By the Committees on Appropriations; Banking and Insurance; and Senator Alexander

309-2532-03

A bill to be entitled

An act relating to motor vehicle insurance costs; providing a short title; providing legislative findings and purpose; amending s. 119.105, F.S.; prohibiting disclosure of confidential police reports for purposes of commercial solicitation; amending s. 316.066, F.S.; requiring the filing of a sworn statement as a condition to accessing a crash report stating the report will not be used for commercial solicitation; providing a penalty; creating part XIII of ch. 400, F.S., entitled the Health Care Clinic Act; providing for definitions and exclusions; providing for the licensure, inspection, and regulation of health care clinics by the Agency for Health Care Administration; requiring licensure and background screening; providing for clinic inspections; providing rulemaking authority; providing licensure fees; providing fines and penalties for operating an unlicensed clinic; providing for clinic responsibilities with respect to personnel and operations; providing accreditation requirements; providing for injunctive proceedings and agency actions; providing administrative penalties; amending s. 456.0375, F.S.; excluding certain entities from clinic registration requirements; providing retroactive application; amending s. 456.072, F.S.; providing that making a claim with respect to personal injury protection which is

upcoded or which is submitted for payment of services not rendered constitutes grounds for disciplinary action; amending s. 626.7451, F.S.; providing a per-policy fee to be remitted to the insurer's Special Investigations Unit, the Division of Insurance Fraud of the Department of Financial Services, and the Office of Statewide Prosecution for purposes of preventing, detecting, and prosecuting motor vehicle insurance fraud; amending s. 627.732, F.S.; providing definitions; amending s. 627.736, F.S.; requiring that medical services be lawfully rendered; providing allowable amounts for specified services; requiring the Department of Health, in consultation with medical boards, to identify certain diagnostic tests; specifying effective dates; providing for application of fee schedules; specifying effective dates; deleting certain provisions governing arbitration; providing for compliance with billing procedures; prohibiting insurers from authorizing physicians to change opinion in reports; providing requirements for physicians with respect to maintaining such reports; expanding provisions providing for a demand letter; providing a medical peer review process; providing requirements for alternative dispute resolution; limiting attorney's fees if matters are not resolved by medical peer review and alternative dispute resolution; authorizing the Financial Services Commission to determine

cost savings under personal injury protection benefits under specified conditions; amending s. 627.739, F.S.; specifying application of a deductible amount; amending s. 768.79, F.S.; specifying applicability of provisions relating to offer of judgment and demand for judgment; amending s. 817.234, F.S.; providing that it is a material omission and insurance fraud for a physician or other provider to waive a deductible or copayment or not collect the total amount of a charge; increasing the penalties for certain acts of solicitation of accident victims; providing mandatory minimum penalties; prohibiting certain solicitation of accident victims; providing penalties; prohibiting a person from participating in an intentional motor vehicle accident for the purpose of making motor vehicle tort claims; providing penalties, including mandatory minimum penalties; amending s. 817.236, F.S.; increasing penalties for false and fraudulent motor vehicle insurance application; creating s. 817.2361, F.S.; prohibiting the creation or use of false or fraudulent motor vehicle insurance cards; providing penalties; amending s. 921.0022, F.S.; revising the offense severity ranking chart of the Criminal Punishment Code to reflect changes in penalties and the creation of additional offenses under the act; providing legislative intent with respect to the retroactive application of

certain provisions; repealing s. 456.0375, F.S., relating to the regulation of clinics by the Department of Health; requiring certain insurers to make a rate filing to conform the per-policy fee to the requirements of the act; specifying the application of any increase in benefits approved by the Financial Services Commission; providing for application of other provisions of the act; requiring reports; providing an appropriation and authorizing additional positions; providing effective dates.

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

Section 1. Florida Motor Vehicle Insurance Affordability Reform Act; legislative findings; purpose.--

(1) This act may be cited as the "Florida Motor Vehicle Insurance Affordability Reform Act."

(2) The Legislature finds and declares that:

(a) The Florida Motor Vehicle No-Fault Law, enacted 32 years ago, has provided valuable benefits over the years to consumers in this state. The principle underlying the philosophical basis of the no-fault or personal injury protection (PIP) insurance system is that of a trade-off of one benefit for another, specifically providing medical and other benefits in return for a limitation on the right to sue for nonserious injuries.

(b) The PIP insurance system has provided benefits in the form of medical payments, lost wages, replacement

services, funeral payments, and other benefits, without regard to fault, to consumers injured in automobile accidents.

(c) However, the goals behind the adoption of the no-fault law in 1971, which were to quickly and efficiently compensate accident victims regardless of fault, to reduce the volume of lawsuits by eliminating minor injuries from the tort system, and to reduce overall motor vehicle insurance costs, have been significantly compromised due to the fraud and abuse that has permeated the PIP insurance market.

(d) Motor vehicle insurance fraud and abuse, other than in the hospital setting, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, solicitation of accident victims, falsification of records, or in any other form, has increased premiums for consumers and must be uncovered and vigorously prosecuted. The problem of inappropriate medical treatment and inflated claims for PIP have generally not occurred in the hospital setting.

(e) The no-fault system has been weakened in part due to certain insurers not adequately or timely compensating injured accident victims or health care providers. In addition, the system has become increasingly litigious with attorneys obtaining large fees by litigating, in certain instances, over relatively small amounts that are in dispute. There is an overwhelming public necessity to expand the provisions of the demand letter, to establish an expedited peer review process for medical issues and an expedited alternative dispute resolution process for other issues, and to minimize litigation costs and fees in order to encourage settlements, decrease litigation, and maintain a healthy insurance market.

(f) It is a matter of great public importance that, in order to provide a healthy and competitive automobile insurance market, consumers be able to obtain affordable coverage, insurers be entitled to earn an adequate rate of return, and providers of services be compensated fairly.

(g) It is further a matter of great public importance that, in order to protect the public's health, safety, and welfare, it is necessary to enact the provisions contained in this act in order to prevent PIP insurance fraud and abuse and to curb escalating medical, legal, and other related costs, and the Legislature finds that the provisions of this act are the least restrictive actions necessary to achieve this goal.

(h) Therefore, the purpose of this act is to restore the health of the PIP insurance market in Florida by addressing these issues, preserving the no-fault system, and realizing cost-savings for all people in this state.

Section 2. Section 119.105, Florida Statutes, is amended to read:

119.105 Protection of victims of crimes or accidents.--Police reports are public records except as otherwise made exempt or confidential by general or special law. Every person is allowed to examine nonexempt or nonconfidential police reports. A ~~No~~ person who comes into possession of exempt or confidential information contained in police reports may not ~~inspects or copies police reports for the purpose of obtaining the names and addresses of the victims of crimes or accidents shall~~ use that ~~any~~ information ~~contained therein~~ for any commercial solicitation of the victims or relatives of the victims of the reported crimes or accidents and may not knowingly disclose such information to any third party for the purpose of such solicitation during

the period of time that information remains exempt or confidential. This section does not ~~Nothing herein shall~~ prohibit the publication of such information to the general public by any news media legally entitled to possess that information or the use of such information for any other data collection or analysis purposes by those entitled to possess that information.

Section 3. Paragraph (c) of subsection (3) of section 316.066, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

316.066 Written reports of crashes.--

(3)

(c) Crash reports required by this section which reveal the identity, home or employment telephone number or home or employment address of, or other personal information concerning the parties involved in the crash and which are received or prepared by any agency that regularly receives or prepares information from or concerning the parties to motor vehicle crashes are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution for a period of 60 days after the date the report is filed. However, such reports may be made immediately available to the parties involved in the crash, their legal representatives, their licensed insurance agents, their insurers or insurers to which they have applied for coverage, persons under contract with such insurers to provide claims or underwriting information, prosecutorial authorities, radio and television stations licensed by the Federal Communications Commission, newspapers qualified to publish legal notices under ss. 50.011 and 50.031, and free newspapers of general circulation, published once a week or more often, available and of interest to the

public generally for the dissemination of news. For the purposes of this section, the following products or publications are not newspapers as referred to in this section: those intended primarily for members of a particular profession or occupational group; those with the primary purpose of distributing advertising; and those with the primary purpose of publishing names and other personally identifying information concerning parties to motor vehicle crashes. Any local, state, or federal agency, agent, or employee that is authorized to have access to such reports by any provision of law shall be granted such access in the furtherance of the agency's statutory duties notwithstanding the provisions of this paragraph. Any local, state, or federal agency, agent, or employee receiving such crash reports shall maintain the confidential and exempt status of those reports and shall not disclose such crash reports to any person or entity. As a condition precedent to accessing a ~~Any person attempting to access~~ crash report ~~reports~~ within 60 days after the date the report is filed, a person must present a valid driver's license or other photographic identification, proof of status ~~legitimate credentials~~ or identification that demonstrates his or her qualifications to access that information, and file a written sworn statement with the state or local agency in possession of the information stating that information from a crash report made confidential by this section will not be used for any commercial solicitation of accident victims, or knowingly disclosed to any third party for the purpose of such solicitation, during the period of time that the information remains confidential. In lieu of requiring such photographic identification, proof of qualifications, and written sworn statement, an agency may

provide crash reports by electronic means to third-party vendors approved by the Division of Insurance Fraud of the Department of Financial Services, which vendors contractually agree and represent that information from a crash report made confidential by this section will not be used for any commercial solicitation of accident victims by the vendors, or knowingly disclosed to any third party for the purpose of such solicitation, during the period of time that the information remains confidential, and which vendors contractually agree with the division to provide such crash reports solely to insurers and to obtain from such insurers their agreement and representation to use such reports solely for the adjustment and investigations of claims and underwriting purposes. This subsection does not prevent the dissemination or publication of news to the general public by any legitimate media entitled to access confidential information pursuant to this section. A law enforcement officer as defined in s. 943.10(1) may enforce this subsection.This exemption is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature.

(d) Any employee of a state or local agency in possession of information made confidential by this section who knowingly discloses such confidential information to a person not entitled to access such information under this section is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(e) Any person, knowing that he or she is not entitled to obtain information made confidential by this section, who obtains or attempts to obtain such information is guilty of a

felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(f) Any person who knowingly uses confidential information in violation of a filed written sworn statement or contractual agreement required by this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 4. Effective October 1, 2003, part XIII of chapter 400, Florida Statutes, consisting of sections 400.901, 400.903, 400.905, 400.907, 400.909, 400.911, 400.913, 400.915, 400.917, 400.919, and 400.921 is created to read:

400.901 Short title; legislative findings.--

(1) This part, consisting of ss. 400.901-400.921, may be cited as the "Health Care Clinic Act."

(2) The Legislature finds that the regulation of health care clinics must be strengthened to prevent significant cost and harm to consumers. The purpose of this part is to provide for the licensure, establishment, and enforcement of basic standards for health care clinics and to provide administrative oversight by the Agency for Health Care Administration.

400.903 Definitions.--

(1) "Agency" means the Agency for Health Care Administration.

(2) "Applicant" means an individual owner, corporation, partnership, firm, business, association, or other entity that owns or controls, directly or indirectly, 5 percent or more of an interest in the clinic and that applies for a clinic license.

(3) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges

for reimbursement for such services. For purposes of this part the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 390, chapter 394, chapter 395, chapter 397, this chapter, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, this chapter, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 390, chapter 394, chapter, 395, chapter 397, this chapter, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, this chapter, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) and any community college or university clinic.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III,

part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by a licensed health care practitioner, or the licensed health care practitioner and the spouse, parent, or child of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the services performed therein and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license.

(g) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(4) "Medical director" means a physician who is employed or under contract with a clinic and who maintains a full and unencumbered physician license in accordance with chapter 458, chapter 459, chapter 460, or chapter 461. However, if the clinic is limited to providing health care services pursuant to chapter 457, chapter 484, chapter 486, chapter 490, or chapter 491 or part I, part III, part X, part XIII, or part XIV of chapter 468, the clinic may appoint a health care practitioner licensed under that chapter to serve as a clinic director who is responsible for the clinic's activities. A health care practitioner may not serve as the clinic director if the services provided at the clinic are beyond the scope of that practitioner's license.

400.905 License requirements; background screenings; prohibitions.--

(1) Each clinic, as defined in s. 400.903, must be licensed and shall at all times maintain a valid license with the agency. Each clinic location shall be licensed separately

regardless of whether the clinic is operated under the same business name or management as another clinic. Mobile clinics must perform health care services only at a single location.

(2) The initial clinic license application shall be filed with the agency by all clinics, as defined in s. 400.903, on or before March 1, 2004. A clinic license must be renewed biennially.

(3) Applicants that submit an application on or before March 1, 2004, which meets all requirements for initial licensure as specified in this section shall receive a temporary license until the completion of an initial inspection verifying that the applicant meets all requirements in rules authorized by s. 400.911. However, a clinic engaged in magnetic resonance imaging services may not receive a temporary license unless it presents evidence satisfactory to the agency that such clinic is making a good-faith effort and substantial progress in seeking accreditation required under s. 400.915.

(4) Application for an initial clinic license or for renewal of an existing license shall be notarized on forms furnished by the agency and must be accompanied by the appropriate license fee as provided in s. 400.911. The agency shall take final action on an initial license application within 60 days after receipt of all required documentation.

(5) The application shall contain information that includes, but need not be limited to, information pertaining to the name, residence and business address, phone number, social security number, and license number of the medical or clinic director, of the licensed medical providers employed or under contract with the clinic, and of each person who,

directly or indirectly, owns or controls 5 percent or more of an interest in the clinic.

(6) The applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of each professional staff member to be employed; and

(c) Proof of financial ability to operate. An applicant must demonstrate financial ability to operate a clinic by submitting a balance sheet and an income and expense statement for the first year of operation which provide evidence of the applicant's having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant shall have demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. All documents required under this subsection must be prepared in accordance with generally accepted accounting principles, may be in a compilation form, and the financial statement must be signed by a certified public accountant.

(7) Each applicant for licensure shall comply with the following requirements:

(a) As used in this subsection, the term "applicant" means individuals owning or controlling, directly or indirectly, 5 percent or more of an interest in a clinic; the medical or clinic director, or a similarly titled person who is responsible for the day-to-day operation of the licensed clinic; the financial officer or similarly titled individual

who is responsible for the financial operation of the clinic; and licensed medical providers at the clinic.

(b) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of this paragraph.

(c) Each applicant must submit to the agency, with the application, a description and explanation of any exclusions, permanent suspensions, or terminations of an applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interest under the Medicaid or Medicare programs may be accepted in lieu of this submission. The description and explanation may indicate whether such exclusions, suspensions, or terminations were voluntary or not voluntary on the part of the applicant.

(d) A license may not be granted to a clinic if the applicant has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, or a violation of insurance fraud under s. 817.234, within the past 5 years. If the applicant has been convicted of an offense prohibited under the level 2 standards or insurance fraud in any jurisdiction, the applicant must show that his or her civil rights have been restored prior to submitting an application.

(e) The agency may deny or revoke licensure if the applicant has falsely represented any material fact or omitted any material fact from the application required by this part.

(8) Requested information omitted from an application for licensure, license renewal, or transfer of ownership must be filed with the agency within 21 days after receipt of the agency's request for omitted information, or the application shall be deemed incomplete and shall be withdrawn from further consideration.

(9) The failure to file a timely renewal application shall result in a late fee charged to the facility in an amount equal to 50 percent of the current license fee.

400.907 Clinic inspections; emergency suspension; costs.--

(1) Any authorized officer or employee of the agency shall make inspections of the clinic as part of the initial license application or renewal application. The application for a clinic license issued under this part or for a renewal license constitutes permission for an appropriate agency inspection to verify the information submitted on or in connection with the application or renewal.

(2) An authorized officer or employee of the agency may make unannounced inspections of clinics licensed pursuant to this part as are necessary to determine that the clinic is in compliance with this part and with applicable rules. A licensed clinic shall allow full and complete access to the premises and to billing records or information to any representative of the agency who makes an inspection to determine compliance with this part and with applicable rules.

(3) Failure by a clinic licensed under this part to allow full and complete access to the premises and to billing

records or information to any representative of the agency who makes a request to inspect the clinic to determine compliance with this part or failure by a clinic to employ a qualified medical director or clinic director constitutes a ground for emergency suspension of the license by the agency pursuant to s. 120.60(6).

(4) In addition to any administrative fines imposed, the agency may assess a fee equal to the cost of conducting a complaint investigation.

400.909 License renewal; transfer of ownership; provisional license.--

(1) An application for license renewal must contain information as required by the agency.

(2) Ninety days before the expiration date, an application for renewal must be submitted to the agency.

(3) The clinic must file with the renewal application satisfactory proof that it is in compliance with this part and applicable rules. If there is evidence of financial instability, the clinic must submit satisfactory proof of its financial ability to comply with the requirements of this part.

(4) When transferring the ownership of a clinic, the transferee must submit an application for a license at least 60 days before the effective date of the transfer.

(5) The license may not be sold, leased, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the clinic owners and location for which originally issued.

(6) A clinic against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a provisional license effective until final disposition

by the agency of such proceedings. If judicial relief is sought from the final disposition, the agency that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

400.911 Rulemaking authority; license fees.--

(1) The agency shall adopt rules necessary to administer the clinic administration, regulation, and licensure program, including rules establishing the specific licensure requirements, procedures, forms, and fees. It shall adopt rules establishing a procedure for the biennial renewal of licenses. The rules shall specify the expiration dates of licenses, the process of tracking compliance with financial responsibility requirements, and any other conditions of renewal required by law or rule.

(2) The agency shall adopt rules specifying limitations on the number of licensed clinics and licensees for which a medical director or a clinic director may assume responsibility for purposes of this part. In determining the quality of supervision a medical director or a clinic director can provide, the agency shall consider the number of clinic employees, the clinic location, and the health care services provided by the clinic.

(3) License application and renewal fees must be reasonably calculated by the agency to cover its costs in carrying out its responsibilities under this part, including the cost of licensure, inspection, and regulation of clinics, and must be of such amount that the total fees collected do not exceed the cost of administering and enforcing compliance with this part. Clinic licensure fees are nonrefundable and may not exceed $2,000. The agency shall adjust the license fee annually by not more than the change in the Consumer Price

Index based on the 12 months immediately preceding the increase. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

400.913 Unlicensed clinics; penalties; fines; verification of licensure status.--

(1) It is unlawful to own, operate, or maintain a clinic without obtaining a license under this part.

(2) Any person who owns, operates, or maintains an unlicensed clinic commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(3) Any person found guilty of violating subsection (2) a second or subsequent time commits a felony of the second degree, punishable as provided under s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(4) Any person who owns, operates, or maintains an unlicensed clinic due to a change in this part or a modification in agency rules within 6 months after the effective date of such change or modification and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(5) Any clinic that fails to cease operation after agency notification may be fined for each day of noncompliance pursuant to this part.

(6) When a person has an interest in more than one clinic, and fails to obtain a license for any one of these clinics, the agency may revoke the license, impose a moratorium, or impose a fine pursuant to this part on any or all of the licensed clinics until such time as the unlicensed clinic is licensed or ceases operation.

(7) Any person aware of the operation of an unlicensed clinic must report that facility to the agency.

(8) Any health care provider who is aware of the operation of an unlicensed clinic shall report that facility to the agency. Failure to report a clinic that the provider knows or has reasonable cause to suspect is unlicensed shall be reported to the provider's licensing board.

(9) The agency may not issue a license to a clinic that has any unpaid fines assessed under this part.

400.915 Clinic responsibilities.--

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(a) Have signs identifying the medical director or clinic director posted in a conspicuous location within the clinic readily visible to all patients.

(b) Ensure that all practitioners providing health care services or supplies to patients maintain a current active and unencumbered Florida license.

(c) Review any patient referral contracts or agreements executed by the clinic.

(d) Ensure that all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided.

(e) Serve as the clinic records owner as defined in s. 456.057.

(f) Ensure compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of chapter 456, the respective practice acts, and rules adopted under this part.

(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action.

(2) Any business that becomes a clinic after commencing operations must, within 5 days after becoming a clinic, file a license application under this part and shall be subject to all provisions of this part applicable to a clinic.

(3) Any contract to serve as a medical director or a clinic director entered into or renewed by a physician or a licensed health care practitioner in violation of this part is void as contrary to public policy. This subsection shall apply to contracts entered into or renewed on or after March 1, 2004.

(4) All charges or reimbursement claims made by or on behalf of a clinic that is required to be licensed under this part, but that is not so licensed, or that is otherwise operating in violation of this part, are unlawful charges, and therefore are noncompensable and unenforceable.

(5) Any person establishing, operating, or managing an unlicensed clinic otherwise required to be licensed under this part, or any person who knowingly files a false or misleading license application or license renewal application, or false or misleading information related to such application or

department rule, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6) Any licensed health care provider who violates this part is subject to discipline in accordance with this chapter and his or her respective practice act.

(7) The agency may fine, or suspend or revoke the license of, any clinic licensed under this part for operating in violation of the requirements of this part or the rules adopted by the agency.

(8) The agency shall investigate allegations of noncompliance with this part and the rules adopted under this part.

(9) Any person or entity providing health care services which is not a clinic, as defined under s. 400.903, may voluntarily apply for licensure under its exempt status with the agency on a form that sets forth its name or names and addresses, a statement of the reasons why it cannot be defined as a clinic, and other information deemed necessary by the agency.

(10) The clinic shall display its license in a conspicuous location within the clinic readily visible to all patients.

(11)(a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, within 1 year after licensure. However, a clinic may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic can not be accredited within 1 year

after licensure, and that such accreditation will be completed within the 6-month extension.

(b) The agency may disallow the application of any entity formed for the purpose of avoiding compliance with the accreditation provisions of this subsection and whose principals were previously principals of an entity that was unable to meet the accreditation requirements within the specified timeframes. The agency may adopt rules as to the accreditation of magnetic resonance imaging clinics.

(12) The agency shall give full faith and credit pertaining to any past variance and waiver granted to a magnetic resonance imaging clinic from Rule 64-2002, Florida Administrative Code, by the Department of Health, until September 2004. After that date, such clinic must request a variance and waiver from the agency under s. 120.542.

400.917 Injunctions.--

(1) The agency may institute injunctive proceedings in a court of competent jurisdiction in order to:

(a) Enforce the provisions of this part or any minimum standard, rule, or order issued or entered into pursuant to this part if the attempt by the agency to correct a violation through administrative fines has failed; if the violation materially affects the health, safety, or welfare of clinic patients; or if the violation involves any operation of an unlicensed clinic.

(b) Terminate the operation of a clinic if a violation of any provision of this part, or any rule adopted pursuant to this part, materially affects the health, safety, or welfare of clinic patients.

(2) Such injunctive relief may be temporary or permanent.

(3) If action is necessary to protect clinic patients from life-threatening situations, the court may allow a temporary injunction without bond upon proper proof being made. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should issue, the court, pending the determination on final hearing, shall enjoin operation of the clinic.

400.919 Agency actions.--Administrative proceedings challenging agency licensure enforcement action shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

400.921 Agency administrative penalties.--

(1) The agency may impose administrative penalties against clinics of up to $5,000 per violation for violations of the requirements of this part. In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a patient will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner, medical director, or clinic director to correct violations.

(c) Any previous violations.

(d) The financial benefit to the clinic of committing or continuing the violation.

(2) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(3) Any action taken to correct a violation shall be documented in writing by the owner, medical director, or clinic director of the clinic and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated clinic, revoke or deny a clinic's license when a clinic medical director or clinic director fraudulently misrepresents actions taken to correct a violation.

(4) For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(5) Any unlicensed clinic that continues to operate after agency notification is subject to a $1,000 fine per day.

(6) Any licensed clinic whose owner, medical director, or clinic director concurrently operates an unlicensed clinic shall be subject to an administrative fine of $5,000 per day.

(7) Any clinic whose owner fails to apply for a change-of-ownership license in accordance with s. 400.909 and operates the clinic under the new ownership is subject to a fine of $5,000.

(8) The agency, as an alternative to or in conjunction with an administrative action against a clinic for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner, medical director, or clinic director of the clinic, prior to written notification. The agency, instead of fixing a period within which the clinic shall enter into compliance with standards, may request a plan of corrective action from the clinic which demonstrates a good-faith effort

to remedy each violation by a specific date, subject to the approval of the agency.

(9) Administrative fines paid by any clinic under this section shall be deposited into the Health Care Trust Fund.

Section 5. Paragraph (b) of subsection (1) of section 456.0375, Florida Statutes, is amended to read:

456.0375 Registration of certain clinics; requirements; discipline; exemptions.--

(1)

(b) For purposes of this section, the term "clinic" does not include and the registration requirements herein do not apply to:

1. Entities licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, ~~or~~ chapter 484, or chapter 651.

2. Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

3. Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

4. Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, chapter 484, or chapter 651.

5.~~2.~~ Entities exempt from federal taxation under 26 U.S.C. s. 501(c)(3) and community college and university clinics.

6.~~3.~~ Sole proprietorships, group practices, partnerships, or corporations that provide health care services by licensed health care practitioners pursuant to chapters 457, 458, 459, 460, 461, 462, 463, 466, 467, 484, 486, 490, 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by licensed health care practitioners or the licensed health care practitioner and the spouse, parent, or child of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the services performed therein and is legally responsible for the entity's compliance with all federal and state laws. However, no health care practitioner may supervise services beyond the scope of the practitioner's license.

7. Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

Section 6. Paragraphs (dd) and (ee) are added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(dd) With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill that has been upcoded. "Upcoding" means an action that submits a billing code that

would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. "Upcoding" does not include an otherwise lawful bill by an independent diagnostic testing facility, as defined in s. 627.732, which globally combines both technical and professional components for services listed in that definition, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

(ee) With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

Section 7. Subsection (11) of section 626.7451, Florida Statutes, is amended to read:

626.7451 Managing general agents; required contract provisions.--No person acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibility for a particular function, specifies the division of responsibilities, and contains the following minimum provisions:

(11) A licensed managing general agent, when placing business with an insurer under this code, may charge a per-policy fee not to exceed$40~~$25~~. In no instance shall the aggregate of per-policy fees for a placement of business authorized under this section, when combined with any other per-policy fee charged by the insurer, result in per-policy fees which exceed the aggregate amount of$40~~$25~~. The per-policy fee shall be a component of the insurer's rate

filing and shall be fully earned. A managing general agent that collects a per-policy fee shall remit a minimum of $5 per policy to the insurer for the funding of a Special Investigations Unit dedicated to the prevention of insurance fraud; $2 per policy to the Division of Insurance Fraud of the Department of Financial Services, which shall be dedicated to the prevention and detection of insurance fraud; and $3 per policy to the Office of Statewide Prosecution, which shall be dedicated to the prosecution of insurance fraud. Any insurer that writes directly without a managing general agent and that charges a per-policy fee may charge an additional policy fee up to $5 per policy to fund its Special Investigations Unit, which shall be dedicated to the prevention of insurance fraud; up to $2 per policy to be remitted to the Division of Insurance Fraud of the Department of Financial Services, which shall be dedicated to the prevention and detection of insurance fraud; and up to $3 per policy to the Office of Statewide Prosecution, which shall be dedicated to the prosecution of insurance fraud.

For the purposes of this section and ss. 626.7453 and 626.7454, the term "controlling person" or "controlling" has the meaning set forth in s. 625.012(5)(b)1., and the term "controlled person" or "controlled" has the meaning set forth in s. 625.012(5)(b)2.

Section 8. Subsection (1) of section 627.732, Florida Statutes, is amended, and subsections (8) through (19) are added to that section, to read:

627.732 Definitions.--As used in ss. 627.730-627.7405, the term:

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; nor does the term include a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic registered under s. 456.0375;

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

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or

pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment cannot be used by patients who are not patients of the registered clinic for medical treatment of services. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period provided in this paragraph may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(8) "Certify" means to swear or attest to being true or represented in writing.

(9) "Countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

(10) "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can physically see the activities of all employees and respond immediately to any emergencies if needed.

(11) "Incident," with respect to services considered as incident to a physician's professional service, for a

physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means such services must be an integral, even if incidental, part of a covered physician's service.

(12) "Knowingly" means that a person, with respect to information, has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the information, and proof of specific intent to defraud is not required.

(13) "Lawful" or "lawfully" means in compliance with all applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.

(14) "Hospital" means a facility that, at the time services or treatment were rendered, was licensed under chapter 395.

(15) "Properly completed" means providing truthful, complete, and accurate responses to each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as agreed by the parties.

(16) "Render," with respect to the license required in the performance of medical services or treatment, means to have properly licensed personnel actually physically perform the medical service or physically transfer the supplies to the insured incident to the provider's professional services. The term does not include scheduling medical services or ordering medical supplies for the insured.

(17) "Upcoding" means an action that submits a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the

services performed. The term does not include an otherwise lawful bill by an independent diagnostic treating facility, which globally combines both technical and professional components for services listed in that definition, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

(18) "Unbundling" means an action that submits a billing code that is properly billed under one billing code, but that has been separated into two or more billing codes, and would result in payment greater in amount than would be paid using one billing code.

(19) "Independent diagnostic testing facility" means a fixed facility that performs the technical component of magnetic resonance imaging, static radiographs (static X ray), computer tomography, positron emission tomography, and also provides the professional components of such services through either an employee or independent contractor, if:

(a) No person ordering or prescribing such services has any financial interest in the facility providing such services and no such person receives any consideration directly or indirectly from such facility for ordering or prescribing such services; and

(b) The facility does not directly or indirectly provide therapy or treatment services to patients for which it also provides such diagnostic services.

Section 9. Subsections (3), (4), (5), (6), (7), (8), (10), and (11) of section 627.736, Florida Statutes, are amended, present subsection (12) of that section is redesignated as subsection (14) and amended, and new

subsections (12), (13), and (15) are added to that section, to read:

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

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.--No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury,

sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. Written notice for medical benefits, except for services or treatment rendered in a hospital, shall not be considered to have been provided to the insurer unless all the requirements of paragraphs (5)(e) and (f) are met and all of the medical treatment records applicable to the billing for which payment is being requested have been provided to the insurer, to the extent requested by the insurer pursuant to subsection (6). If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider

related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. However, notwithstanding the fact that written notice has been furnished to the insurer, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion by the insurer may be made at any time, including after payment of the claim or after the 30-day time period for payment set forth in this paragraph.

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

(d) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

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

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

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

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

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

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

(e) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be

entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(f) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(g) Benefits shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or if it is established in a court of competent jurisdiction. Any insurance fraud shall void all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. An insurer is entitled to its costs and attorney's fees in any action in which it prevails in enforcing its right of recovery under this paragraph.

(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 the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies 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 properly completed 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 services or supplies or has agreed to accept or intends to collect as full reimbursement from the particular patient ~~in cases involving no insurance~~.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;~~.~~

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not meet the applicable requirements of paragraph (e);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with applicable billing standards. To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care

provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good-faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. Charges for the professional and technical services of medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy(including, but not limited to, cineradiography, or motion X ray), range of motion testing, muscle strength testing, functional capacity testing, and surface electromyography shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule or other payment methodology established pursuant to s. 440.13 and in effect for the date on which the services were rendered. Such charges shall not be payable by the insurer or insured if there is no reimbursement allowance established pursuant to s. 440.13.

3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for the professional and technical components of medically necessary nerve conduction testing services when done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 who is

also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, and in effect for October 1, 2001, for the area in which the treatment was rendered~~, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida~~.

4. Effective for services and treatment on or after October 1, 2003, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for the technical and professional components of medically necessary nerve conduction, H-reflex, neuromuscular, somatosensory, and dermatonal testing, when any such testing is done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 who is also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialities or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors, shall not exceed the amount allowable under paragraph (c).

5.~~4.~~ Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for the professional and technical components of medically necessary nerve conduction, H-reflex, neuromuscular, somatosensory, and dermatonal testing that does not meet the requirements of subparagraph 3. shall not exceed the

applicable fee schedule or other payment methodology established pursuant to s. 440.13 and in effect on the date on which the services were rendered. Such charges shall not be payable by the insurer or insured if there is no reimbursement allowance established pursuant to s. 440.13.

6.~~5.~~ Effective for services and treatment rendered on or after June 19, 2001,~~upon this act becoming a law~~ and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, and in effect on June 19, 2001,for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, and in effect on June 19, 2001,for the area in which the treatment was rendered, ~~adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida,~~except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered~~,~~ ~~adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida~~.

7. Subparagraphs 3. through 6. do ~~This paragraph does~~ not apply to charges for magnetic resonance imaging services and nerve conduction, H-reflex, neuromuscular, somatosensory, and dermatonal testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395. Effective for services and treatment on or after October 1, 2003, allowable amounts that may be charged for services under subparagraph 6. may not exceed the amount allowable under paragraph (c).

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

(c) Except as provided in paragraph (b), effective for services and treatment beginning on October 1, 2003, other than services and treatment rendered by a hospital:

1. A person or institution providing treatment, accommodations, products, or services to an injured person for

an injury covered by personal injury protection benefits shall not require, request, charge, bill, or accept payment for the treatment, accommodations, products, or services from the insurer or insured in excess of 200 percent of the allowable amount under the Medicare Part B participating physicians fee schedule which is in effect on July 1, 2003, for the area in which the services are rendered, without regard to whether a fee is allowable for a particular provider under federal law and regulations.

2. The allowable amount for services and treatment subject to the Medicare Part B participating fee schedule under this subsection shall be adjusted as provided in this subparagraph. Commencing in 2004, the Financial Services Commission shall at least annually review any changes made to the Medicare Part B participating fee schedule and shall determine the extent to which such changes shall apply under this subsection in order to ensure the availability of quality services to insureds and to maintain the affordability of insurance under this section. Any changes approved by the commission shall be effective for services and treatment rendered 90 days after such determination is final.

3. If a charge has not been calculated under subparagraph 1., the amount of the charge may not exceed the applicable fee schedule or other payment established pursuant to s. 440.13 in effect on the date the services were rendered.

4. If a charge has not been calculated under subparagraph 1., or subparagraph 3., the treatment, accommodation, product, or services is presumed to be not reasonable and not reimbursable by the insurer and insured pursuant to this section. Upon the request of any person, the Financial Services Commission, in consultation with the Agency

for Health Care Administration, may determine any charge that it finds to be reasonable for reimbursement by the insurer and insured pursuant to this section for services provided after the determination becomes effective.

5. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology, the Accreditation Association for Ambulatory Health Care, or the Joint Commission on Accreditation of Healthcare Organizations may not exceed 200 percent of the allowable amount under the Medicare Part B participating physician fee schedule which is in effect on the date the services are rendered for the area in which the services are rendered.

6. If treatment is rendered out of state, the allowable amounts shall be for the area where the insured resides in this state.

(d)1.~~(c)~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, 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 35 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, 75 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.

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

a.~~1.~~ A denial letter from the incorrect insurer; or

b.~~2.~~ Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

3. For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph; and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (e), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance

in accordance with billing standards recognized by the Health Care Finance Administration.

4. 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 and emergency 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 35 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, 75 days before the postmark date of the statement.

~~(d) 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 at least 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.~~

(e) 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 a properly completed Centers for Medicare and Medicaid Services (CMS) ~~Health Care Finance Administration~~ 1500 form, UB 92 forms, or any other standard form approved by the department for purposes of this paragraph. All billings for such services rendered by providers other than hospitals 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 Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals 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 Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration.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, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(f)1. Each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

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

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

d. That the physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian.

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

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests

or other services that are of such a nature that they are not required to be performed in the presence of the insured.

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

5. The original completed disclosure and acknowledgement form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. This disclosure and acknowledgement form is not required for services billed by a hospital or billed by another provider for emergency services as defined in s. 395.002, for inpatient services rendered at a hospital-owned facility, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

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

(g) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly

billed, the insurer shall notify the insured, the person making the written notification and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, then the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

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

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

(a) Every employer shall, if a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, furnish forthwith, in a form approved by the department, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(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 and why the items identified by the insurer were reasonable in amount and medically necessary, 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; provided that this shall not limit the introduction of evidence at trial. 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 or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and

copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section ~~about an injured person's earnings or about his or her history, condition, or treatment, or the dates and costs of such treatment~~, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

(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 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, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, 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 valid 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. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is

factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer, or on behalf of an insurer through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination

rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.--With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 shall apply, except as provided in subsections ~~subsection~~ (11), (12), and (13).

(10)(a) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of

this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(b) Paragraph (a) does not prohibit an insurer that chooses not to offer a preferred provider policy from providing the benefits described in subsection (1) pursuant to a contract entered into directly or indirectly with a licensed health care provider or hospital that establishes agreed amounts to be charged by such health care provider or hospital for services rendered to persons entitled to such benefits. Such agreement shall establish the reasonable amount for such services in accord with subsection (1).

(11) DEMAND LETTER.--

(a) As a condition precedent to filing any action for ~~an overdue claim for~~ benefits under this section ~~paragraph (4)(b)~~, the insurer must be provided with written notice of an intent to initiate litigation~~; provided, however, that, except~~

~~with regard to a claim or amended claim or judgment for interest only which was not paid or was incorrectly calculated, such notice is not required for an overdue claim that the insurer has denied or reduced, nor is such notice required if the insurer has been provided documentation or information at the insurer's request pursuant to subsection (6)~~. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice required shall state that it is a "demand letter under s. 627.736(11)" and shall state with specificity:

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

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

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(e) or the lost-wage statement previously submitted ~~Health Care Finance Administration 1500 form, UB 92, or successor forms approved by the Secretary of the United States Department of Health and Human Services~~ may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice

withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection ~~section~~ must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant ~~provider~~ in the notice, when the insurer pays the ~~overdue~~ claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection ~~section, on the document denying or reducing the amount asserted by the filer to be overdue~~. Each licensed insurer, whether domestic, foreign, or alien, shall ~~may~~ file with the office ~~department~~ designation of the name and address of the person to whom notices pursuant to this subsection ~~section~~ shall be sent which the office shall make available on its Internet website ~~when such document does not specify the name and address to whom the notices under this section are to be sent or when there is no such document~~. The name and address on file with the office ~~department~~ pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection ~~section~~ in the event no other designation has been made.

(d) If, within 15 ~~7 business~~ days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action ~~for nonpayment or late payment~~ may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet

rendered, no action may be brought against the insurer if, within 15 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section.To the extent the insurer determines not to pay any ~~the overdue~~ amount demanded, the penalty shall not be payable in any subsequent action ~~for nonpayment or late payment~~. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement,is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer shall not be obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for a period of 15 business days by the mailing of the notice required by this subsection.

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

(12) MEDICAL PEER REVIEW.--

(a) Applicability.--This subsection applies to all medical benefits payable under paragraph (1)(a); however, this subsection is limited to disputes of whether a service,

treatment, or otherwise is medically necessary, reasonable in the amount charged, correctly coded, and related to the injury covered by the policy under s. 627.736. The applicability of this subsection shall be broadly construed to favor inclusion of disputes. The parties voluntarily may include other issues related to the items and issues in dispute.

(b) Definitions.--As used in this subsection, the term:

1. "Agency" means the Agency for Health Care Administration.

2. "Claimant" means the insured injured person or the medical provider involved in a dispute under this subsection.

3. "Initiating party" means the party filing a notice.

4. "Notice means the notice initiating peer review.

5. "Peer reviewer" means the health care practitioner defined in s. 456.001(4) or other person who is employed by or, under contract with, a peer review organization, to whom a particular medical dispute has been referred by the peer review organization, and who from other work derives less than 25 percent of his or her income from insurers of any kind. For issues of medical necessity, the health care organization must use a health care practitioner who is licensed under the same chapter as the health care practitioner involved in this dispute. A health care practitioner must have an active patient practice of at least 8 hours per week.

6. "Peer review organization" means one or more qualified entities selected by and contracted with the agency that employs or contracts with peer reviewers.

7. "Respondent" means the party upon whom a notice is filed.

(c) Program implementation.--The agency shall establish a program by October 1, 2003, to provide assistance to medical providers, insurers, and insured injured persons for the expedited resolution of disputed medical claims for personal injury protection benefits under this section. The agency shall contract with one or more peer review organizations for the performance of peer review of medical issues. Contracted peer review organizations shall be fully accredited by URAC, also known as the American Accreditation HealthCare Commission, Inc., or another comparable nationally recognized organization if approved by the agency, shall maintain an office in this state, be subject to the jurisdiction of this state, and shall be responsible for properly credentialing and educating peer reviewers and ensuring compliance with the provisions of this subsection. The agency shall take reasonable measures to ensure that the peer review organization and peer reviewers are not biased toward the insurer or claimant, that the reports required in paragraph (g) are timely, and that the insurer and claimant timely submit the documentation required in paragraph (f).

(d) Immunity.--Peer review organizations and peer reviewers are immune from liability in the execution of their peer review functions to the extent provided in s. 766.101.

(e) Notice initiating review.--If the insurer does not pay the amount demanded within 15 days after its receipt of the demand letter referenced under subsection (11), peer review may be initiated under this subsection by the delivery of a notice under this paragraph. To facilitate faster resolution of claims, a claimant may simultaneously and together deliver the demand letter and a notice under this section to the insurer and the peer review organization, in

which case the insurer shall have 10 additional days to provide the explanation and supporting documentation provided for in paragraph (f) and to make the written offer provided for in paragraph (i). The initiating party shall deliver a notice to the peer review organization which shall state that it is a "notice initiating peer review under section 627.736(12), Florida Statutes," and shall also provide the same information required under subsection (11) as to any item or issue still in dispute. To facilitate cost-efficient resolution of disputes, the petitioner shall aggregate in its notice all matters that are in dispute and subject to this subsection. The initiating party, if the claimant, shall deliver a copy of the notice to the person and address for demand letters under paragraph (11)(c) and, if the insurer, shall deliver a copy of the notice to the person or entity that filed the demand letter under subsection (11). Each notice must be delivered by United States certified or registered mail, return receipt requested. Notice shall be treated as being delivered on the date notice is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery.

(f) Supporting documentation.--As to matters in dispute, the initiating party shall submit to the peer review organization and the respondent an explanation of its position and supporting documentation within 10 days after it gives its notice, and the respondent shall submit to the peer review organization and the initiating party an explanation of its position and supporting documentation within 10 days after its receipt of the notice. The peer review organization may require the parties to submit additional documentation.

(g) Review process.--The peer reviewer shall issue a written report within 10 days after its receipt of all written documentation. The report must include a statement of the issues posed and, as applicable, an itemized statement of the items determined to be medically necessary, reasonable, and related to the injury, and the type, frequency, and duration of future treatment determined to be reasonable and medically necessary. Issues shall be decided in a summary manner by the peer reviewer from the records and pleadings submitted by the claimant and insurer. The peer review process is dependent upon the initiating party and respondent each explaining in writing the nature of the dispute and upon providing sufficient documentation for resolution of the issue or claim. The peer reviewer may consider any documents submitted by either party subject only to the requirements of this subsection. The peer reviewer shall not examine the claimant or insurer. The peer reviewer may, in its discretion, schedule a telephone conference with the insurer and claimant to facilitate the dispute resolution in a cost-effective, efficient manner. The provisions of chapter 90 governing the rules of evidence shall not apply to proceedings before the peer reviewer. Applying the standards of care, applicable practice parameters, including those related to utilization, and relevant provisions of this section, the peer reviewer shall make a recommendation, pursuant to its contract with the peer review organization, of the medical merits of the dispute.

(h) Dispute costs.--The agency shall approve a review cost fee schedule and a late payment fee schedule for use by the peer review organization. The rules adopted by the agency shall reflect procedures that minimize the costs of a review

and specify the circumstances under which review costs are not incurred, including when the insurer pays the amount demanded so as to resolve a dispute without submission of supporting documentation to the review organization or a party declines to participate in the peer review. The initiating party and respondent shall each pay 50 percent of all review costs. However, if the amount recommended by the peer reviewer is greater than the amount offered in writing to the claimant by the insurer within 15 days after the initiation of the review, the insurer shall pay all of the review costs up to the first $500, and the remainder shall be divided equally between the insurer and the claimant. Neither party nor the review organization shall reveal the amount of the insurer's offer to the peer reviewer.

(i) Payment by insurer.--As to any item in dispute, if the insurer pays the item recommended by the peer review organization within 10 business days after its receipt of the written recommendation of the peer reviewer, or if at any time prior to or during the pendency of a dispute under this subsection the insurer pays the item demanded by the claimant, together with applicable interest under paragraph (4)(c), a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, then as to the disputed items so paid the insurer is not liable in any action for attorney's fees otherwise required by provisions of the insurance code or for damages under s. 624.155. If the dispute involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the insurer is not liable in any action for attorney's fees otherwise required by the insurance code or for damages under s. 624.155 if, within 10 business days after its receipt of the written

recommendation of the peer reviewer, or at any time prior to or during the pendency of a dispute under this subsection, the insurer mails to the claimant a written statement of its agreement to pay for such treatment in accordance with the claimant's demand or peer reviewer's recommendation and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with this section. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery.

(j) Access to court.--Peer review under this subsection is a condition precedent to the filing of any action based on a dispute subject to this subsection. A party may not file an action related to a disputed amount subject to this section while a dispute is pending under this subsection. The respondent may decline to participate as to the entirety or any item in dispute. To the extent that the insurer declines to participate or declines to pay the items recommended, the insurer remains potentially liable for reasonable attorney's fees otherwise required by the insurance code and for damages under s. 624.155. To the extent that the claimant declines to participate or declines to accept payment from the insurer tendered in accordance with paragraph (i), the insurer is not liable for attorney's fees otherwise required by the insurance code or for damages under s. 624.155. The decision of the peer reviewer is not binding on any party and the parties retain access to courts in

accordance with this subsection. A party may seek judicial review of the recommendation of the peer reviewer to determine whether the recommendation was reasonable. A recommendation is reasonable unless it was procured by corruption, fraud, or other undue means; there was evident partiality by the peer reviewer or misconduct prejudicing the rights of any party; or the peer reviewer exceeded the authority and power granted by this subsection. If the court declares the peer review recommendation to be not reasonable, the peer review recommendation shall be vacated, the peer review organization shall provide a different peer reviewer to review the dispute and issued a recommendation, and the peer review process shall proceed as if no action had been filed.

(k) Evidence in litigation.--The notice of dispute and all documents submitted by the health care practitioner and the insurer, together with the notice of resolution and the resolution of any appeal, may be introduced into evidence in any civil action if such documents are admissible pursuant to the Florida Evidence Code.

(l) Rules.--The agency shall adopt rules to administer this subsection.

(13) ALTERNATIVE DISPUTE RESOLUTION.--

(a) This subsection applies to disputes and claims that are not subject to peer review under subsection (12). For purposes of this subsection, the term "mediation" means the alternative dispute resolution provided for in this subsection, and the term "mediator" means the person attempting to resolve the dispute or claim under this subsection. As to any such dispute or claim to which this subsection applies, if the insurer does not pay the amount demanded within 15 days after its receipt of the demand letter

referenced under subsection (1), either party may request mediation of the claim; except that to facilitate faster resolution of claims, a claimant may simultaneously and together deliver both the demand letter and a request under this subsection to the insurer and the department. As to any item that is subject both to peer review under subsection (12) and to this subsection because there is an issue to which subsection (12) does not apply, a party may not request mediation until the peer review process is concluded, absent consent of the other party. The insurer may file a request for mediation only on or before the 15th day after receipt of the demand letter. Mediation is optional and either party may decline to participate.

(b) A request for mediation shall be filed with the department on a form approved by the department. The request for mediation must state the reason for the request for mediation and must include and state all the issues in dispute at the time of the request which are to be mediated. The filing of a request for mediation tolls the applicable time requirements for filing suit for a period of 60 days following the conclusion of the mediation process or the time prescribed in s. 95.11, whichever is later.

(c) The mediation shall be conducted as an informal process in which formal rules of evidence and procedure need not be observed. The party to the mediation is not required to attend the mediation if each representative of the party participating in a mediation has the authority to make a binding decision. All parties must mediate in good faith.

(d) The department shall randomly select mediators. Each party may once reject the mediator selected, either

originally or after the opposing side has exercised its option to reject a mediator.

(e) If the insurer requests mediation, the costs of mediation shall be paid by the insurer. Otherwise, the costs shall be paid equally by both parties, except as provided in paragraph (p).

(f) Only one mediation may be requested for all issues that are, or with due diligence of the requesting party could have been, addressed with such mediation, unless all parties agree to further mediation.

(g) Upon receipt of a request for mediation, the department shall refer the request to a mediator. The mediator shall notify the applicant and all interested parties, as identified by the applicant, and any other parties the mediator believes may have an interest in the mediation, of the date, time, and place of the mediation conference. The conference may be held by telephone, if feasible. The mediation conference shall be held within 45 days after the request for mediation.

(h) The department shall approve mediators to conduct mediations pursuant to this section. All mediators must file an application under oath for approval as a mediator.

(i) To qualify for approval as a mediator, a person must meet the following qualifications:

1. Possess a masters or doctorate degree in psychology, counseling, business, accounting, or economics; be a member of The Florida Bar; be licensed as a certified public accountant; or demonstrate that the applicant for approval has been actively engaged as a qualified mediator for at least 4 years prior to July 1, 1990.

2. Within 4 years immediately preceding the date the application for approval is filed with the department, have completed a minimum of a 40-hour training program approved by the department and successfully passed a final examination included in the training program and approved by the department. The training program shall include and address all of the following:

a. Mediation theory.

b. Mediation process and techniques.

c. Standards of conduct for mediators.

d. Conflict management and intervention skills.

e. Insurance nomenclature.

f. The provisions of this section and additional training if required as to any person not trained concerning applicable principles of law.

(j) The Financial Services Commission must adopt rules of procedure for claims mediation, taking into consideration a system that is consistent with this section and that:

1. Is fair.

2. Promotes settlement.

3. Avoids delay.

4. Is nonadversarial.

5. Used a framework for modern mediating technique.

6. Controls costs and expenses of mediation.

7. Provides that, as to persons not represented by an attorney, consumer affairs specialists of the department shall be available for consultation to the extent that they may lawfully do so, and that the mediator shall diligently inquire and ascertain all facts necessary to formulate a fair and informed recommendation pursuant to paragraph (m).

(k) Disclosures and information divulged in the mediation process are not admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim, except as provided in paragraph (m).

(l) A person demanding mediation under this section may not demand or request mediation after a suit is filed relating to the same issues already mediated.

(m) For matters that are not resolved by the parties at the conclusion of the mediation, the mediator shall prepare a report recommending whether any amount is due and, if so, the amount deemed to be owed on an itemized basis. Such report shall be sent to all parties in attendance at the mediation and to the department. This recommendation is not binding on any party and the parties retain access to courts. The mediator's written recommendation is admissible in any subsequent action or proceeding relating to the claim or to the cause of action giving rise to the claim only for purposes of determining the award of attorney's fees.

(n) If the insurer declines to participate in mediation or declines to pay the amount recommended in a mediator's report, the insurer remains potentially liable for reasonable attorney's fees pursuant to law. In such cases, contingency risk multipliers apply only if the court determines and states explicitly the particular legal or factual issue involved and provides reasons supporting its determination. The contingency risk multiplier shall be 2.5 if the court determines that the issue is of such great public importance that the public interest requires the determination of that issue.

(o) If the claimant declines to mediate or declines to settle the matter in accordance with the recommendation of the

mediator pursuant to this section, the insurer is not liable for attorney's fees otherwise required by provisions of the insurance code or for damages under s. 624.155.

(p) The insurer is not liable for attorney's fees otherwise required by provisions of the insurance code or for damages under s. 624.155 if the insurer tenders payment of the amount demanded in the demand letter at any time prior to the insurer's receipt of the mediator's written recommendation, or tenders the amount recommended within 10 days after the insurer's receipt of the mediator's written recommendation, together with the mediator's fee if any has accrued, applicable interest, and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250. If the dispute involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the insurer is not liable in any action for attorney's fees otherwise required by the insurance code or for damages under s. 624.155 if within 10 business days after its receipt of the written recommendation of the peer reviewer, or at any time prior to or during the pendency of a dispute under this subsection, the insurer tenders the mediator's fee if any has accrued, and mails to the claimant a written statement of its agreement to pay for such treatment in accordance with the claimant's demand or mediator's recommendation and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with this section. However, if the mediator recommends an amount that is in excess of the amount that the insurer has paid, the insurer is liable for reasonable attorney's fees of the claimant of up to $1,000, as determined by the mediator. For purposes of this subsection,

payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment or tender of payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery.

(q) An action may not be brought against an insurer without attaching a copy of the notice required by this subsection and a copy of the proof of delivery of the notice required by this section.

(r) A party may seek judicial review of the recommendation of the mediator to determine whether the recommendation was reasonable. A recommendation is reasonable unless it was procured by corruption, fraud, or other undue means; there was evident partiality by the peer reviewer or misconduct prejudicing the rights of any party; or the mediator exceeded the authority and power granted by this subsection. If the court declares the recommendation to be not reasonable, the mediation recommendation shall be vacated, the department shall provide a different mediator to review the dispute and issue a recommendation, and the mediation process shall proceed as if no action had been filed.

(14)~~(12)~~ CIVIL ACTION FOR INSURANCE FRAUD.--

(a) An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and

punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(b) Notwithstanding its payment, an insurer and insured shall not be precluded from maintaining a civil cause of action against any person or business entity to recover payments for services later determined to have been unlawfully rendered or otherwise in violation of any provision of this section.

(15) If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

Section 10. Subsection (2) of section 627.739, Florida Statutes, is amended to read:

627.739 Personal injury protection; optional limitations; deductibles.--

(2) Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, $1,000, and $2,000. The

deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736. After the deductible is met, each insured is eligible to receive up to $10,000 in total benefits described in s. 627.736(1).~~, such amount to be deducted from the benefits otherwise due each person subject to the deduction.~~However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

Section 11. Subsection (9) is added to section 768.79, Florida Statutes, to read:

768.79 Offer of judgment and demand for judgment.--

(9) This section is applicable to any civil action filed which applies to s. 627.736, in any court in this state. A filing in compliance with this section does not constitute an admission of coverage, and an insurer may not be estopped from denying coverage, denying liability, or defending against any claim on its merits.

Section 12. Subsections (7), (8), and (9) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.--

(7)(a) It shall constitute a material omission and insurance fraud for any physician or other provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the patient or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge.

(b) The provisions of this section shall also apply as to any insurer or adjusting firm or its agents or representatives who, with intent, injure, defraud, or deceive any claimant with regard to any claim. The claimant shall

have the right to recover the damages provided in this section.

(c) An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under s. 627.736(7) or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) A ~~It is unlawful for any~~ person may not~~, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association, to~~ solicit or cause to be solicited any business from a person involved in a motor vehicle accident with the intent of defrauding any other person,~~by any means of communication other than advertising directed to the public~~ for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736. ~~Charges for any services rendered by a health care provider or attorney who violates this subsection in regard to the person for whom such services were rendered are noncompensable and unenforceable as a matter of law.~~Any person who violates the provisions of this paragraph ~~subsection~~ commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

(b) A person may not solicit or cause to be solicited any business from a person involved in a motor vehicle accident by any means of communication other than advertising directed to the public for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736, within 60 days after the occurrence of the motor vehicle accident. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A lawyer, health care practitioner as defined in s. 456.001, or owner or medical director of a clinic required to be licensed pursuant to s. 400.903 may not, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, solicit or cause to be solicited any business from a person involved in a motor vehicle accident by means of in-person or telephone contact at the person's residence, for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736. Any person who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) Charges for any services rendered by any person who violates this subsection in regard to the person for whom such services were rendered are noncompensable and unenforceable as a matter of law.

(9) A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits as required by s. 627.736. ~~It is unlawful for any attorney to solicit any business relating to the representation of a person involved in a motor~~

~~vehicle accident for the purpose of filing a motor vehicle tort claim or a claim for personal injury protection benefits required by s. 627.736. The solicitation by advertising of any business by an attorney relating to the representation of a person injured in a specific motor vehicle accident is prohibited by this section.~~Any person ~~attorney~~ who violates ~~the provisions of~~ this paragraph ~~subsection~~ commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.~~Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney is guilty of a violation of this section, such committee shall forward to the appropriate state attorney a copy of the finding of probable cause and the report being filed in the matter. This section shall not be interpreted to prohibit advertising by attorneys which does not entail a solicitation as described in this subsection and which is permitted by the rules regulating The Florida Bar as promulgated by the Florida Supreme Court.~~

Section 13. Section 817.236, Florida Statutes, is amended to read:

817.236 False and fraudulent motor vehicle insurance application.--Any person who, with intent to injure, defraud, or deceive any motor vehicle insurer, including any statutorily created underwriting association or pool of motor vehicle insurers, presents or causes to be presented any written application, or written statement in support thereof, for motor vehicle insurance knowing that the application or statement contains any false, incomplete, or misleading

information concerning any fact or matter material to the application commits a felony ~~misdemeanor~~ of the third ~~first~~ degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084.

Section 14. Section 817.2361, Florida Statutes, is created to read:

817.2361 False or fraudulent motor vehicle insurance card.--Any person who, with intent to deceive any other person, creates, markets, or presents a false or fraudulent motor vehicle insurance card commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 15. Effective October 1, 2003, paragraphs (c) and (g) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.--

(3) OFFENSE SEVERITY RANKING CHART

Florida Statute	Felony Degree	Description
		(c) LEVEL 3
119.10(3)	3rd	Unlawful use of confidential information from police reports.
316.066(3)(d)-(f)	3rd	Unlawfully obtaining or using confidential crash reports.
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.

316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in marked patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
400.903(3)	3rd	Operating a clinic without a license or filing false license application or other required information.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
796.05(1)	3rd	Live on earnings of a prostitute.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(4)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
817.233	3rd	Burning to defraud insurer.

817.234(8)		
(b)-(c)~~&(9)~~	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
817.236	3rd	Filing a false motor vehicle insurance application.
817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.
817.505(4)	3rd	Patient brokering.
828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
831.29	2nd	Possession of instruments for counterfeiting drivers' licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police dog or horse.
870.01(2)	3rd	Riot; inciting or encouraging.

893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).
893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs within 200 feet of university or public park.
893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs within 200 feet of public housing facility.
893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.

893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.
893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47 (1)(a)1.-2.	3rd	Introduce contraband to correctional facility.

944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.3141	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).
		(g) LEVEL 7
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
409.920(2)	3rd	Medicaid provider fraud.
456.065(2)	3rd	Practicing a health care profession without a license.
456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
458.327(1)	3rd	Practicing medicine without a license.
459.013(1)	3rd	Practicing osteopathic medicine without a license.
460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.

462.17	3rd	Practicing naturopathy without a license.
463.015(1)	3rd	Practicing optometry without a license.
464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(9)	3rd	Practicing medical physics without a license.
484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.
494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.

560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by money transmitter.
560.125(5)(a)	3rd	Money transmitter business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.

784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
784.083(1)	1st	Aggravated battery on code inspector.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.

790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
796.03	2nd	Procuring any person under 16 years for prostitution.
800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
806.01(2)	2nd	Maliciously damage structure by fire or explosive.
810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
812.014(2)(a)	1st	Property stolen, valued at $100,000 or more; cargo stolen valued at $50,000 or more; property stolen while causing other property damage; 1st degree grand theft.

812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000.
827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.

827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
872.06	2nd	Abuse of a dead human body.
893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility or school.
893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.

893.135		
(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
893.135		
(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
893.135		
(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135		
(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
893.135		
(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
893.135		
(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.

896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.

Section 16. The amendments made by this act to sections 456.0375(1)(b) and 627.736(5)(b)3. and 6., Florida Statutes, are intended to clarify the legislative intent of those provisions as they existed at the time those provisions initially took effect. Accordingly, sections 456.0375(1)(b) and 627.736(5)(b)3., Florida Statutes, as amended by this act shall operate retroactively to October 1, 2001; and section 627.736(5)(b)6., as amended by this act, shall operate retroactively to June 19, 2001.

Section 17. Effective March 1, 2004, section 456.0375, Florida Statutes, is repealed.

Section 18. (1) On or before January 1, 2004, every insurer writing with a managing general agent and having a per-policy fee in its rate filing shall make a rate filing under section 627.0651, Florida Statutes, to conform its per-policy fee to the requirements of this act.

(2) Any increase in benefits approved by the Financial Services Commission under subsection (14) of section 627.736, Florida Statutes, as added by this act, shall apply to new and renewal policies that are effective 120 days after the order issued by the commission becomes final. Subsection (2) of section 627.739, Florida Statutes, as amended by this act,

shall apply to new and renewal policies issued on or after October 1, 2003.

(3) Subject to any specific effective dates in this act, paragraphs (4)(b), (5)(b), (5)(c), (5)(e), (5)(f), (5)(g), and (5)(h) of section 627.736, Florida Statutes, as amended by this act, shall apply to treatment and services occurring on or after October 1, 2003.

(4) Subsection (11) of section 627.736, Florida Statutes, as amended by this act, shall apply to actions filed on and after the effective date of this act. Subsections (12) and (13) of section 627.736, Florida Statutes, as amended by this act, shall apply to new and renewal policies issued on and after October 1, 2003.

(5) Paragraph (7)(a) of section 627.736, Florida Statutes, as amended by this act, and paragraph (7)(c) of section 817.234, Florida Statutes, as amended by this act, shall apply to examinations conducted on and after October 1, 2003.

Section 19. By December 31, 2004, the Department of Financial Services, the Department of Health, and the Agency for Health Care Administration each shall submit a report on the implementation of this act and recommendations, if any, to further improve the automobile insurance market, reduce automobile insurance costs, and reduce automobile insurance fraud and abuse to the President of the Senate and the Speaker of the House of Representatives.

Section 20. There is appropriated $2.5 million from the Health Care Trust Fund, and 51 full-time equivalent positions are authorized, for the Agency for Health Care Administration to implement the provisions of this act.

Section 21. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2003.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill CS/SB 1202

The committee substitute establishes an expedited peer review procedure to resolve personal injury protection (PIP) disputes involving medical and other related issues between claimants, providers and insurers. Provides definitions; qualifications for peer reviewers; notice provisions; review procedures; costs; and attorney's fees. The Agency for Health Care Administration (AHCA) will administer the peer review program.

Designates mediation as the alternative dispute resolution process and restricts its application to non-medical issues.

Provides that third-party vendors approved by the Division of Insurance Fraud within the Department of Financial Services may furnish crash reports solely to insurers for adjustment and claims' investigation purposes. Provides that such vendors are subject to criminal penalties.

Provides exceptions to the definition of a "clinic" relating to continuing care facilities, community college and university clinics, and clinical facilities affiliated with medical schools.

Provides for a six-month extension for a magnetic resonance imaging (MRI) facility to become accredited by specified accreditation organizations. Prohibits certain entities formed for the purpose of avoiding compliance with the accreditation requirements from being licensed as clinics.

Provides for the definition of an independent diagnostic testing facility to include both the technical testing component and professional service component and that the lawful billing by such a facility does not violate the upcoding restriction.

Narrows the definition of what services are "incident" to a physician's services.

Reduces the amount of insurance policy fees provided to specified entities for the investigation and prosecution of motor vehicle insurance fraud.

Specifies that certain tests and services, including MRI services, are subject to 200 percent of the Medicare Part B Participating Physician fee schedule and that other specified tests are subject to the workers' compensation fee schedule. Provides for the Financial Services Commission to at least annually review changes to the Medicare fee schedule and adopt such changes for PIP, if warranted to maintain availability and affordability of services.

Clarifies that the disclosure and acknowledgement form pertains to the provision of services instead of charges and exempts specified emergency services.

Removes the authority for the Department of Health to promulgate utilization guidelines.

Provides an appropriation of $2.5 million from the Health Care Trust Fund and 51 FTE's for the Agency for Health Care Administration to implement the provisions of the act.

Provides for effective dates.