Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Seiler offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause, and insert:

Section 1. Florida Motor Vehicle Insurance Affordability Reform Act of 2003; findings; purpose.--

(1) This act may be referred to as the Florida Motor Vehicle Insurance Affordability Reform Act of 2003.

(2) The Legislature finds and declares as follows:

(a) Maintaining a healthy market for motor vehicle insurance, in which consumers may obtain affordable coverage, insurers may operate profitably and competitively, and providers of services may be compensated fairly, is a matter of great public importance.

(b) After many years of relative stability, the market has in recent years failed to achieve these goals, resulting in

substantial premium increases to consumers and a decrease in the availability of coverage.

(c) The failure of the market is in part the result of fraudulent acts and other abuses of the system, including, among other things, staged accidents, vehicle repair fraud, fraudulent insurance applications and claims, solicitation of accident victims, and the growing role of medical clinics that exist primarily to provide services to persons involved in crashes. While many of these issues were brought to light by the Fifteenth Statewide Grand Jury and were addressed by the Legislature in 2001 in chapter 2001-271, Laws of Florida, further action is now appropriate.

(3) The purpose of this act is to restore the health of the market and the affordability of motor vehicle insurance by comprehensively addressing issues of fraud, clinic regulation, and related matters.

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

119.105 Protection of victims of ~~crimes or~~ accidents.--Any person who is authorized by law to have access to confidential or exempt information contained in police reports that identify motor vehicle accident victims must maintain the confidential or exempt status of such information received, except as otherwise expressly provided in the law creating the exemption. Nothing in this section shall be construed to prohibit the publication of such information to the general public by any news media legally entitled to possess that information. Under no circumstances may any person, including the news media, use confidential or exempt information contained in police reports for any commercial

solicitation of the victims or relatives of the victims of the reported crimes or accidents. ~~Police reports are public records except as otherwise made exempt or confidential by general or special law. Every person is allowed to examine nonexempt or nonconfidential police reports. No person who inspects or copies police reports for the purpose of obtaining the names and addresses of the victims of crimes or accidents shall use any information contained therein for any commercial solicitation of the victims or relatives of the victims of the reported crimes or accidents. Nothing herein shall prohibit the publication of such information by any news media or the use of such information for any other data collection or analysis purposes.~~

Section 3. Subsection (3) of section 316.066, Florida Statutes, is amended to read:

316.066 Written reports of crashes.--

(3)(a) Every law enforcement officer who in the regular course of duty investigates a motor vehicle crash:

1. Which crash resulted in death or personal injury shall, within 10 days after completing the investigation, forward a written report of the crash to the department or traffic records center.

2. Which crash involved a violation of s. 316.061(1) or s. 316.193 shall, within 10 days after completing the investigation, forward a written report of the crash to the department or traffic records center.

3. In which crash a vehicle was rendered inoperative to a degree which required a wrecker to remove it from traffic may, within 10 days after completing the investigation, forward a written report of the crash to the department or traffic records

center if such action is appropriate, in the officer's discretion.

However, in every case in which a crash report is required by this section and a written report to a law enforcement officer is not prepared, the law enforcement officer shall provide each party involved in the crash a short-form report, prescribed by the state, to be completed by the party. The short-form report must include, but is not limited to: the date, time, and location of the crash; a description of the vehicles involved; the names and addresses of the parties involved; the names and addresses of witnesses; the name, badge number, and law enforcement agency of the officer investigating the crash; and the names of the insurance companies for the respective parties involved in the crash. Each party to the crash shall provide the law enforcement officer with proof of insurance to be included in the crash report. If a law enforcement officer submits a report on the accident, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information is guilty of an infraction for a nonmoving violation, punishable as provided in chapter 318 unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

(b) One or more counties may enter into an agreement with the appropriate state agency to be certified by the agency to

have a traffic records center for the purpose of tabulating and analyzing countywide traffic crash reports. The agreement must include: certification by the agency that the center has adequate auditing and monitoring mechanisms in place to ensure the quality and accuracy of the data; the time period in which the traffic records center must report crash data to the agency; and the medium in which the traffic records must be submitted to the agency. In the case of a county or multicounty area that has a certified central traffic records center, a law enforcement agency or driver must submit to the center within the time limit prescribed in this section a written report of the crash. A driver who is required to file a crash report must be notified of the proper place to submit the completed report. Fees for copies of public records provided by a certified traffic records center shall be charged and collected as follows:

For a crash report.....$2 per copy.
For a homicide report.....$25 per copy.
For a uniform traffic citation.....$0.50 per copy.

the fees collected for copies of the public records provided by a certified traffic records center shall be used to fund the center or otherwise as designated by the county or counties participating in the center.

(c) Crash reports required by this section which reveal the identity, home or employment telephone number or home or employment address of, or other personal information concerning the parties involved in the crash and which are received or prepared by any agency that regularly receives or prepares

information from or concerning the parties to motor vehicle crashes are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution for a period of 60 days after the date the report is filed. However, such reports may be made immediately available to the parties involved in the crash, their legal representatives, their licensed insurance agents, their insurers or insurers to which they have applied for coverage, persons under contract with such insurers to provide claims or underwriting information, prosecutorial authorities, radio and television stations licensed by the Federal Communications Commission, newspapers qualified to publish legal notices under ss. 50.011 and 50.031, and free newspapers of general circulation, published once a week or more often, available and of interest to the public generally for the dissemination of news. As conditions precedent to accessing crash reports within 60 days after the date the report is filed, a person must present a driver’s license or other photographic identification and proof of status that demonstrates his or her qualifications to access that information and must also file a written sworn statement with the state or local agency in possession of the information stating that no information from any crash report made confidential by this section will be used for any prohibited commercial solicitations of accident victims or knowingly disclosed to any third party for the purpose of such solicitation during the period of time that the information remains confidential. Nothing in this paragraph shall be construed to prevent the dissemination or publication of news to the general public by any media organization entitled to access confidential information pursuant to this section. Any law

enforcement officer as defined in s. 943.10(1) shall have the authority to enforce this subsection. For the purposes of this section, the following products or publications are not newspapers as referred to in this section: those intended primarily for members of a particular profession or occupational group; those with the primary purpose of distributing advertising; and those with the primary purpose of publishing names and other personally identifying information concerning parties to motor vehicle crashes. Any local, state, or federal agency, agent, or employee that is authorized to have access to such reports by any provision of law shall be granted such access in the furtherance of the agency's statutory duties notwithstanding the provisions of this paragraph. Any local, state, or federal agency, agent, or employee receiving such crash reports shall maintain the confidential and exempt status of those reports and shall not disclose such crash reports to any person or entity. Any person attempting to access crash reports within 60 days after the date the report is filed must present legitimate credentials or identification that demonstrates his or her qualifications to access that information. This exemption is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature.

(d) Any employee of a state or local agency in possession of information made confidential by this section who knowingly discloses such confidential information to a person not entitled to access such information under this section commits ~~is guilty~~

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

(e) Any person, knowing that he or she is not entitled to obtain information made confidential by this section, who obtains or attempts to obtain such information commits ~~is guilty of~~ a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

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

Section 4. Section 408.7058, Florida Statutes, is created to read:

408.7058 Statewide health care practitioner and personal injury protection insurer claim dispute resolution program.--

(1) As used in this section:

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

(b) "Resolution organization" means a qualified independent third-party claim dispute resolution entity selected by and contracted with the Agency for Health Care Administration.

(c) "Health care practitioner" means a health care practitioner defined in s. 456.001(4).

(d) "Claim" means a claim for payment for services submitted under s. 627.736(5).

(e) "Claim dispute" means a dispute between a health care practitioner and an insurer as to the proper coding of a charge

submitted on a claim under s. 627.736(5) by a health care practitioner, or the reasonableness of the amount charged by the health care practitioner.

(f) "Insurer" means an insurer providing benefits under s. 627.736.

(2)(a) The agency shall establish a program by January 1, 2004, to provide assistance to health care practitioners and insurers for resolution of claim disputes that are not resolved by the health care practitioner and the insurer. The agency shall contract with a resolution organization to timely review and consider claim disputes submitted by health care practitioners and insurers and recommend to the agency an appropriate resolution of those disputes.

(b) The resolution organization shall review claim disputes filed by health care practitioners and insurers pursuant to this section when a notice of participation is submitted pursuant to subsection (3), unless a demand letter has been submitted to the insurer under s. 627.736(11) or a suit has been filed on the claim against the insurer relating to the disputed claim.

(3) Resolutions by the resolution organization shall be initiated as follows:

(a) A health care practitioner may initiate a dispute resolution by submitting a notice of dispute within 10 days after receipt of a payment under s. 627.736(5)(b), which payment is less than the amount of the charge submitted on the claim. The notice of dispute shall be submitted to both the agency and the insurer by United States certified mail or registered mail, return receipt requested. The health care practitioner shall

include with the notice of dispute any documentation that the health care practitioner wishes the resolution organization to consider, demonstrating that the charge or charges submitted on the claim are reasonable. The insurer shall have 10 days after the date of receipt of the notice of dispute within which to submit both to the resolution organization and the health care practitioner by United States certified mail or registered mail, return receipt requested, a notice of participation in the dispute resolution and any documentation that the insurer wishes the resolution organization to consider demonstrating that the charge or charges submitted on the claim are not reasonable.

(b) An insurer may initiate a dispute resolution prior to the claim being overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b), by submitting a notice of dispute together with a payment to the health care practitioner under s. 627.736(5)(b) of the amount the insurer contends is the highest proper reasonable charge for the claim. The notice of dispute shall be submitted to both the agency and the health care practitioner by United States certified mail or registered mail, return receipt requested. The insurer shall include with the notice of dispute any documentation which the insurer wishes the resolution organization to consider demonstrating that the charge or charges submitted on the claim are not reasonable. The health care practitioner shall have 10 days after the date of receipt of the notice of dispute within which to submit both to the resolution organization and the insurer by United States certified mail or registered mail, return receipt requested, a notice of participation in the dispute resolution and any

documentation which the health care practitioner wishes the resolution organization to consider, demonstrating that the charge or charges submitted on the claim are reasonable.

(c) An insurer or health care practitioner may refuse to participate in a dispute resolution by not submitting a notice of participation in the dispute resolution pursuant to paragraph (a) or (b). An insurer or health care practitioner shall not be liable for the review costs, as established pursuant to subsection (8), of the dispute resolution conducted pursuant to this section unless it has participated in the dispute resolution pursuant to this subsection and is liable for such costs pursuant to subsection (6).

(d) Upon initiation of a dispute resolution pursuant to this section, no demand letter under s. 627.736(11) may be sent in regard to the subject matter of the dispute resolution unless:

1. A notice of participation has not been timely submitted pursuant to paragraphs (a) or (b);

2. The dispute resolution organization or the agency has not been able to issue a notice of resolution or final order within the time provided pursuant to subsection (6); or

3. The insurer has failed to pay the reasonable amount pursuant to the final order adopting the notice of resolution together with the interest and penalties of subsection (6), if applicable.

(e) The applicable statute of limitations shall be tolled while a dispute resolution is pending and for a period of 15 business days following:

1. Expiration of time for the submission of a notice of participation pursuant to paragraphs (a) or (b);

2. Expiration of time for the filing of the final order adopting the notice of resolution pursuant to subsection (6); or

3. The filing, with the agency clerk, of the final order adopting the notice of resolution.

(4)(a) The resolution organization shall issue a notice of resolution within 10 business days after the date the organization receives all documentation from the health care practitioner or the insurer pursuant to subsection (3).

(b) The resolution organization shall dismiss a notice of dispute if:

1. The resolution organization has not received a notice of participation pursuant to subsection (3) within 15 days after receiving a notice of dispute; or

2. The dispute resolution organization is unable to issue a notice of resolution within the time provided by subsection (5), provided, the parties may with mutual agreement extend the time for the issuance of the notice of resolution by sending the dispute resolution organization a written notice of extension signed by both parties and specifying the date by which a notice of resolution must be issued or the notice of dispute will be deemed dismissed.

(c) The resolution organization may, in its discretion, schedule and conduct a telephone conference with the health care practitioner and the insurer to facilitate the dispute resolution in a cost-effective, efficient manner.

(d) In determining the reasonableness of a charge or charges, the resolution organization may consider whether a

billing code or codes submitted on the claim are the codes that accurately reflect the diagnostic or treatment service on the claim or whether the billing code or codes should be bundled or unbundled.

(e) In determining the reasonableness of a charge or charges, the resolution organization shall determine whether the charge or charges are less than or equal to the highest reasonable charge or charges that represent the usual and customary rates charged by similar health care practitioners licensed under the same chapter for the geographic area of the health care practitioner involved in the dispute, and, if the charges in dispute are less than or equal to such charges, the resolution organization shall find them reasonable. In determining the usual and customary rates in accordance with this paragraph, the dispute resolution organization may not take into consideration any information relating to, or based wholly or partially on, any governmentally set fee schedule, or any contracted-for or discounted rates charged by health care practitioners who contract with health insurers, health maintenance organizations, or managed care organizations.

(f) A health care practitioner, who must be licensed under the same chapter as the health care practitioner involved in the dispute, may be used to advise the resolution organization if such advice will assist the resolution organization to resolve the dispute in a more cost-effective, efficient manner.

(5)(a) The resolution organization shall issue a notice of resolution within 10 business days after receipt of the notice of participation pursuant to subsection (3). The notice of resolution shall be based upon findings of fact and shall be

considered a recommended order. The notice of resolution shall be submitted to the health care practitioner and the insurer by United States certified mail or registered mail, return receipt requested, and to the agency.

(b) The notice of resolution shall state:

1. Whether the charge or charges submitted on the claim are reasonable; or

2. If the resolution organization finds that any charge or charges submitted on the claim are not reasonable, the highest amount for such charge or charges that the resolution organization finds to be reasonable.

(6)(a) In the event that the notice of resolution finds that any charge or charges submitted on the claim are not reasonable but that the highest reasonable charge or charges are more than the amount or amounts paid by the insurer, the insurer shall pay the additional amount found to be reasonable within 10 business days after receipt of the final order adopting the notice of resolution, together with applicable interest under s. 627.736(4)(c), a penalty of 10 percent of the additional amount found to be reasonable, subject to a maximum penalty of $250.

(b) In the event that the notice of resolution finds that the charge or charges submitted on the claim are reasonable, the insurer shall pay the additional amount or amounts found to be reasonable within 10 business days after receipt of the final order adopting the notice of resolution, together with applicable interest under s. 627.736(4)(c), a penalty of 20 percent of the additional amount found to be reasonable, subject to a maximum penalty of $500.

(c) In the event that the final order adopting the notice of resolution finds that the amount or amounts paid by the insurer are equal to or greater than the highest reasonable charge, the insurer shall not be liable for any interest or penalties.

(d) The agency shall issue a final order adopting the notice of resolution within 10 days after receipt of the notice of resolution. The final order shall be submitted to the health care practitioner and the insurer by United States certified mail or registered mail, return receipt requested.

(7)(a) If the insurer has paid the highest reasonable amount or amounts as determined by the final order adopting the notice of resolution, together with the interest and penalties provided in subsection (6), if applicable, then no civil action by the health care practitioner shall lie against the insurer on the basis of the reasonableness of the charge or charges, and no attorney's fees may be awarded for legal assistance related to the charge or charges. The injured party is not liable for, and the health care practitioner shall not bill the injured party for, any amounts other than the copayment and any applicable deductible based on the highest reasonable amount as determined by the final order adopting the notice of resolution.

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

(8) The insurer shall be responsible for payment of the entirety of the review costs established pursuant to subsection (9).

(9) The agency shall adopt rules to establish a process to be used by the resolution organization in considering claim disputes submitted by a health care practitioner or insurer and the fees which may be charged by the agency for processing disputes under this section. Such fees shall not exceed $75.00 for each review.

Section 5. Section 456.0375, Florida Statutes, is amended to read:

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

(1)(a) As used in this section, the term:

1. "Clinic" means a business operating in a single structure or facility, or in a group of adjacent structures or facilities operating under the same business name or management, at which health care services are provided to individuals and which tender charges for reimbursement for such services. The term also includes an entity that performs such functions from a vehicle or otherwise having no fixed location.

2. "Disqualified person" means any individual who, within the last 10 years, has been convicted of or who, regardless of adjudication, has pleaded guilty or nolo contendere to any felony under federal law or under the law of any state.

3. "Participate in the business of" a clinic means to be a medical director in a clinic, to be an independent contractor of a clinic, or to control any interest in a clinic.

4. "Independent diagnostic testing facility” means an individual, partnership, firm, or other business entity that provides diagnostic imaging services but does not include an individual or entity that has a disqualified person under subparagraph 2. as an investor.

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

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

b. Entities that own, directly or indirectly, entities licensed pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, or chapter 484.

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

d. Entities which are under common ownership, directly or indirectly, with an entity licensed pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, or chapter 484.

2. Entities exempt from federal taxation under 26 U.S.C. s. 501(c)(3).

3. Sole proprietorships, group practices, partnerships, or corporations that provide health care services by licensed

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

(2)(a) Every clinic, as defined in paragraph (1)(a), must register, and must at all times maintain a valid registration, with the Department of Health. Each clinic location shall be registered separately even though operated under the same business name or management, and each clinic shall appoint a medical director or clinical director.

(b)1. The department shall adopt rules necessary to implement the registration program, including rules establishing the specific registration procedures, forms, and fees. Registration fees must be reasonably calculated to cover the cost of registration and must be of such amount that the total fees collected do not exceed the cost of administering and enforcing compliance with this section. Registration may be conducted electronically. The registration program must require:

a.~~1.~~ The clinic to file the registration form with the department within 60 days after the effective date of this section or prior to the inception of operation. The registration

expires automatically 2 years after its date of issuance and must be renewed biennially.

b.~~2.~~ The registration form to contain the name, residence and business address, phone number, and license number of the medical director or clinical director for the clinic, and of each person who owns a controlling interest in the clinic.

c.~~3.~~ The clinic to display the registration certificate in a conspicuous location within the clinic readily visible to all patients.

2. Any business that becomes a clinic after commencing other operations shall, within 30 days after becoming a clinic, file a registration statement under this subsection and shall be subject to all provisions of this section applicable to a clinic.

(c) A disqualified person may not participate in the business of the clinic. This paragraph does not apply to any participation in the business of the clinic that existed as of the effective date of this paragraph. A disqualified person may participate in the business of the clinic if such person has the written consent of the department, which consent specifically refers to this subsection. Effective October 1, 2003, the registration statement required by this section must include, or be amended to include, information about each disqualified person participating in the business of the clinic, including any person participating with the written consent of the department. A clinic must make a diligent effort to determine whether any disqualified person is participating in the business of the clinic, to include conducting background investigations on medical directors and control persons. Certification of

accreditation and reaccredidation by the appropriate accrediting entity or entities shall be conclusive proof of compliance with this paragraph, unless it is shown that such accreditation has been suspended, withdrawn, or revoked. Such certification and each subsequent certificate of reaccreditation shall be provided by the clinic to the insurer one time, prior to the filing of the first claim for payment after accreditation or reaccreditation. Each claim seeking reimbursement based on such accreditation shall bear the statement: "This clinic is currently accredited by American College of Radiology and was so at the time services were rendered," or "This clinic is currently accredited by American College of Radiology and the Joint Commission on Accreditation of Health Care Organizations and was so at the time services were rendered."

(d) Every clinic engaged in the provision of magnetic resonance imaging services must be accredited by the American College of Radiology or the Joint Commission on Accreditation of Health Care Organizations by January 1, 2005. Subsequent providers engaged in the provision of magnetic resonance imaging services must be accredited by the American College of Radiology or the Joint Commission on Accreditation of Health Care Organizations within 18 months after the effective date of registration.

(3)(a) Each clinic must employ or contract with a physician maintaining a full and unencumbered physician license in accordance with chapter 458, chapter 459, chapter 460, or chapter 461 to serve as the medical director. However, if the clinic is limited to providing health care services pursuant to chapter 457, chapter 484, chapter 486, chapter 490, or chapter

491 or part I, part III, part X, part XIII, or part XIV of chapter 468, the clinic may appoint a health care practitioner licensed under that chapter to serve as a clinical director who is responsible for the clinic's activities. A health care practitioner may not serve as the clinical director if the services provided at the clinic are beyond the scope of that practitioner's license.

(b) The medical director or clinical director shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinical director shall:

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

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

3. Review any patient referral contracts or agreements executed by the clinic.

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

5. Serve as the clinic records holder as defined in s. 456.057.

6. Ensure compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of this chapter, the respective practice acts, and rules adopted thereunder.

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

(c) Any contract to serve as a medical director or a clinical director entered into or renewed by a physician or a licensed health care practitioner in violation of this section is void as contrary to public policy. This section shall apply to contracts entered into or renewed on or after October 1, 2001.

(d) The department, in consultation with the boards, shall adopt rules specifying limitations on the number of registered clinics and licensees for which a medical director or a clinical director may assume responsibility for purposes of this section. In determining the quality of supervision a medical director or a clinical director can provide, the department shall consider the number of clinic employees, clinic location, and services provided by the clinic.

(4)(a) Any person or entity providing medical services or treatment that is not a clinic may voluntarily register its exempt status with the department on a form that sets forth its name or names and addresses, a statement of the reasons why it is not a clinic, and such other information deemed necessary by the department.

(b) The department shall adopt rules necessary to implement the registration program, including rules establishing the specific registration procedures, forms, and fees. Registration fees must be reasonably calculated to cover the cost of registration and must be of such amount that the total

fees collected do not exceed the cost of administering and enforcing compliance with this section. Registration may be conducted electronically.

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

(b) Any person establishing, operating, or managing an unregistered clinic otherwise required to be registered under this section, or any person who knowingly files a false or misleading registration or false or misleading information required by subsection (2), subsection (4), or department rule, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Any licensed health care practitioner who violates this section is subject to discipline in accordance with this chapter and the respective practice act.

(d) The department shall revoke the registration of any clinic registered under this section for operating in violation of the requirements of this section or the rules adopted by the department.

(e) The department shall investigate allegations of noncompliance with this section and the rules adopted pursuant to this section. The Division of Insurance Fraud of the Department of Financial Services, at the request of the department, may provide assistance in investigating allegations of noncompliance with this section and the rules adopted pursuant to this section.

(f) The department may make unannounced inspections of clinics registered pursuant to this section to determine compliance with this section.

(g) A clinic registered under this section shall allow full and complete access to the premises and to billing records or information to any representative of the department who makes a request to inspect the clinic to determine compliance with this section.

(h) Failure by a clinic registered under this section to allow full and complete access to the premises and to billing records or information to any representative of the department who makes a request to inspect the clinic to determine compliance with this section or which fails to employ a qualified medical director or clinical director shall constitute a ground for emergency suspension of the registration by the department pursuant to s. 120.60(6).

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

456.072 Grounds for discipline; penalties; enforcement.--

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

(dd) With respect to making a claim for personal injury protection as required by s. 627.736:

1. Intentionally submitting a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the actual services performed, which practice is commonly referred to as "upcoding.” Global diagnostic imaging

billing by the technical component provider is not considered upcoding.

2. Intentionally filing a claim for payment of services that were not performed.

3. Intentionally using information obtained in violation of s. 119.105 or s. 316.066 to solicit or obtain patients personally or through an agent, regardless of whether the information is derived directly from an accident report, derived from a summary of an accident report, from another person, or otherwise.

4. Intentionally submitting a claim for a diagnostic treatment or submitting a claim for a diagnostic treatment or procedure that is properly billed under one billing code but which has been separated into two or more billing codes, which practice is commonly referred to as "unbundling."

(ee) Treating a person for injuries resulting from a staged motor vehicle accident with knowledge that the person was a participant in the staged motor vehicle accident.

Section 7. Subsection (8) is added to section 627.732, Florida Statutes, to read:

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

(8) "Global diagnostic imaging billing" means the submission of a statement or bill related to the completion of a diagnostic imaging test that includes a charge which encompasses both the production of the diagnostic image, the "technical component," and the interpretation of the diagnostic image, the "professional component," whether or not the individual or entity providing the professional component was performing these

services as an independent contractor or employee of the entity providing the technical component.

Section 8. Paragraph (g) is added to subsection (4) of section 627.736, Florida Statutes, and subsection (5), paragraph (a) of subsection (7), subsection (8), paragraph (d) of subsection (11), and subsection (12) of said section are amended, 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.

(g) Benefits shall not be due or payable to 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 claimant or is established in a court of competent jurisdiction. Any benefits paid prior to the discovery of the insured’s or

claimant's insurance fraud shall be recoverable in their entirety by the insurer from the insured or claimant who perpetrated the fraud upon demand for such benefits. The prevailing party shall be entitled to its costs and attorney's fees in any action under this paragraph. However, payments to a health care practitioner, who is without knowledge of such fraud, for services rendered in good faith pursuant to this section shall not be subject to recovery.

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

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

(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 services or treatment by a clinic as defined in s. 456.0375, if, at the time the service or treatment was rendered,

the clinic was not in compliance with any applicable provision of that section or rules adopted under such section.

c. For services or treatment by a clinic, as defined in s. 456.0375, if, at the time the services or treatment were rendered, a person controlled the clinic or its medical director, had been convicted of, or who, regardless of adjudication of guilt, had pleaded guilty or nolo contendere to a felony under federal law or the law of any state.

d. For any service or treatment that was not lawful at the time it was rendered.

e. To any person or entity who knowingly submits false or misleading statements and bills for medical services, or for any statement or bill.

f. For medical services or treatment unless such services are rendered by the physician or are incident to professional services and are included on the physician's bills. This sub-subparagraph does not apply to services furnished in a licensed health care facility or in an independent diagnostic testing facility as defined in s. 456.0375.

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 or the American Chiropractic Academy of Neurology or its predecessors 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, adjusted annually 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 Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually by

an additional amount equal to the medical Consumer Price Index for Florida based on the month of January for each year, 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 Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually by an additional amount equal to the medical Consumer Price Index for Florida based on the month of January for each year. 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 both the American College of Radiology and the Joint Commission on Accreditation of Health Care Organizations shall be 225 percent of the allowable amount for Medicare Part B for 2001 for the area in which the treatment was rendered, adjusted annually by an amount equal to the 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.

(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 by noninstitutional providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology(CPT) or Healthcare Correct Procedural Coding System (HCPCS) 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). In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Officer of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises as may be defined by rule of the Department of Health. 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 with all information being provided in such statements or bills, which means that the statement or bill contains all of the information required by the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology Editorial Panel and Healthcare Correct Procedural Coding System. An insurer shall not deny or reduce claims based upon compliance with s. 456.0375(2)(d) unless the insurer can show the required certification was not provided to the insurer.

(e) Each physician, clinic, or other medical institution, except for a hospital, providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person to either sign a form acknowledging that the diagnostic or treatment services listed on the form were provided to the insured on the date that the insured signs the form, or in the alternative, the insured may sign the patient records generated that day reflecting the diagnostic or treatment procedures received.

(f) An insurer may not bundle codes or change a diagnosis or diagnosis code on a claim submitted by a health care provider without the consent of the health care provider. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

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

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a physician licensed under the same chapter as the treating

physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that for ~~during the~~ 3 consecutive years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer, or on behalf of an insurer through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may 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.

(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), provided a court must receive evidence and consider the following factors prior to awarding any multiplier:

(a) Whether the relevant market requires a contingency fee multiplier to obtain competent counsel.

(b) Whether the attorney was able to mitigate the risk of nonpayment in any way.

(c) Whether any of the following factors are applicable:

1. The time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.

2. The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.

3. The fee customarily charged in the locality for similar legal services.

4. The amount involved and the results obtained.

5. The time limitations imposed by the client or by the circumstances.

6. The nature and length of the professional relationship with the client.

7. The experience, reputation, and ability of the lawyer or lawyers performing the services.

8. Whether the fee is fixed or contingent.

If the court determines, pursuant to this subsection, that a multiplier is appropriate, and if the court determines that success was more likely than not at the outset, the court may apply a multiplier of 1 to 1.5; if the court determines that the likelihood of success was approximately even at the outset, the court may apply a multiplier of 1.5 to 2.0; and if the court determines that success was unlikely at the outset of the case, the court may apply a multiplier of 2.0 to 2.5.

(11) DEMAND LETTER.--

(d) If, within 10 ~~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. To the extent the insurer determines not to pay the overdue amount, the penalty shall not be payable in any action for nonpayment or late payment. For purposes of this subsection, payment shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment 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 within the time prescribed by this subsection.

(12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer and an insured shall have a cause of action against any person who has committed ~~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. Any party ~~An insurer~~ prevailing in an action brought under this subsection may recover treble compensatory damages, consequential damages, 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 under ~~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.

Section 9. Paragraph (a) of subsection (1) of section 627.745, Florida Statutes, is amended to read:

627.745 Mediation of claims.--

(1)(a) In any claim filed with an insurer for personal injury ~~in an amount of $10,000 or less~~ or any claim for property damage in any amount, arising out of the ownership, operation, use, or maintenance of a motor vehicle, either party may demand mediation of the claim prior to the institution of litigation.

Section 10. Section 627.747, Florida Statutes, is created to read:

627.747 Legislative oversight; reporting of information.--In order to ensure continuing legislative oversight of motor vehicle insurance in general and the personal injury protection system in particular, the following agencies shall, on January 1 and July 1 of each year, provide the

information required by this section to the President of the Senate, the Speaker of the House of Representatives, the minority party leaders of the Senate and the House of Representatives, and the chairs of the standing committees of the Senate and the House of Representatives having authority over insurance matters.

(1) The Office of Insurance Regulation of the Financial Services Commission shall provide data and analysis on motor vehicle insurance loss cost trends and premium trends, together with such other information as the office deems appropriate to enable the Legislature to evaluate the effectiveness of the reforms contained in the Florida Motor Vehicle Insurance Affordability Reform Act of 2003, and such other information as may be requested from time to time by any of the officers referred to in this section.

(2) The Division of Insurance Fraud of the Department of Financial Services shall provide data and analysis on the incidence and cost of motor vehicle insurance fraud, including violations, investigations, and prosecutions, together with such other information as the division deems appropriate to enable the Legislature to evaluate the effectiveness of the reforms contained in the Florida Motor Vehicle Insurance Affordability Reform Act of 2003, and such other information as may be requested from time to time by any of the officers referred to in this section.

Section 11. Subsections (8) and (9) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.--

(8)(a)1. It is unlawful for any person, intending to defraud any other person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association, to solicit or cause to be solicited any business from a person involved in a motor vehicle accident by any means of communication other than advertising directed to the public for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736. Charges for any services rendered by a health care provider or attorney who violates this subsection in regard to the person for whom such services were rendered are noncompensable and unenforceable as a matter of law. Any person who violates the provisions of this paragraph ~~subsection~~ commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Such person shall be sentenced to a minimum term of imprisonment of 2 years.

2. Notwithstanding the provisions of s. 948.01 with respect to any person who is found to have violated this paragraph, adjudication of guilt or imposition of sentence shall not be suspended, deferred, or withheld nor shall such person be eligible for parole prior to serving the mandatory minimum term of imprisonment prescribed by this paragraph. A person sentenced to a mandatory term of imprisonment under this paragraph is not eligible for any form of discretionary early release, except pardon or executive clemency or conditional medical release under s. 947.149, prior to serving the mandatory minimum term of imprisonment.

3. The state attorney may move the sentencing court to reduce or suspend the sentence of any person who is convicted of a violation of this paragraph and who provides substantial assistance in the identification, arrest, or conviction of any of that person’s accomplices, accessories, coconspirators, or principals. The arresting agency shall be given an opportunity to be heard in aggravation or mitigation in reference to any such motion. Upon good cause shown, the motion may be filed and heard in camera. The judge hearing the motion may reduce or suspend the sentence if the judge finds that the defendant rendered such substantial assistance.

(b)1. It is unlawful for any person to solicit or cause to be solicited any business from a person involved in a motor vehicle accident, by any means of communication other than advertising directed to the public, for the purpose of making, settling, or adjusting motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736, within 60 days after the occurrence of the motor vehicle accident. Any person who violates the provisions of this subparagraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. It is unlawful for any person, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, to solicit or cause to be solicited any business from a person involved in a motor vehicle accident, by means of any personal or telephone contact at the person's residence, other than by mail or by advertising directed to the public, for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736. Any

person who violates the provisions of this subparagraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Charges for any services rendered by any person who violates this subsection in regard to the person for whom such services were rendered are noncompensable and unenforceable as a matter of law. Any contract, release or other document executed by a person involved in a motor vehicle accident, or a family member of such person, related to a violation of this section is unenforceable by the person who violated this section or that person's principal or successor in interest.

(d) For purposes of this section, the term "solicit" does not include an insurance company making contact with its insured, nor does it include an insurance company making contact with a person involved in a motor vehicle accident where the person involved in a motor vehicle accident has directly or indirectly requested to be contacted by the insurance company.

(9)(a) It is unlawful for any person to organize, plan, or in any way participate in an intentional motor vehicle crash for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits as required by s. 627.736 ~~attorney to solicit any business relating to the representation of a person involved in a motor vehicle accident for the purpose of filing a motor vehicle tort claim or a claim for personal injury protection benefits required by s. 627.736. The solicitation by advertising of any business by an attorney relating to the representation of a person injured in a specific motor vehicle accident is prohibited by this section~~. Any person ~~attorney~~ who violates the provisions of this paragraph

~~subsection~~ commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. A person who is convicted of a violation of this subsection shall be sentenced to a minimum term of imprisonment of 2 years.

(b) Notwithstanding the provisions of s. 948.01, with respect to any person who is found to have violated this subsection, adjudication of guilt or imposition of sentence shall not be suspended, deferred, or withheld nor shall such person be eligible for parole prior to serving the mandatory minimum term of imprisonment prescribed by this subsection. A person sentenced to a mandatory minimum term of imprisonment under this subsection is not eligible for any form of discretionary early release, except pardon, executive clemency, or conditional medical release under s. 947.149, prior to serving the mandatory minimum term of imprisonment.

(c) The state attorney may move the sentencing court to reduce or suspend the sentence of any person who is convicted of a violation of this subsection and who provides substantial assistance in the identification, arrest, or conviction of any of that person's accomplices, accessories, coconspirators, or principals. The arresting agency shall be given an opportunity to be heard in aggravation or mitigation in reference to any such motion. Upon good cause shown, the motion may be filed and heard in camera. The judge hearing the motion may reduce or suspend the sentence if the judge finds that the defendant rendered such substantial assistance. ~~Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney is guilty of a violation of this section, such committee shall~~

~~forward to the appropriate state attorney a copy of the finding of probable cause and the report being filed in the matter. This section shall not be interpreted to prohibit advertising by attorneys which does not entail a solicitation as described in this subsection and which is permitted by the rules regulating The Florida Bar as promulgated by the Florida Supreme Court.~~

Section 12. Section 817.236, Florida Statutes, is amended to read:

817.236 False and fraudulent motor vehicle insurance application.--Any person who, with intent to injure, defraud, or deceive any motor vehicle insurer, including any statutorily created underwriting association or pool of motor vehicle insurers, presents or causes to be presented any written application, or written statement in support thereof, for motor vehicle insurance knowing that the application or statement contains any false, incomplete, or misleading information concerning any fact or matter material to the application commits a felony ~~misdemeanor~~ of the third ~~first~~ degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084.

Section 13. Section 817.2361, Florida Statutes, is created to read:

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

Section 14. Section 817.413, Florida Statutes, is created to read:

817.413 Sale of used motor vehicle goods as new; penalty.--

(1) With respect to a transaction for which any charges will be paid from the proceeds of a motor vehicle insurance policy and in which the purchase price of motor vehicle goods exceeds $100, it is unlawful for the seller to misrepresent orally, in writing, or by failure to speak that the goods are new or original when they are used or repossessed or have been used for sales demonstration.

(2) A person who violates the provisions of this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 15. Section 860.15, Florida Statutes, is amended to read:

860.15 Overcharging for repairs and parts; penalty.--

(1) It is unlawful for a person to knowingly charge for any services on motor vehicles which are not actually performed, to knowingly and falsely charge for any parts and accessories for motor vehicles not actually furnished, or to knowingly and fraudulently substitute parts when such substitution has no relation to the repairing or servicing of the motor vehicle.

(2) Any person willfully violating the provisions of this section shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(3) If the charges referred to in subsection (1) will be paid from the proceeds of a motor vehicle insurance policy, a person who willfully violates the provisions of this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 16. Paragraphs (c) and (e) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

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

(3) OFFENSE SEVERITY RANKING CHART

Florida Statute	Felony Degree	Description
		(c) LEVEL 3
<u>119.10(3)</u>	<u>3rd</u>	<u>Unlawful use of confidential information from police reports.</u>
<u>316.066(3)(d)-(f)</u>	<u>3rd</u>	<u>Unlawfully obtaining or using confidential crash reports.</u>
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in marked patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate

		of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
456.0375(4)(b)	3rd	Operating a clinic without registration or filing false registration or other required information.

	501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
1373	697.08	3rd	Equity skimming.
1374	790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
1375	796.05(1)	3rd	Live on earnings of a prostitute.
1376	806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
1377	806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
1378	810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
1379	812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
1380	812.0145(2)(c)	3rd	Theft from person 65 years of

		age or older; $300 or more but less than $10,000.
815.04(4)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
817.233	3rd	Burning to defraud insurer.
817.234(8)(b)~~&(9)~~	3rd	Certain unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
817.236	3rd	False and fraudulent motor vehicle insurance application.
817.2361	3rd	False and fraudulent motor vehicle insurance card.
817.413	3rd	Sale of used motor vehicle goods as new.
817.505(4)	3rd	Patient brokering.
828.12(2)	3rd	Tortures any animal with

		intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
831.29	2nd	Possession of instruments for counterfeiting drivers' licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police dog or horse.
860.15(3)	3rd	Overcharging for motor vehicle repairs and parts; insurance involved.
870.01(2)	3rd	Riot; inciting or encouraging.
893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3.,

			(2)(c)5.,(2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).
1398			
	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.
1399			
	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.
1400			
	893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
1401			
	893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
1402			
	893.13(7)(a)9.	3rd	Obtain or attempt to obtain

		controlled substance by fraud, forgery, misrepresentation, etc.
893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.
893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for

		a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47(1)(a)1.-2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.3141	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).
		(e) LEVEL 5
316.027(1)(a)	3rd	Accidents involving personal injuries, failure to stop; leaving scene.
316.1935(4)	2nd	Aggravated fleeing or eluding.

322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
790.01(2)	3rd	Carrying a concealed firearm.
790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of deadly explosive or weapon of mass destruction.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms or electronic weapons or devices.
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years.

800.04(7)(c)	2nd	Lewd or lascivious exhibition; offender 18 years or older.
806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
817.234(8)(a)	2nd	Unlawful solicitation of persons involved in motor vehicle accidents intending to defraud.

1435	817.234(9)	2nd	Intentional motor vehicle crashes.
	817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
1436	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.
1437	817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device or reencoder.
1438	825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
1439	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
1440	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.
843.01	3rd	Resist officer with violence to person; resist arrest with violence.
874.05(2)	2nd	Encouraging or recruiting another to join a criminal street gang; second or subsequent offense.
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).
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.
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).

Section 17. The amendment to s. 456.0375(1)(b)1., Florida Statutes, in this act is intended to clarify the legislative

intent of that provision as it existed at the time the provision initially took effect. Accordingly, the amendment to s. 456.0375(1)(b)1., Florida Statutes, in this act shall operate retroactively to October 1, 2001.

Section 18. The Office of Insurance Regulation is directed to undertake and complete not later than January 1, 2004, a report to the Speaker of the House of Representatives and the President of the Senate evaluating the costs citizens of this state are required to pay for the private passenger automobile insurance that is presently mandated by law, in relation to the benefits of such mandates to citizens of this state. Such report shall include, but not be limited to, an evaluation of the costs and benefits of the Florida Motor Vehicle No-Fault Law.

Section 19. If any law amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.

Section 20. Except as otherwise provided herein, this act shall take effect October 1. 2003.

================= T I T L E A M E N D M E N T =================

Remove the entire title, and insert:

A bill to be entitled

An act relating to motor vehicle insurance affordability reform; creating the Motor Vehicle Insurance Affordability Reform Act of 2003; providing legislative findings and declarations; providing purposes; amending

s. 119.105, F.S.; requiring certain persons to maintain confidential and exempt status of certain information under certain circumstances; providing construction; prohibiting use of certain confidential or exempt information relating to motor vehicle accident victims for certain commercial solicitation activities; deleting provisions relating to police reports as public records; amending s. 316.066, F.S.; specifying conditions precedent to providing access to crash reports to persons entitled to such access; providing construction; providing for enforcement; providing a criminal penalty for using certain confidential information; creating s. 408.7058, F.S.; providing definitions; creating a dispute resolution organization for disputes between health care practitioners and insurers; providing duties of the Agency for Health Care Administration; providing duties of the dispute resolution organization; providing procedures, requirements, limitations, and restrictions for resolving disputes; providing agency rulemaking authority; amending s. 456.0375, F.S.; revising definitions; providing additional requirements relating to the registration of certain clinics; limiting participation by disqualified persons; providing for voluntary registration of exempt status; providing rulemaking authority; specifying unlawful charges; prohibiting the filing of certain false or misleading forms or information; providing criminal penalties; providing for inspections of and access to clinics under certain circumstances; providing for emergency suspension

of registration; amending s. 456.072, F.S.; providing additional grounds for discipline of health professionals; amending s. 627.732, F.S.; providing a definition; amending s. 627.736, F.S.; revising provisions relating to required personal injury protection benefits and payment thereof; specifying conditions of insurance fraud and recovery of certain charges; providing for recovery of costs and attorney's fees in certain insurer actions; specifying certain charges that are uncollectible and unenforceable; limiting charges for certain services; providing procedures and requirements for correcting certain information relating to processing claims; prohibiting an insurer from taking certain actions with respect to a claim submitted by a health care provider; prohibiting an insurer from taking certain actions with respect to an independent medical examination; requiring certain recordkeeping; deleting provisions relating to arbitration of certain disputes between insurers and medical providers; providing certain statements and forms requirements, limitations, and restrictions; specifying factors for court consideration in applying attorney contingency fee multipliers; extending the time within which an insurer may respond to a demand letter; expanding civil actions for insurance fraud; amending s. 627.745, F.S.; expanding the availability of mediation of certain claims; creating s. 627.747, F.S.; providing for legislative oversight of motor vehicle insurance; requiring the Office of Insurance Regulation of the

Financial Services Commission and the Division of Insurance Fraud of the Department of Financial Services to regularly report certain data and analysis of certain information to specified officers of the Legislature; amending s. 817.234, F.S.; increasing criminal penalties for certain acts of solicitation of accident victims; providing mandatory minimum penalties; prohibiting certain solicitation of accident victims; providing criminal penalties; prohibiting a person from organizing, planning, or participating in a staged motor vehicle accident; providing criminal penalties, including mandatory minimum penalties; amending s. 817.236, F.S.; increasing a criminal penalty for false and fraudulent motor vehicle insurance application; creating s. 817.2361, F.S.; prohibiting marketing or presenting false or fraudulent motor vehicle insurance cards; providing criminal penalties; creating s. 817.413, F.S.; prohibiting certain sale of used motor vehicle goods as new; providing criminal penalties; amending s. 860.15, F.S.; providing a criminal penalty for charging for certain motor vehicle repairs and parts to be paid from a motor vehicle insurance policy; amending s. 921.0022, F.S.; revising the offense severity ranking chart to reflect changes in criminal penalties and the creation of additional offenses under the act; providing that the amendment to s. 456.0375(1)(b)1., F.S., is intended to clarify existing intent; providing retroactive operation; requiring the Office of Insurance Regulation to report to the Legislature on the economic condition of private

passenger automobile insurance in this state; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session of the Legislature; providing effective dates.