Amendment No. (for drafter’s use only)

CHAMBER ACTION

Senate	House
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Representative Seiler offered the following:

Amendment

Remove line(s) 901-1675, and insert:

Section 8. Subsections (4), (5), (6), (7), (8), (10), and (12) of section 627.736, Florida Statutes, are amended, present subsection (13) is renumbered as subsection (14), and a new subsection (13) is added to said section, to read:

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

(4) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss.

627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

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

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and

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

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

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

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant

of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

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

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

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

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

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

(e) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata

share of the benefits paid and expenses incurred in processing the claim.

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

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

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

(a) Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and

supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the Department of Insurance upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies ~~in cases involving no insurance~~. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

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

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

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

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

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

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good-faith effort to do so, as documented in the insurer's file; and

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

2. Charges for medically necessary cephalic thermograms, peripheral thermograms, spinal ultrasounds, extremity ultrasounds, video fluoroscopy, and surface electromyography shall not exceed the maximum reimbursement allowance for such procedures as set forth in the applicable fee schedule or other payment methodology established pursuant to s. 440.13.

3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically necessary nerve conduction testing when done in conjunction with a needle electromyography procedure and both are performed and billed solely by a physician licensed under chapter 458, chapter

459, chapter 460, or chapter 461 who is also certified by the American Board of Electrodiagnostic Medicine or by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or who holds diplomate status with the American Chiropractic Neurology Board or its predecessors shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor ~~by an additional amount equal to the medical Consumer Price Index for Florida~~.

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

5. Effective upon this act becoming a law and before November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 200 percent of the allowable amount under Medicare Part B for year 2001, for the area in which the treatment was rendered. Beginning November 1, 2001, allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the

allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor ~~by an additional amount equal to the medical Consumer Price Index for Florida~~, except that allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services provided in facilities accredited by the American College of Radiology or the Joint Commission on Accreditation of Healthcare Organizations shall not exceed 200 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect the prior calendar year's changes in the annual Medical Care Item of the Consumer Price Index for All Urban Consumers in the South Region as determined by the Bureau of Labor Statistics of the United States Department of Labor ~~by an additional amount equal to the medical Consumer Price Index for Florida~~. This paragraph does not apply to charges for magnetic resonance imaging services and nerve conduction testing for inpatients and emergency services and care as defined in chapter 395 rendered by facilities licensed under chapter 395.

6. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury

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

(c)1. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid

because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

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

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

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

with billing standards recognized by the Health Care Finance Administration.

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

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

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

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

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

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

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

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

institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) ~~Health Care Finance Administration~~ 1500 form, UB 92 forms, or any other standard form approved by the department for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer shall not be considered to have been furnished with notice of the amount of covered loss or

medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

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

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

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

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

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

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

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the

services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

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

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

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

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

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

8. As used in this paragraph, "countersigned" means a second or verifying signature, as on a previously signed

document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed.

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

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

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

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No

cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph(4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section ~~about an injured person's earnings or about his or her history, condition, or treatment, or the dates and costs of such treatment~~, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order

to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

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

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

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

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably

accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or

accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the

examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.

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

(10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or

lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other

factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

Section 9. Effective October 1, 2003, subsection (11) of section 627.736, Florida Statutes, is amended to read:

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

(11) DEMAND LETTER.--

(a) As a condition precedent to filing any action for ~~an overdue claim for~~ benefits under this section ~~paragraph(4)(b)~~, the insurer must be provided with written notice of an intent to initiate litigation~~; provided, however, that, except with regard to a claim or amended claim or judgment for interest only which was not paid or was incorrectly calculated, such notice is not required for an overdue claim that the insurer has denied or reduced, nor is such notice required if the insurer has been provided documentation or information at the insurer's request pursuant to subsection (6)~~. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

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

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

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

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

(c) Each notice required by this subsection ~~section~~ must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant ~~provider~~ in the notice, when the insurer pays the ~~overdue~~ claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection ~~section, on the document denying or reducing the amount asserted by the filer to be overdue~~. Each licensed insurer, whether domestic, foreign, or alien, shall ~~may~~

file with the office ~~department~~ designation of the name and address of the person to whom notices pursuant to this subsection ~~section~~ shall be sent which the office shall make available on its Internet website ~~when such document does not specify the name and address to whom the notices under this section are to be sent or when there is no such document~~. The name and address on file with the office ~~department~~ pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection ~~section~~ in the event no other designation has been made.

(d) If, within 15 ~~7 business~~ days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action ~~for nonpayment or late payment~~ may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 15 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any ~~the overdue~~ amount demanded, the penalty shall not be payable in any subsequent action ~~for nonpayment or late payment~~. For purposes of this subsection, payment or the insurer's agreement shall be treated as being

made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer shall not be obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

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

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