1 A bill to be entitled
2 An act relating to motor vehicle insurance affordability
3 reform; creating the Motor Vehicle Insurance Affordability
4 Reform Act of 2003; providing legislative findings and
5 declarations; providing purposes; amending s. 95.11, F.S.;
6 providing a statute of limitations for certain personal
7 injury protection benefit actions; amending s. 119.105,
8 F.S.; requiring certain persons to maintain confidential
9 and exempt status of certain information under certain
10 circumstances; providing construction; prohibiting use of
11 certain confidential or exempt information relating to
12 motor vehicle accident victims for certain commercial
13 solicitation activities; deleting provisions relating to
14 police reports as public records; amending s. 316.066,
15 F.S.; specifying conditions precedent to providing access
16 to crash reports to persons entitled to such access;
17 providing construction; providing for enforcement;
18 providing a criminal penalty for using certain
19 confidential information; creating s. 408.7058, F.S.;
20 providing definitions; creating a dispute resolution
21 organization for disputes between health care
22 practitioners and insurers; providing duties of the Agency
23 for Health Care Administration; providing duties of the
24 dispute resolution organization; providing procedures,
25 requirements, limitations, and restrictions for resolving
26 disputes; providing agency rulemaking authority; amending
27 s. 456.0375, F.S.; revising definitions; providing
28 additional requirements relating to the registration of
29 certain clinics; limiting participation by disqualified
30 persons; providing for voluntary registration of exempt

31 status; providing rulemaking authority; specifying
32 unlawful charges; prohibiting the filing of certain false
33 or misleading forms or information; providing criminal
34 penalties; providing for inspections of and access to
35 clinics under certain circumstances; providing for
36 emergency suspension of registration; amending s. 456.057,
37 F.S.; requiring health care practitioners to maintain
38 certain medical records of certain activities relating to
39 patient visits; providing a required statement be included
40 in the medical records for patient visits pursuant to a
41 claim of injury; providing statement requirements;
42 amending s. 456.072, F.S.; providing additional grounds
43 for discipline of health professionals; amending s.
44 627.732, F.S.; providing a definition; amending s.
45 627.736, F.S.; revising provisions relating to required
46 personal injury protection benefits and payment thereof;
47 specifying conditions of insurance fraud and recovery of
48 certain charges; providing for recovery of costs and
49 attorney's fees in certain insurer actions; specifying
50 certain charges that are uncollectible and unenforceable;
51 limiting charges for certain services; providing
52 procedures and requirements for correcting certain
53 information relating to processing claims; prohibiting an
54 insurer from taking certain actions with respect to a
55 claim submitted by a health care provider; prohibiting an
56 insurer from taking certain actions with respect to an
57 independent medical examination; requiring certain
58 recordkeeping; deleting provisions relating to arbitration
59 of certain disputes between insurers and medical
60 providers; providing certain statements and forms

61 requirements, limitations, and restrictions; specifying
62 factors for court consideration in applying attorney
63 contingency fee multipliers; extending the time within
64 which an insurer may respond to a demand letter; expanding
65 civil actions for insurance fraud; amending s. 627.745,
66 F.S.; expanding the availability of mediation of certain
67 claims; creating s. 627.747, F.S.; providing for
68 legislative oversight of motor vehicle insurance;
69 requiring the Office of Insurance Regulation of the
70 Financial Services Commission and the Division of
71 Insurance Fraud of the Department of Financial Services to
72 regularly report certain data and analysis of certain
73 information to specified officers of the Legislature;
74 amending s. 768.79, F.S.; specifying applicability of
75 provisions relating to offer of judgment and demand for
76 judgment; amending s. 817.234, F.S.; increasing criminal
77 penalties for certain acts of solicitation of accident
78 victims; providing mandatory minimum penalties;
79 prohibiting certain solicitation of accident victims;
80 providing criminal penalties; prohibiting a person from
81 organizing, planning, or participating in a staged motor
82 vehicle accident; providing criminal penalties, including
83 mandatory minimum penalties; amending s. 817.236, F.S.;
84 increasing a criminal penalty for false and fraudulent
85 motor vehicle insurance application; creating s. 817.2361,
86 F.S.; prohibiting marketing or presenting false or
87 fraudulent motor vehicle insurance cards; providing
88 criminal penalties; creating s. 817.413, F.S.; prohibiting
89 certain sale of used motor vehicle goods as new; providing
90 criminal penalties; amending s. 860.15, F.S.; providing a

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

91 criminal penalty for charging for certain motor vehicle
92 repairs and parts to be paid from a motor vehicle
93 insurance policy; amending s. 921.0022, F.S.; revising the
94 offense severity ranking chart to reflect changes in
95 criminal penalties and the creation of additional offenses
96 under the act; providing that the amendment to s.
97 456.0375(1)(b)1., F.S., is intended to clarify existing
98 intent; providing retroactive operation; requiring the
99 Office of Insurance Regulation to report to the
100 Legislature on the economic condition of private passenger
101 automobile insurance in this state; providing for October
102 1, 2005, repeal of ss. 627.730, 627.731, 627.732, 627.733,
103 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403,
104 and 627.7405, F.S., relating to the Florida Motor Vehicle
105 No-Fault Law, unless reenacted during the 2004 Regular
106 Session, and specifying certain effect; authorizing
107 insurers to include in policies a notice of termination
108 relating to such repeal; providing an effective date.
109
110 Be It Enacted by the Legislature of the State of Florida:
111
112 Section 1. Florida Motor Vehicle Insurance Affordability
113 Reform Act of 2003; findings; purpose.--
114 (1) This act may be referred to as the Florida Motor
115 Vehicle Insurance Affordability Reform Act of 2003.
116 (2) The Legislature finds and declares as follows:
117 (a) Maintaining a healthy market for motor vehicle
118 insurance, in which consumers may obtain affordable coverage,
119 insurers may operate profitably and competitively, and providers

120 of services may be compensated fairly, is a matter of great
121 public importance.
122 (b) After many years of relative stability, the market has
123 in recent years failed to achieve these goals, resulting in
124 substantial premium increases to consumers and a decrease in the
125 availability of coverage.
126 (c) The failure of the market is in part the result of
127 fraudulent acts and other abuses of the system, including, among
128 other things, staged accidents, vehicle repair fraud, fraudulent
129 insurance applications and claims, solicitation of accident
130 victims, and the growing role of medical clinics that exist
131 primarily to provide services to persons involved in crashes.
132 While many of these issues were brought to light by the
133 Fifteenth Statewide Grand Jury and were addressed by the
134 Legislature in 2001 in chapter 2001-271, Laws of Florida,
135 further action is now appropriate.
136 (d) The failure of the market is also in part the result
137 of a no-fault insurance system that has become increasingly
138 litigious and, insofar as the system no longer effectively
139 limits the use of the tort system to injuries that are serious
140 and permanent, no longer functions as it was intended.
141 (3) The purpose of this act is to restore the health of
142 the market and the affordability of motor vehicle insurance by
143 comprehensively addressing issues of fraud, clinic regulation,
144 and related matters.
145 Section 2. Paragraph (h) is added to subsection (4) of
146 section 95.11, Florida Statutes, to read:
147 95.11 Limitations other than for the recovery of real
148 property.--Actions other than for recovery of real property
149 shall be commenced as follows:

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

150 (4) WITHIN TWO YEARS.--
151 (h) An action for personal injury protection benefits
152 under s. 627.736, whether founded in violation of such section,
153 breach of contract, or otherwise, provided that the period of
154 limitations shall run from the time the cause of action is
155 discovered or should have been discovered with the exercise of
156 due diligence.
157 Section 3. Section 119.105, Florida Statutes, is amended
158 to read:
159 119.105 Protection of victims of ~~crimes or~~ accidents.--Any
160 person who is authorized by law to have access to confidential
161 or exempt information contained in police reports that identify
162 motor vehicle accident victims must maintain the confidential or
163 exempt status of such information received, except as otherwise
164 expressly provided in the law creating the exemption. Nothing in
165 this section shall be construed to prohibit the publication of
166 such information to the general public by any news media legally
167 entitled to possess that information. Under no circumstances may
168 any person, including the news media, use confidential or exempt
169 information contained in police reports for any commercial
170 solicitation of the victims or relatives of the victims of the
171 reported crimes or accidents. ~~Police reports are public records~~
172 ~~except as otherwise made exempt or confidential by general or~~
173 ~~special law. Every person is allowed to examine nonexempt or~~
174 ~~nonconfidential police reports. No person who inspects or copies~~
175 ~~police reports for the purpose of obtaining the names and~~
176 ~~addresses of the victims of crimes or accidents shall use any~~
177 ~~information contained therein for any commercial solicitation of~~
178 ~~the victims or relatives of the victims of the reported crimes~~
179 ~~or accidents. Nothing herein shall prohibit the publication of~~

180 ~~such information by any news media or the use of such~~
181 ~~information for any other data collection or analysis purposes.~~
182 Section 4. Subsection (3) of section 316.066, Florida
183 Statutes, is amended to read:
184 316.066 Written reports of crashes.--
185 (3)(a) Every law enforcement officer who in the regular
186 course of duty investigates a motor vehicle crash:
187 1. Which crash resulted in death or personal injury shall,
188 within 10 days after completing the investigation, forward a
189 written report of the crash to the department or traffic records
190 center.
191 2. Which crash involved a violation of s. 316.061(1) or s.
192 316.193 shall, within 10 days after completing the
193 investigation, forward a written report of the crash to the
194 department or traffic records center.
195 3. In which crash a vehicle was rendered inoperative to a
196 degree which required a wrecker to remove it from traffic may,
197 within 10 days after completing the investigation, forward a
198 written report of the crash to the department or traffic records
199 center if such action is appropriate, in the officer's
200 discretion.
201
202 However, in every case in which a crash report is required by
203 this section and a written report to a law enforcement officer
204 is not prepared, the law enforcement officer shall provide each
205 party involved in the crash a short-form report, prescribed by
206 the state, to be completed by the party. The short-form report
207 must include, but is not limited to: the date, time, and
208 location of the crash; a description of the vehicles involved;
209 the names and addresses of the parties involved; the names and

210 addresses of witnesses; the name, badge number, and law
211 enforcement agency of the officer investigating the crash; and
212 the names of the insurance companies for the respective parties
213 involved in the crash. Each party to the crash shall provide the
214 law enforcement officer with proof of insurance to be included
215 in the crash report. If a law enforcement officer submits a
216 report on the accident, proof of insurance must be provided to
217 the officer by each party involved in the crash. Any party who
218 fails to provide the required information is guilty of an
219 infraction for a nonmoving violation, punishable as provided in
220 chapter 318 unless the officer determines that due to injuries
221 or other special circumstances such insurance information cannot
222 be provided immediately. If the person provides the law
223 enforcement agency, within 24 hours after the crash, proof of
224 insurance that was valid at the time of the crash, the law
225 enforcement agency may void the citation.
226 (b) One or more counties may enter into an agreement with
227 the appropriate state agency to be certified by the agency to
228 have a traffic records center for the purpose of tabulating and
229 analyzing countywide traffic crash reports. The agreement must
230 include: certification by the agency that the center has
231 adequate auditing and monitoring mechanisms in place to ensure
232 the quality and accuracy of the data; the time period in which
233 the traffic records center must report crash data to the agency;
234 and the medium in which the traffic records must be submitted to
235 the agency. In the case of a county or multicounty area that has
236 a certified central traffic records center, a law enforcement
237 agency or driver must submit to the center within the time limit
238 prescribed in this section a written report of the crash. A
239 driver who is required to file a crash report must be notified

240 of the proper place to submit the completed report. Fees for
241 copies of public records provided by a certified traffic records
242 center shall be charged and collected as follows:
243
244 For a crash report....................$2 per copy.
245 For a homicide report................$25 per copy.
246 For a uniform traffic citation ....$0.50 per copy.
247
248 The fees collected for copies of the public records provided by
249 a certified traffic records center shall be used to fund the
250 center or otherwise as designated by the county or counties
251 participating in the center.
252 (c) Crash reports required by this section which reveal
253 the identity, home or employment telephone number or home or
254 employment address of, or other personal information concerning
255 the parties involved in the crash and which are received or
256 prepared by any agency that regularly receives or prepares
257 information from or concerning the parties to motor vehicle
258 crashes are confidential and exempt from s. 119.07(1) and s.
259 24(a), Art. I of the State Constitution for a period of 60 days
260 after the date the report is filed. However, such reports may be
261 made immediately available to the parties involved in the crash,
262 their legal representatives, their licensed insurance agents,
263 their insurers or insurers to which they have applied for
264 coverage, persons under contract with such insurers to provide
265 claims or underwriting information, prosecutorial authorities,
266 radio and television stations licensed by the Federal
267 Communications Commission, newspapers qualified to publish legal
268 notices under ss. 50.011 and 50.031, and free newspapers of
269 general circulation, published once a week or more often,

270 available and of interest to the public generally for the
271 dissemination of news. As conditions precedent to accessing
272 crash reports within 60 days after the date the report is filed,
273 a person must present a driver's license or other photographic
274 identification and proof of status that demonstrates his or her
275 qualifications to access that information and must also file a
276 written sworn statement with the state or local agency in
277 possession of the information stating that no information from
278 any crash report made confidential by this section will be used
279 for any prohibited commercial solicitations of accident victims
280 or knowingly disclosed to any third party for the purpose of
281 such solicitation during the period of time that the information
282 remains confidential. Nothing in this paragraph shall be
283 construed to prevent the dissemination or publication of news to
284 the general public by any media organization entitled to access
285 confidential information pursuant to this section. Any law
286 enforcement officer as defined in s. 943.10(1) shall have the
287 authority to enforce this subsection. For the purposes of this
288 section, the following products or publications are not
289 newspapers as referred to in this section: those intended
290 primarily for members of a particular profession or occupational
291 group; those with the primary purpose of distributing
292 advertising; and those with the primary purpose of publishing
293 names and other personally identifying information concerning
294 parties to motor vehicle crashes. Any local, state, or federal
295 agency, agent, or employee that is authorized to have access to
296 such reports by any provision of law shall be granted such
297 access in the furtherance of the agency's statutory duties
298 notwithstanding the provisions of this paragraph. Any local,
299 state, or federal agency, agent, or employee receiving such

300 crash reports shall maintain the confidential and exempt status
301 of those reports and shall not disclose such crash reports to
302 any person or entity. Any person attempting to access crash
303 reports within 60 days after the date the report is filed must
304 present legitimate credentials or identification that
305 demonstrates his or her qualifications to access that
306 information. This exemption is subject to the Open Government
307 Sunset Review Act of 1995 in accordance with s. 119.15, and
308 shall stand repealed on October 2, 2006, unless reviewed and
309 saved from repeal through reenactment by the Legislature.
310 (d) Any employee of a state or local agency in possession
311 of information made confidential by this section who knowingly
312 discloses such confidential information to a person not entitled
313 to access such information under this section commits ~~is guilty~~
314 of a felony of the third degree, punishable as provided in s.
315 775.082, s. 775.083, or s. 775.084.
316 (e) Any person, knowing that he or she is not entitled to
317 obtain information made confidential by this section, who
318 obtains or attempts to obtain such information commits ~~is guilty~~
319 of a felony of the third degree, punishable as provided in s.
320 775.082, s. 775.083, or s. 775.084.
321 (f) Any person who knowingly uses information made
322 confidential by this section in violation of a filed, written,
323 and sworn statement required by this section commits a felony of
324 the third degree, punishable as provided in s. 775.082, s.
325 775.083, or s. 775.084.
326 Section 5. Section 408.7058, Florida Statutes, is created
327 to read:
328 408.7058 Statewide health care practitioner and personal
329 injury protection insurer claim dispute resolution program.--

330 (1) As used in this section:
331 (a) "Agency" means the Agency for Health Care
332 Administration.
333 (b) "Resolution organization" means a qualified
334 independent third-party claim dispute resolution entity selected
335 by and contracted with the Agency for Health Care
336 Administration.
337 (c) "Health care practitioner" means a health care
338 practitioner defined in s. 456.001(4).
339 (d) "Claim" means a claim for payment for services
340 submitted under s. 627.736(5).
341 (e) "Claim dispute" means a dispute between a health care
342 practitioner and an insurer as to the proper coding of a charge
343 submitted on a claim under s. 627.736(5) by a health care
344 practitioner, or the reasonableness of the amount paid on such a
345 claim by an insurer.
346 (f) "Insurer" means an insurer providing benefits under s.
347 627.736.
348 (2)(a) The agency shall establish a program by January 1,
349 2004, to provide assistance to health care practitioners and
350 insurers for resolution of claim disputes that are not resolved
351 by the health care practitioner and the insurer. The agency
352 shall contract with a resolution organization to timely review
353 and consider claim disputes submitted by health care
354 practitioners and insurers and recommend to the agency an
355 appropriate resolution of those disputes.
356 (b) The resolution organization shall review claim
357 disputes filed by health care practitioners and insurers unless
358 a demand letter has been submitted to the insurer under s.

359 627.736(11) or a suit has been filed on the claim against the
360 insurer relating to the disputed claim.
361 (3) Resolutions by the resolution organization shall be
362 initiated as follows:
363 (a) A health care practitioner may initiate a dispute
364 resolution by submitting a notice of dispute within 10 days
365 after receipt of a payment under s. 627.736(5)(b), which payment
366 is less than the amount of the charge submitted on the claim.
367 The notice of dispute shall be submitted to both the agency and
368 the insurer by United States certified mail or registered mail,
369 return receipt requested. The health care practitioner shall
370 include with the notice of dispute any documentation that the
371 health care practitioner wishes the resolution organization to
372 consider, demonstrating that the charge or charges submitted on
373 the claim are reasonable. The insurer shall have 10 days after
374 the date of receipt of the notice of dispute within which to
375 submit both to the resolution organization and the health care
376 practitioner by United States certified mail or registered mail,
377 return receipt requested, any documentation that the insurer
378 wishes the resolution organization to consider demonstrating
379 that the charge or charges submitted on the claim are not
380 reasonable.
381 (b) An insurer may initiate a dispute resolution by
382 submitting a notice of dispute together with a payment to the
383 health care practitioner under s. 627.736(5)(b) of the amount
384 the insurer contends is the highest proper reasonable charge for
385 the claim. The notice of dispute shall be submitted to both the
386 agency and the health care practitioner by United States
387 certified mail or registered mail, return receipt requested. The
388 insurer shall include with the notice of dispute any

389 documentation which the insurer wishes the resolution
390 organization to consider demonstrating that the charge or
391 charges submitted on the claim are not reasonable. The health
392 care practitioner shall have 10 days after the date of receipt
393 of the notice of dispute within which to submit both to the
394 resolution organization and the insurer by United States
395 certified mail or registered mail, return receipt requested any
396 documentation which the health care practitioner wishes the
397 resolution organization to consider, demonstrating that the
398 charge or charges submitted on the claim are reasonable.
399 (c) An insurer or health care practitioner may refuse to
400 participate in a dispute resolution by sending a statement,
401 within 10 business days after its receipt of a notice of
402 dispute, to the other party and the agency that the insurer or
403 health care practitioner will not participate in a dispute
404 resolution. An insurer or health care practitioner shall not be
405 liable for any costs of a dispute resolution if the insurer or
406 health care practitioner has issued such a statement.
407 (d)1. Upon initiation of a dispute resolution pursuant to
408 this section, no demand letter under s. 627.736(11) may be sent
409 in regard to the subject matter of the dispute resolution
410 unless:
411 a. The insurer has failed to pay the reasonable amount
412 pursuant to the final order adopting the notice of resolution
413 together with the interest and penalties provided in subsection
414 (6), if applicable;
415 b. Either the insurer or the health care practitioner has
416 sent a statement of refusal pursuant to paragraph (c); or

417 c. The dispute resolution organization or the agency has
418 not been able to issue a notice of resolution or final order
419 within the time provided by this section.
420 2. The applicable statute of limitations shall be tolled
421 while a dispute resolution is pending and for a period of 15
422 business days following:
423 a. The filing with the agency clerk of the final order
424 adopting the notice of resolution;
425 b. Expiration of time for the filing of the final order
426 adopting the notice of resolution; or
427 c. Receipt of a statement of refusal pursuant to paragraph
428 (c).
429 (4)(a) The resolution organization shall issue a notice of
430 resolution within 10 business days after the date the
431 organization receives all documentation from the health care
432 practitioner and the insurer, or within 10 business days after
433 the deadline for submitting such information if either the
434 responding health care practitioner or insurer fails to submit
435 information.
436 (b) The resolution organization shall dismiss a notice of
437 dispute if:
438 1. An insurer or health care practitioner has submitted a
439 statement of refusal pursuant to paragraph (3)(c) that the
440 insurer or health care practitioner will not participate in a
441 dispute resolution; or
442 2. The dispute resolution organization is unable to issue
443 a notice of resolution within the time provided by this section.
444 (c) The resolution organization may, in its discretion,
445 schedule and conduct a telephone conference with the health care

446 practitioner and the insurer to facilitate the dispute
447 resolution in a cost-effective, efficient manner.
448 (d) In determining the reasonableness of a charge or
449 charges, the resolution organization may consider whether a
450 billing code or codes submitted on the claim are the codes that
451 accurately reflect the diagnostic or treatment service on the
452 claim or whether the billing code or codes should be bundled or
453 unbundled.
454 (e) In determining the reasonableness of a charge or
455 charges, the resolution organization shall determine whether the
456 charge or charges are less than or equal to the highest
457 reasonable charge or charges that represent the usual and
458 customary rates charged by similar health care practitioners
459 licensed under the same chapter for the geographic area of the
460 health care practitioner involved in the dispute, and, if the
461 charges in dispute are less than or equal to such charges, the
462 resolution organization shall find them reasonable. In
463 determining the usual and customary rates in accordance with
464 this paragraph, the dispute resolution organization may not take
465 into consideration any information relating to, or based wholly
466 or partially on, any governmentally set fee schedule, or any
467 contracted-for or discounted rates charged by health care
468 practitioners who contract with health insurers, health
469 maintenance organizations, or managed care organizations.
470 (f) A health care practitioner, who must be licensed under
471 the same chapter as the health care practitioner involved in the
472 dispute, may be used to advise the resolution organization if
473 such advice will assist the resolution organization to resolve
474 the dispute in a more cost-effective, efficient manner.

475 (5)(a) The resolution organization shall issue a notice of
476 resolution within 10 business days after receipt of all
477 documentation submitted by the health care practitioner and
478 insurer or the deadline for receipt of the documentation. The
479 notice of resolution shall be based upon findings of fact and
480 shall be considered a recommended order. The notice of
481 resolution shall be submitted to the health care practitioner
482 and the insurer by United States certified mail or registered
483 mail, return receipt requested, and to the agency.
484 (b) The notice of resolution shall state:
485 1. Whether the charge or charges submitted on the claim
486 are reasonable; or
487 2. If the resolution organization finds that any charge or
488 charges submitted on the claim are not reasonable, the highest
489 amount for such charge or charges that the resolution
490 organization finds to be reasonable.
491 (6)(a) In the event that the notice of resolution finds
492 that any charge or charges submitted on the claim are not
493 reasonable but that the highest reasonable charge or charges are
494 more than the amount or amounts paid by the insurer, the insurer
495 shall pay the additional amount found to be reasonable within 10
496 business days after receipt of the final order adopting the
497 notice of resolution, together with applicable interest under s.
498 627.736(4)(c), a penalty of 10 percent of the additional amount
499 found to be reasonable, subject to a maximum penalty of $250,
500 and the entirety of the review costs under subsection (8).
501 (b) In the event that the notice of resolution finds that
502 the charge or charges submitted on the claim are reasonable, the
503 insurer shall pay the additional amount or amounts found to be
504 reasonable within 10 business days after receipt of the final

505 order adopting the notice of resolution, together with
506 applicable interest under s. 627.736(4)(c), a penalty of 20
507 percent of the additional amount found to be reasonable, subject
508 to a maximum penalty of $500, and the entirety of the review
509 costs under subsection (8).
510 (c) In the event that the final order adopting the notice
511 of resolution finds that the amount or amounts paid by the
512 insurer are equal to or greater than the highest reasonable
513 charge, the insurer shall not be liable for any interest or
514 penalties, and the health care practitioner shall be responsible
515 for the entirety of the review costs under subsection (8).
516 (d) The agency shall issue a final order adopting the
517 notice of resolution within 10 days after receipt of the notice
518 of resolution. The final order shall be submitted to the health
519 care practitioner and the insurer by United States certified
520 mail or registered mail, return receipt requested.
521 (7)(a) If the insurer has paid the highest reasonable
522 amount or amounts as determined by the final order adopting the
523 notice of resolution, together with the interest and penalties
524 provided in subsection (6), if applicable, then no civil action
525 by the health care practitioner shall lie against the insurer on
526 the basis of the reasonableness of the charge or charges, and no
527 attorney's fees may be awarded for legal assistance related to
528 the charge or charges. The injured party is not liable for, and
529 the health care practitioner shall not bill the injured party
530 for, any amounts other than the copayment and any applicable
531 deductible based on the highest reasonable amount as determined
532 by the final order adopting the notice of resolution.
533 (b) The notice of dispute and all documents submitted by
534 the health care practitioner and the insurer, together with the

535 notice of resolution and the final order adopting the notice of
536 resolution, may be introduced into evidence in any civil action.
537 (8) The agency shall adopt rules to establish a process to
538 be used by the resolution organization in considering claim
539 disputes submitted by a health care practitioner or insurer and
540 the fees which may be charged by the agency for processing
541 disputes under this section.
542 Section 6. Section 456.0375, Florida Statutes, is amended
543 to read:
544 456.0375 Registration of certain clinics; requirements;
545 discipline; exemptions.--
546 (1)(a) As used in this section, the term:
547 1. "Clinic" means a business operating in a single
548 structure or facility, or in a group of adjacent structures or
549 facilities operating under the same business name or management,
550 at which health care services are provided to individuals and
551 which tender charges for reimbursement for such services. The
552 term also includes an entity that performs such functions from a
553 vehicle or otherwise having no fixed location.
554 2. "Disqualified person" means any individual who, within
555 the last 10 years, has been convicted of or who, regardless of
556 adjudication, has pleaded guilty or nolo contendere to any
557 felony under federal law or under the law of any state.
558 3. "Participate in the business of" a clinic means to be
559 employed by a clinic, to be an independent contractor of a
560 clinic, or to own or control any interest of any nature in a
561 clinic.
562 4. "Independent diagnostic testing facility" means an
563 individual, partnership, firm, or other business entity that
564 provides diagnostic imaging services but does not include an

565 individual or entity that has a disqualified person under
566 subparagraph 2. as an investor.
567 (b) For purposes of this section, the term "clinic" does
568 not include and the registration requirements herein do not
569 apply to:
570 1.a. Entities licensed or registered by the state pursuant
571 to chapter 390, chapter 394, chapter 395, chapter 397, chapter
572 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter
573 480, or chapter 484.
574 b. Entities that own, directly or indirectly, entities
575 licensed pursuant to chapter 390, chapter 394, chapter 395,
576 chapter 397, chapter 400, chapter 463, chapter 465, chapter 466,
577 chapter 478, chapter 480, or chapter 484.
578 c. Entities that are owned, directly or indirectly, by an
579 entity licensed pursuant to chapter 390, chapter 394, chapter
580 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter
581 466, chapter 478, chapter 480, or chapter 484.
582 d. Entities which are under common ownership, directly or
583 indirectly, with an entity licensed pursuant to chapter 390,
584 chapter 394, chapter 395, chapter 397, chapter 400, chapter 463,
585 chapter 465, chapter 466, chapter 478, chapter 480, or chapter
586 484.
587 2. Entities exempt from federal taxation under 26 U.S.C.
588 s. 501(c)(3).
589 3. Sole proprietorships, group practices, partnerships, or
590 corporations that provide health care services by licensed
591 health care practitioners pursuant to chapters 457, 458, 459,
592 460, 461, 462, 463, 466, 467, 484, 486, 490, 491, or part I,
593 part III, part X, part XIII, or part XIV of chapter 468, or s.
594 464.012, which are wholly owned by licensed health care

595 practitioners or the licensed health care practitioner and the
596 spouse, parent, or child of a licensed health care practitioner,
597 so long as one of the owners who is a licensed health care
598 practitioner is supervising the services performed therein and
599 is legally responsible for the entity's compliance with all
600 federal and state laws. However, no health care practitioner may
601 supervise services beyond the scope of the practitioner's
602 license.
603 (2)(a) Every clinic, as defined in paragraph (1)(a), must
604 register, and must at all times maintain a valid registration,
605 with the Department of Health. Each clinic location shall be
606 registered separately even though operated under the same
607 business name or management, and each clinic shall appoint a
608 medical director or clinical director.
609 (b)1. The department shall adopt rules necessary to
610 implement the registration program, including rules establishing
611 the specific registration procedures, forms, and fees.
612 Registration fees must be reasonably calculated to cover the
613 cost of registration and must be of such amount that the total
614 fees collected do not exceed the cost of administering and
615 enforcing compliance with this section. Registration may be
616 conducted electronically. The registration program must require:
617 a.~~1.~~ The clinic to file the registration form with the
618 department within 60 days after the effective date of this
619 section or prior to the inception of operation. The registration
620 expires automatically 2 years after its date of issuance and
621 must be renewed biennially.
622 b.~~2.~~ The registration form to contain the name, residence
623 and business address, phone number, and license number of the
624 medical director or clinical director for the clinic, and of

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625 each person who directly or indirectly owns or controls the
626 clinic or any interest in the clinic.
627 c.~~3.~~ The clinic to display the registration certificate in
628 a conspicuous location within the clinic readily visible to all
629 patients.
630 2. Any business that becomes a clinic after commencing
631 other operations shall, within 5 days after becoming a clinic,
632 file a registration statement under this subsection and shall be
633 subject to all provisions of this section applicable to a
634 clinic.
635 (c) A disqualified person may not participate in the
636 business of the clinic. This paragraph does not apply to any
637 participation in the business of the clinic that existed as of
638 the effective date of this paragraph. A disqualified person may
639 participate in the business of the clinic if such person has the
640 written consent of the department, which consent specifically
641 refers to this subsection. Effective October 1, 2003, the
642 registration statement required by this section must include, or
643 be amended to include, information about each disqualified
644 person participating in the business of the clinic, including
645 any person participating with the written consent of the
646 department. A clinic must make a diligent effort to determine
647 whether any disqualified person is participating in the business
648 of the clinic, to include conducting background investigations
649 on its employees, medical directors, owners, and control
650 persons. Certification of accreditation and reaccredidation by
651 the appropriate accrediting entity or entities shall be
652 conclusive proof of compliance with this paragraph, unless it is
653 shown that such accreditation has been suspended, withdrawn, or
654 revoked. Such certification and each subsequent certificate of

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655 reaccreditation shall be provided by the clinic to the insurer
656 one time, prior to the filing of any claim seeking reimbursement
657 based on such accreditation. Each claim seeking reimbursement
658 based on such accreditation shall bear the statement: "This
659 clinic is currently accredited by American College of Radiology
660 and was so at the time services were rendered," or "This clinic
661 is currently accredited by American College of Radiology and the
662 Joint Commission on Accreditation of Health Care Organizations
663 and was so at the time services were rendered."
664 (d) Every clinic engaged in the provision of magnetic
665 resonance imaging services must be accredited by the American
666 College of Radiology or the Joint Commission on Accreditation of
667 Health Care Organizations by January 1, 2005. Subsequent
668 providers engaged in the provision of magnetic resonance imaging
669 services must be accredited by the American College of Radiology
670 or the Joint Commission on Accreditation of Health Care
671 Organizations within 18 months after the effective date of
672 registration.
673 (3)(a) Each clinic must employ or contract with a
674 physician maintaining a full and unencumbered physician license
675 in accordance with chapter 458, chapter 459, chapter 460, or
676 chapter 461 to serve as the medical director. However, if the
677 clinic is limited to providing health care services pursuant to
678 chapter 457, chapter 484, chapter 486, chapter 490, or chapter
679 491 or part I, part III, part X, part XIII, or part XIV of
680 chapter 468, the clinic may appoint a health care practitioner
681 licensed under that chapter to serve as a clinical director who
682 is responsible for the clinic's activities. A health care
683 practitioner may not serve as the clinical director if the

684 services provided at the clinic are beyond the scope of that
685 practitioner's license.
686 (b) The medical director or clinical director shall agree
687 in writing to accept legal responsibility for the following
688 activities on behalf of the clinic. The medical director or the
689 clinical director shall:
690 1. Have signs identifying the medical director or clinical
691 director posted in a conspicuous location within the clinic
692 readily visible to all patients.
693 2. Ensure that all practitioners providing health care
694 services or supplies to patients maintain a current active and
695 unencumbered Florida license.
696 3. Review any patient referral contracts or agreements
697 executed by the clinic.
698 4. Ensure that all health care practitioners at the clinic
699 have active appropriate certification or licensure for the level
700 of care being provided.
701 5. Serve as the clinic records holder as defined in s.
702 456.057.
703 6. Ensure compliance with the recordkeeping, office
704 surgery, and adverse incident reporting requirements of this
705 chapter, the respective practice acts, and rules adopted
706 thereunder.
707 7. Conduct systematic reviews of clinic billings to ensure
708 that the billings are not fraudulent or unlawful. Upon discovery
709 of an unlawful charge, the medical director shall take immediate
710 corrective action.
711 (c) Any contract to serve as a medical director or a
712 clinical director entered into or renewed by a physician or a
713 licensed health care practitioner in violation of this section

714 is void as contrary to public policy. This section shall apply
715 to contracts entered into or renewed on or after October 1,
716 2001.
717 (d) The department, in consultation with the boards, shall
718 adopt rules specifying limitations on the number of registered
719 clinics and licensees for which a medical director or a clinical
720 director may assume responsibility for purposes of this section.
721 In determining the quality of supervision a medical director or
722 a clinical director can provide, the department shall consider
723 the number of clinic employees, clinic location, and services
724 provided by the clinic.
725 (4)(a) Any person or entity providing medical services or
726 treatment that is not a clinic may voluntarily register its
727 exempt status with the department on a form that sets forth its
728 name or names and addresses, a statement of the reasons why it
729 is not a clinic, and such other information deemed necessary by
730 the department.
731 (b) The department shall adopt rules necessary to
732 implement the registration program, including rules establishing
733 the specific registration procedures, forms, and fees.
734 Registration fees must be reasonably calculated to cover the
735 cost of registration and must be of such amount that the total
736 fees collected do not exceed the cost of administering and
737 enforcing compliance with this section. Registration may be
738 conducted electronically.
739 (5)~~(4)~~(a) All charges or reimbursement claims made by or
740 on behalf of a clinic that is required to be registered under
741 this section, but that is not so registered, or that is
742 otherwise operating in violation of this section, are unlawful
743 charges and therefore are noncompensable and unenforceable.

744 (b) Any person establishing, operating, or managing an
745 unregistered clinic otherwise required to be registered under
746 this section, or any person who knowingly files a false or
747 misleading registration or false or misleading information
748 required by subsection (2), subsection (4), or department rule,
749 commits a felony of the third degree, punishable as provided in
750 s. 775.082, s. 775.083, or s. 775.084.
751 (c) Any licensed health care practitioner who violates
752 this section is subject to discipline in accordance with this
753 chapter and the respective practice act.
754 (d) The department shall revoke the registration of any
755 clinic registered under this section for operating in violation
756 of the requirements of this section or the rules adopted by the
757 department.
758 (e) The department shall investigate allegations of
759 noncompliance with this section and the rules adopted pursuant
760 to this section. The Division of Insurance Fraud of the
761 Department of Financial Services, at the request of the
762 department, may provide assistance in investigating allegations
763 of noncompliance with this section and the rules adopted
764 pursuant to this section.
765 (f) The department may make unannounced inspections of
766 clinics registered pursuant to this section to determine
767 compliance with this section.
768 (g) A clinic registered under this section shall allow
769 full and complete access to the premises and to billing records
770 or information to any representative of the department who makes
771 a request to inspect the clinic to determine compliance with
772 this section.

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773 (h) Failure by a clinic registered under this section to
774 allow full and complete access to the premises and to billing
775 records or information to any representative of the department
776 who makes a request to inspect the clinic to determine
777 compliance with this section or which fails to employ a
778 qualified medical director or clinical director shall constitute
779 a ground for emergency suspension of the registration by the
780 department pursuant to s. 120.60(6).
781 Section 7. Subsection (20) is added to section 456.057,
782 Florida Statutes, to read:
783 456.057 Ownership and control of patient records; report
784 or copies of records to be furnished.--
785 (20) Any health care practitioner required to retain
786 medical records pursuant to this section, after making a
787 physical or mental examination of, or administering treatment or
788 dispensing legend drugs to, any person pursuant to a claim of
789 injury under s. 627.736, shall keep on record a statement for
790 each visit to be signed by both the patient and the health care
791 practitioner at the time services are rendered. Such statement
792 shall be certified under oath, subject to the penalty of perjury
793 and prosecution for insurance fraud under s. 817.234, that the
794 services were in fact rendered for the patient on the date
795 certified, that the provider has complied and will comply with
796 the terms of s. 456.054, that the patient neither received nor
797 will receive remuneration in any form from the practitioner or
798 any other person for the visit, and that no other person was
799 compensated or will be compensated in any form for referring the
800 patient to the practitioner unless specifically permitted under
801 s. 456.054. Such statement shall also include the text of s.
802 456.054. In addition to the provisions of this section, any

803 statement signed pursuant to this subsection shall be made
804 available for inspection and copying upon request by the
805 Department of Financial Services, the Department of Health, the
806 applicable licensing board, the applicable insurance company to
807 which submission for payment has been made or will be made by
808 the practitioner or patient, the patient, and the patient's
809 legal representative.
810 Section 8. Paragraphs (dd) and (ee) are added to
811 subsection (1) of section 456.072, Florida Statutes, to read:
812 456.072 Grounds for discipline; penalties; enforcement.--
813 (1) The following acts shall constitute grounds for which
814 the disciplinary actions specified in subsection (2) may be
815 taken:
816 (dd) With respect to making a claim for personal injury
817 protection as required by s. 627.736:
818 1. Intentionally submitting a claim, statement, or bill
819 using a billing code that would result in payment greater in
820 amount than would be paid using a billing code that accurately
821 describes the actual services performed, which practice is
822 commonly referred to as "upcoding." Global diagnostic imaging
823 billing by the technical component provider is not considered
824 upcoding.
825 2. Intentionally filing a claim for payment of services
826 that were not performed.
827 3. Intentionally using information obtained in violation
828 of s. 119.105 or s. 316.066 to solicit or obtain patients
829 personally or through an agent, regardless of whether the
830 information is derived directly from an accident report, derived
831 from a summary of an accident report, from another person, or
832 otherwise.

833 4. Intentionally submitting a claim for a diagnostic
834 treatment or submitting a claim for a diagnostic treatment or
835 procedure that is properly billed under one billing code but
836 which has been separated into two or more billing codes, which
837 practice is commonly referred to as "unbundling."
838 (ee) Treating a person for injuries resulting from a
839 staged motor vehicle accident with knowledge that the person was
840 a participant in the staged motor vehicle accident.
841 Section 9. Subsection (8) is added to section 627.732,
842 Florida Statutes, to read:
843 627.732 Definitions.--As used in ss. 627.730-627.7405, the
844 term:
845 (8) "Global diagnostic imaging billing" means the
846 submission of a statement or bill related to the completion of a
847 diagnostic imaging test that includes a charge which encompasses
848 both the production of the diagnostic image, the "technical
849 component," and the interpretation of the diagnostic image, the
850 "professional component," whether or not the individual or
851 entity providing the professional component was performing these
852 services as an independent contractor or employee of the entity
853 providing the technical component.
854 Section 10. Paragraph (g) is added to subsection (4) of
855 section 627.736, Florida Statutes, and subsection (5), paragraph
856 (a) of subsection (7), subsection (8), paragraph (d) of
857 subsection (11), and subsection (12) of said section are
858 amended, to read:
859 627.736 Required personal injury protection benefits;
860 exclusions; priority; claims.--
861 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer
862 under ss. 627.730-627.7405 shall be primary, except that

863 benefits received under any workers' compensation law shall be
864 credited against the benefits provided by subsection (1) and
865 shall be due and payable as loss accrues, upon receipt of
866 reasonable proof of such loss and the amount of expenses and
867 loss incurred which are covered by the policy issued under ss.
868 627.730-627.7405. When the Agency for Health Care Administration
869 provides, pays, or becomes liable for medical assistance under
870 the Medicaid program related to injury, sickness, disease, or
871 death arising out of the ownership, maintenance, or use of a
872 motor vehicle, benefits under ss. 627.730-627.7405 shall be
873 subject to the provisions of the Medicaid program.
874 (g) Benefits shall not be due or payable to or on behalf
875 of an insured person if that person has committed, by a material
876 act or omission, any insurance fraud relating to personal injury
877 protection coverage under his or her policy if the fraud is
878 admitted to in a sworn statement by the insured or claimant or
879 is established in a court of competent jurisdiction. Any
880 insurance fraud shall void the policy in its entirety,
881 irrespective of whether a portion of the insured's or claimant's
882 claim may be legitimate, and any benefits paid prior to the
883 discovery of the insured's or claimant's insurance fraud shall
884 be recoverable in their entirety by the insurer from the insured
885 or claimant who perpetrated the fraud upon demand for such
886 benefits. An insurer shall be entitled to its costs and
887 attorney's fees in any action in which the insurer prevails in
888 enforcing its right of recovery under this paragraph.
889 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--
890 (a) Any physician, hospital, clinic, or other person or
891 institution lawfully rendering treatment to an injured person
892 for a bodily injury covered by personal injury protection

893 insurance may charge only a reasonable amount for the services
894 and supplies rendered, and the insurer providing such coverage
895 may pay for such charges directly to such person or institution
896 lawfully rendering such treatment, if the insured receiving such
897 treatment or his or her guardian has countersigned the invoice,
898 bill, or claim form approved by the Department of Insurance upon
899 which such charges are to be paid for as having actually been
900 rendered, to the best knowledge of the insured or his or her
901 guardian. In no event, however, may such a charge be in excess
902 of the amount the person or institution customarily charges for
903 like services or supplies in cases involving no insurance.
904 (b)1. An insurer or insured is not required to pay a claim
905 or charges:
906 a. Made by a broker or by a person making a claim on
907 behalf of a broker.
908 b. For services or treatment by a clinic as defined in s.
909 456.0375, if, at the time the service or treatment was rendered,
910 the clinic was not in compliance with any applicable provision
911 of that section or rules adopted under such section.
912 c. For services or treatment by a clinic, as defined in s.
913 456.0375, if, at the time the services or treatment were
914 rendered, a person who directly or indirectly owned or
915 controlled the clinic or had any interest in the clinic, or its
916 medical director, had been convicted of, or who, regardless of
917 adjudication of guilt, had pleaded guilty or nolo contendere to
918 a felony under federal law or the law of any state.
919 d. For any service or treatment that was not lawful at the
920 time it was rendered.

921 e. To any person or entity who knowingly submits false or
922 misleading statements and bills for medical services, or for any
923 statement or bill.
924 f. With respect to a bill or statement that does not meet
925 the applicable requirements of paragraph (e).
926 g. For any treatment or service that is miscoded, or that
927 is unbundled when such treatment or services should be bundled,
928 in accordance with applicable billing standards. To facilitate
929 prompt payment of lawful services, an insurer may change codes
930 that the insurer believes to have been improperly or incorrectly
931 upcoded or unbundled and may make payment based on the changed
932 code, without affecting the right of the provider to dispute the
933 change by the insurer. An insurer may not deny reimbursement for
934 global diagnostic imaging billing submitted by the provider of
935 the technical component.
936 h. For medical services or treatment unless such services
937 are rendered by the physician or are incident to professional
938 services and are included on the physician's bills. This sub-
939 subparagraph does not apply to services furnished in a licensed
940 health care facility or in an independent diagnostic testing
941 facility as defined in s. 456.0375.
942 2. Charges for medically necessary cephalic thermograms,
943 peripheral thermograms, spinal ultrasounds, extremity
944 ultrasounds, video fluoroscopy, and surface electromyography
945 shall not exceed the maximum reimbursement allowance for such
946 procedures as set forth in the applicable fee schedule or other
947 payment methodology established pursuant to s. 440.13.
948 3. Allowable amounts that may be charged to a personal
949 injury protection insurance insurer and insured for medically
950 necessary nerve conduction testing when done in conjunction with

951 a needle electromyography procedure and both are performed and
952 billed solely by a physician licensed under chapter 458, chapter
953 459, chapter 460, or chapter 461 who is also certified by the
954 American Board of Electrodiagnostic Medicine or by a board
955 recognized by the American Board of Medical Specialties or the
956 American Osteopathic Association or who holds diplomate status
957 with the American Chiropractic Neurology Board or its
958 predecessors shall not exceed 200 percent of the allowable
959 amount under Medicare Part B for year 2001, for the area in
960 which the treatment was rendered, adjusted annually by an
961 additional amount equal to the medical Consumer Price Index for
962 Florida.

963 4. Allowable amounts that may be charged to a personal
964 injury protection insurance insurer and insured for medically
965 necessary nerve conduction testing that does not meet the
966 requirements of subparagraph 3. shall not exceed the applicable
967 fee schedule or other payment methodology established pursuant
968 to s. 440.13.

969 5. Effective upon this act becoming a law and before
970 November 1, 2001, allowable amounts that may be charged to a
971 personal injury protection insurance insurer and insured for
972 magnetic resonance imaging services shall not exceed 200 percent
973 of the allowable amount under <u>the participating fee schedule of</u>
974 Medicare Part B for year 2001, for the area in which the
975 treatment was rendered. Beginning November 1, 2001, allowable
976 amounts that may be charged to a personal injury protection
977 insurance insurer and insured for magnetic resonance imaging
978 services shall not exceed 175 percent of the allowable amount
979 under <u>the participating fee schedule of</u> Medicare Part B for year
980 2001, for the area in which the treatment was rendered, adjusted

981 annually by an additional amount equal to the medical Consumer
982 Price Index for Florida based on the month of January for each
983 year, except that allowable amounts that may be charged to a
984 personal injury protection insurance insurer and insured for
985 magnetic resonance imaging services provided in facilities
986 accredited by the American College of Radiology or the Joint
987 Commission on Accreditation of Healthcare Organizations shall
988 not exceed 200 percent of the allowable amount under the
989 participating fee schedule of Medicare Part B for year 2001, for
990 the area in which the treatment was rendered, adjusted annually
991 by an additional amount equal to the medical Consumer Price
992 Index for Florida based on the month of January for each year.
993 Allowable amounts that may be charged to a personal injury
994 protection insurance insurer and insured for magnetic resonance
995 imaging services provided in facilities accredited by both the
996 American College of Radiology and the Joint Commission on
997 Accreditation of Health Care Organizations shall not exceed 225
998 percent of the allowable amount for Medicare Part B for 2001 for
999 the area in which the treatment was rendered, adjusted annually
1000 by an amount equal to the Consumer Price Index for Florida. This
1001 paragraph does not apply to charges for magnetic resonance
1002 imaging services and nerve conduction testing for inpatients and
1003 emergency services and care as defined in chapter 395 rendered
1004 by facilities licensed under chapter 395.
1005 (c)1. With respect to any treatment or service, other than
1006 medical services billed by a hospital or other provider for
1007 emergency services as defined in s. 395.002 or inpatient
1008 services rendered at a hospital-owned facility, the statement of
1009 charges must be furnished to the insurer by the provider and may
1010 not include, and the insurer is not required to pay, charges for

1011 treatment or services rendered more than 35 days before the
1012 postmark date of the statement, except for past due amounts
1013 previously billed on a timely basis under this paragraph~~, and~~
1014 ~~except that, if the provider submits to the insurer a notice of~~
1015 ~~initiation of treatment within 21 days after its first~~
1016 ~~examination or treatment of the claimant, the statement may~~
1017 ~~include charges for treatment or services rendered up to, but~~
1018 ~~not more than, 75 days before the postmark date of the~~
1019 ~~statement~~. The injured party is not liable for, and the provider
1020 shall not bill the injured party for, charges that are unpaid
1021 because of the provider's failure to comply with this paragraph.
1022 Any agreement requiring the injured person or insured to pay for
1023 such charges is unenforceable.
1024 2. If, however, the insured fails to furnish the provider
1025 with the correct name and address of the insured's personal
1026 injury protection insurer, or if the provider claims that the
1027 billing was lost in the mailing process, the provider has 35
1028 days from the date the provider obtains the correct information
1029 to furnish the insurer with a statement of the charges. In order
1030 to claim a right to receive payment for services that were not
1031 billed on a timely basis due to incorrect information provided
1032 by the insured or to the billing being lost in the mailing
1033 process, a medical provider must demonstrate a documented
1034 diligent effort to ascertain the correct personal injury
1035 protection insurer, which shall include, but not be limited to,
1036 verification of the name, address, and telephone number of the
1037 insurer, as opposed to an insurance agency, as soon as
1038 practicable. The insurer is not required to pay for such charges
1039 unless the provider includes with the statement documentary
1040 evidence that was provided by the insured during the 35-day

1041 period demonstrating that the provider reasonably relied on
1042 erroneous information from the insured, or the billing was lost
1043 in the mailing process, and either:
1044 a.~~1.~~ A denial letter from the incorrect insurer; or
1045 b.~~2.~~ Proof of mailing, which may include an affidavit
1046 under penalty of perjury, reflecting timely mailing to the
1047 incorrect address or insurer, or timely mailing to the correct
1048 address of the insurer where it is claimed the billing was lost
1049 in the mailing process.
1050 3. For emergency services and care as defined in s.
1051 395.002 rendered in a hospital emergency department or for
1052 transport and treatment rendered by an ambulance provider
1053 licensed pursuant to part III of chapter 401, the provider is
1054 not required to furnish the statement of charges within the time
1055 periods established by this paragraph; and the insurer shall not
1056 be considered to have been furnished with notice of the amount
1057 of covered loss for purposes of paragraph (4)(b) until it
1058 receives a statement complying with paragraph (d)~~(e)~~, or copy
1059 thereof, which specifically identifies the place of service to
1060 be a hospital emergency department or an ambulance in accordance
1061 with billing standards recognized by the Health Care Finance
1062 Administration.
1063 4. Each notice of insured's rights under s. 627.7401 must
1064 include the following statement in type no smaller than 12
1065 points:
1066 BILLING REQUIREMENTS.--Florida Statutes provide that with
1067 respect to any treatment or services, other than certain
1068 hospital and emergency services, the statement of charges
1069 furnished to the insurer by the provider may not include, and
1070 the insurer and the injured party are not required to pay,

1071 charges for treatment or services rendered more than 35 days
1072 before the postmark date of the statement, except for past due
1073 amounts previously billed on a timely basis~~, and except that, if~~
1074 ~~the provider submits to the insurer a notice of initiation of~~
1075 ~~treatment within 21 days after its first examination or~~
1076 ~~treatment of the claimant, the statement may include charges for~~
1077 ~~treatment or services rendered up to, but not more than, 75 days~~
1078 ~~before the postmark date of the statement~~.
1079 ~~(d) Every insurer shall include a provision in its policy~~
1080 ~~for personal injury protection benefits for binding arbitration~~
1081 ~~of any claims dispute involving medical benefits arising between~~
1082 ~~the insurer and any person providing medical services or~~
1083 ~~supplies if that person has agreed to accept assignment of~~
1084 ~~personal injury protection benefits. The provision shall specify~~
1085 ~~that the provisions of chapter 682 relating to arbitration shall~~
1086 ~~apply. The prevailing party shall be entitled to attorney's fees~~
1087 ~~and costs. For purposes of the award of attorney's fees and~~
1088 ~~costs, the prevailing party shall be determined as follows:~~
1089 ~~1. When the amount of personal injury protection benefits~~
1090 ~~determined by arbitration exceeds the sum of the amount offered~~
1091 ~~by the insurer at arbitration plus 50 percent of the difference~~
1092 ~~between the amount of the claim asserted by the claimant at~~
1093 ~~arbitration and the amount offered by the insurer at~~
1094 ~~arbitration, the claimant is the prevailing party.~~
1095 ~~2. When the amount of personal injury protection benefits~~
1096 ~~determined by arbitration is less than the sum of the amount~~
1097 ~~offered by the insurer at arbitration plus 50 percent of the~~
1098 ~~difference between the amount of the claim asserted by the~~
1099 ~~claimant at arbitration and the amount offered by the insurer at~~
1100 ~~arbitration, the insurer is the prevailing party.~~

1101 ~~3. When neither subparagraph 1. nor subparagraph 2.~~
1102 ~~applies, there is no prevailing party. For purposes of this~~
1103 ~~paragraph, the amount of the offer or claim at arbitration is~~
1104 ~~the amount of the last written offer or claim made at least 30~~
1105 ~~days prior to the arbitration.~~
1106 ~~4. In the demand for arbitration, the party requesting~~
1107 ~~arbitration must include a statement specifically identifying~~
1108 ~~the issues for arbitration for each examination or treatment in~~
1109 ~~dispute. The other party must subsequently issue a statement~~
1110 ~~specifying any other examinations or treatment and any other~~
1111 ~~issues that it intends to raise in the arbitration. The parties~~
1112 ~~may amend their statements up to 30 days prior to arbitration,~~
1113 ~~provided that arbitration shall be limited to those identified~~
1114 ~~issues and neither party may add additional issues during~~
1115 ~~arbitration.~~
1116 (d)~~(e)~~ All statements and bills for medical services
1117 rendered by any physician, hospital, clinic, or other person or
1118 institution shall be submitted to the insurer on a properly
1119 completed Centers for Medicare and Medicaid Services (CMS)
1120 ~~Health Care Finance Administration~~ 1500 form, UB 92 forms, or
1121 any other standard form approved by the department for purposes
1122 of this paragraph. All billings for such services by
1123 noninstitutional providers shall, to the extent applicable,
1124 follow the Physicians' Current Procedural Terminology (CPT) or
1125 Healthcare Correct Procedural Coding System (HCPCS) in effect
1126 for the year in which services are rendered, and comply with the
1127 Centers for Medicare and Medicaid Services (CMS) 1500 form
1128 instructions and the American Medical Association Current
1129 Procedural Terminology (CPT) Editorial Panel and Healthcare
1130 Correct Procedural Coding System (HCPCS). In determining

1131 compliance with applicable CPT and HCPCS coding, guidance shall
1132 be provided by the Physicians' Current Procedural Terminology
1133 (CPT) or Healthcare Correct Procedural Coding System (HCPCS) in
1134 effect for the year in which services were rendered, the Officer
1135 of the Inspector General (OIG), Physicians Compliance
1136 Guidelines, and other authoritative treatises. No statement of
1137 medical services may include charges for medical services of a
1138 person or entity that performed such services without possessing
1139 the valid licenses required to perform such services. For
1140 purposes of paragraph (4)(b), an insurer shall not be considered
1141 to have been furnished with notice of the amount of covered loss
1142 or medical bills due unless the statements or bills comply with
1143 this paragraph, and unless the statements or bills are properly
1144 completed in their entirety with all information being provided
1145 in such statements or bills, which means that the statement or
1146 bill contains all of the information required by the Centers for
1147 Medicare and Medicaid Services (CMS) 1500 form instructions and
1148 the American Medical Association Current Procedural Terminology
1149 Editorial Panel and Healthcare Correct Procedural Coding System.
1150 An insurer shall not deny or reduce claims based upon compliance
1151 with s. 456.0375(2)(d) unless the insurer can show the required
1152 certification was not provided to the insurer.
1153 (e)1. Every physician, clinic, or other medical
1154 institution, except for an independent diagnostic testing
1155 facility as defined in s. 456.0375 or a facility licensed under
1156 chapter 395, providing medical services upon which a claim for
1157 personal injury protection benefits is based shall require an
1158 insured person to execute a disclosure and acknowledgment form,
1159 which reflects at a minimum that:

1160 a. The insured, or his or her guardian, must countersign
1161 the form approved by the department attesting to the fact that
1162 the charges set forth therein are for services that were
1163 actually rendered.
1164 b. The insured, or his or her guardian, has both the right
1165 and the affirmative duty to confirm that any charges are for
1166 services actually rendered.
1167 c. The medical provider must fully and completely explain
1168 any and all Current Procedural Terminology (CPT) codes or any
1169 other information set forth on the billing form so that the
1170 countersignature of the insured, or his or her guardian, is
1171 provided with informed consent.
1172 d. The insured, or his or her guardian, was not solicited
1173 by any person to seek any services from the medical provider.
1174 e. Any misrepresentation by the insured, or his or her
1175 guardian shall be under penalty of perjury and may subject the
1176 insured person, or his or her guardian to arrest, prosecution,
1177 and conviction for insurance fraud.
1178 2. The department shall adopt a standard disclosure and
1179 acknowledgment form which shall be used to fulfill the
1180 requirements of this section.
1181 3. The licensed medical professional rendering treatment
1182 for which payment is being claimed must sign, by his or her own
1183 hand, the form approved by the department.
1184 (f) An insurer may not change a diagnosis or diagnosis
1185 code on a claim submitted by a health care provider without the
1186 consent of the health care provider. Such action constitutes a
1187 material misrepresentation under s. 626.9541(1)(i)2.
1188 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1189 REPORTS.--

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

1190 (a) Whenever the mental or physical condition of an
1191 injured person covered by personal injury protection is material
1192 to any claim that has been or may be made for past or future
1193 personal injury protection insurance benefits, such person
1194 shall, upon the request of an insurer, submit to mental or
1195 physical examination by a physician or physicians. The costs of
1196 any examinations requested by an insurer shall be borne entirely
1197 by the insurer. Such examination shall be conducted within the
1198 municipality where the insured is receiving treatment, or in a
1199 location reasonably accessible to the insured, which, for
1200 purposes of this paragraph, means any location within the
1201 municipality in which the insured resides, or any location
1202 within 10 miles by road of the insured's residence, provided
1203 such location is within the county in which the insured resides.
1204 If the examination is to be conducted in a location reasonably
1205 accessible to the insured, and if there is no qualified
1206 physician to conduct the examination in a location reasonably
1207 accessible to the insured, then such examination shall be
1208 conducted in an area of the closest proximity to the insured's
1209 residence. Personal protection insurers are authorized to
1210 include reasonable provisions in personal injury protection
1211 insurance policies for mental and physical examination of those
1212 claiming personal injury protection insurance benefits. An
1213 insurer may not withdraw payment of a treating physician without
1214 the consent of the injured person covered by the personal injury
1215 protection, unless the insurer first obtains a valid report by a
1216 physician licensed under the same chapter as the treating
1217 physician whose treatment authorization is sought to be
1218 withdrawn, stating that treatment was not reasonable, related,
1219 or necessary. A valid report is one that is prepared and signed

1220 by the physician examining the injured person or reviewing the
1221 treatment records of the injured person and is factually
1222 supported by the examination and treatment records if reviewed
1223 and that has not been modified by anyone other than the
1224 physician. The physician preparing the report must be in active
1225 practice, unless the physician is physically disabled. Active
1226 practice means that for ~~during the~~ 3 consecutive years
1227 immediately preceding the date of the physical examination or
1228 review of the treatment records the physician must have devoted
1229 professional time to the active clinical practice of evaluation,
1230 diagnosis, or treatment of medical conditions or to the
1231 instruction of students in an accredited health professional
1232 school or accredited residency program or a clinical research
1233 program that is affiliated with an accredited health
1234 professional school or teaching hospital or accredited residency
1235 program. The physician preparing a report at the request of an
1236 insurer, or on behalf of an insurer through an attorney or
1237 another entity, shall maintain, for at least 3 years, copies of
1238 all examination reports as medical records and shall maintain,
1239 for at least 3 years, records of all payments for the
1240 examinations and reports. Neither an insurer nor any person
1241 acting at the direction of or on behalf of an insurer may change
1242 an opinion in a report prepared under this paragraph or direct
1243 the physician preparing the report to change such opinion. The
1244 denial of a payment as the result of such a changed opinion
1245 constitutes a material misrepresentation under s.
1246 626.9541(1)(i)2.
1247 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
1248 FEES.--With respect to any dispute under the provisions of ss.
1249 627.730-627.7405 between the insured and the insurer, or between

1250 an assignee of an insured's rights and the insurer, the
1251 provisions of s. 627.428 shall apply, except as provided in
1252 subsection (11), provided a court must receive evidence and
1253 consider the following factors prior to awarding any multiplier:
1254 (a) Whether the relevant market requires a contingency fee
1255 multiplier to obtain competent counsel.
1256 (b) Whether the attorney was able to mitigate the risk of
1257 nonpayment in any way.
1258 (c) Whether any of the following factors are applicable:
1259 1. The time and labor required, the novelty and difficulty
1260 of the question involved, and the skill requisite to perform the
1261 legal service properly.
1262 2. The likelihood, if apparent to the client, that the
1263 acceptance of the particular employment will preclude other
1264 employment by the lawyer.
1265 3. The fee customarily charged in the locality for similar
1266 legal services.
1267 4. The amount involved and the results obtained.
1268 5. The time limitations imposed by the client or by the
1269 circumstances.
1270 6. The nature and length of the professional relationship
1271 with the client.
1272 7. The experience, reputation, and ability of the lawyer
1273 or lawyers performing the services.
1274 8. Whether the fee is fixed or contingent.
1275
1276 If the court determines, pursuant to this subsection, that a
1277 multiplier is appropriate, and if the court determines that
1278 success was more likely than not at the outset, the court may
1279 apply a multiplier of 1 to 1.5; if the court determines that the

1280 likelihood of success was approximately even at the outset, the
1281 court may apply a multiplier of 1.5 to 2.0; and if the court
1282 determines that success was unlikely at the outset of the case,
1283 the court may apply a multiplier of 2.0 to 2.5.
1284 (11) DEMAND LETTER.--
1285 (d) If, within 10 7 business days after receipt of notice
1286 by the insurer, the overdue claim specified in the notice is
1287 paid by the insurer together with applicable interest and a
1288 penalty of 10 percent of the overdue amount paid by the insurer,
1289 subject to a maximum penalty of $250, no action for nonpayment
1290 or late payment may be brought against the insurer. To the
1291 extent the insurer determines not to pay the overdue amount, the
1292 penalty shall not be payable in any action for nonpayment or
1293 late payment. For purposes of this subsection, payment shall be
1294 treated as being made on the date a draft or other valid
1295 instrument that is equivalent to payment is placed in the United
1296 States mail in a properly addressed, postpaid envelope, or if
1297 not so posted, on the date of delivery. The insurer shall not be
1298 obligated to pay any attorney's fees if the insurer pays the
1299 claim within the time prescribed by this subsection.
1300 (12) CIVIL ACTION FOR INSURANCE FRAUD.—
1301 (a) An insurer and an insured shall have a cause of action
1302 against any person who has committed convicted of, or who,
1303 regardless of adjudication of guilt, pleads guilty or nolo
1304 contendere to insurance fraud under s. 817.234, patient
1305 brokering under s. 817.505, or kickbacks under s. 456.054,
1306 associated with a claim for personal injury protection benefits
1307 in accordance with this section. An insurer or an insured
1308 prevailing in an action brought under this subsection may
1309 recover treble compensatory damages, consequential damages, and

1310 punitive damages subject to the requirements and limitations of
1311 part II of chapter 768, and attorney's fees and costs incurred
1312 in litigating a cause of action under ~~against any person~~
1313 ~~convicted of, or who, regardless of adjudication of guilt,~~
1314 ~~pleads guilty or nolo contendere to insurance fraud under s.~~
1315 ~~817.234, patient brokering under s. 817.505, or kickbacks under~~
1316 ~~s. 456.054, associated with a claim for personal injury~~
1317 ~~protection benefits in accordance with~~ this section.
1318 (b) Notwithstanding its payment, neither an insurer nor an
1319 insured shall be precluded from maintaining a civil cause of
1320 action against any person or business entity to recover payment
1321 for services later determined to have not been lawfully rendered
1322 or otherwise in violation of any provision of this section.
1323 Section 11. Paragraph (a) of subsection (1) of section
1324 627.745, Florida Statutes, is amended to read:
1325 627.745 Mediation of claims.--
1326 (1)(a) In any claim filed with an insurer for personal
1327 injury ~~in an amount of $10,000 or less~~ or any claim for property
1328 damage in any amount, arising out of the ownership, operation,
1329 use, or maintenance of a motor vehicle, either party may demand
1330 mediation of the claim prior to the institution of litigation.
1331 Section 12. Section 627.747, Florida Statutes, is created
1332 to read:
1333 627.747 Legislative oversight; reporting of
1334 information.--In order to ensure continuing legislative
1335 oversight of motor vehicle insurance in general and the personal
1336 injury protection system in particular, the following agencies
1337 shall, on January 1 and July 1 of each year, provide the
1338 information required by this section to the President of the
1339 Senate, the Speaker of the House of Representatives, the

1340 minority party leaders of the Senate and the House of
1341 Representatives, and the chairs of the standing committees of
1342 the Senate and the House of Representatives having authority
1343 over insurance matters.
1344 (1) The Office of Insurance Regulation of the Financial
1345 Services Commission shall provide data and analysis on motor
1346 vehicle insurance loss cost trends and premium trends, together
1347 with such other information as the office deems appropriate to
1348 enable the Legislature to evaluate the effectiveness of the
1349 reforms contained in the Florida Motor Vehicle Insurance
1350 Affordability Reform Act of 2003, and such other information as
1351 may be requested from time to time by any of the officers
1352 referred to in this section.
1353 (2) The Division of Insurance Fraud of the Department of
1354 Financial Services shall provide data and analysis on the
1355 incidence and cost of motor vehicle insurance fraud, including
1356 violations, investigations, and prosecutions, together with such
1357 other information as the division deems appropriate to enable
1358 the Legislature to evaluate the effectiveness of the reforms
1359 contained in the Florida Motor Vehicle Insurance Affordability
1360 Reform Act of 2003, and such other information as may be
1361 requested from time to time by any of the officers referred to
1362 in this section.
1363 Section 13. Subsection (1) of section 768.79, Florida
1364 Statutes, is amended to read:
1365 768.79 Offer of judgment and demand for judgment.--
1366 (1)(a) In any civil action for damages filed in the courts
1367 of this state, if a defendant files an offer of judgment which
1368 is not accepted by the plaintiff within 30 days, the defendant
1369 shall be entitled to recover reasonable costs and attorney's

1370 fees incurred by her or him or on the defendant's behalf
1371 pursuant to a policy of liability insurance or other contract
1372 from the date of filing of the offer if the judgment is one of
1373 no liability or the judgment obtained by the plaintiff is at
1374 least 25 percent less than such offer, and the court shall set
1375 off such costs and attorney's fees against the award. Where such
1376 costs and attorney's fees total more than the judgment, the
1377 court shall enter judgment for the defendant against the
1378 plaintiff for the amount of the costs and fees, less the amount
1379 of the plaintiff's award. If a plaintiff files a demand for
1380 judgment which is not accepted by the defendant within 30 days
1381 and the plaintiff recovers a judgment in an amount at least 25
1382 percent greater than the offer, she or he shall be entitled to
1383 recover reasonable costs and attorney's fees incurred from the
1384 date of the filing of the demand. If rejected, neither an offer
1385 nor demand is admissible in subsequent litigation, except for
1386 pursuing the penalties of this section.
1387 (b) This section also applies to any action filed in
1388 relation to s. 627.736 in any court. A filing that complies with
1389 this section does not constitute an admission of coverage and an
1390 insurer shall not be estopped from denying coverage, denying
1391 liability, or defending against any claim on the merits as a
1392 result of an offer of judgment under this section.
1393 Section 14. Subsections (8) and (9) of section 817.234,
1394 Florida Statutes, are amended to read:
1395 817.234 False and fraudulent insurance claims.--
1396 (8)(a)1. It is unlawful for any person, intending to
1397 defraud any other person, ~~in his or her individual capacity or~~
1398 ~~in his or her capacity as a public or private employee, or for~~
1399 ~~any firm, corporation, partnership, or association,~~ to solicit

1400 or cause to be solicited any business from a person involved in
1401 a motor vehicle accident ~~by any means of communication other~~
1402 ~~than advertising directed to the public~~ for the purpose of
1403 making motor vehicle tort claims or claims for personal injury
1404 protection benefits required by s. 627.736. ~~Charges for any~~
1405 ~~services rendered by a health care provider or attorney who~~
1406 ~~violates this subsection in regard to the person for whom such~~
1407 ~~services were rendered are noncompensable and unenforceable as a~~
1408 ~~matter of law.~~ Any person who violates the provisions of this
1409 paragraph ~~subsection~~ commits a felony of the second ~~third~~
1410 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1411 775.084. Such person shall be sentenced to a minimum term of
1412 imprisonment of 2 years.
1413 2. Notwithstanding the provisions of s. 948.01 with
1414 respect to any person who is found to have violated this
1415 paragraph, adjudication of guilt or imposition of sentence shall
1416 not be suspended, deferred, or withheld nor shall such person be
1417 eligible for parole prior to serving the mandatory minimum term
1418 of imprisonment prescribed by this paragraph. A person sentenced
1419 to a mandatory term of imprisonment under this paragraph is not
1420 eligible for any form of discretionary early release, except
1421 pardon or executive clemency or conditional medical release
1422 under s. 947.149, prior to serving the mandatory minimum term of
1423 imprisonment.
1424 3. The state attorney may move the sentencing court to
1425 reduce or suspend the sentence of any person who is convicted of
1426 a violation of this paragraph and who provides substantial
1427 assistance in the identification, arrest, or conviction of any
1428 of that person's accomplices, accessories, coconspirators, or
1429 principals. The arresting agency shall be given an opportunity

1430 to be heard in aggravation or mitigation in reference to any
1431 such motion. Upon good cause shown, the motion may be filed and
1432 heard in camera. The judge hearing the motion may reduce or
1433 suspend the sentence if the judge finds that the defendant
1434 rendered such substantial assistance.
1435 (b)1. It is unlawful for any person to solicit or cause to
1436 be solicited any business from a person involved in a motor
1437 vehicle accident, by any means of communication other than
1438 advertising directed to the public, for the purpose of making
1439 motor vehicle tort claims or claims for personal injury
1440 protection benefits required by s. 627.736, within 60 days after
1441 the occurrence of the motor vehicle accident. Any person who
1442 violates the provisions of this subparagraph commits a felony of
1443 the third degree, punishable as provided in s. 775.082, s.
1444 775.083, or s. 775.084.
1445 2. It is unlawful for any attorney, or health care
1446 practitioner as defined in s. 456.001, at any time after 60 days
1447 have elapsed from the occurrence of a motor vehicle accident, to
1448 solicit or cause to be solicited any business from a person
1449 involved in a motor vehicle accident, by means of any personal
1450 or telephone contact at the person's residence, other than by
1451 mail or by advertising directed to the public, for the purpose
1452 of making motor vehicle tort claims or claims for personal
1453 injury protection benefits required by s. 627.736. Any person
1454 who violates the provisions of this subparagraph commits a
1455 felony of the third degree, punishable as provided in s.
1456 775.082, s. 775.083, or s. 775.084.
1457 (c) Charges for any services rendered by any person who
1458 violates this subsection in regard to the person for whom such

1459 services were rendered are noncompensable and unenforceable as a
1460 matter of law.
1461 (9)(a) It is unlawful for any person to organize, plan, or
1462 in any way participate in an intentional motor vehicle crash
1463 ~~attorney to solicit any business relating to the representation~~
1464 ~~of a person involved in a motor vehicle accident for the purpose~~
1465 ~~of filing a motor vehicle tort claim or a claim for personal~~
1466 ~~injury protection benefits required by s. 627.736. The~~
1467 ~~solicitation by advertising of any business by an attorney~~
1468 ~~relating to the representation of a person injured in a specific~~
1469 ~~motor vehicle accident is prohibited by this section~~. Any person
1470 ~~attorney~~ who violates the provisions of this subsection commits
1471 a felony of the second ~~third~~ degree, punishable as provided in
1472 s. 775.082, s. 775.083, or s. 775.084. Such person shall be
1473 sentenced to a minimum term of imprisonment of 2 years.
1474 (b) Notwithstanding the provisions of s. 948.01, with
1475 respect to any person who is found to have violated this
1476 subsection, adjudication of guilt or imposition of sentence
1477 shall not be suspended, deferred, or withheld nor shall such
1478 person be eligible for parole prior to serving the mandatory
1479 minimum term of imprisonment prescribed by this subsection. A
1480 person sentenced to a mandatory minimum term of imprisonment
1481 under this subsection is not eligible for any form of
1482 discretionary early release, except pardon, executive clemency,
1483 or conditional medical release under s. 947.149, prior to
1484 serving the mandatory minimum term of imprisonment.
1485 (c) The state attorney may move the sentencing court to
1486 reduce or suspend the sentence of any person who is convicted of
1487 a violation of this subsection and who provides substantial
1488 assistance in the identification, arrest, or conviction of any

1489 of that person's accomplices, accessories, coconspirators, or
1490 principals. The arresting agency shall be given an opportunity
1491 to be heard in aggravation or mitigation in reference to any
1492 such motion. Upon good cause shown, the motion may be filed and
1493 heard in camera. The judge hearing the motion may reduce or
1494 suspend the sentence if the judge finds that the defendant
1495 rendered such substantial assistance.
1496 (d) In addition to any other remedies provided by this
1497 act, any person convicted under this subsection shall be
1498 required to pay restitution in the sums shown by a court of
1499 competent jurisdiction to have been obtained in violation of any
1500 provisions of this act. Such restitution shall be payable to the
1501 Department of Financial Services and deposited in a designated
1502 insurance fraud fund, as established by the Department of
1503 Financial Services for the benefit of the Division of Insurance
1504 Fraud. ~~Whenever any circuit or special grievance committee~~
1505 ~~acting under the jurisdiction of the Supreme Court finds~~
1506 ~~probable cause to believe that an attorney is guilty of a~~
1507 ~~violation of this section, such committee shall forward to the~~
1508 ~~appropriate state attorney a copy of the finding of probable~~
1509 ~~cause and the report being filed in the matter. This section~~
1510 ~~shall not be interpreted to prohibit advertising by attorneys~~
1511 ~~which does not entail a solicitation as described in this~~
1512 ~~subsection and which is permitted by the rules regulating The~~
1513 ~~Florida Bar as promulgated by the Florida Supreme Court.~~
1514 Section 15. Section 817.236, Florida Statutes, is amended
1515 to read:
1516 817.236 False and fraudulent motor vehicle insurance
1517 application.--Any person who, with intent to injure, defraud, or
1518 deceive any motor vehicle insurer, including any statutorily

1519 created underwriting association or pool of motor vehicle
1520 insurers, presents or causes to be presented any written
1521 application, or written statement in support thereof, for motor
1522 vehicle insurance knowing that the application or statement
1523 contains any false, incomplete, or misleading information
1524 concerning any fact or matter material to the application
1525 commits a felony ~~misdemeanor~~ of the third ~~first~~ degree,
1526 punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s.
1527 775.084.
1528 Section 16. Section 817.2361, Florida Statutes, is created
1529 to read:
1530 817.2361 False or fraudulent motor vehicle insurance
1531 card.--Any person who, with intent to deceive any other person,
1532 creates, markets, or presents a false or fraudulent motor
1533 vehicle insurance card commits a felony of the third degree,
1534 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
1535 Section 17. Section 817.413, Florida Statutes, is created
1536 to read:
1537 817.413 Sale of used motor vehicle goods as new;
1538 penalty.--
1539 (1) With respect to a transaction for which any charges
1540 will be paid from the proceeds of a motor vehicle insurance
1541 policy and in which the purchase price of motor vehicle goods
1542 exceeds $100, it is unlawful for the seller to misrepresent
1543 orally, in writing, or by failure to speak that the goods are
1544 new or original when they are used or repossessed or have been
1545 used for sales demonstration.
1546 (2) A person who violates the provisions of this section
1547 commits a felony of the third degree, punishable as provided in
1548 s. 775.082, s. 775.083, or s. 775.084.

1549 Section 18. Section 860.15, Florida Statutes, is amended
1550 to read:
1551 860.15 Overcharging for repairs and parts; penalty.--
1552 (1) It is unlawful for a person to knowingly charge for
1553 any services on motor vehicles which are not actually performed,
1554 to knowingly and falsely charge for any parts and accessories
1555 for motor vehicles not actually furnished, or to knowingly and
1556 fraudulently substitute parts when such substitution has no
1557 relation to the repairing or servicing of the motor vehicle.
1558 (2) Any person willfully violating the provisions of this
1559 section shall be guilty of a misdemeanor of the second degree,
1560 punishable as provided in s. 775.082 or s. 775.083.
1561 (3) If the charges referred to in subsection (1) will be
1562 paid from the proceeds of a motor vehicle insurance policy, a
1563 person who willfully violates the provisions of this section
1564 commits a felony of the third degree, punishable as provided in
1565 s. 775.082, s. 775.083, or s. 775.084.
1566 Section 19. Paragraphs (c) and (e) of subsection (3) of
1567 section 921.0022, Florida Statutes, are amended to read:
1568 921.0022 Criminal Punishment Code; offense severity
1569 ranking chart.--
1570 (3) OFFENSE SEVERITY RANKING CHART

Florida Statute	Felony Degree	Description
1571	(c) LEVEL 3	
1572 119.10(3)	3rd	Unlawful use of confidential information from police reports.
1573 316.066(3)(d)-	3rd	Unlawfully obtaining or using

	(f)		confidential crash reports.
1574	316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
1575	316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in marked patrol vehicle with siren and lights activated.
1576	319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
1577	319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
1578	319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
1579	319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
1580	327.35(2)(b)	3rd	Felony BUI.
1581	328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
1582	328.07(4)	3rd	Manufacture, exchange, or possess

			vessel with counterfeit or wrong ID number.
1583	376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
1584	456.0375(4)(b)	3rd	Operating a clinic without registration or filing false registration or other required information.
1585	501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
1586	697.08	3rd	Equity skimming.
1587	790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
1588	796.05(1)	3rd	Live on earnings of a prostitute.
1589	806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
1590	806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
1591	810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with

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			firearm or dangerous weapon.
1592	812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
1593	812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
1594	815.04(4)(b)	2nd	Computer offense devised to defraud or obtain property.
1595	817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
1596	817.233	3rd	Burning to defraud insurer.
1597	817.234(8)(b)&(9)	3rd	Certain unlawful solicitation of persons involved in motor vehicle accidents.
1598	817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
1599	817.236	3rd	False and fraudulent motor vehicle insurance application.
1600	817.2361	3rd	False and fraudulent motor vehicle insurance card.
1601	817.413	3rd	Sale of used motor vehicle goods as new.

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1602	817.505(4)	3rd	Patient brokering.
1603	828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
1604	831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
1605	831.29	2nd	Possession of instruments for counterfeiting drivers' licenses or identification cards.
1606	838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
1607	843.19	3rd	Injure, disable, or kill police dog or horse.
1608	860.15(3)	3rd	Overcharging for motor vehicle repairs and parts; insurance involved.
1609	870.01(2)	3rd	Riot; inciting or encouraging.
1610	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),

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			or (4) drugs).
1611	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.
1612	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.
1613	893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
1614	893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
1615	893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
1616	893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
1617	893.13(7)(a)11.	3rd	Furnish false or fraudulent

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			material information on any document or record required by chapter 893.
1618	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.
1619	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.
1620	893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
1621	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.
1622	918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.

1623

944.47(1)(a)1.-2.	3rd	Introduce contraband to correctional facility.

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944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.

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985.3141	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

1626

(e) LEVEL 5

1627

316.027(1)(a)	3rd	Accidents involving personal injuries, failure to stop; leaving scene.

1628

316.1935(4)	2nd	Aggravated fleeing or eluding.

1629

322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.

1630

327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.

1631

381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.

1632

790.01(2)	3rd	Carrying a concealed firearm.

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790.162	2nd	Threat to throw or discharge

			destructive device.
1634	790.163(1)	2nd	False report of deadly explosive or weapon of mass destruction.
1635	790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
1636	790.23	2nd	Felons in possession of firearms or electronic weapons or devices.
1637	800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years.
1638	800.04(7)(c)	2nd	Lewd or lascivious exhibition; offender 18 years or older.
1639	806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
1640	812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
1641	812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
1642	812.019(1)	2nd	Stolen property; dealing in or trafficking in.
1643	812.131(2)(b)	3rd	Robbery by sudden snatching.
1644			

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	812.16(2)	3rd	Owning, operating, or conducting a chop shop.
1645	817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
1646	817.234(8)(a)	2nd	Unlawful solicitation of persons involved in motor vehicle accidents intending to defraud.
1647	817.234(9)	2nd	Intentional motor vehicle crashes.
1648	817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
1649	817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $75,000 or more.
1650	817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device or reencoder.
1651	825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
1652	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes

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			sexual conduct by a child.
1653	839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
1654	843.01	3rd	Resist officer with violence to person; resist arrest with violence.
1655	874.05(2)	2nd	Encouraging or recruiting another to join a criminal street gang; second or subsequent offense.
1656	893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
1657	893.13(1)(c)2.	2nd	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) within 1,000 feet of a child care facility or school.
1658	893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs) within 200 feet of

		university or public park.
893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under 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) within 1,000 feet of property used for religious services or a specified business site.
893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)4. drugs) within 200 feet of public housing facility.
893.13(4)(b)	2nd	Deliver to minor 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).

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1663 Section 20. The amendment to s. 456.0375(1)(b)1., Florida
1664 Statutes, in this act is intended to clarify the legislative
1665 intent of that provision as it existed at the time the provision
1666 initially took effect. Accordingly, the amendment to s.
1667 456.0375(1)(b)1., Florida Statutes, in this act shall operate
1668 retroactively to October 1, 2001.
1669 Section 21. The Office of Insurance Regulation is directed
1670 to undertake and complete not later than January 1, 2004, a

1671 report to the Speaker of the House of Representatives and the
1672 President of the Senate evaluating the costs citizens of this
1673 state are required to pay for the private passenger automobile
1674 insurance that is presently mandated by law, in relation to the
1675 benefits of such mandates to citizens of this state. Such report
1676 shall include, but not be limited to, an evaluation of the costs
1677 and benefits of the Florida Motor Vehicle No-Fault Law.
1678 (1) Effective October 1, 2005, sections 627.730, 627.731,
1679 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401,
1680 627.7403, and 627.7405, Florida Statutes, constituting the
1681 Florida Motor Vehicle No-Fault Law, are repealed, unless
1682 reenacted by Legislature during the 2004 Regular Session and
1683 such reenactment becomes law to take effect for policies issued
1684 or renewed on or after October 1, 2004.
1685 (2) Insurers are authorized to provide, in all policies
1686 issues or renewed after October 1, 2003, that such policies may
1687 terminate on or after October 1, 2005, as provided in subsection
1688 (1).
1689 Section 22. Except as otherwise provided herein, this act
1690 shall take effect upon becoming a law.

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