b) of subsection (6), and paragraph (a) of subsection (7) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority.--

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(a) Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury

protection insurance may charge only a reasonable amount for the products, services, and accommodations rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the invoice, bill, or claim form approved by the Department of Insurance upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like products, services, or accommodations in cases involving no insurance, provided that charges for cephalic thermograms and peripheral thermograms shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule established pursuant to s. 440.13.

(b) With respect to any treatment or service, other than hospital services provided within the first 30 days after the accident, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 30 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment 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, 60 days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that

are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, other than certain hospital services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 30 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment 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, 60 days before the postmark date of the statement.

(c) Every insurer shall include a provision in its policy for personal injury protection benefits for binding arbitration of any claims dispute involving medical benefits arising between the insurer and any person providing medical services or supplies if that person has agreed to accept assignment of personal injury protection benefits. The provision shall specify that the provisions of chapter 682 relating to arbitration shall apply. The prevailing party shall be entitled to attorney's fees and costs. For purposes

of the award of attorney's fees and costs, the prevailing party shall be determined as follows:

1. When the amount of personal injury protection benefits determined by arbitration exceeds the sum of the amount offered by the insurer at arbitration plus 50 percent of the difference between the amount of the claim asserted by the claimant at arbitration and the amount offered by the insurer at arbitration, the claimant is the prevailing party.

2. When the amount of personal injury protection benefits determined by arbitration is less than the sum of the amount offered by the insurer at arbitration plus 50 percent of the difference between the amount of the claim asserted by the claimant at arbitration and the amount offered by the insurer at arbitration, the insurer is the prevailing party.

3. When neither subparagraph 1. nor subparagraph 2. applies, there is no prevailing party. For purposes of this paragraph, the amount of the offer or claim at arbitration is the amount of the last written offer or claim made more than 30 days prior to the arbitration.

4. In the demand for arbitration, the party requesting arbitration must include a statement specifically identifying the issues for arbitration for each examination or treatment in dispute. The other party must subsequently issue a statement specifying any other examinations or treatment and any other issues that it intends to raise in the arbitration. The parties may amend their statements up to 30 days prior to arbitration, provided that arbitration shall be limited to those identified issues and neither party may add additional issues during arbitration.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person

or institution shall be submitted to the insurer on an HCFA 1500 form, UB 92 forms, or any other standard form approved by the department for purposes of this paragraph. All billings for such services shall, to the extent applicable, follow the appropriate physicians' current procedural terminology (CPT) in the year in which services are rendered. No statement of medical services may include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph.

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding

such history, condition, treatment, dates, and costs of treatment. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation under this paragraph within 20 days after having received notice of the amount of a covered loss under s. 627.736(4)(a), the insurer shall pay the amount or partial amount of covered loss to which such documentation relates in accordance with s. 627.736(4)(b) or within 10 days after the insurer's receipt of the requested documentation, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.--

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within ~~the municipality of residence of the insured~~

~~or in~~ the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, ~~within the municipality of residence of the insured~~ and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured ~~within such municipality~~, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a report by a physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary.

Section 3. This act shall take effect October 1, 1998.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 2052

Deletes the provision relating to basic homeowners' insurance policies.

Allows general lines insurance agents to charge an applicant for motor vehicle insurance a reasonable, nonrefundable fee to obtain a motor vehicle report (MVR) to reimburse the agent the actual cost of obtaining the MVR.

Requires medical providers to submit treatment bills directly to insurer within 30 days of service for personal injury protection (PIP) insurance benefits. Alternatively, if the provider furnishes the insurer with 21 days notice of initiation of treatment, the provider may submit medical bills within 60 days of service date. Neither the insurer nor the injured person is required to pay medical bills untimely submitted.

Specifies a method to determine who is the "prevailing party" entitled to attorneys fees and costs when a dispute between an insurer and a medical provider is arbitrated pursuant to the PIP law. Specifies time limits as to submission of issues, offers and claims for purposes of arbitration.

Provides the time period within which payment is due for a claim for PIP benefits under circumstances when an insurer makes a discovery request to a provider.

Provides that an insurer's independent medical examination (IME) be conducted within the municipality where the injured person is being treated, within the municipality where the injured person resides, or within 10 miles of the injured person's home, provided the location is within the insured's county of residence.