By the Committees on Judiciary; Health Care; and Banking and Insurance

590-2344-06

A bill to be entitled

An act relating to motor vehicle insurance; reorganizing provisions pertaining to personal injury protection benefits under the Florida Motor Vehicle No-Fault Law for the purpose of clarifying its meaning and intent and for the purpose of better comprehension; amending s. 627.736, F.S.; providing that a self-employed injured person or an injured person owning 25 percent or more interest in an employer offer proof of income and lost wages to insurers as a condition precedent for payment; providing for a statement of earnings; requiring an insured to notify an insurer in writing of election to reserve benefits for lost wages; specifying that such notification takes priority over other claims, except specified hospital liens; providing for Medicaid benefits; requiring the Department of Health to determine by rule tests deemed not to be medically necessary; providing guidance as to criteria to be considered; providing for required payment of benefits; authorizing a parent or legal guardian of an injured minor to complete application for personal injury protection benefits; providing for changes for treatment of injured persons; providing requirements for compliance with billing procedures; specifying the time period within which a health care provider or other specified provider must submit a statement of charges; prohibiting providers from billing an

injured person under specified conditions for emergency services and care; requiring insurers to provide specified documents to insureds; requiring that amounts repayable to an insurer include the statutory interest penalty; increasing the time period for an insurer to respond to a demand letter; providing requirements for the production and inspection of an injured person's medical records from a provider; providing a right of compensation to health care providers for responding to requests for information by insurers; providing for application of attorney's fees; providing that persons notifying insurers of improper billing may obtain a reward; restricting venue for any personal injury protection claim to specified jurisdictions and providing for costs of transferring venue; amending s. 316.068, F.S.; specifying information to be included in a crash report; creating a rebuttable presumption regarding the existence of passengers; specifying conditions relating to reporting passengers; amending s. 322.26, F.S.; providing an additional circumstance relating to insurance crimes for mandatory revocation of a person's driver's license; amending s. 817.234, F.S.; revising provisions specifying material omission and insurance fraud; prohibiting scheming to create documentation of a motor vehicle crash that did not occur; providing a criminal penalty; amending s.

817.2361, F.S.; providing that creating, marketing, or presenting fraudulent proof of motor vehicle insurance is a felony of the third degree; providing appropriations; authorizing positions and a salary rate; abrogating the repeal of provisions pertaining to the Florida Motor Vehicle No-Fault Law; providing an effective date.

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

Section 1. Section 627.736, Florida Statutes, is amended to read:

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

(1) REQUIRED <u>PERSONAL INJURY PROTECTION</u> BENEFITS.--Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of <u>subsections (3)</u> ~~subsection (2)~~ and<u>(6)</u> ~~paragraph (4)(d)~~, to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.--Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including

prosthetic devices, and medically necessary ambulance, hospital, and nursing services. Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies upon spiritual means through prayer alone for healing, in accordance with his or her religious beliefs; however, this sentence does not affect the determination of what other services or procedures are medically necessary.

(b) Disability benefits.--

1. Sixty percent of any loss of gross income and loss of earning capacity per injured person ~~individual~~ from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.

2. For an injured person who is self employed or an injured person who owns over a 25-percent interest in his or her employer, as a condition precedent to payment for lost wages, the injured person must produce to the insurer reasonable proof as to the injured person's income and loss of earning capacity or additional expense, such that the insurer may reasonably calculate the amount of the loss of income.

3. 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 office, a sworn statement of the earnings, since the time of the bodily injury

and for a 13-week time period before the injury, of the person upon whose injury the claim is based.

4. If the insured elects to have disability benefits reserved for lost wages, the insured shall notify the insurer in writing, which shall be binding on the insurer. Receipt of such notification shall take priority over all claims subject to an assignment of benefits received after receipt of such notice, except that receipt by the insurer of a properly perfected hospital lien, prior to payment of the lost wage claim, shall take priority over the insured's election to reserve all benefits for lost wages.

(c) Death benefits.--The insurer shall pay death benefits in the amount of $5,000 per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

(d) Medicaid benefits.--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.

(2) AMOUNT OF PROPERTY DAMAGE COVERAGE.--

(a) Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits.

(b) Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

(3)~~(2)~~ AUTHORIZED EXCLUSIONS.--Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or

2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of subsection (8) ~~paragraph (4)(b)~~ shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

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

(5) NONREIMBURSABLE SERVICES.--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 as defined in s. 627.732 for use in either the diagnosis or treatment of persons sustaining bodily injury covered by personal injury

protection benefits under this section. The list shall be revised from time to time as determined by the Department of Health, in consultation with the appropriate professional licensing boards. In determining whether a test is medically necessary for purposes of this subsection, the department may consider the degree of positive diagnostic or treatment benefits in relation to costs; whether there is substantial demonstrated medical value for the injured person; the availability of alternative methods of treatment or diagnosis; the immediacy or remoteness of likely benefit for the injured person; whether there is evidence of overuse by providers primarily for financial gain; whether there is acceptance of the use of the tests for injured persons; and whether there are reservations regarding such use as reported to the department by the appropriate professional licensing boards. The department shall give greater weight to the advice of the appropriate licensing boards on whether a test is medically unnecessary than to a degree of acceptance by some individuals or groups within the relevant provider communities. Notwithstanding a test's inclusion on a fee schedule in this section, an insurer or an insured is not required to pay any charges or reimburse claims for any diagnostic test determined not medically necessary by the Department of Health.

(6) REQUIRED PAYMENT OF BENEFITS.--The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

(a) 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.

(b) 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.

(c) Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in paragraphs (a) and (b), 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.

(d) 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:

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

2. 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.

(7)~~(4)~~ CLAIMS SUBMISSION ~~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, subject to the following:~~. 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) Medicaid reimbursement.--Medical benefits payable under s. 627.736 shall reimburse fully any payment made by the Medicaid program, up to the limits of coverage.

(b)~~(a)~~ Personal injury protection application.--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. If the injured person is a minor, the parent or legal guardian of the minor, if requested by the insurer, must accurately complete the personal injury protection application.

(c) Charges for treatment of injured persons; billing requirements.--

1. 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 office 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. 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.

2. 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) 1500 form or its successor or a UB 92 form or its successor.

3. All billings for such services, procedures, and supplies submitted by health care providers and medical suppliers shall comply with the Healthcare Correct Procedural Coding System (HCPCS) and International Classification of Diseases (ICD-9-CM) or their successors in effect at the time of patient discharge, if applicable, or when the service was rendered, if applicable, for the year in which services are rendered.

4. All claims forms submitted by health care providers, medical suppliers other than ambulance providers licensed under part III of chapter 401, hospitals, and physicians providing emergency care as defined in s. 395.002 shall include on the applicable claim form the signature and professional license number of the provider who rendered services in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials" and the date of the signature.

5. In determining compliance with applicable HCPCS and ICD-9-CM coding, or their successors, guidance shall be provided by the Healthcare Correct Procedural Coding System (HCPCS) or its successor, International Classification of Diseases (ICD-9-CM) or its successor, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, rules of the Agency for Health Care Administration, the Florida Health Information Management Association (FHIMA), and other authoritative treatises.

6. 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.

7. 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.

8. 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 7. shall not exceed the applicable fee schedule or other payment methodology established pursuant to s. 440.13.

9. 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 for the 12-month period ending June 30 of that 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 Accreditation Association for Ambulatory Health Care, 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 for the 12-month period ending June 30 of that year. 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.

10. A statement of medical services may not include charges for medical services of a person or entity that rendered such services without possessing all valid qualifications and licenses required to lawfully provide and bill for such services. However, a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 466 may delegate diagnostic or treatment tasks to an employee to be performed under the supervision of the physician in accordance with the requirements and provisions of the applicable licensing section.

11. For purposes of subsection (8), 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 required information being provided therein.

12. 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.

(d) Direct billing an insurer for personal injury protection benefits.--The insurer providing coverage may pay for charges directly to the insured or the insured's assignee.

(e) Timely billing for nonemergency services.--With respect to any treatment or service, other than medical services billed by an ambulance provider licensed pursuant to part III of chapter 401, 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 the following:

1. Past due amounts previously billed on a timely basis under this subsection.

2. 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, 50 days before the postmark date of the statement. The injured person is not liable for, and the provider shall not bill the injured person 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.

3. If 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. A denial letter from the incorrect insurer; or

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

(f) Timely billing for emergency services.--

1. 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 subsection; however, such charges must be submitted within 75 days after the date the treatment was rendered, and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of subsection (8) until it receives a statement complying with subsection (7), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance.

2. If the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 75 days following 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:

a. Documentary evidence that was provided by the insured during the 75-day period demonstrating that the provider reasonably relied on erroneous information from the insured;

b. A denial letter from the incorrect insurer; or

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

(g) Billing notice and disclosures.--

1. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12-point font:

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 person 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, 50 days before the postmark date of the statement.

2. Except for ambulance transport and treatment or hospital and emergency services and care rendered pursuant to s. 395.002, on each date services are rendered the health care provider shall provide to the insured patient a written bill, superbill, fee slip, or other similar document that establishes in plain language a detailed description of the service provided and the cost associated with the service. The insured must sign the written bill, superbill, fee slip, or other similar document immediately after having received services. Copies of such disclosures shall be maintained as part of the patient's medical records in accordance with minimal record keeping standards. Health care providers or service providers who do not render services in the presence of the insured are not required to comply with this section.

(h) Upon request, the insured and his or her assigns shall be sent a letter containing a payment log itemizing all payments made, the applicable insurance declarations page, and a copy of the insurance policy within 30 days after the written request. Such request shall state that it is a "request under s. 627.736(7)" and shall state with specificity:

1. The name of the insured upon whom 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.

Such request must be sent to the person and address specified by the insurer for the purposes of receiving notices or requests under this section.

(i) 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.

(8) OVERDUE PERSONAL INJURY PROTECTION BENEFITS.--

(a)~~(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 amount ~~fact~~ of a covered loss, including a properly completed CMS 1500 form or its successor or UB 92 form or its successor, assignment of benefits, or, in the case of disability benefits, proper written documentation of the claim

~~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.~~

(b) Timely payment by an insurer ~~This paragraph~~ does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was for services not lawfully

performed, 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, this section ~~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 subsection ~~paragraph~~.

~~(c) All overdue payments shall bear simple interest at the rate established 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.~~

~~(c) 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.~~

(c)~~(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.

(9) CALCULATION OF TIME OF 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 that 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.

(10) INTEREST ON OVERDUE PAYMENTS.--All overdue payments shall bear simple interest at the rate established 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. In the case of payment made by an insurer to the insured, or insured's assignee, interest shall be due at the time payment of the overdue claim is made. All amounts repayable to the insurer shall bear simple interest at the rate established under s. 55.03 for the year in which the payment became repayable, calculated from the date the insurer tendered payment.

~~(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 office 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. 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.~~

(11) CLAIMS NOT PROPERLY PAYABLE.--

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

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

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

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

(d)~~d.~~ With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph(7)(b)~~(d)~~;

(e)~~e.~~ For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with subsection (7) ~~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)~~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.~~

~~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. 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 for the 12-month period ending June 30 of that 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 Accreditation Association for Ambulatory Health Care, 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 for the 12-month period ending June 30 of that year. 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. A denial letter from the incorrect insurer; or~~

~~b. 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), 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) 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) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission 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.~~

(12) DEMAND LETTER.--

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to subsection (8).

(b) The notice required shall state that it is a "demand letter under s. 627.736(14)" and shall state with specificity:

1. The name of the insured upon whom 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 subsection (7) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under subsection (15) 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 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 in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the

office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.

(d) If, within 21 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 may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under subsection (15) for future treatment not yet rendered, no action may be brought against the insurer if, within 21 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 amount demanded, the penalty shall not be payable in any subsequent action. 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 is not 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 21 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 is engaging in an unfair trade practice under the insurance code.

(13) DISCLOSURE AND ACKNOWLEDGEMENT FORM.--

(a)~~(c)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:

1.~~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;

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

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

4.~~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

5.~~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.

(b)~~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.

(c)~~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.

(d)~~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 subsection ~~paragraph~~.

(e)~~5.~~ The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to subsection (8) ~~paragraph (4)(b)~~ and may not be electronically furnished.

(f)~~6.~~ This disclosure and acknowledgment 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.

(g)~~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 subsection ~~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.~~

(h)~~8.~~ As used in this subsection ~~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.

(i)~~9.~~ ~~The requirements of~~ This subsection applies ~~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. The requirements of this paragraph ~~subparagraph~~ for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

~~(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.~~

~~(g) 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 office, 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.~~

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

(a)~~(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:~~,~~

1. 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.~~,~~

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

2. Provide ~~together with~~ a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained. 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."

3. Identify ~~and identifying~~ which portion of the expenses for such treatment or services was incurred as a result of such bodily injury.~~,~~

4. ~~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."~~

(b) However, if the records are maintained at an alternative location, the requested records shall be made available at the principal place of business within 25 working days after the request. If the requested records are not made available within this time period and such records are later admitted into evidence or otherwise used to support a claim by the health care provider against the insurer, the court shall not award attorney's fees to the provider pursuant to this section or s. 627.428. At the time of the records inspection, the health care provider shall allow the insurer to inspect records and photograph the equipment and associated documents associated with the insured's treatment, services, or supplies.

(c) A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy is not ~~shall be~~ permitted against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section.

(d) The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith.

(e) 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 subsection (7) ~~paragraph (4)(a)~~, the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with subsection (8) ~~paragraph (4)(b)~~ or within 15 ~~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 subsection ~~paragraph~~.

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

(g)~~(c)~~ In the event of any dispute regarding an insurer's right to discovery of facts under this section, 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.

(h) A health care provider is entitled to reasonable compensation for complying with a request for information by an insurer.

(i)~~(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.

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

(15)~~(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.

(b) The costs of any examinations requested by an insurer shall be borne entirely by the insurer.

(c) 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.

(d) 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.

(e) ~~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.

(f) 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.

(g) 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.

(h) 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.

(i) 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.

(j) 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 subsection ~~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.

(k)~~(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).~~

(16)~~(9)~~ CANCELLATION OR NONRENEWAL.--

(a) Each insurer that ~~which~~ has issued a policy providing personal injury protection benefits shall report the renewal, cancellation, or nonrenewal thereof to the Department of Highway Safety and Motor Vehicles within 45 days from the effective date of the renewal, cancellation, or nonrenewal.

(b) Upon the issuance of a policy providing personal injury protection benefits to a named insured not previously insured by the insurer thereof during that calendar year, the insurer shall report the issuance of the new policy to the Department of Highway Safety and Motor Vehicles within 30 days. The report shall be in such form and format and contain

such information as is ~~may be~~ required by the Department of Highway Safety and Motor Vehicles which shall include a format compatible with the data processing capabilities of such ~~said~~ department, and the Department of Highway Safety and Motor Vehicles is authorized to adopt rules necessary with respect thereto. Failure by an insurer to file proper reports with the Department of Highway Safety and Motor Vehicles as required by this subsection or rules adopted with respect to the requirements of this subsection constitutes a violation of the Florida Insurance Code.

(c) Reports of cancellations and policy renewals and reports of the issuance of new policies received by the Department of Highway Safety and Motor Vehicles are confidential and exempt from the provisions of s. 119.07(1).

(d) These records are to be used for enforcement and regulatory purposes only, including the generation by the department of data regarding compliance by owners of motor vehicles with financial responsibility coverage requirements. In addition, the Department of Highway Safety and Motor Vehicles shall release, upon a written request by a person involved in a motor vehicle accident, by the person's attorney, or by a representative of the person's motor vehicle insurer, the name of the insurance company and the policy number for the policy covering the vehicle named by the requesting party. The written request must include a copy of the appropriate accident form as provided in s. 316.065, s. 316.066, or s. 316.068.

(e)~~(b)~~ Every insurer with respect to each insurance policy providing personal injury protection benefits shall notify the named insured or in the case of a commercial fleet policy, the first named insured in writing that any

cancellation or nonrenewal of the policy will be reported by the insurer to the Department of Highway Safety and Motor Vehicles. The notice shall also inform the named insured that failure to maintain personal injury protection and property damage liability insurance on a motor vehicle when required by law may result in the loss of registration and driving privileges in this state, and the notice shall inform the named insured of the amount of the reinstatement fees required by s. 627.733(7). This notice is for informational purposes only, and no civil liability shall attach to an insurer due to failure to provide this notice.

(17) ATTORNEY'S FEES.--With respect to any dispute under ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, s. 627.428 shall apply, except as provided in subsection (12).

(18)~~(10)~~ PREFERRED PROVIDERS.--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.

~~(11) DEMAND LETTER.~~

~~(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. 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 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 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 in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.~~

~~(d) If, within 15 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 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 amount demanded, the penalty shall not be payable in any subsequent action. 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 is engaging in an unfair trade practice under the insurance code.~~

(19)~~(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.

(20)~~(13)~~ MINIMUM BENEFIT COVERAGE.--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.

(21) REWARD.--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, the insurer shall pay to the person 40 percent of the amount of the reduction up to $500.

(22) VENUE.--Venue for any personal injury protection claim, in the case of an assignment of benefits, shall be in the jurisdiction where the insured resides, where the accident occurs, or where the disputed health care services were performed. Venue may be raised at any time. The cost of transferring venue shall be borne by the plaintiff, and such costs shall not be recoverable as plaintiff's damages.

Section 2. Subsection (2) of section 316.068, Florida Statutes, is amended to read:

316.068 Crash report forms.--

(2) Every crash report required to be made in writing must be made on the appropriate form approved by the department and must contain all the information required therein to include:

(a) The date, time, and location of the crash;

(b) A description of the vehicles involved;

(c) The names and addresses of the parties involved;

(d) The names and addresses of all drivers and passengers in the vehicles involved;

(e) The names and addresses of witnesses;

(f) The name, badge number, and law enforcement agency of the officer investigating the crash; and

(g) The names of the insurance companies for the respective parties involved in the crash unless not available.

The absence of information in such written crash reports regarding the existence of passengers in the vehicles involved in the crash constitutes a rebuttable presumption that no such passengers were involved in the reported crash.

Notwithstanding any other provisions of this section, a crash report produced electronically by a law enforcement officer must, at a minimum, contain the same information as is called for on those forms approved by the department.

Section 3. Subsection (9) is added to section 322.26, Florida Statutes, to read:

322.26 Mandatory revocation of license by department.--The department shall forthwith revoke the license or driving privilege of any person upon receiving a record of such person's conviction of any of the following offenses:

(9) Conviction in any court having jurisdiction over offenses committed under s. 817.234(8) or (9) or s. 817.505.

Section 4. Paragraph (a) of subsection (7) and subsection (9) of section 817.234, Florida Statutes, are amended to read:

817.234 False and fraudulent insurance claims.--

(7)(a) It shall constitute a material omission and insurance fraud, punishable as provided in subsection (11), for any service ~~physician or other~~ provider, other than a hospital, to engage in a general business practice of billing amounts as its usual and customary charge, if such provider has agreed with the insured ~~patient~~ or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge. With respect to a determination as to whether a service ~~physician or other~~ provider has engaged in such general business

practice, consideration shall be given to evidence of whether the physician or other provider made a good faith attempt to collect such deductible or copayment. This paragraph does not apply to physicians or other providers who waive deductibles or copayments or reduce their bills as part of a bodily injury settlement or verdict.

(9) A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash or a scheme to create documentation of a motor vehicle crash that did not occur for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits as required by s. 627.736. Any person who violates this subsection commits a felony of the second 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.

Section 5. Section 817.2361, Florida Statutes, is amended to read:

817.2361 False or fraudulent proof of motor vehicle insurance ~~card~~.--Any person who, with intent to deceive any other person, creates, markets, or presents a false or fraudulent proof of 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 6. For the 2006-2007 fiscal year, the sums of $510,276 in recurring funds and $111,455 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund of the Department of Financial Services to the Division of Insurance Fraud within the department for the purpose of providing a new fraud unit within the division consisting of six sworn law enforcement officers, one non-sworn

investigator, one crime analyst, and one clerical position. A total of nine full-time equivalent positions and associated salary rate of 381,500 are authorized. This appropriation is for the purposes provided in s. 626.989, Florida Statutes.

Section 7. For the 2006-2007 fiscal year, the sums of $415,291 in recurring funds and $52,430 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund of the Department of Financial Services to the Division of Insurance Fraud within the department and 10 full-time equivalent positions and associated salary rate of 342,500 are authorized. This appropriation is for the purposes provided in s. 626.989, Florida Statutes.

Section 8. Effective January 1, 2009, sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes, constituting the Florida Motor Vehicle No-Fault Law, are repealed, unless reviewed and reenacted by the Legislature before that date.

Section 9. Section 19 of chapter 2003-411, Laws of Florida, is repealed.

Section 10. This act shall take effect October 1, 2006.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for CS for SB 2114

The committee substitute:

-- Restores a provision from existing law that an insurer or an insured is not required to pay charges or reimburse claims for any diagnostic test determined not medically necessary by the Department of Health;

-- Specifies that a health care provider is entitled to reasonable compensation for complying with a request for information by an insurer;

-- Restores a provision from current law governing attorney's fees in certain disputes between the insured and the insurer;

-- Deletes an appropriation of $1.53 million for a competitive pay adjustment for certain sworn law enforcement officer positions in the Division of Insurance; and

-- Deletes an appropriation of $750,000 for certain state attorney offices to prosecute insurance fraud cases.