

1 A bill to be entitled

2 An act relating to motor vehicle insurance; amending s.
3 316.646, F.S.; requiring each person operating a motor
4 vehicle to have in his or her possession proof of property
5 damage liability coverage; conforming a cross-reference to
6 changes made by the act; amending s. 320.02, F.S.;
7 clarifying the requirements concerning insurance and
8 liability coverage for certain motor vehicles registered
9 in this state; amending s. 321.245, F.S., relating to the
10 disposition of certain funds in the Highway Safety
11 Operating Trust Fund; conforming a cross-reference;
12 amending s. 324.022, F.S.; revising provisions requiring
13 the owner or operator of a motor vehicle to maintain
14 property damage liability coverage; specifying the
15 requirements that apply to such a policy; providing
16 definitions; requiring that a nonresident owner or
17 registrant of a motor vehicle maintain property damage
18 liability coverage if the motor vehicle is in the state
19 longer than a specified period; providing an exception for
20 a member of the United States Armed Forces who is on
21 active duty outside the United States; creating s.
22 324.0221, F.S.; requiring insurers to report to the
23 Department of Highway Safety and Motor Vehicles the
24 renewal, cancellation, or nonrenewal of a policy providing
25 personal injury protection coverage or motor vehicle
26 property damage liability coverage; authorizing the
27 department to adopt rules for the reports; providing that
28 failure to report as required is a violation of the

29 Florida Insurance Code; requiring that an insurer notify
30 the named insured that a cancelled or nonrenewed policy
31 will be reported to the department; requiring that the
32 department suspend the registration and driver's license
33 of an owner or registrant of a motor vehicle who fails to
34 maintain the required liability coverage; providing for
35 the reinstatement of a registration or driver's license
36 upon payment of certain fees; requiring that a person
37 obtain noncancelable coverage following such
38 reinstatement; providing for the deposit and use of
39 reinstatement fees; amending ss. 627.7275 and 627.7295,
40 F.S., relating to motor vehicle insurance policies and
41 contracts; conforming provisions to changes made by the
42 act; reviving and reenacting ss. 627.730, 627.731,
43 627.732, 627.734, 627.737, 627.739, 627.7401, 627.7403,
44 and 627.7405, F.S., and reviving, reenacting, and amending
45 ss. 627.733 and 627.736, the Florida Motor Vehicle No-
46 Fault Law, notwithstanding the repeal of such law provided
47 in s. 19, chapter 2003-411, Laws of Florida; deleting
48 certain provisions relating to the suspension and
49 reinstatement of a driver's license and registration and
50 notice to the Department of Highway Safety and Motor
51 Vehicles; conforming provisions to changes made by the
52 act; providing legislative intent with respect to the
53 reenactment and codification of the Florida Motor Vehicle
54 No-Fault Law, notwithstanding its prior repeal; amending
55 s. 627.736, F.S., as reenacted and amended; revising
56 provisions governing the medical benefits provided as

57 required personal injury protection benefits; providing
58 medical benefits for services and care ordered or
59 prescribed by a physician or provided by certain persons
60 or entities that meet certain requirements; requiring the
61 Financial services Commission to adopt rules; revising a
62 limitation on the amount of death benefits payable;
63 requiring personal injury protection insurers to reserve
64 benefits for certain providers for a specified period;
65 tolling the time period for the insurer to pay claims from
66 other providers; authorizing an insurer to limit
67 reimbursement for personal injury protection benefits to a
68 specified percentage of a schedule of maximum charges;
69 prohibiting provider from billing or attempting to collect
70 amounts in excess of such limits, except for amounts that
71 are not covered by personal injury protection coverage;
72 deleting provisions specifying allowable amounts for
73 certain tests and services; providing for electronic
74 transmission of certain statements; prohibiting attorney's
75 fees contingency risk multiplier; restricting the amount
76 of attorney's fees; extending the period during which an
77 insurer may pay an overdue claim following receipt of a
78 demand letter without incurring a penalty; providing for
79 penalties to be imposed against certain insurers for
80 failing to pay claims for personal injury protection;
81 authorizing the Department of Legal Affairs to investigate
82 violations and initiate enforcement action; requiring that
83 all claims related to the same health care provider for
84 the same injured person be brought in one act unless good

85 cause is shown; authorizing notices and communications
86 required or authorized under the Florida Motor Vehicle No-
87 Fault Law to be transmitted electronically under certain
88 conditions; providing legislative intent concerning the
89 application of the act; requiring insurers to deliver
90 revised notices of premium and policy changes to certain
91 policyholders; requiring an insurer to cancel the policy
92 and return any unearned premium if the insured fails to
93 timely respond to the notice; providing for calculating
94 the amount of unearned premium; requiring that insurers
95 continue to use certain forms and rates until a specified
96 date unless the Office of Insurance Regulation approves
97 new forms or rates or such new forms or rates are
98 otherwise legally allowed; providing that a person
99 purchasing a motor vehicle insurance policy without
100 personal injury protection coverage is exempt from the
101 requirement for such coverage and is not subject to
102 certain liability provisions for a specified period;
103 requiring that insurers provide notice of the requirement
104 for personal injury protection coverage or add an
105 endorsement to the policy providing such coverage;
106 providing effective dates.

107
108 Be It Enacted by the Legislature of the State of Florida:

109
110 Section 1. Subsections (1) and (3) of section 316.646,
111 Florida Statutes, are amended to read:

112 316.646 Security required; proof of security and display

113 thereof; dismissal of cases.--

114 (1) Any person required by s. 324.022 to maintain property
 115 damage liability security, required by s. 324.023 to maintain
 116 liability security for bodily injury or death, ~~or any person~~
 117 required by s. 627.733 to maintain personal injury protection
 118 security on a motor vehicle shall have in his or her immediate
 119 possession at all times while operating such motor vehicle
 120 proper proof of maintenance of the required security. Such proof
 121 shall be ~~either~~ a uniform proof-of-insurance card in a form
 122 prescribed by the department, a valid insurance policy, an
 123 insurance policy binder, a certificate of insurance, or such
 124 other proof as may be prescribed by the department.

125 (3) Any person who violates this section commits a
 126 nonmoving traffic infraction subject to the penalty provided in
 127 chapter 318 and shall be required to furnish proof of security
 128 as provided in this section. If any person charged with a
 129 violation of this section fails to furnish proof, at or before
 130 the scheduled court appearance date, that security was in effect
 131 at the time of the violation, the court may immediately suspend
 132 the registration and driver's license of such person. Such
 133 license and registration may ~~only~~ be reinstated only as provided
 134 in s. 324.0221 ~~627.733~~.

135 Section 2. Paragraphs (a) and (d) of subsection (5) of
 136 section 320.02, Florida Statutes, are amended to read:

137 320.02 Registration required; application for
 138 registration; forms.--

139 (5) (a) Proof that personal injury protection benefits have
 140 been purchased when required under s. 627.733, that property

141 damage liability coverage has been purchased as required under
 142 s. 324.022, that bodily injury or death coverage has been
 143 purchased if required under s. 324.023, and that combined bodily
 144 liability insurance and property damage liability insurance have
 145 been purchased when required under s. 627.7415 shall be provided
 146 in the manner prescribed by law by the applicant at the time of
 147 application for registration of any motor vehicle that is
 148 subject to such requirements ~~owned as defined in s. 627.732~~. The
 149 issuing agent shall refuse to issue registration if such proof
 150 of purchase is not provided. Insurers shall furnish uniform
 151 proof-of-purchase cards in a form prescribed by the department
 152 and shall include the name of the insured's insurance company,
 153 the coverage identification number, and the make, year, and
 154 vehicle identification number of the vehicle insured. The card
 155 shall contain a statement notifying the applicant of the penalty
 156 specified in s. 316.646(4). The card or insurance policy,
 157 insurance policy binder, or certificate of insurance or a
 158 photocopy of any of these; an affidavit containing the name of
 159 the insured's insurance company, the insured's policy number,
 160 and the make and year of the vehicle insured; or such other
 161 proof as may be prescribed by the department shall constitute
 162 sufficient proof of purchase. If an affidavit is provided as
 163 proof, it shall be in substantially the following form:

164
 165 Under penalty of perjury, I (Name of insured) do hereby
 166 certify that I have (Personal Injury Protection, Property
 167 Damage Liability, and, when required, Bodily Injury Liability)
 168 Insurance currently in effect with (Name of insurance company)

169 under (policy number) covering (make, year, and vehicle
 170 identification number of vehicle) . (Signature of Insured)

171
 172 Such affidavit shall include the following warning:

173
 174 WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A VEHICLE
 175 REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER FLORIDA
 176 LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT IS
 177 SUBJECT TO PROSECUTION.

178
 179 When an application is made through a licensed motor vehicle
 180 dealer as required in s. 319.23, the original or a photostatic
 181 copy of such card, insurance policy, insurance policy binder, or
 182 certificate of insurance or the original affidavit from the
 183 insured shall be forwarded by the dealer to the tax collector of
 184 the county or the Department of Highway Safety and Motor
 185 Vehicles for processing. By executing the aforesaid affidavit,
 186 no licensed motor vehicle dealer will be liable in damages for
 187 any inadequacy, insufficiency, or falsification of any statement
 188 contained therein. A card shall also indicate the existence of
 189 any bodily injury liability insurance voluntarily purchased.

190 (d) The verifying of proof of personal injury protection
 191 insurance, proof of property damage liability insurance, proof
 192 of combined bodily liability insurance and property damage
 193 liability insurance, or proof of financial responsibility
 194 insurance and the issuance or failure to issue the motor vehicle
 195 registration under the provisions of this chapter may not be
 196 construed in any court as a warranty of the reliability or

197 accuracy of the evidence of such proof. Neither the department
 198 nor any tax collector is liable in damages for any inadequacy,
 199 insufficiency, falsification, or unauthorized modification of
 200 any item of the proof of personal injury protection insurance,
 201 proof of property damage liability insurance, proof of combined
 202 bodily liability insurance and property damage liability
 203 insurance, or proof of financial responsibility insurance ~~either~~
 204 prior to, during, or subsequent to the verification of the
 205 proof. The issuance of a motor vehicle registration does not
 206 constitute prima facie evidence or a presumption of insurance
 207 coverage.

208 Section 3. Section 321.245, Florida Statutes, is amended
 209 to read:

210 321.245 Disposition of certain funds in the Highway Safety
 211 Operating Trust Fund.--The director of the Florida Highway
 212 Patrol, after receiving recommendations from the commander of
 213 the auxiliary, is authorized to purchase uniforms and equipment
 214 for auxiliary law enforcement officers as defined in s. 321.24
 215 from funds described in s. 324.0221(3) ~~627.733(7)~~. The amounts
 216 expended under this section shall not exceed \$50,000 in any one
 217 fiscal year.

218 Section 4. Section 324.022, Florida Statutes, is amended
 219 to read:

220 324.022 Financial responsibility for property damage.--

221 (1) Every owner or operator of a motor vehicle, ~~which~~
 222 ~~motor vehicle is subject to the requirements of ss. 627.730-~~
 223 ~~627.7405 and~~ required to be registered in this state, shall, ~~by~~
 224 ~~one of the methods established in s. 324.031 or by having a~~

225 ~~policy that complies with s. 627.7275,~~ establish and maintain
 226 the ability to respond in damages for liability on account of
 227 accidents arising out of the use of the motor vehicle in the
 228 amount of \$10,000 because of damage to, or destruction of,
 229 property of others in any one crash. The requirements of this
 230 section may be met by one of the methods established in s.
 231 324.031; by self-insuring as authorized by s. 768.28(16); or by
 232 maintaining an insurance policy providing coverage for property
 233 damage liability in the amount of at least \$10,000 because of
 234 damage to, or destruction of, property of others in any one
 235 accident arising out of the use of the motor vehicle. The
 236 requirements of this section may also be met by having a policy
 237 which provides coverage in the amount of at least \$30,000 for
 238 combined property damage liability and bodily injury liability
 239 for any one crash arising out of the use of the motor vehicle.
 240 The policy, with respect to coverage for property damage
 241 liability, must meet the applicable requirements of s. 324.151,
 242 subject to the usual policy exclusions that have been approved
 243 in policy forms by the Office of Insurance Regulation. No
 244 insurer shall have any duty to defend uncovered claims
 245 irrespective of their joinder with covered claims.

- 246 (2) As used in this section, the term:
 247 (a) "Motor vehicle" means any self-propelled vehicle that
 248 has four or more wheels and that is of a type designed and
 249 required to be licensed for use on the highways of this state,
 250 and any trailer or semitrailer designed for use with such
 251 vehicle. The term does not include:
 252 1. A mobile home.

253 2. A motor vehicle that is used in mass transit and
 254 designed to transport more than five passengers, exclusive of
 255 the operator of the motor vehicle, and that is owned by a
 256 municipality, transit authority, or political subdivision of the
 257 state.

258 3. A school bus as defined in s. 1006.25.

259 4. A vehicle providing for-hire transportation that is
 260 subject to the provisions of s. 324.031. A taxicab shall
 261 maintain security as required under s. 324.032(1).

262 (b) "Owner" means the person who holds legal title to a
 263 motor vehicle or the debtor or lessee who has the right to
 264 possession of a motor vehicle that is the subject of a security
 265 agreement or lease with an option to purchase.

266 (3) Each nonresident owner or registrant of a motor
 267 vehicle that, whether operated or not, has been physically
 268 present within this state for more than 90 days during the
 269 preceding 365 days shall maintain security as required by
 270 subsection (1) that is in effect continuously throughout the
 271 period the motor vehicle remains within this state.

272 (4) The owner or registrant of a motor vehicle is exempt
 273 from the requirements of this section if she or he is a member
 274 of the United States Armed Forces and is called to or on active
 275 duty outside the United States in an emergency situation. The
 276 exemption provided by this subsection applies only as long as
 277 the member of the Armed Forces is on such active duty outside
 278 the United States and applies only while the vehicle is not
 279 operated by any person. Upon receipt of a written request by the
 280 insured to whom the exemption provided in this subsection

281 applies, the insurer shall cancel the coverages and return any
 282 unearned premium or suspend the security required by this
 283 section. Notwithstanding s. 324.0221(3), the department may not
 284 suspend the registration or operator's license of any owner or
 285 registrant of a motor vehicle during the time she or he
 286 qualifies for an exemption under this subsection. Any owner or
 287 registrant of a motor vehicle who qualifies for an exemption
 288 under this subsection shall immediately notify the department
 289 prior to and at the end of the expiration of the exemption.

290 Section 5. Section 324.0221, Florida Statutes, is created
 291 to read:

292 324.0221 Reports by insurers to the department; suspension
 293 of driver's license and vehicle registrations; reinstatement.--

294 (1)(a) Each insurer that has issued a policy providing
 295 personal injury protection coverage or property damage liability
 296 coverage shall report the renewal, cancellation, or nonrenewal
 297 thereof to the department within 45 days after the effective
 298 date of each renewal, cancellation, or nonrenewal. Upon the
 299 issuance of a policy providing personal injury protection
 300 coverage or property damage liability coverage to a named
 301 insured not previously insured by the insurer during that
 302 calendar year, the insurer shall report the issuance of the new
 303 policy to the department within 30 days. The report shall be in
 304 the form and format and contain any information required by the
 305 department and must be provided in a format that is compatible
 306 with the data-processing capabilities of the department. The
 307 department may adopt rules regarding the form and documentation
 308 required. Failure by an insurer to file proper reports with the

309 department as required by this subsection or rules adopted with
310 respect to the requirements of this subsection constitutes a
311 violation of the Florida Insurance Code. These records shall be
312 used by the department only for enforcement and regulatory
313 purposes, including the generation by the department of data
314 regarding compliance by owners of motor vehicles with the
315 requirements for financial responsibility coverage.

316 (b) With respect to an insurance policy providing personal
317 injury protection coverage or property damage liability
318 coverage, each insurer shall notify the named insured, or the
319 first-named insured in the case of a commercial fleet policy, in
320 writing that any cancellation or nonrenewal of the policy will
321 be reported by the insurer to the department. The notice must
322 also inform the named insured that failure to maintain personal
323 injury protection coverage and property damage liability
324 coverage on a motor vehicle when required by law may result in
325 the loss of registration and driving privileges in this state
326 and inform the named insured of the amount of the reinstatement
327 fees required by this section. This notice is for informational
328 purposes only, and an insurer is not civilly liable for failing
329 to provide this notice.

330 (2) The department shall suspend, after due notice and an
331 opportunity to be heard, the registration and driver's license
332 of any owner or registrant of a motor vehicle with respect to
333 which security is required under ss. 324.022 and 627.733 upon:

334 (a) The department's records showing that the owner or
335 registrant of such motor vehicle did not have in full force and
336 effect when required security that complies with the

337 requirements of ss. 324.022 and 627.733; or

338 (b) Notification by the insurer to the department, in a
339 form approved by the department, of cancellation or termination
340 of the required security.

341 (3) An operator or owner whose driver's license or
342 registration has been suspended under this section or s. 316.646
343 may effect its reinstatement upon compliance with the
344 requirements of this section and upon payment to the department
345 of a nonrefundable reinstatement fee of \$150 for the first
346 reinstatement. The reinstatement fee is \$250 for the second
347 reinstatement and \$500 for each subsequent reinstatement during
348 the 3 years following the first reinstatement. A person
349 reinstating her or his insurance under this subsection must also
350 secure noncancelable coverage as described in ss. 324.021(8),
351 324.023, and 627.7275(2) and present to the appropriate person
352 proof that the coverage is in force on a form adopted by the
353 department, and such proof shall be maintained for 2 years. If
354 the person does not have a second reinstatement within 3 years
355 after her or his initial reinstatement, the reinstatement fee is
356 \$150 for the first reinstatement after that 3-year period. If a
357 person's license and registration are suspended under this
358 section or s. 316.646, only one reinstatement fee must be paid
359 to reinstate the license and the registration. All fees shall be
360 collected by the department at the time of reinstatement. The
361 department shall issue proper receipts for such fees and shall
362 promptly deposit those fees in the Highway Safety Operating
363 Trust Fund. One-third of the fees collected under this
364 subsection shall be distributed from the Highway Safety

365 Operating Trust Fund to the local governmental entity or state
 366 agency that employed the law enforcement officer seizing the
 367 license plate pursuant to s. 324.201. The funds may be used by
 368 the local governmental entity or state agency for any authorized
 369 purpose.

370 Section 6. Section 627.7275, Florida Statutes, is amended
 371 to read:

372 627.7275 Motor vehicle liability.--

373 (1) A motor vehicle insurance policy providing personal
 374 injury protection as set forth in s. 627.736 may not be
 375 delivered or issued for delivery in this state with respect to
 376 any specifically insured or identified motor vehicle registered
 377 or principally garaged in this state unless the policy also
 378 provides coverage for property damage liability as required by
 379 s. 324.022 in the amount of at least \$10,000 because of damage
 380 ~~to, or destruction of, property of others in any one accident~~
 381 ~~arising out of the use of the motor vehicle or unless the policy~~
 382 ~~provides coverage in the amount of at least \$30,000 for combined~~
 383 ~~property damage liability and bodily injury liability in any one~~
 384 ~~accident arising out of the use of the motor vehicle. The~~
 385 ~~policy, as to coverage of property damage liability, must meet~~
 386 ~~the applicable requirements of s. 324.151, subject to the usual~~
 387 ~~policy exclusions that have been approved in policy forms by the~~
 388 ~~office.~~

389 (2) (a) Insurers writing motor vehicle insurance in this
 390 state shall make available, subject to the insurers' usual
 391 underwriting restrictions:

392 1. Coverage under policies as described in subsection (1)

393 to any applicant for private passenger motor vehicle insurance
394 coverage who is seeking the coverage in order to reinstate the
395 applicant's driving privileges in this state when the driving
396 privileges were revoked or suspended pursuant to s. 316.646 or
397 s. 324.0221 ~~627.733~~ due to the failure of the applicant to
398 maintain required security.

399 2. Coverage under policies as described in subsection (1),
400 which also provides liability coverage for bodily injury, death,
401 and property damage arising out of the ownership, maintenance,
402 or use of the motor vehicle in an amount not less than the
403 limits described in s. 324.021(7) and conforms to the
404 requirements of s. 324.151, to any applicant for private
405 passenger motor vehicle insurance coverage who is seeking the
406 coverage in order to reinstate the applicant's driving
407 privileges in this state after such privileges were revoked or
408 suspended under s. 316.193 or s. 322.26(2) for driving under the
409 influence.

410 (b) The policies described in paragraph (a) shall be
411 issued for a period of at least 6 months and as to the minimum
412 coverages required under this section shall not be cancelable by
413 the insured for any reason or by the insurer after a period not
414 to exceed 30 days during which the insurer must complete
415 underwriting of the policy. After the insurer has completed
416 underwriting the policy within the 30-day period, the insurer
417 shall notify the Department of Highway Safety and Motor Vehicles
418 that the policy is in full force and effect and the policy shall
419 not be cancelable for the remainder of the policy period. A
420 premium shall be collected and coverage shall be in effect for

421 the 30-day period during which the insurer is completing the
 422 underwriting of the policy whether or not the person's driver
 423 license, motor vehicle tag, and motor vehicle registration are
 424 in effect. Once the noncancelable provisions of the policy
 425 become effective, the coverage or risk shall not be changed
 426 during the policy period and the premium shall be nonrefundable.
 427 If, during the pendency of the 2-year proof of insurance period
 428 required under s. 324.0221 ~~627.733(7)~~ or during the 3-year proof
 429 of financial responsibility required under s. 324.131, whichever
 430 is applicable, the insured obtains additional coverage or
 431 coverage for an additional risk or changes territories, the
 432 insured must obtain a new 6-month noncancelable policy in
 433 accordance with the provisions of this section. However, if the
 434 insured must obtain a new 6-month policy and obtains the policy
 435 from the same insurer, the policyholder shall receive credit on
 436 the new policy for any premium paid on the previously issued
 437 policy.

438 (c) This subsection controls to the extent of any conflict
 439 with any other section.

440 (d) An insurer issuing a policy subject to this section
 441 may cancel the policy if, during the policy term, the named
 442 insured or any other operator, who resides in the same household
 443 or customarily operates an automobile insured under the policy,
 444 has his or her driver's license suspended or revoked.

445 (e) Nothing in this subsection requires an insurer to
 446 offer a policy of insurance to an applicant if such offer would
 447 be inconsistent with the insurer's underwriting guidelines and
 448 procedures.

449 Section 7. Paragraph (a) of subsection (1) of section
 450 627.7295, Florida Statutes, is amended to read:

451 627.7295 Motor vehicle insurance contracts.--

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

453 (a) "Policy" means a motor vehicle insurance policy that
 454 provides personal injury protection coverage, ~~and~~ property
 455 damage liability coverage, or both.

456 Section 8. Notwithstanding the repeal of the Florida Motor
 457 Vehicle No-Fault Law, which occurred on October 1, 2007, section
 458 627.730, Florida Statutes, is revived and reenacted to read:

459 627.730 Florida Motor Vehicle No-Fault Law.--Sections
 460 627.730-627.7405 may be cited and known as the "Florida Motor
 461 Vehicle No-Fault Law."

462 Section 9. Notwithstanding the repeal of the Florida Motor
 463 Vehicle No-Fault Law, which occurred on October 1, 2007, section
 464 627.731, Florida Statutes, is revived and reenacted to read:

465 627.731 Purpose.--The purpose of ss. 627.730-627.7405 is
 466 to provide for medical, surgical, funeral, and disability
 467 insurance benefits without regard to fault, and to require motor
 468 vehicle insurance securing such benefits, for motor vehicles
 469 required to be registered in this state and, with respect to
 470 motor vehicle accidents, a limitation on the right to claim
 471 damages for pain, suffering, mental anguish, and inconvenience.

472 Section 10. Notwithstanding the repeal of the Florida
 473 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 474 section 627.732, Florida Statutes, is revived and reenacted to
 475 read:

476 627.732 Definitions.--As used in ss. 627.730-627.7405, the

477 term:

478 (1) "Broker" means any person not possessing a license
479 under chapter 395, chapter 400, chapter 429, chapter 458,
480 chapter 459, chapter 460, chapter 461, or chapter 641 who
481 charges or receives compensation for any use of medical
482 equipment and is not the 100-percent owner or the 100-percent
483 lessee of such equipment. For purposes of this section, such
484 owner or lessee may be an individual, a corporation, a
485 partnership, or any other entity and any of its 100-percent-
486 owned affiliates and subsidiaries. For purposes of this
487 subsection, the term "lessee" means a long-term lessee under a
488 capital or operating lease, but does not include a part-time
489 lessee. The term "broker" does not include a hospital or
490 physician management company whose medical equipment is
491 ancillary to the practices managed, a debt collection agency, or
492 an entity that has contracted with the insurer to obtain a
493 discounted rate for such services; nor does the term include a
494 management company that has contracted to provide general
495 management services for a licensed physician or health care
496 facility and whose compensation is not materially affected by
497 the usage or frequency of usage of medical equipment or an
498 entity that is 100-percent owned by one or more hospitals or
499 physicians. The term "broker" does not include a person or
500 entity that certifies, upon request of an insurer, that:

- 501 (a) It is a clinic licensed under ss. 400.990-400.995;
502 (b) It is a 100-percent owner of medical equipment; and
503 (c) The owner's only part-time lease of medical equipment
504 for personal injury protection patients is on a temporary basis

505 not to exceed 30 days in a 12-month period, and such lease is
 506 solely for the purposes of necessary repair or maintenance of
 507 the 100-percent-owned medical equipment or pending the arrival
 508 and installation of the newly purchased or a replacement for the
 509 100-percent-owned medical equipment, or for patients for whom,
 510 because of physical size or claustrophobia, it is determined by
 511 the medical director or clinical director to be medically
 512 necessary that the test be performed in medical equipment that
 513 is open-style. The leased medical equipment cannot be used by
 514 patients who are not patients of the registered clinic for
 515 medical treatment of services. Any person or entity making a
 516 false certification under this subsection commits insurance
 517 fraud as defined in s. 817.234. However, the 30-day period
 518 provided in this paragraph may be extended for an additional 60
 519 days as applicable to magnetic resonance imaging equipment if
 520 the owner certifies that the extension otherwise complies with
 521 this paragraph.

522 (2) "Medically necessary" refers to a medical service or
 523 supply that a prudent physician would provide for the purpose of
 524 preventing, diagnosing, or treating an illness, injury, disease,
 525 or symptom in a manner that is:

526 (a) In accordance with generally accepted standards of
 527 medical practice;

528 (b) Clinically appropriate in terms of type, frequency,
 529 extent, site, and duration; and

530 (c) Not primarily for the convenience of the patient,
 531 physician, or other health care provider.

532 (3) "Motor vehicle" means any self-propelled vehicle with

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533 four or more wheels which is of a type both designed and
534 required to be licensed for use on the highways of this state
535 and any trailer or semitrailer designed for use with such
536 vehicle and includes:

537 (a) A "private passenger motor vehicle," which is any
538 motor vehicle which is a sedan, station wagon, or jeep-type
539 vehicle and, if not used primarily for occupational,
540 professional, or business purposes, a motor vehicle of the
541 pickup, panel, van, camper, or motor home type.

542 (b) A "commercial motor vehicle," which is any motor
543 vehicle which is not a private passenger motor vehicle.

544

545 The term "motor vehicle" does not include a mobile home or any
546 motor vehicle which is used in mass transit, other than public
547 school transportation, and designed to transport more than five
548 passengers exclusive of the operator of the motor vehicle and
549 which is owned by a municipality, a transit authority, or a
550 political subdivision of the state.

551 (4) "Named insured" means a person, usually the owner of a
552 vehicle, identified in a policy by name as the insured under the
553 policy.

554 (5) "Owner" means a person who holds the legal title to a
555 motor vehicle; or, in the event a motor vehicle is the subject
556 of a security agreement or lease with an option to purchase with
557 the debtor or lessee having the right to possession, then the
558 debtor or lessee shall be deemed the owner for the purposes of
559 ss. 627.730-627.7405.

560 (6) "Relative residing in the same household" means a

561 relative of any degree by blood or by marriage who usually makes
 562 her or his home in the same family unit, whether or not
 563 temporarily living elsewhere.

564 (7) "Certify" means to swear or attest to being true or
 565 represented in writing.

566 (8) "Immediate personal supervision," as it relates to the
 567 performance of medical services by nonphysicians not in a
 568 hospital, means that an individual licensed to perform the
 569 medical service or provide the medical supplies must be present
 570 within the confines of the physical structure where the medical
 571 services are performed or where the medical supplies are
 572 provided such that the licensed individual can respond
 573 immediately to any emergencies if needed.

574 (9) "Incident," with respect to services considered as
 575 incident to a physician's professional service, for a physician
 576 licensed under chapter 458, chapter 459, chapter 460, or chapter
 577 461, if not furnished in a hospital, means such services must be
 578 an integral, even if incidental, part of a covered physician's
 579 service.

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

585 (11) "Lawful" or "lawfully" means in substantial
 586 compliance with all relevant applicable criminal, civil, and
 587 administrative requirements of state and federal law related to
 588 the provision of medical services or treatment.

589 (12) "Hospital" means a facility that, at the time
590 services or treatment were rendered, was licensed under chapter
591 395.

592 (13) "Properly completed" means providing truthful,
593 substantially complete, and substantially accurate responses as
594 to all material elements to each applicable request for
595 information or statement by a means that may lawfully be
596 provided and that complies with this section, or as agreed by
597 the parties.

598 (14) "Upcoding" means an action that submits a billing
599 code that would result in payment greater in amount than would
600 be paid using a billing code that accurately describes the
601 services performed. The term does not include an otherwise
602 lawful bill by a magnetic resonance imaging facility, which
603 globally combines both technical and professional components, if
604 the amount of the global bill is not more than the components if
605 billed separately; however, payment of such a bill constitutes
606 payment in full for all components of such service.

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

612 Section 11. Notwithstanding the repeal of the Florida
613 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
614 section 627.733, Florida Statutes, is revived, reenacted, and
615 amended to read:

616 627.733 Required security.--

617 (1) (a) Every owner or registrant of a motor vehicle, other
 618 than a motor vehicle used as a school bus as defined in s.
 619 1006.25 or limousine, required to be registered and licensed in
 620 this state shall maintain security as required by subsection (3)
 621 in effect continuously throughout the registration or licensing
 622 period.

623 (b) Every owner or registrant of a motor vehicle used as a
 624 taxicab shall not be governed by paragraph (1) (a) but shall
 625 maintain security as required under s. 324.032(1), and s.
 626 627.737 shall not apply to any motor vehicle used as a taxicab.

627 (2) Every nonresident owner or registrant of a motor
 628 vehicle which, whether operated or not, has been physically
 629 present within this state for more than 90 days during the
 630 preceding 365 days shall thereafter maintain security as defined
 631 by subsection (3) in effect continuously throughout the period
 632 such motor vehicle remains within this state.

633 (3) Such security shall be provided:

634 (a) By an insurance policy delivered or issued for
 635 delivery in this state by an authorized or eligible motor
 636 vehicle liability insurer which provides the benefits and
 637 exemptions contained in ss. 627.730-627.7405. Any policy of
 638 insurance represented or sold as providing the security required
 639 hereunder shall be deemed to provide insurance for the payment
 640 of the required benefits; or

641 (b) By any other method authorized by s. 324.031(2), (3),
 642 or (4) and approved by the Department of Highway Safety and
 643 Motor Vehicles as affording security equivalent to that afforded
 644 by a policy of insurance or by self-insuring as authorized by s.

645 768.28(16). The person filing such security shall have all of
646 the obligations and rights of an insurer under ss. 627.730-
647 627.7405.

648 (4) An owner of a motor vehicle with respect to which
649 security is required by this section who fails to have such
650 security in effect at the time of an accident shall have no
651 immunity from tort liability, but shall be personally liable for
652 the payment of benefits under s. 627.736. With respect to such
653 benefits, such an owner shall have all of the rights and
654 obligations of an insurer under ss. 627.730-627.7405.

655 (5) In addition to other persons who are not required to
656 provide required security as required under this section and s.
657 324.022, the owner or registrant of a motor vehicle is exempt
658 from such requirements if she or he is a member of the United
659 States Armed Forces and is called to or on active duty outside
660 the United States in an emergency situation. The exemption
661 provided by this subsection applies only as long as the member
662 of the armed forces is on such active duty outside the United
663 States and applies only while the vehicle covered by the
664 security required by this section and s. 324.022 is not operated
665 by any person. Upon receipt of a written request by the insured
666 to whom the exemption provided in this subsection applies, the
667 insurer shall cancel the coverages and return any unearned
668 premium or suspend the security required by this section and s.
669 324.022. Notwithstanding s. 324.0221(2) ~~subsection (6)~~, the
670 Department of Highway Safety and Motor Vehicles may not suspend
671 the registration or operator's license of any owner or
672 registrant of a motor vehicle during the time she or he

673 qualifies for an exemption under this subsection. Any owner or
674 registrant of a motor vehicle who qualifies for an exemption
675 under this subsection shall immediately notify the department
676 prior to and at the end of the expiration of the exemption.

677 ~~(6) The Department of Highway Safety and Motor Vehicles~~
678 ~~shall suspend, after due notice and an opportunity to be heard,~~
679 ~~the registration and driver's license of any owner or registrant~~
680 ~~of a motor vehicle with respect to which security is required~~
681 ~~under this section and s. 324.022.~~

682 ~~(a) Upon its records showing that the owner or registrant~~
683 ~~of such motor vehicle did not have in full force and effect when~~
684 ~~required security complying with the terms of this section; or~~

685 ~~(b) Upon notification by the insurer to the Department of~~
686 ~~Highway Safety and Motor Vehicles, in a form approved by the~~
687 ~~department, of cancellation or termination of the required~~
688 ~~security.~~

689 ~~(7) Any operator or owner whose driver's license or~~
690 ~~registration has been suspended pursuant to this section or s.~~
691 ~~316.646 may effect its reinstatement upon compliance with the~~
692 ~~requirements of this section and upon payment to the Department~~
693 ~~of Highway Safety and Motor Vehicles of a nonrefundable~~
694 ~~reinstatement fee of \$150 for the first reinstatement. Such~~
695 ~~reinstatement fee shall be \$250 for the second reinstatement and~~
696 ~~\$500 for each subsequent reinstatement during the 3 years~~
697 ~~following the first reinstatement. Any person reinstating her or~~
698 ~~his insurance under this subsection must also secure~~
699 ~~noncancelable coverage as described in ss. 324.021(8), 324.023,~~
700 ~~and 627.7275(2) and present to the appropriate person proof that~~

701 ~~the coverage is in force on a form promulgated by the Department~~
702 ~~of Highway Safety and Motor Vehicles, such proof to be~~
703 ~~maintained for 2 years. If the person does not have a second~~
704 ~~reinstatement within 3 years after her or his initial~~
705 ~~reinstatement, the reinstatement fee shall be \$150 for the first~~
706 ~~reinstatement after that 3 year period. In the event that a~~
707 ~~person's license and registration are suspended pursuant to this~~
708 ~~section or s. 316.646, only one reinstatement fee shall be paid~~
709 ~~to reinstate the license and the registration. All fees shall be~~
710 ~~collected by the Department of Highway Safety and Motor Vehicles~~
711 ~~at the time of reinstatement. The Department of Highway Safety~~
712 ~~and Motor Vehicles shall issue proper receipts for such fees and~~
713 ~~shall promptly deposit those fees in the Highway Safety~~
714 ~~Operating Trust Fund. One third of the fee collected under this~~
715 ~~subsection shall be distributed from the Highway Safety~~
716 ~~Operating Trust Fund to the local government entity or state~~
717 ~~agency which employed the law enforcement officer who seizes a~~
718 ~~license plate pursuant to s. 324.201. Such funds may be used by~~
719 ~~the local government entity or state agency for any authorized~~
720 ~~purpose.~~

721 Section 12. Notwithstanding the repeal of the Florida
722 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
723 section 627.734, Florida Statutes, is revived and reenacted to
724 read:

725 627.734 Proof of security; security requirements;
726 penalties.--

727 (1) The provisions of chapter 324 which pertain to the
728 method of giving and maintaining proof of financial

729 responsibility and which govern and define a motor vehicle
 730 liability policy shall apply to filing and maintaining proof of
 731 security required by ss. 627.730-627.7405.

732 (2) Any person who:

733 (a) Gives information required in a report or otherwise as
 734 provided for in ss. 627.730-627.7405, knowing or having reason
 735 to believe that such information is false;

736 (b) Forges or, without authority, signs any evidence of
 737 proof of security; or

738 (c) Files, or offers for filing, any such evidence of
 739 proof, knowing or having reason to believe that it is forged or
 740 signed without authority,

741
 742 is guilty of a misdemeanor of the first degree, punishable as
 743 provided in s. 775.082 or s. 775.083.

744 Section 13. Notwithstanding the repeal of the Florida
 745 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 746 section 627.736, Florida Statutes, is revived, reenacted, and
 747 amended to read:

748 627.736 Required personal injury protection benefits;
 749 exclusions; priority; claims.--

750 (1) REQUIRED BENEFITS.--Every insurance policy complying
 751 with the security requirements of s. 627.733 shall provide
 752 personal injury protection to the named insured, relatives
 753 residing in the same household, persons operating the insured
 754 motor vehicle, passengers in such motor vehicle, and other
 755 persons struck by such motor vehicle and suffering bodily injury
 756 while not an occupant of a self-propelled vehicle, subject to

757 the provisions of subsection (2) and paragraph (4)(d), to a
758 limit of \$10,000 for loss sustained by any such person as a
759 result of bodily injury, sickness, disease, or death arising out
760 of the ownership, maintenance, or use of a motor vehicle as
761 follows:

762 (a) Medical benefits.--Eighty percent of all reasonable
763 expenses for medically necessary medical, surgical, X-ray,
764 dental, and rehabilitative services, including prosthetic
765 devices, and medically necessary ambulance, hospital, and
766 nursing services. Such benefits shall also include necessary
767 remedial treatment and services recognized and permitted under
768 the laws of the state for an injured person who relies upon
769 spiritual means through prayer alone for healing, in accordance
770 with his or her religious beliefs; however, this sentence does
771 not affect the determination of what other services or
772 procedures are medically necessary.

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

782 (c) Death benefits.--Death benefits of \$5,000 per
783 individual. The insurer may pay such benefits to the executor
784 or administrator of the deceased, to any of the deceased's

785 relatives by blood or legal adoption or connection by marriage,
 786 or to any person appearing to the insurer to be equitably
 787 entitled thereto.

788
 789 Only insurers writing motor vehicle liability insurance in this
 790 state may provide the required benefits of this section, and no
 791 such insurer shall require the purchase of any other motor
 792 vehicle coverage other than the purchase of property damage
 793 liability coverage as required by s. 627.7275 as a condition for
 794 providing such required benefits. Insurers may not require that
 795 property damage liability insurance in an amount greater than
 796 \$10,000 be purchased in conjunction with personal injury
 797 protection. Such insurers shall make benefits and required
 798 property damage liability insurance coverage available through
 799 normal marketing channels. Any insurer writing motor vehicle
 800 liability insurance in this state who fails to comply with such
 801 availability requirement as a general business practice shall be
 802 deemed to have violated part IX of chapter 626, and such
 803 violation shall constitute an unfair method of competition or an
 804 unfair or deceptive act or practice involving the business of
 805 insurance; and any such insurer committing such violation shall
 806 be subject to the penalties afforded in such part, as well as
 807 those which may be afforded elsewhere in the insurance code.

808 (2) AUTHORIZED EXCLUSIONS.--Any insurer may exclude
 809 benefits:

810 (a) For injury sustained by the named insured and
 811 relatives residing in the same household while occupying another
 812 motor vehicle owned by the named insured and not insured under

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813 the policy or for injury sustained by any person operating the
814 insured motor vehicle without the express or implied consent of
815 the insured.

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

- 819 1. Causing injury to himself or herself intentionally; or
- 820 2. Being injured while committing a felony.

821

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

830 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
831 TORT CLAIMS.--No insurer shall have a lien on any recovery in
832 tort by judgment, settlement, or otherwise for personal injury
833 protection benefits, whether suit has been filed or settlement
834 has been reached without suit. An injured party who is entitled
835 to bring suit under the provisions of ss. 627.730-627.7405, or
836 his or her legal representative, shall have no right to recover
837 any damages for which personal injury protection benefits are
838 paid or payable. The plaintiff may prove all of his or her
839 special damages notwithstanding this limitation, but if special
840 damages are introduced in evidence, the trier of facts, whether

841 judge or jury, shall not award damages for personal injury
842 protection benefits paid or payable. In all cases in which a
843 jury is required to fix damages, the court shall instruct the
844 jury that the plaintiff shall not recover such special damages
845 for personal injury protection benefits paid or payable.

846 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer
847 under ss. 627.730-627.7405 shall be primary, except that
848 benefits received under any workers' compensation law shall be
849 credited against the benefits provided by subsection (1) and
850 shall be due and payable as loss accrues, upon receipt of
851 reasonable proof of such loss and the amount of expenses and
852 loss incurred which are covered by the policy issued under ss.
853 627.730-627.7405. When the Agency for Health Care Administration
854 provides, pays, or becomes liable for medical assistance under
855 the Medicaid program related to injury, sickness, disease, or
856 death arising out of the ownership, maintenance, or use of a
857 motor vehicle, benefits under ss. 627.730-627.7405 shall be
858 subject to the provisions of the Medicaid program.

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

863 (b) Personal injury protection insurance benefits paid
864 pursuant to this section shall be overdue if not paid within 30
865 days after the insurer is furnished written notice of the fact
866 of a covered loss and of the amount of same. If such written
867 notice is not furnished to the insurer as to the entire claim,
868 any partial amount supported by written notice is overdue if not

869 | paid within 30 days after such written notice is furnished to
870 | the insurer. Any part or all of the remainder of the claim that
871 | is subsequently supported by written notice is overdue if not
872 | paid within 30 days after such written notice is furnished to
873 | the insurer. When an insurer pays only a portion of a claim or
874 | rejects a claim, the insurer shall provide at the time of the
875 | partial payment or rejection an itemized specification of each
876 | item that the insurer had reduced, omitted, or declined to pay
877 | and any information that the insurer desires the claimant to
878 | consider related to the medical necessity of the denied
879 | treatment or to explain the reasonableness of the reduced
880 | charge, provided that this shall not limit the introduction of
881 | evidence at trial; and the insurer shall include the name and
882 | address of the person to whom the claimant should respond and a
883 | claim number to be referenced in future correspondence. However,
884 | notwithstanding the fact that written notice has been furnished
885 | to the insurer, any payment shall not be deemed overdue when the
886 | insurer has reasonable proof to establish that the insurer is
887 | not responsible for the payment. For the purpose of calculating
888 | the extent to which any benefits are overdue, payment shall be
889 | treated as being made on the date a draft or other valid
890 | instrument which is equivalent to payment was placed in the
891 | United States mail in a properly addressed, postpaid envelope
892 | or, if not so posted, on the date of delivery. This paragraph
893 | does not preclude or limit the ability of the insurer to assert
894 | that the claim was unrelated, was not medically necessary, or
895 | was unreasonable or that the amount of the charge was in excess
896 | of that permitted under, or in violation of, subsection (5).

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897 Such assertion by the insurer may be made at any time, including
898 after payment of the claim or after the 30-day time period for
899 payment set forth in this paragraph.

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

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

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

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

917 3. Accidental bodily injury sustained by a relative of the
918 owner residing in the same household, under the circumstances
919 described in subparagraph 1. or subparagraph 2., provided the
920 relative at the time of the accident is domiciled in the owner's
921 household and is not himself or herself the owner of a motor
922 vehicle with respect to which security is required under ss.
923 627.730-627.7405.

924 4. Accidental bodily injury sustained in this state by any

925 other person while occupying the owner's motor vehicle or, if a
 926 resident of this state, while not an occupant of a self-
 927 propelled vehicle, if the injury is caused by physical contact
 928 with such motor vehicle, provided the injured person is not
 929 himself or herself:

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

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

934 (e) If two or more insurers are liable to pay personal
 935 injury protection benefits for the same injury to any one
 936 person, the maximum payable shall be as specified in subsection
 937 (1), and any insurer paying the benefits shall be entitled to
 938 recover from each of the other insurers an equitable pro rata
 939 share of the benefits paid and expenses incurred in processing
 940 the claim.

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

945 (g) Benefits shall not be due or payable to or on the
 946 behalf of an insured person if that person has committed, by a
 947 material act or omission, any insurance fraud relating to
 948 personal injury protection coverage under his or her policy, if
 949 the fraud is admitted to in a sworn statement by the insured or
 950 if it is established in a court of competent jurisdiction. Any
 951 insurance fraud shall void all coverage arising from the claim
 952 related to such fraud under the personal injury protection

953 coverage of the insured person who committed the fraud,
954 irrespective of whether a portion of the insured person's claim
955 may be legitimate, and any benefits paid prior to the discovery
956 of the insured person's insurance fraud shall be recoverable by
957 the insurer from the person who committed insurance fraud in
958 their entirety. The prevailing party is entitled to its costs
959 and attorney's fees in any action in which it prevails in an
960 insurer's action to enforce its right of recovery under this
961 paragraph.

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

963 (a) Any physician, hospital, clinic, or other person or
964 institution lawfully rendering treatment to an injured person
965 for a bodily injury covered by personal injury protection
966 insurance may charge the insurer and injured party only a
967 reasonable amount pursuant to this section for the services and
968 supplies rendered, and the insurer providing such coverage may
969 pay for such charges directly to such person or institution
970 lawfully rendering such treatment, if the insured receiving such
971 treatment or his or her guardian has countersigned the properly
972 completed invoice, bill, or claim form approved by the office
973 upon which such charges are to be paid for as having actually
974 been rendered, to the best knowledge of the insured or his or
975 her guardian. In no event, however, may such a charge be in
976 excess of the amount the person or institution customarily
977 charges for like services or supplies. With respect to a
978 determination of whether a charge for a particular service,
979 treatment, or otherwise is reasonable, consideration may be
980 given to evidence of usual and customary charges and payments

981 | accepted by the provider involved in the dispute, and
 982 | reimbursement levels in the community and various federal and
 983 | state medical fee schedules applicable to automobile and other
 984 | insurance coverages, and other information relevant to the
 985 | reasonableness of the reimbursement for the service, treatment,
 986 | or supply.

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

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

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

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

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

997 | e. For any treatment or service that is upcoded, or that
 998 | is unbundled when such treatment or services should be bundled,
 999 | in accordance with paragraph (d). To facilitate prompt payment
 1000 | of lawful services, an insurer may change codes that it
 1001 | determines to have been improperly or incorrectly upcoded or
 1002 | unbundled, and may make payment based on the changed codes,
 1003 | without affecting the right of the provider to dispute the
 1004 | change by the insurer, provided that before doing so, the
 1005 | insurer must contact the health care provider and discuss the
 1006 | reasons for the insurer's change and the health care provider's
 1007 | reason for the coding, or make a reasonable good faith effort to
 1008 | do so, as documented in the insurer's file; and

1009 f. For medical services or treatment billed by a physician
 1010 and not provided in a hospital unless such services are rendered
 1011 by the physician or are incident to his or her professional
 1012 services and are included on the physician's bill, including
 1013 documentation verifying that the physician is responsible for
 1014 the medical services that were rendered and billed.

1015 2. Charges for medically necessary cephalic thermograms,
 1016 peripheral thermograms, spinal ultrasounds, extremity
 1017 ultrasounds, video fluoroscopy, and surface electromyography
 1018 shall not exceed the maximum reimbursement allowance for such
 1019 procedures as set forth in the applicable fee schedule or other
 1020 payment methodology established pursuant to s. 440.13.

1021 3. Allowable amounts that may be charged to a personal
 1022 injury protection insurance insurer and insured for medically
 1023 necessary nerve conduction testing when done in conjunction with
 1024 a needle electromyography procedure and both are performed and
 1025 billed solely by a physician licensed under chapter 458, chapter
 1026 459, chapter 460, or chapter 461 who is also certified by the
 1027 American Board of Electrodiagnostic Medicine or by a board
 1028 recognized by the American Board of Medical Specialties or the
 1029 American Osteopathic Association or who holds diplomate status
 1030 with the American Chiropractic Neurology Board or its
 1031 predecessors shall not exceed 200 percent of the allowable
 1032 amount under the participating physician fee schedule of
 1033 Medicare Part B for year 2001, for the area in which the
 1034 treatment was rendered, adjusted annually on August 1 to reflect
 1035 the prior calendar year's changes in the annual Medical Care
 1036 Item of the Consumer Price Index for All Urban Consumers in the

1037 South Region as determined by the Bureau of Labor Statistics of
 1038 the United States Department of Labor.

1039 4. Allowable amounts that may be charged to a personal
 1040 injury protection insurance insurer and insured for medically
 1041 necessary nerve conduction testing that does not meet the
 1042 requirements of subparagraph 3. shall not exceed the applicable
 1043 fee schedule or other payment methodology established pursuant
 1044 to s. 440.13.

1045 5. Allowable amounts that may be charged to a personal
 1046 injury protection insurance insurer and insured for magnetic
 1047 resonance imaging services shall not exceed 175 percent of the
 1048 allowable amount under the participating physician fee schedule
 1049 of Medicare Part B for year 2001, for the area in which the
 1050 treatment was rendered, adjusted annually on August 1 to reflect
 1051 the prior calendar year's changes in the annual Medical Care
 1052 Item of the Consumer Price Index for All Urban Consumers in the
 1053 South Region as determined by the Bureau of Labor Statistics of
 1054 the United States Department of Labor for the 12-month period
 1055 ending June 30 of that year, except that allowable amounts that
 1056 may be charged to a personal injury protection insurance insurer
 1057 and insured for magnetic resonance imaging services provided in
 1058 facilities accredited by the Accreditation Association for
 1059 Ambulatory Health Care, the American College of Radiology, or
 1060 the Joint Commission on Accreditation of Healthcare
 1061 Organizations shall not exceed 200 percent of the allowable
 1062 amount under the participating physician fee schedule of
 1063 Medicare Part B for year 2001, for the area in which the
 1064 treatment was rendered, adjusted annually on August 1 to reflect

1065 the prior calendar year's changes in the annual Medical Care
 1066 Item of the Consumer Price Index for All Urban Consumers in the
 1067 South Region as determined by the Bureau of Labor Statistics of
 1068 the United States Department of Labor for the 12-month period
 1069 ending June 30 of that year. This paragraph does not apply to
 1070 charges for magnetic resonance imaging services and nerve
 1071 conduction testing for inpatients and emergency services and
 1072 care as defined in chapter 395 rendered by facilities licensed
 1073 under chapter 395.

1074 6. The Department of Health, in consultation with the
 1075 appropriate professional licensing boards, shall adopt, by rule,
 1076 a list of diagnostic tests deemed not to be medically necessary
 1077 for use in the treatment of persons sustaining bodily injury
 1078 covered by personal injury protection benefits under this
 1079 section. The initial list shall be adopted by January 1, 2004,
 1080 and shall be revised from time to time as determined by the
 1081 Department of Health, in consultation with the respective
 1082 professional licensing boards. Inclusion of a test on the list
 1083 of invalid diagnostic tests shall be based on lack of
 1084 demonstrated medical value and a level of general acceptance by
 1085 the relevant provider community and shall not be dependent for
 1086 results entirely upon subjective patient response.
 1087 Notwithstanding its inclusion on a fee schedule in this
 1088 subsection, an insurer or insured is not required to pay any
 1089 charges or reimburse claims for any invalid diagnostic test as
 1090 determined by the Department of Health.

1091 (c)1. With respect to any treatment or service, other than
 1092 medical services billed by a hospital or other provider for

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1093 emergency services as defined in s. 395.002 or inpatient
1094 services rendered at a hospital-owned facility, the statement of
1095 charges must be furnished to the insurer by the provider and may
1096 not include, and the insurer is not required to pay, charges for
1097 treatment or services rendered more than 35 days before the
1098 postmark date of the statement, except for past due amounts
1099 previously billed on a timely basis under this paragraph, and
1100 except that, if the provider submits to the insurer a notice of
1101 initiation of treatment within 21 days after its first
1102 examination or treatment of the claimant, the statement may
1103 include charges for treatment or services rendered up to, but
1104 not more than, 75 days before the postmark date of the
1105 statement. The injured party is not liable for, and the provider
1106 shall not bill the injured party for, charges that are unpaid
1107 because of the provider's failure to comply with this paragraph.
1108 Any agreement requiring the injured person or insured to pay for
1109 such charges is unenforceable.

1110 2. If, however, the insured fails to furnish the provider
1111 with the correct name and address of the insured's personal
1112 injury protection insurer, the provider has 35 days from the
1113 date the provider obtains the correct information to furnish the
1114 insurer with a statement of the charges. The insurer is not
1115 required to pay for such charges unless the provider includes
1116 with the statement documentary evidence that was provided by the
1117 insured during the 35-day period demonstrating that the provider
1118 reasonably relied on erroneous information from the insured and
1119 either:

1120 a. A denial letter from the incorrect insurer; or

1121 b. Proof of mailing, which may include an affidavit under
 1122 penalty of perjury, reflecting timely mailing to the incorrect
 1123 address or insurer.

1124 3. For emergency services and care as defined in s.
 1125 395.002 rendered in a hospital emergency department or for
 1126 transport and treatment rendered by an ambulance provider
 1127 licensed pursuant to part III of chapter 401, the provider is
 1128 not required to furnish the statement of charges within the time
 1129 periods established by this paragraph; and the insurer shall not
 1130 be considered to have been furnished with notice of the amount
 1131 of covered loss for purposes of paragraph (4) (b) until it
 1132 receives a statement complying with paragraph (d), or copy
 1133 thereof, which specifically identifies the place of service to
 1134 be a hospital emergency department or an ambulance in accordance
 1135 with billing standards recognized by the Health Care Finance
 1136 Administration.

1137 4. Each notice of insured's rights under s. 627.7401 must
 1138 include the following statement in type no smaller than 12
 1139 points:

1140
 1141 BILLING REQUIREMENTS.--Florida Statutes provide that with
 1142 respect to any treatment or services, other than certain
 1143 hospital and emergency services, the statement of charges
 1144 furnished to the insurer by the provider may not include, and
 1145 the insurer and the injured party are not required to pay,
 1146 charges for treatment or services rendered more than 35 days
 1147 before the postmark date of the statement, except for past due
 1148 amounts previously billed on a timely basis, and except that, if

1149 the provider submits to the insurer a notice of initiation of
1150 treatment within 21 days after its first examination or
1151 treatment of the claimant, the statement may include charges for
1152 treatment or services rendered up to, but not more than, 75 days
1153 before the postmark date of the statement.

1154 (d) All statements and bills for medical services rendered
1155 by any physician, hospital, clinic, or other person or
1156 institution shall be submitted to the insurer on a properly
1157 completed Centers for Medicare and Medicaid Services (CMS) 1500
1158 form, UB 92 forms, or any other standard form approved by the
1159 office or adopted by the commission for purposes of this
1160 paragraph. All billings for such services rendered by providers
1161 shall, to the extent applicable, follow the Physicians' Current
1162 Procedural Terminology (CPT) or Healthcare Correct Procedural
1163 Coding System (HCPCS), or ICD-9 in effect for the year in which
1164 services are rendered and comply with the Centers for Medicare
1165 and Medicaid Services (CMS) 1500 form instructions and the
1166 American Medical Association Current Procedural Terminology
1167 (CPT) Editorial Panel and Healthcare Correct Procedural Coding
1168 System (HCPCS). All providers other than hospitals shall include
1169 on the applicable claim form the professional license number of
1170 the provider in the line or space provided for "Signature of
1171 Physician or Supplier, Including Degrees or Credentials." In
1172 determining compliance with applicable CPT and HCPCS coding,
1173 guidance shall be provided by the Physicians' Current Procedural
1174 Terminology (CPT) or the Healthcare Correct Procedural Coding
1175 System (HCPCS) in effect for the year in which services were
1176 rendered, the Office of the Inspector General (OIG), Physicians

1177 Compliance Guidelines, and other authoritative treatises
 1178 designated by rule by the Agency for Health Care Administration.
 1179 No statement of medical services may include charges for medical
 1180 services of a person or entity that performed such services
 1181 without possessing the valid licenses required to perform such
 1182 services. For purposes of paragraph (4)(b), an insurer shall not
 1183 be considered to have been furnished with notice of the amount
 1184 of covered loss or medical bills due unless the statements or
 1185 bills comply with this paragraph, and unless the statements or
 1186 bills are properly completed in their entirety as to all
 1187 material provisions, with all relevant information being
 1188 provided therein.

1189 (e)1. At the initial treatment or service provided, each
 1190 physician, other licensed professional, clinic, or other medical
 1191 institution providing medical services upon which a claim for
 1192 personal injury protection benefits is based shall require an
 1193 insured person, or his or her guardian, to execute a disclosure
 1194 and acknowledgment form, which reflects at a minimum that:

1195 a. The insured, or his or her guardian, must countersign
 1196 the form attesting to the fact that the services set forth
 1197 therein were actually rendered;

1198 b. The insured, or his or her guardian, has both the right
 1199 and affirmative duty to confirm that the services were actually
 1200 rendered;

1201 c. The insured, or his or her guardian, was not solicited
 1202 by any person to seek any services from the medical provider;

1203 d. That the physician, other licensed professional,
 1204 clinic, or other medical institution rendering services for

1205 which payment is being claimed explained the services to the
1206 insured or his or her guardian; and

1207 e. If the insured notifies the insurer in writing of a
1208 billing error, the insured may be entitled to a certain
1209 percentage of a reduction in the amounts paid by the insured's
1210 motor vehicle insurer.

1211 2. The physician, other licensed professional, clinic, or
1212 other medical institution rendering services for which payment
1213 is being claimed has the affirmative duty to explain the
1214 services rendered to the insured, or his or her guardian, so
1215 that the insured, or his or her guardian, countersigns the form
1216 with informed consent.

1217 3. Countersignature by the insured, or his or her
1218 guardian, is not required for the reading of diagnostic tests or
1219 other services that are of such a nature that they are not
1220 required to be performed in the presence of the insured.

1221 4. The licensed medical professional rendering treatment
1222 for which payment is being claimed must sign, by his or her own
1223 hand, the form complying with this paragraph.

1224 5. The original completed disclosure and acknowledgment
1225 form shall be furnished to the insurer pursuant to paragraph
1226 (4) (b) and may not be electronically furnished.

1227 6. This disclosure and acknowledgment form is not required
1228 for services billed by a provider for emergency services as
1229 defined in s. 395.002, for emergency services and care as
1230 defined in s. 395.002 rendered in a hospital emergency
1231 department, or for transport and treatment rendered by an
1232 ambulance provider licensed pursuant to part III of chapter 401.

1233 7. The Financial Services Commission shall adopt, by rule,
1234 a standard disclosure and acknowledgment form that shall be used
1235 to fulfill the requirements of this paragraph, effective 90 days
1236 after such form is adopted and becomes final. The commission
1237 shall adopt a proposed rule by October 1, 2003. Until the rule
1238 is final, the provider may use a form of its own which otherwise
1239 complies with the requirements of this paragraph.

1240 8. As used in this paragraph, "countersigned" means a
1241 second or verifying signature, as on a previously signed
1242 document, and is not satisfied by the statement "signature on
1243 file" or any similar statement.

1244 9. The requirements of this paragraph apply only with
1245 respect to the initial treatment or service of the insured by a
1246 provider. For subsequent treatments or service, the provider
1247 must maintain a patient log signed by the patient, in
1248 chronological order by date of service, that is consistent with
1249 the services being rendered to the patient as claimed. The
1250 requirements of this subparagraph for maintaining a patient log
1251 signed by the patient may be met by a hospital that maintains
1252 medical records as required by s. 395.3025 and applicable rules
1253 and makes such records available to the insurer upon request.

1254 (f) Upon written notification by any person, an insurer
1255 shall investigate any claim of improper billing by a physician
1256 or other medical provider. The insurer shall determine if the
1257 insured was properly billed for only those services and
1258 treatments that the insured actually received. If the insurer
1259 determines that the insured has been improperly billed, the
1260 insurer shall notify the insured, the person making the written

1261 notification and the provider of its findings and shall reduce
 1262 the amount of payment to the provider by the amount determined
 1263 to be improperly billed. If a reduction is made due to such
 1264 written notification by any person, the insurer shall pay to the
 1265 person 20 percent of the amount of the reduction, up to \$500. If
 1266 the provider is arrested due to the improper billing, then the
 1267 insurer shall pay to the person 40 percent of the amount of the
 1268 reduction, up to \$500.

1269 (g) An insurer may not systematically downcode with the
 1270 intent to deny reimbursement otherwise due. Such action
 1271 constitutes a material misrepresentation under s.
 1272 626.9541(1)(i)2.

1273 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
 1274 DISPUTES.--

1275 (a) Every employer shall, if a request is made by an
 1276 insurer providing personal injury protection benefits under ss.
 1277 627.730-627.7405 against whom a claim has been made, furnish
 1278 forthwith, in a form approved by the office, a sworn statement
 1279 of the earnings, since the time of the bodily injury and for a
 1280 reasonable period before the injury, of the person upon whose
 1281 injury the claim is based.

1282 (b) Every physician, hospital, clinic, or other medical
 1283 institution providing, before or after bodily injury upon which
 1284 a claim for personal injury protection insurance benefits is
 1285 based, any products, services, or accommodations in relation to
 1286 that or any other injury, or in relation to a condition claimed
 1287 to be connected with that or any other injury, shall, if
 1288 requested to do so by the insurer against whom the claim has

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1289 | been made, furnish forthwith a written report of the history,
1290 | condition, treatment, dates, and costs of such treatment of the
1291 | injured person and why the items identified by the insurer were
1292 | reasonable in amount and medically necessary, together with a
1293 | sworn statement that the treatment or services rendered were
1294 | reasonable and necessary with respect to the bodily injury
1295 | sustained and identifying which portion of the expenses for such
1296 | treatment or services was incurred as a result of such bodily
1297 | injury, and produce forthwith, and permit the inspection and
1298 | copying of, his or her or its records regarding such history,
1299 | condition, treatment, dates, and costs of treatment; provided
1300 | that this shall not limit the introduction of evidence at trial.
1301 | Such sworn statement shall read as follows: "Under penalty of
1302 | perjury, I declare that I have read the foregoing, and the facts
1303 | alleged are true, to the best of my knowledge and belief." No
1304 | cause of action for violation of the physician-patient privilege
1305 | or invasion of the right of privacy shall be permitted against
1306 | any physician, hospital, clinic, or other medical institution
1307 | complying with the provisions of this section. The person
1308 | requesting such records and such sworn statement shall pay all
1309 | reasonable costs connected therewith. If an insurer makes a
1310 | written request for documentation or information under this
1311 | paragraph within 30 days after having received notice of the
1312 | amount of a covered loss under paragraph (4) (a), the amount or
1313 | the partial amount which is the subject of the insurer's inquiry
1314 | shall become overdue if the insurer does not pay in accordance
1315 | with paragraph (4) (b) or within 10 days after the insurer's
1316 | receipt of the requested documentation or information, whichever

1317 | occurs later. For purposes of this paragraph, the term "receipt"
 1318 | includes, but is not limited to, inspection and copying pursuant
 1319 | to this paragraph. Any insurer that requests documentation or
 1320 | information pertaining to reasonableness of charges or medical
 1321 | necessity under this paragraph without a reasonable basis for
 1322 | such requests as a general business practice is engaging in an
 1323 | unfair trade practice under the insurance code.

1324 | (c) In the event of any dispute regarding an insurer's
 1325 | right to discovery of facts under this section, the insurer may
 1326 | petition a court of competent jurisdiction to enter an order
 1327 | permitting such discovery. The order may be made only on motion
 1328 | for good cause shown and upon notice to all persons having an
 1329 | interest, and it shall specify the time, place, manner,
 1330 | conditions, and scope of the discovery. Such court may, in order
 1331 | to protect against annoyance, embarrassment, or oppression, as
 1332 | justice requires, enter an order refusing discovery or
 1333 | specifying conditions of discovery and may order payments of
 1334 | costs and expenses of the proceeding, including reasonable fees
 1335 | for the appearance of attorneys at the proceedings, as justice
 1336 | requires.

1337 | (d) The injured person shall be furnished, upon request, a
 1338 | copy of all information obtained by the insurer under the
 1339 | provisions of this section, and shall pay a reasonable charge,
 1340 | if required by the insurer.

1341 | (e) Notice to an insurer of the existence of a claim shall
 1342 | not be unreasonably withheld by an insured.

1343 | (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
 1344 | REPORTS.--

1345 (a) Whenever the mental or physical condition of an
1346 injured person covered by personal injury protection is material
1347 to any claim that has been or may be made for past or future
1348 personal injury protection insurance benefits, such person
1349 shall, upon the request of an insurer, submit to mental or
1350 physical examination by a physician or physicians. The costs of
1351 any examinations requested by an insurer shall be borne entirely
1352 by the insurer. Such examination shall be conducted within the
1353 municipality where the insured is receiving treatment, or in a
1354 location reasonably accessible to the insured, which, for
1355 purposes of this paragraph, means any location within the
1356 municipality in which the insured resides, or any location
1357 within 10 miles by road of the insured's residence, provided
1358 such location is within the county in which the insured resides.
1359 If the examination is to be conducted in a location reasonably
1360 accessible to the insured, and if there is no qualified
1361 physician to conduct the examination in a location reasonably
1362 accessible to the insured, then such examination shall be
1363 conducted in an area of the closest proximity to the insured's
1364 residence. Personal protection insurers are authorized to
1365 include reasonable provisions in personal injury protection
1366 insurance policies for mental and physical examination of those
1367 claiming personal injury protection insurance benefits. An
1368 insurer may not withdraw payment of a treating physician without
1369 the consent of the injured person covered by the personal injury
1370 protection, unless the insurer first obtains a valid report by a
1371 Florida physician licensed under the same chapter as the
1372 treating physician whose treatment authorization is sought to be

1373 withdrawn, stating that treatment was not reasonable, related,
1374 or necessary. A valid report is one that is prepared and signed
1375 by the physician examining the injured person or reviewing the
1376 treatment records of the injured person and is factually
1377 supported by the examination and treatment records if reviewed
1378 and that has not been modified by anyone other than the
1379 physician. The physician preparing the report must be in active
1380 practice, unless the physician is physically disabled. Active
1381 practice means that during the 3 years immediately preceding the
1382 date of the physical examination or review of the treatment
1383 records the physician must have devoted professional time to the
1384 active clinical practice of evaluation, diagnosis, or treatment
1385 of medical conditions or to the instruction of students in an
1386 accredited health professional school or accredited residency
1387 program or a clinical research program that is affiliated with
1388 an accredited health professional school or teaching hospital or
1389 accredited residency program. The physician preparing a report
1390 at the request of an insurer and physicians rendering expert
1391 opinions on behalf of persons claiming medical benefits for
1392 personal injury protection, or on behalf of an insured through
1393 an attorney or another entity, shall maintain, for at least 3
1394 years, copies of all examination reports as medical records and
1395 shall maintain, for at least 3 years, records of all payments
1396 for the examinations and reports. Neither an insurer nor any
1397 person acting at the direction of or on behalf of an insurer may
1398 materially change an opinion in a report prepared under this
1399 paragraph or direct the physician preparing the report to change
1400 such opinion. The denial of a payment as the result of such a

1401 changed opinion constitutes a material misrepresentation under
 1402 s. 626.9541(1)(i)2.; however, this provision does not preclude
 1403 the insurer from calling to the attention of the physician
 1404 errors of fact in the report based upon information in the claim
 1405 file.

1406 (b) If requested by the person examined, a party causing
 1407 an examination to be made shall deliver to him or her a copy of
 1408 every written report concerning the examination rendered by an
 1409 examining physician, at least one of which reports must set out
 1410 the examining physician's findings and conclusions in detail.
 1411 After such request and delivery, the party causing the
 1412 examination to be made is entitled, upon request, to receive
 1413 from the person examined every written report available to him
 1414 or her or his or her representative concerning any examination,
 1415 previously or thereafter made, of the same mental or physical
 1416 condition. By requesting and obtaining a report of the
 1417 examination so ordered, or by taking the deposition of the
 1418 examiner, the person examined waives any privilege he or she may
 1419 have, in relation to the claim for benefits, regarding the
 1420 testimony of every other person who has examined, or may
 1421 thereafter examine, him or her in respect to the same mental or
 1422 physical condition. If a person unreasonably refuses to submit
 1423 to an examination, the personal injury protection carrier is no
 1424 longer liable for subsequent personal injury protection
 1425 benefits.

1426 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 1427 FEES.--With respect to any dispute under the provisions of ss.
 1428 627.730-627.7405 between the insured and the insurer, or between

1429 an assignee of an insured's rights and the insurer, the
1430 provisions of s. 627.428 shall apply, except as provided in
1431 subsection (10) ~~(11)~~.

1432 ~~(9)(a) Each insurer which has issued a policy providing~~
1433 ~~personal injury protection benefits shall report the renewal,~~
1434 ~~cancellation, or nonrenewal thereof to the Department of Highway~~
1435 ~~Safety and Motor Vehicles within 45 days from the effective date~~
1436 ~~of the renewal, cancellation, or nonrenewal. Upon the issuance~~
1437 ~~of a policy providing personal injury protection benefits to a~~
1438 ~~named insured not previously insured by the insurer thereof~~
1439 ~~during that calendar year, the insurer shall report the issuance~~
1440 ~~of the new policy to the Department of Highway Safety and Motor~~
1441 ~~Vehicles within 30 days. The report shall be in such form and~~
1442 ~~format and contain such information as may be required by the~~
1443 ~~Department of Highway Safety and Motor Vehicles which shall~~
1444 ~~include a format compatible with the data processing~~
1445 ~~capabilities of said department, and the Department of Highway~~
1446 ~~Safety and Motor Vehicles is authorized to adopt rules necessary~~
1447 ~~with respect thereto. Failure by an insurer to file proper~~
1448 ~~reports with the Department of Highway Safety and Motor Vehicles~~
1449 ~~as required by this subsection or rules adopted with respect to~~
1450 ~~the requirements of this subsection constitutes a violation of~~
1451 ~~the Florida Insurance Code. Reports of cancellations and policy~~
1452 ~~renewals and reports of the issuance of new policies received by~~
1453 ~~the Department of Highway Safety and Motor Vehicles are~~
1454 ~~confidential and exempt from the provisions of s. 119.07(1).~~
1455 ~~These records are to be used for enforcement and regulatory~~
1456 ~~purposes only, including the generation by the department of~~

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1457 ~~data regarding compliance by owners of motor vehicles with~~
1458 ~~financial responsibility coverage requirements. In addition, the~~
1459 ~~Department of Highway Safety and Motor Vehicles shall release,~~
1460 ~~upon a written request by a person involved in a motor vehicle~~
1461 ~~accident, by the person's attorney, or by a representative of~~
1462 ~~the person's motor vehicle insurer, the name of the insurance~~
1463 ~~company and the policy number for the policy covering the~~
1464 ~~vehicle named by the requesting party. The written request must~~
1465 ~~include a copy of the appropriate accident form as provided in~~
1466 ~~s. 316.065, s. 316.066, or s. 316.068.~~

1467 ~~(b) Every insurer with respect to each insurance policy~~
1468 ~~providing personal injury protection benefits shall notify the~~
1469 ~~named insured or in the case of a commercial fleet policy, the~~
1470 ~~first named insured in writing that any cancellation or~~
1471 ~~nonrenewal of the policy will be reported by the insurer to the~~
1472 ~~Department of Highway Safety and Motor Vehicles. The notice~~
1473 ~~shall also inform the named insured that failure to maintain~~
1474 ~~personal injury protection and property damage liability~~
1475 ~~insurance on a motor vehicle when required by law may result in~~
1476 ~~the loss of registration and driving privileges in this state,~~
1477 ~~and the notice shall inform the named insured of the amount of~~
1478 ~~the reinstatement fees required by s. 627.733(7). This notice~~
1479 ~~is for informational purposes only, and no civil liability shall~~
1480 ~~attach to an insurer due to failure to provide this notice.~~

1481 ~~(9)-(10)~~ (9) An insurer may negotiate and enter into contracts
1482 with licensed health care providers for the benefits described
1483 in this section, referred to in this section as "preferred
1484 providers," which shall include health care providers licensed

1485 under chapters 458, 459, 460, 461, and 463. The insurer may
 1486 provide an option to an insured to use a preferred provider at
 1487 the time of purchase of the policy for personal injury
 1488 protection benefits, if the requirements of this subsection are
 1489 met. If the insured elects to use a provider who is not a
 1490 preferred provider, whether the insured purchased a preferred
 1491 provider policy or a nonpreferred provider policy, the medical
 1492 benefits provided by the insurer shall be as required by this
 1493 section. If the insured elects to use a provider who is a
 1494 preferred provider, the insurer may pay medical benefits in
 1495 excess of the benefits required by this section and may waive or
 1496 lower the amount of any deductible that applies to such medical
 1497 benefits. If the insurer offers a preferred provider policy to a
 1498 policyholder or applicant, it must also offer a nonpreferred
 1499 provider policy. The insurer shall provide each policyholder
 1500 with a current roster of preferred providers in the county in
 1501 which the insured resides at the time of purchase of such
 1502 policy, and shall make such list available for public inspection
 1503 during regular business hours at the principal office of the
 1504 insurer within the state.

1505 (10)~~(11)~~ DEMAND LETTER.--

1506 (a) As a condition precedent to filing any action for
 1507 benefits under this section, the insurer must be provided with
 1508 written notice of an intent to initiate litigation. Such notice
 1509 may not be sent until the claim is overdue, including any
 1510 additional time the insurer has to pay the claim pursuant to
 1511 paragraph (4) (b) .

1512 (b) The notice required shall state that it is a "demand

1513 letter under s. 627.736 (10) ~~(11)~~" and shall state with
1514 specificity:

1515 1. The name of the insured upon which such benefits are
1516 being sought, including a copy of the assignment giving rights
1517 to the claimant if the claimant is not the insured.

1518 2. The claim number or policy number upon which such claim
1519 was originally submitted to the insurer.

1520 3. To the extent applicable, the name of any medical
1521 provider who rendered to an insured the treatment, services,
1522 accommodations, or supplies that form the basis of such claim;
1523 and an itemized statement specifying each exact amount, the date
1524 of treatment, service, or accommodation, and the type of benefit
1525 claimed to be due. A completed form satisfying the requirements
1526 of paragraph (5) (d) or the lost-wage statement previously
1527 submitted may be used as the itemized statement. To the extent
1528 that the demand involves an insurer's withdrawal of payment
1529 under paragraph (7) (a) for future treatment not yet rendered,
1530 the claimant shall attach a copy of the insurer's notice
1531 withdrawing such payment and an itemized statement of the type,
1532 frequency, and duration of future treatment claimed to be
1533 reasonable and medically necessary.

1534 (c) Each notice required by this subsection must be
1535 delivered to the insurer by United States certified or
1536 registered mail, return receipt requested. Such postal costs
1537 shall be reimbursed by the insurer if so requested by the
1538 claimant in the notice, when the insurer pays the claim. Such
1539 notice must be sent to the person and address specified by the
1540 insurer for the purposes of receiving notices under this

1541 subsection. Each licensed insurer, whether domestic, foreign, or
 1542 alien, shall file with the office designation of the name and
 1543 address of the person to whom notices pursuant to this
 1544 subsection shall be sent which the office shall make available
 1545 on its Internet website. The name and address on file with the
 1546 office pursuant to s. 624.422 shall be deemed the authorized
 1547 representative to accept notice pursuant to this subsection in
 1548 the event no other designation has been made.

1549 (d) If, within 15 days after receipt of notice by the
 1550 insurer, the overdue claim specified in the notice is paid by
 1551 the insurer together with applicable interest and a penalty of
 1552 10 percent of the overdue amount paid by the insurer, subject to
 1553 a maximum penalty of \$250, no action may be brought against the
 1554 insurer. If the demand involves an insurer's withdrawal of
 1555 payment under paragraph (7) (a) for future treatment not yet
 1556 rendered, no action may be brought against the insurer if,
 1557 within 15 days after its receipt of the notice, the insurer
 1558 mails to the person filing the notice a written statement of the
 1559 insurer's agreement to pay for such treatment in accordance with
 1560 the notice and to pay a penalty of 10 percent, subject to a
 1561 maximum penalty of \$250, when it pays for such future treatment
 1562 in accordance with the requirements of this section. To the
 1563 extent the insurer determines not to pay any amount demanded,
 1564 the penalty shall not be payable in any subsequent action. For
 1565 purposes of this subsection, payment or the insurer's agreement
 1566 shall be treated as being made on the date a draft or other
 1567 valid instrument that is equivalent to payment, or the insurer's
 1568 written statement of agreement, is placed in the United States

1569 mail in a properly addressed, postpaid envelope, or if not so
 1570 posted, on the date of delivery. The insurer shall not be
 1571 obligated to pay any attorney's fees if the insurer pays the
 1572 claim or mails its agreement to pay for future treatment within
 1573 the time prescribed by this subsection.

1574 (e) The applicable statute of limitation for an action
 1575 under this section shall be tolled for a period of 15 business
 1576 days by the mailing of the notice required by this subsection.

1577 (f) Any insurer making a general business practice of not
 1578 paying valid claims until receipt of the notice required by this
 1579 subsection is engaging in an unfair trade practice under the
 1580 insurance code.

1581 (11)~~(12)~~ CIVIL ACTION FOR INSURANCE FRAUD.--An insurer
 1582 shall have a cause of action against any person convicted of, or
 1583 who, regardless of adjudication of guilt, pleads guilty or nolo
 1584 contendere to insurance fraud under s. 817.234, patient
 1585 brokering under s. 817.505, or kickbacks under s. 456.054,
 1586 associated with a claim for personal injury protection benefits
 1587 in accordance with this section. An insurer prevailing in an
 1588 action brought under this subsection may recover compensatory,
 1589 consequential, and punitive damages subject to the requirements
 1590 and limitations of part II of chapter 768, and attorney's fees
 1591 and costs incurred in litigating a cause of action against any
 1592 person convicted of, or who, regardless of adjudication of
 1593 guilt, pleads guilty or nolo contendere to insurance fraud under
 1594 s. 817.234, patient brokering under s. 817.505, or kickbacks
 1595 under s. 456.054, associated with a claim for personal injury
 1596 protection benefits in accordance with this section.

1597 (12)~~(13)~~ MINIMUM BENEFIT COVERAGE.--If the Financial
 1598 Services Commission determines that the cost savings under
 1599 personal injury protection insurance benefits paid by insurers
 1600 have been realized due to the provisions of this act, prior
 1601 legislative reforms, or other factors, the commission may
 1602 increase the minimum \$10,000 benefit coverage requirement. In
 1603 establishing the amount of such increase, the commission must
 1604 determine that the additional premium for such coverage is
 1605 approximately equal to the premium cost savings that have been
 1606 realized for the personal injury protection coverage with limits
 1607 of \$10,000.

1608 (13)~~(14)~~ FRAUD ADVISORY NOTICE.--Upon receiving notice of
 1609 a claim under this section, an insurer shall provide a notice to
 1610 the insured or to a person for whom a claim for reimbursement
 1611 for diagnosis or treatment of injuries has been filed, advising
 1612 that:

1613 (a) Pursuant to s. 626.9892, the Department of Financial
 1614 Services may pay rewards of up to \$25,000 to persons providing
 1615 information leading to the arrest and conviction of persons
 1616 committing crimes investigated by the Division of Insurance
 1617 Fraud arising from violations of s. 440.105, s. 624.15, s.
 1618 626.9541, s. 626.989, or s. 817.234.

1619 (b) Solicitation of a person injured in a motor vehicle
 1620 crash for purposes of filing personal injury protection or tort
 1621 claims could be a violation of s. 817.234, s. 817.505, or the
 1622 rules regulating The Florida Bar and should be immediately
 1623 reported to the Division of Insurance Fraud if such conduct has
 1624 taken place.

1625 Section 14. Notwithstanding the repeal of the Florida
 1626 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 1627 section 627.737, Florida Statutes, is revived and reenacted to
 1628 read:

1629 627.737 Tort exemption; limitation on right to damages;
 1630 punitive damages.--

1631 (1) Every owner, registrant, operator, or occupant of a
 1632 motor vehicle with respect to which security has been provided
 1633 as required by ss. 627.730-627.7405, and every person or
 1634 organization legally responsible for her or his acts or
 1635 omissions, is hereby exempted from tort liability for damages
 1636 because of bodily injury, sickness, or disease arising out of
 1637 the ownership, operation, maintenance, or use of such motor
 1638 vehicle in this state to the extent that the benefits described
 1639 in s. 627.736(1) are payable for such injury, or would be
 1640 payable but for any exclusion authorized by ss. 627.730-
 1641 627.7405, under any insurance policy or other method of security
 1642 complying with the requirements of s. 627.733, or by an owner
 1643 personally liable under s. 627.733 for the payment of such
 1644 benefits, unless a person is entitled to maintain an action for
 1645 pain, suffering, mental anguish, and inconvenience for such
 1646 injury under the provisions of subsection (2).

1647 (2) In any action of tort brought against the owner,
 1648 registrant, operator, or occupant of a motor vehicle with
 1649 respect to which security has been provided as required by ss.
 1650 627.730-627.7405, or against any person or organization legally
 1651 responsible for her or his acts or omissions, a plaintiff may
 1652 recover damages in tort for pain, suffering, mental anguish, and

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1653 inconvenience because of bodily injury, sickness, or disease
1654 arising out of the ownership, maintenance, operation, or use of
1655 such motor vehicle only in the event that the injury or disease
1656 consists in whole or in part of:

1657 (a) Significant and permanent loss of an important bodily
1658 function.

1659 (b) Permanent injury within a reasonable degree of medical
1660 probability, other than scarring or disfigurement.

1661 (c) Significant and permanent scarring or disfigurement.

1662 (d) Death.

1663 (3) When a defendant, in a proceeding brought pursuant to
1664 ss. 627.730-627.7405, questions whether the plaintiff has met
1665 the requirements of subsection (2), then the defendant may file
1666 an appropriate motion with the court, and the court shall, on a
1667 one-time basis only, 30 days before the date set for the trial
1668 or the pretrial hearing, whichever is first, by examining the
1669 pleadings and the evidence before it, ascertain whether the
1670 plaintiff will be able to submit some evidence that the
1671 plaintiff will meet the requirements of subsection (2). If the
1672 court finds that the plaintiff will not be able to submit such
1673 evidence, then the court shall dismiss the plaintiff's claim
1674 without prejudice.

1675 (4) In any action brought against an automobile liability
1676 insurer for damages in excess of its policy limits, no claim for
1677 punitive damages shall be allowed.

1678 Section 15. Notwithstanding the repeal of the Florida
1679 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
1680 section 627.739, Florida Statutes, is revived and reenacted to

1681 read:

1682 627.739 Personal injury protection; optional limitations;
1683 deductibles.--

1684 (1) The named insured may elect a deductible or modified
1685 coverage or combination thereof to apply to the named insured
1686 alone or to the named insured and dependent relatives residing
1687 in the same household, but may not elect a deductible or
1688 modified coverage to apply to any other person covered under the
1689 policy.

1690 (2) Insurers shall offer to each applicant and to each
1691 policyholder, upon the renewal of an existing policy,
1692 deductibles, in amounts of \$250, \$500, and \$1,000. The
1693 deductible amount must be applied to 100 percent of the expenses
1694 and losses described in s. 627.736. After the deductible is met,
1695 each insured is eligible to receive up to \$10,000 in total
1696 benefits described in s. 627.736(1). However, this subsection
1697 shall not be applied to reduce the amount of any benefits
1698 received in accordance with s. 627.736(1)(c).

1699 (3) Insurers shall offer coverage wherein, at the election
1700 of the named insured, the benefits for loss of gross income and
1701 loss of earning capacity described in s. 627.736(1)(b) shall be
1702 excluded.

1703 (4) The named insured shall not be prevented from electing
1704 a deductible under subsection (2) and modified coverage under
1705 subsection (3). Each election made by the named insured under
1706 this section shall result in an appropriate reduction of premium
1707 associated with that election.

1708 (5) All such offers shall be made in clear and unambiguous

1709 language at the time the initial application is taken and prior
 1710 to each annual renewal and shall indicate that a premium
 1711 reduction will result from each election. At the option of the
 1712 insurer, the requirements of the preceding sentence are met by
 1713 using forms of notice approved by the office, or by providing
 1714 the following notice in 10-point type in the insurer's
 1715 application for initial issuance of a policy of motor vehicle
 1716 insurance and the insurer's annual notice of renewal premium:

1717 For personal injury protection insurance, the named insured may
 1718 elect a deductible and to exclude coverage for loss of gross
 1719 income and loss of earning capacity ("lost wages"). These
 1720 elections apply to the named insured alone, or to the named
 1721 insured and all dependent resident relatives. A premium
 1722 reduction will result from these elections. The named insured is
 1723 hereby advised not to elect the lost wage exclusion if the named
 1724 insured or dependent resident relatives are employed, since lost
 1725 wages will not be payable in the event of an accident.

1726 Section 16. Notwithstanding the repeal of the Florida
 1727 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 1728 section 627.7401, Florida Statutes, is revived and reenacted to
 1729 read:

1730 627.7401 Notification of insured's rights.--

1731 (1) The commission, by rule, shall adopt a form for the
 1732 notification of insureds of their right to receive personal
 1733 injury protection benefits under the Florida Motor Vehicle No-
 1734 Fault Law. Such notice shall include:

1735 (a) A description of the benefits provided by personal
 1736 injury protection, including, but not limited to, the specific

1737 types of services for which medical benefits are paid,
1738 disability benefits, death benefits, significant exclusions from
1739 and limitations on personal injury protection benefits, when
1740 payments are due, how benefits are coordinated with other
1741 insurance benefits that the insured may have, penalties and
1742 interest that may be imposed on insurers for failure to make
1743 timely payments of benefits, and rights of parties regarding
1744 disputes as to benefits.

1745 (b) An advisory informing insureds that:

1746 1. Pursuant to s. 626.9892, the Department of Financial
1747 Services may pay rewards of up to \$25,000 to persons providing
1748 information leading to the arrest and conviction of persons
1749 committing crimes investigated by the Division of Insurance
1750 Fraud arising from violations of s. 440.105, s. 624.15, s.
1751 626.9541, s. 626.989, or s. 817.234.

1752 2. Pursuant to s. 627.736(5)(e)1., if the insured notifies
1753 the insurer of a billing error, the insured may be entitled to a
1754 certain percentage of a reduction in the amount paid by the
1755 insured's motor vehicle insurer.

1756 (c) A notice that solicitation of a person injured in a
1757 motor vehicle crash for purposes of filing personal injury
1758 protection or tort claims could be a violation of s. 817.234, s.
1759 817.505, or the rules regulating The Florida Bar and should be
1760 immediately reported to the Division of Insurance Fraud if such
1761 conduct has taken place.

1762 (2) Each insurer issuing a policy in this state providing
1763 personal injury protection benefits must mail or deliver the
1764 notice as specified in subsection (1) to an insured within 21

1765 days after receiving from the insured notice of an automobile
 1766 accident or claim involving personal injury to an insured who is
 1767 covered under the policy. The office may allow an insurer
 1768 additional time to provide the notice specified in subsection
 1769 (1) not to exceed 30 days, upon a showing by the insurer that an
 1770 emergency justifies an extension of time.

1771 (3) The notice required by this section does not alter or
 1772 modify the terms of the insurance contract or other requirements
 1773 of this act.

1774 Section 17. Notwithstanding the repeal of the Florida
 1775 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 1776 section 627.7403, Florida Statutes, is revived and reenacted to
 1777 read:

1778 627.7403 Mandatory joinder of derivative claim.--In any
 1779 action brought pursuant to the provisions of s. 627.737 claiming
 1780 personal injuries, all claims arising out of the plaintiff's
 1781 injuries, including all derivative claims, shall be brought
 1782 together, unless good cause is shown why such claims should be
 1783 brought separately.

1784 Section 18. Notwithstanding the repeal of the Florida
 1785 Motor Vehicle No-Fault Law, which occurred on October 1, 2007,
 1786 section 627.7405, Florida Statutes, is revived and reenacted to
 1787 read:

1788 627.7405 Insurers' right of
 1789 reimbursement.--Notwithstanding any other provisions of ss.
 1790 627.730-627.7405, any insurer providing personal injury
 1791 protection benefits on a private passenger motor vehicle shall
 1792 have, to the extent of any personal injury protection benefits

1793 paid to any person as a benefit arising out of such private
 1794 passenger motor vehicle insurance, a right of reimbursement
 1795 against the owner or the insurer of the owner of a commercial
 1796 motor vehicle, if the benefits paid result from such person
 1797 having been an occupant of the commercial motor vehicle or
 1798 having been struck by the commercial motor vehicle while not an
 1799 occupant of any self-propelled vehicle.

1800 Section 19. This act revives and reenacts, with
 1801 amendments, the Florida Motor Vehicle No-Fault Law, which
 1802 expired by operation of law on October 1, 2007. This act is
 1803 intended to be remedial and curative in nature and to minimize
 1804 confusion concerning the changes made by this act to ss.
 1805 627.730-627.7405, Florida Statutes. Therefore, the Florida Motor
 1806 Vehicle No-Fault Law shall continue to be codified as ss.
 1807 627.730-627.7405, Florida Statutes, notwithstanding the repeal
 1808 of those sections contained in s. 19, chapter 2003-411, Laws of
 1809 Florida.

1810 Section 20. Effective January 15, 2008, and applicable to
 1811 policies issued or renewed on or after that date, subsections
 1812 (1) and (4), paragraphs (a), (b), and (c) of subsection (5),
 1813 subsection (8), and paragraphs (d) and (e) of subsection (10) of
 1814 section 627.736, Florida Statutes, as reenacted and amended by
 1815 this act, are amended, subsections (11), (12), and (13) of that
 1816 section, as reenacted and amended by this act, are renumbered as
 1817 subsections (12), (13), and (14), respectively, and a new
 1818 subsection (11) and subsections (15) and (16) are added to that
 1819 section, to read:

1820 627.736 Required personal injury protection benefits;

1821 exclusions; priority; claims.--

1822 (1) REQUIRED BENEFITS.--Every insurance policy complying
 1823 with the security requirements of s. 627.733 shall provide
 1824 personal injury protection to the named insured, relatives
 1825 residing in the same household, persons operating the insured
 1826 motor vehicle, passengers in such motor vehicle, and other
 1827 persons struck by such motor vehicle and suffering bodily injury
 1828 while not an occupant of a self-propelled vehicle, subject to
 1829 the provisions of subsection (2) and paragraph (4) (e)~~(d)~~, to a
 1830 limit of \$10,000 for loss sustained by any such person as a
 1831 result of bodily injury, sickness, disease, or death arising out
 1832 of the ownership, maintenance, or use of a motor vehicle as
 1833 follows:

1834 (a) Medical benefits.--Eighty percent of all reasonable
 1835 expenses for medically necessary medical, surgical, X-ray,
 1836 dental, and rehabilitative services, including prosthetic
 1837 devices, and medically necessary ambulance, hospital, and
 1838 nursing services. However, the medical benefits shall provide
 1839 reimbursement only for such services and care that are provided,
 1840 lawfully supervised, ordered, or prescribed by a physician
 1841 licensed under chapter 458 or chapter 459 or a dentist licensed
 1842 under chapter 466 or that are provided by any of the following
 1843 persons or entities:

- 1844 1. A chiropractic physician licensed under chapter 460.
- 1845 2. A hospital or ambulatory surgical center licensed under
 1846 chapter 395.
- 1847 3. A person or entity licensed under ss. 401.2101-401.45
 1848 that provides emergency transportation and treatment.

1849 4. An entity wholly owned by one or more physicians
 1850 licensed under chapter 458 or chapter 459, chiropractic
 1851 physicians licensed under chapter 460, or dentists licensed
 1852 under chapter 466 or by such practitioner or practitioners and
 1853 the spouse, parent, child, or sibling of that practitioner or
 1854 those practitioners.

1855 5. An entity wholly owned, directly or indirectly, by a
 1856 hospital or hospitals.

1857 6. A health care clinic licensed under ss. 400.990-400.995
 1858 that is:

1859 a. Accredited by the Joint Commission on Accreditation of
 1860 Healthcare Organizations, the American Osteopathic Association,
 1861 the Commission on Accreditation of Rehabilitation Facilities, or
 1862 the Accreditation Association for Ambulatory Health Care, Inc.;
 1863 or

1864 b. A health care clinic that:

1865 (I) Has a medical director licensed under chapter 458,
 1866 chapter 459, or chapter 460;

1867 (II) Has been continuously licensed for more than 3 years
 1868 or is a publicly traded corporation that issues securities
 1869 traded on an exchange registered with the United States
 1870 Securities and Exchange Commission as a national securities
 1871 exchange; and

1872 (III) Provides at least four of the following medical
 1873 specialties:

1874 (A) General medicine.

1875 (B) Radiography.

1876 (C) Orthopedic medicine.

1877 (D) Physical medicine.
 1878 (E) Physical therapy.
 1879 (F) Physical rehabilitation.
 1880 (G) Prescribing or dispensing outpatient prescription
 1881 medication.
 1882 (H) Laboratory services.
 1883 7. A person or entity providing magnetic resonance imaging
 1884 services if such services have been lawfully ordered by a
 1885 licensed health care practitioner.
 1886
 1887 The Financial Services Commission shall adopt by rule the form
 1888 that must be used by an insurer and a health care provider
 1889 specified in subparagraph 4., subparagraph 5., or subparagraph
 1890 6. to document that the health care provider meets the criteria
 1891 of this paragraph, which rule must include a requirement for a
 1892 sworn statement or affidavit ~~Such benefits shall also include~~
 1893 ~~necessary remedial treatment and services recognized and~~
 1894 ~~permitted under the laws of the state for an injured person who~~
 1895 ~~relies upon spiritual means through prayer alone for healing, in~~
 1896 ~~accordance with his or her religious beliefs; however, this~~
 1897 ~~sentence does not affect the determination of what other~~
 1898 ~~services or procedures are medically necessary.~~
 1899 (b) Disability benefits.--Sixty percent of any loss of
 1900 gross income and loss of earning capacity per individual from
 1901 inability to work proximately caused by the injury sustained by
 1902 the injured person, plus all expenses reasonably incurred in
 1903 obtaining from others ordinary and necessary services in lieu of
 1904 those that, but for the injury, the injured person would have

1905 performed without income for the benefit of his or her
 1906 household. All disability benefits payable under this provision
 1907 shall be paid not less than every 2 weeks.

1908 (c) Death benefits.--Death benefits equal to the lesser of
 1909 \$5,000 or the remainder of unused personal injury protection
 1910 benefits per individual. The insurer may pay such benefits to
 1911 the executor or administrator of the deceased, to any of the
 1912 deceased's relatives by blood or legal adoption or connection by
 1913 marriage, or to any person appearing to the insurer to be
 1914 equitably entitled thereto.

1915
 1916 Only insurers writing motor vehicle liability insurance in this
 1917 state may provide the required benefits of this section, and no
 1918 such insurer shall require the purchase of any other motor
 1919 vehicle coverage other than the purchase of property damage
 1920 liability coverage as required by s. 627.7275 as a condition for
 1921 providing such required benefits. Insurers may not require that
 1922 property damage liability insurance in an amount greater than
 1923 \$10,000 be purchased in conjunction with personal injury
 1924 protection. Such insurers shall make benefits and required
 1925 property damage liability insurance coverage available through
 1926 normal marketing channels. Any insurer writing motor vehicle
 1927 liability insurance in this state who fails to comply with such
 1928 availability requirement as a general business practice shall be
 1929 deemed to have violated part IX of chapter 626, and such
 1930 violation shall constitute an unfair method of competition or an
 1931 unfair or deceptive act or practice involving the business of
 1932 insurance; and any such insurer committing such violation shall

1933 be subject to the penalties afforded in such part, as well as
 1934 those which may be afforded elsewhere in the insurance code.

1935 (4) BENEFITS; WHEN DUE.--Benefits due from an insurer
 1936 under ss. 627.730-627.7405 shall be primary, except that
 1937 benefits received under any workers' compensation law shall be
 1938 credited against the benefits provided by subsection (1) and
 1939 shall be due and payable as loss accrues, upon receipt of
 1940 reasonable proof of such loss and the amount of expenses and
 1941 loss incurred which are covered by the policy issued under ss.
 1942 627.730-627.7405. When the Agency for Health Care Administration
 1943 provides, pays, or becomes liable for medical assistance under
 1944 the Medicaid program related to injury, sickness, disease, or
 1945 death arising out of the ownership, maintenance, or use of a
 1946 motor vehicle, benefits under ss. 627.730-627.7405 shall be
 1947 subject to the provisions of the Medicaid program.

1948 (a) An insurer may require written notice to be given as
 1949 soon as practicable after an accident involving a motor vehicle
 1950 with respect to which the policy affords the security required
 1951 by ss. 627.730-627.7405.

1952 (b) Personal injury protection insurance benefits paid
 1953 pursuant to this section shall be overdue if not paid within 30
 1954 days after the insurer is furnished written notice of the fact
 1955 of a covered loss and of the amount of same. If such written
 1956 notice is not furnished to the insurer as to the entire claim,
 1957 any partial amount supported by written notice is overdue if not
 1958 paid within 30 days after such written notice is furnished to
 1959 the insurer. Any part or all of the remainder of the claim that
 1960 is subsequently supported by written notice is overdue if not

1961 | paid within 30 days after such written notice is furnished to
 1962 | the insurer. When an insurer pays only a portion of a claim or
 1963 | rejects a claim, the insurer shall provide at the time of the
 1964 | partial payment or rejection an itemized specification of each
 1965 | item that the insurer had reduced, omitted, or declined to pay
 1966 | and any information that the insurer desires the claimant to
 1967 | consider related to the medical necessity of the denied
 1968 | treatment or to explain the reasonableness of the reduced
 1969 | charge, provided that this shall not limit the introduction of
 1970 | evidence at trial; and the insurer shall include the name and
 1971 | address of the person to whom the claimant should respond and a
 1972 | claim number to be referenced in future correspondence. However,
 1973 | notwithstanding the fact that written notice has been furnished
 1974 | to the insurer, any payment shall not be deemed overdue when the
 1975 | insurer has reasonable proof to establish that the insurer is
 1976 | not responsible for the payment. For the purpose of calculating
 1977 | the extent to which any benefits are overdue, payment shall be
 1978 | treated as being made on the date a draft or other valid
 1979 | instrument which is equivalent to payment was placed in the
 1980 | United States mail in a properly addressed, postpaid envelope
 1981 | or, if not so posted, on the date of delivery. This paragraph
 1982 | does not preclude or limit the ability of the insurer to assert
 1983 | that the claim was unrelated, was not medically necessary, or
 1984 | was unreasonable or that the amount of the charge was in excess
 1985 | of that permitted under, or in violation of, subsection (5).
 1986 | Such assertion by the insurer may be made at any time, including
 1987 | after payment of the claim or after the 30-day time period for
 1988 | payment set forth in this paragraph.

1989 (c) Upon receiving notice of an accident that is
 1990 potentially covered by personal injury protection benefits, the
 1991 insurer must reserve \$5,000 of personal injury protection
 1992 benefits for payment to physicians licensed under chapter 458 or
 1993 chapter 459 or dentists licensed under chapter 466 who provide
 1994 emergency services and care, as defined in s. 395.002(9), or who
 1995 provide hospital inpatient care. The amount required to be held
 1996 in reserve may be used only to pay claims from such physicians
 1997 or dentists until 30 days after the date the insurer receives
 1998 notice of the accident. After the 30-day period, any amount of
 1999 the reserve for which the insurer has not received notice of a
 2000 claim from a physician or dentist who provided emergency
 2001 services and care or who provided hospital inpatient care may
 2002 then be used by the insurer to pay other claims. The time
 2003 periods specified in paragraph (b) for required payment of
 2004 personal injury protection benefits shall be tolled for the
 2005 period of time that an insurer is required by this paragraph to
 2006 hold payment of a claim that is not from a physician or dentist
 2007 who provided emergency services and care or who provided
 2008 hospital inpatient care to the extent that the personal injury
 2009 protection benefits not held in reserve are insufficient to pay
 2010 the claim. This paragraph does not require an insurer to
 2011 establish a claim reserve for insurance accounting purposes.

2012 (d)(e) All overdue payments shall bear simple interest at
 2013 the rate established under s. 55.03 or the rate established in
 2014 the insurance contract, whichever is greater, for the year in
 2015 which the payment became overdue, calculated from the date the
 2016 insurer was furnished with written notice of the amount of

2017 covered loss. Interest shall be due at the time payment of the
 2018 overdue claim is made.

2019 (e)~~(d)~~ The insurer of the owner of a motor vehicle shall
 2020 pay personal injury protection benefits for:

2021 1. Accidental bodily injury sustained in this state by the
 2022 owner while occupying a motor vehicle, or while not an occupant
 2023 of a self-propelled vehicle if the injury is caused by physical
 2024 contact with a motor vehicle.

2025 2. Accidental bodily injury sustained outside this state,
 2026 but within the United States of America or its territories or
 2027 possessions or Canada, by the owner while occupying the owner's
 2028 motor vehicle.

2029 3. Accidental bodily injury sustained by a relative of the
 2030 owner residing in the same household, under the circumstances
 2031 described in subparagraph 1. or subparagraph 2., provided the
 2032 relative at the time of the accident is domiciled in the owner's
 2033 household and is not himself or herself the owner of a motor
 2034 vehicle with respect to which security is required under ss.
 2035 627.730-627.7405.

2036 4. Accidental bodily injury sustained in this state by any
 2037 other person while occupying the owner's motor vehicle or, if a
 2038 resident of this state, while not an occupant of a self-
 2039 propelled vehicle, if the injury is caused by physical contact
 2040 with such motor vehicle, provided the injured person is not
 2041 himself or herself:

2042 a. The owner of a motor vehicle with respect to which
 2043 security is required under ss. 627.730-627.7405; or

2044 b. Entitled to personal injury benefits from the insurer

2045 of the owner or owners of such a motor vehicle.

2046 (f)~~(e)~~ If two or more insurers are liable to pay personal
 2047 injury protection benefits for the same injury to any one
 2048 person, the maximum payable shall be as specified in subsection
 2049 (1), and any insurer paying the benefits shall be entitled to
 2050 recover from each of the other insurers an equitable pro rata
 2051 share of the benefits paid and expenses incurred in processing
 2052 the claim.

2053 (g)~~(f)~~ It is a violation of the insurance code for an
 2054 insurer to fail to timely provide benefits as required by this
 2055 section with such frequency as to constitute a general business
 2056 practice.

2057 (h)~~(g)~~ Benefits shall not be due or payable to or on the
 2058 behalf of an insured person if that person has committed, by a
 2059 material act or omission, any insurance fraud relating to
 2060 personal injury protection coverage under his or her policy, if
 2061 the fraud is admitted to in a sworn statement by the insured or
 2062 if it is established in a court of competent jurisdiction. Any
 2063 insurance fraud shall void all coverage arising from the claim
 2064 related to such fraud under the personal injury protection
 2065 coverage of the insured person who committed the fraud,
 2066 irrespective of whether a portion of the insured person's claim
 2067 may be legitimate, and any benefits paid prior to the discovery
 2068 of the insured person's insurance fraud shall be recoverable by
 2069 the insurer from the person who committed insurance fraud in
 2070 their entirety. The prevailing party is entitled to its costs
 2071 and attorney's fees in any action in which it prevails in an
 2072 insurer's action to enforce its right of recovery under this

2073 paragraph.

2074 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

2075 (a)1. Any physician, hospital, clinic, or other person or
 2076 institution lawfully rendering treatment to an injured person
 2077 for a bodily injury covered by personal injury protection
 2078 insurance may charge the insurer and injured party only a
 2079 reasonable amount pursuant to this section for the services and
 2080 supplies rendered, and the insurer providing such coverage may
 2081 pay for such charges directly to such person or institution
 2082 lawfully rendering such treatment, if the insured receiving such
 2083 treatment or his or her guardian has countersigned the properly
 2084 completed invoice, bill, or claim form approved by the office
 2085 upon which such charges are to be paid for as having actually
 2086 been rendered, to the best knowledge of the insured or his or
 2087 her guardian. In no event, however, may such a charge be in
 2088 excess of the amount the person or institution customarily
 2089 charges for like services or supplies. With respect to a
 2090 determination of whether a charge for a particular service,
 2091 treatment, or otherwise is reasonable, consideration may be
 2092 given to evidence of usual and customary charges and payments
 2093 accepted by the provider involved in the dispute, and
 2094 reimbursement levels in the community and various federal and
 2095 state medical fee schedules applicable to automobile and other
 2096 insurance coverages, and other information relevant to the
 2097 reasonableness of the reimbursement for the service, treatment,
 2098 or supply.

2099 2. The insurer may limit reimbursement to 80 percent of
 2100 the following schedule of maximum charges:

2101 a. For emergency transport and treatment by providers
 2102 licensed under chapter 401, 200 percent of Medicare.

2103 b. For emergency services and care provided by a hospital
 2104 licensed under chapter 395, 75 percent of the hospital's usual
 2105 and customary charges.

2106 c. For emergency services and care rendered by a physician
 2107 and related hospital inpatient services rendered by a physician,
 2108 the usual and customary charges in the community.

2109 d. For hospital inpatient services, other than emergency
 2110 services and care, 200 percent of the Medicare Part A
 2111 prospective payment applicable to the specific hospital
 2112 providing the inpatient services.

2113 e. For hospital outpatient services, other than emergency
 2114 services and care, 200 percent of the Medicare Part A Ambulatory
 2115 Payment Classification for the specific hospital providing the
 2116 outpatient services.

2117 f. For all other medical services, supplies, and care, 200
 2118 percent of the applicable Medicare Part B fee schedule. However,
 2119 if such services, supplies, or care are not reimbursable under
 2120 Medicare Part B, the insurer may limit reimbursement to 80
 2121 percent of the maximum reimbursable allowance under workers'
 2122 compensation, as determined under s. 440.13 and rules adopted
 2123 thereunder which are in effect at the time such services,
 2124 supplies, or care are provided. Services, supplies, or care that
 2125 are not reimbursable under Medicare or workers' compensation are
 2126 not required to be reimbursed by the insurer.

2127 3. For purposes of subparagraph 2., the applicable fee
 2128 schedule or payment limitation under Medicare is the fee

2129 schedule or payment limitation in effect at the time the
 2130 services, supplies, or care were rendered and for the area in
 2131 which such services were rendered, except that it may not be
 2132 less than the applicable Medicare Part B fee schedule for
 2133 medical services, supplies, and care subject to Medicare Part B.

2134 4. Subparagraph 2. does not allow the insurer to apply any
 2135 limitation on the number of treatments or other utilization
 2136 limits that apply under Medicare or workers' compensation. An
 2137 insurer that applies the allowable payment limitations of
 2138 subparagraph 2. must reimburse a provider who lawfully provided
 2139 care or treatment under the scope of his or her license,
 2140 regardless of whether such provider would be entitled to
 2141 reimbursement under Medicare due to restrictions or limitations
 2142 on the types or discipline of health care providers who may be
 2143 reimbursed for particular procedures or procedure codes.

2144 5. If an insurer limits payment as authorized by
 2145 subparagraph 2., the person providing such services, supplies,
 2146 or care may not bill or attempt to collect from the insured any
 2147 amount in excess of such limits, except for amounts that are not
 2148 covered by the insured's personal injury protection coverage due
 2149 to the coinsurance amount or maximum policy limits.

2150 (b)1. An insurer or insured is not required to pay a claim
 2151 or charges:

2152 a. Made by a broker or by a person making a claim on
 2153 behalf of a broker;

2154 b. For any service or treatment that was not lawful at the
 2155 time rendered;

2156 c. To any person who knowingly submits a false or

2157 misleading statement relating to the claim or charges;
 2158 d. With respect to a bill or statement that does not
 2159 substantially meet the applicable requirements of paragraph (d);
 2160 e. For any treatment or service that is upcoded, or that
 2161 is unbundled when such treatment or services should be bundled,
 2162 in accordance with paragraph (d). To facilitate prompt payment
 2163 of lawful services, an insurer may change codes that it
 2164 determines to have been improperly or incorrectly upcoded or
 2165 unbundled, and may make payment based on the changed codes,
 2166 without affecting the right of the provider to dispute the
 2167 change by the insurer, provided that before doing so, the
 2168 insurer must contact the health care provider and discuss the
 2169 reasons for the insurer's change and the health care provider's
 2170 reason for the coding, or make a reasonable good faith effort to
 2171 do so, as documented in the insurer's file; and
 2172 f. For medical services or treatment billed by a physician
 2173 and not provided in a hospital unless such services are rendered
 2174 by the physician or are incident to his or her professional
 2175 services and are included on the physician's bill, including
 2176 documentation verifying that the physician is responsible for
 2177 the medical services that were rendered and billed.
 2178 ~~2. Charges for medically necessary cephalic thermograms,~~
 2179 ~~peripheral thermograms, spinal ultrasounds, extremity~~
 2180 ~~ultrasounds, video fluoroscopy, and surface electromyography~~
 2181 ~~shall not exceed the maximum reimbursement allowance for such~~
 2182 ~~procedures as set forth in the applicable fee schedule or other~~
 2183 ~~payment methodology established pursuant to s. 440.13.~~
 2184 ~~3. Allowable amounts that may be charged to a personal~~

2185 ~~injury protection insurance insurer and insured for medically~~
 2186 ~~necessary nerve conduction testing when done in conjunction with~~
 2187 ~~a needle electromyography procedure and both are performed and~~
 2188 ~~billed solely by a physician licensed under chapter 458, chapter~~
 2189 ~~459, chapter 460, or chapter 461 who is also certified by the~~
 2190 ~~American Board of Electrodiagnostic Medicine or by a board~~
 2191 ~~recognized by the American Board of Medical Specialties or the~~
 2192 ~~American Osteopathic Association or who holds diplomate status~~
 2193 ~~with the American Chiropractic Neurology Board or its~~
 2194 ~~predecessors shall not exceed 200 percent of the allowable~~
 2195 ~~amount under the participating physician fee schedule of~~
 2196 ~~Medicare Part B for year 2001, for the area in which the~~
 2197 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
 2198 ~~the prior calendar year's changes in the annual Medical Care~~
 2199 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
 2200 ~~South Region as determined by the Bureau of Labor Statistics of~~
 2201 ~~the United States Department of Labor.~~

2202 ~~4. Allowable amounts that may be charged to a personal~~
 2203 ~~injury protection insurance insurer and insured for medically~~
 2204 ~~necessary nerve conduction testing that does not meet the~~
 2205 ~~requirements of subparagraph 3. shall not exceed the applicable~~
 2206 ~~fee schedule or other payment methodology established pursuant~~
 2207 ~~to s. 440.13.~~

2208 ~~5. Allowable amounts that may be charged to a personal~~
 2209 ~~injury protection insurance insurer and insured for magnetic~~
 2210 ~~resonance imaging services shall not exceed 175 percent of the~~
 2211 ~~allowable amount under the participating physician fee schedule~~
 2212 ~~of Medicare Part B for year 2001, for the area in which the~~

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2213 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
2214 ~~the prior calendar year's changes in the annual Medical Care~~
2215 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
2216 ~~South Region as determined by the Bureau of Labor Statistics of~~
2217 ~~the United States Department of Labor for the 12-month period~~
2218 ~~ending June 30 of that year, except that allowable amounts that~~
2219 ~~may be charged to a personal injury protection insurance insurer~~
2220 ~~and insured for magnetic resonance imaging services provided in~~
2221 ~~facilities accredited by the Accreditation Association for~~
2222 ~~Ambulatory Health Care, the American College of Radiology, or~~
2223 ~~the Joint Commission on Accreditation of Healthcare~~
2224 ~~Organizations shall not exceed 200 percent of the allowable~~
2225 ~~amount under the participating physician fee schedule of~~
2226 ~~Medicare Part B for year 2001, for the area in which the~~
2227 ~~treatment was rendered, adjusted annually on August 1 to reflect~~
2228 ~~the prior calendar year's changes in the annual Medical Care~~
2229 ~~Item of the Consumer Price Index for All Urban Consumers in the~~
2230 ~~South Region as determined by the Bureau of Labor Statistics of~~
2231 ~~the United States Department of Labor for the 12-month period~~
2232 ~~ending June 30 of that year. This paragraph does not apply to~~
2233 ~~charges for magnetic resonance imaging services and nerve~~
2234 ~~conduction testing for inpatients and emergency services and~~
2235 ~~care as defined in chapter 395 rendered by facilities licensed~~
2236 ~~under chapter 395.~~

2237 2.6. The Department of Health, in consultation with the
2238 appropriate professional licensing boards, shall adopt, by rule,
2239 a list of diagnostic tests deemed not to be medically necessary
2240 for use in the treatment of persons sustaining bodily injury

2241 covered by personal injury protection benefits under this
 2242 section. The initial list shall be adopted by January 1, 2004,
 2243 and shall be revised from time to time as determined by the
 2244 Department of Health, in consultation with the respective
 2245 professional licensing boards. Inclusion of a test on the list
 2246 of invalid diagnostic tests shall be based on lack of
 2247 demonstrated medical value and a level of general acceptance by
 2248 the relevant provider community and shall not be dependent for
 2249 results entirely upon subjective patient response.

2250 Notwithstanding its inclusion on a fee schedule in this
 2251 subsection, an insurer or insured is not required to pay any
 2252 charges or reimburse claims for any invalid diagnostic test as
 2253 determined by the Department of Health.

2254 (c)1. With respect to any treatment or service, other than
 2255 medical services billed by a hospital or other provider for
 2256 emergency services as defined in s. 395.002 or inpatient
 2257 services rendered at a hospital-owned facility, the statement of
 2258 charges must be furnished to the insurer by the provider and may
 2259 not include, and the insurer is not required to pay, charges for
 2260 treatment or services rendered more than 35 days before the
 2261 postmark date or electronic transmission date of the statement,
 2262 except for past due amounts previously billed on a timely basis
 2263 under this paragraph, and except that, if the provider submits
 2264 to the insurer a notice of initiation of treatment within 21
 2265 days after its first examination or treatment of the claimant,
 2266 the statement may include charges for treatment or services
 2267 rendered up to, but not more than, 75 days before the postmark
 2268 date of the statement. The injured party is not liable for, and

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2269 the provider shall not bill the injured party for, charges that
2270 are unpaid because of the provider's failure to comply with this
2271 paragraph. Any agreement requiring the injured person or insured
2272 to pay for such charges is unenforceable.

2273 2. If, however, the insured fails to furnish the provider
2274 with the correct name and address of the insured's personal
2275 injury protection insurer, the provider has 35 days from the
2276 date the provider obtains the correct information to furnish the
2277 insurer with a statement of the charges. The insurer is not
2278 required to pay for such charges unless the provider includes
2279 with the statement documentary evidence that was provided by the
2280 insured during the 35-day period demonstrating that the provider
2281 reasonably relied on erroneous information from the insured and
2282 either:

2283 a. A denial letter from the incorrect insurer; or

2284 b. Proof of mailing, which may include an affidavit under
2285 penalty of perjury, reflecting timely mailing to the incorrect
2286 address or insurer.

2287 3. For emergency services and care as defined in s.
2288 395.002 rendered in a hospital emergency department or for
2289 transport and treatment rendered by an ambulance provider
2290 licensed pursuant to part III of chapter 401, the provider is
2291 not required to furnish the statement of charges within the time
2292 periods established by this paragraph; and the insurer shall not
2293 be considered to have been furnished with notice of the amount
2294 of covered loss for purposes of paragraph (4)(b) until it
2295 receives a statement complying with paragraph (d), or copy
2296 thereof, which specifically identifies the place of service to

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2297 be a hospital emergency department or an ambulance in accordance
 2298 with billing standards recognized by the Health Care Finance
 2299 Administration.

2300 4. Each notice of insured's rights under s. 627.7401 must
 2301 include the following statement in type no smaller than 12
 2302 points:

2303
 2304 BILLING REQUIREMENTS.--Florida Statutes provide that with
 2305 respect to any treatment or services, other than certain
 2306 hospital and emergency services, the statement of charges
 2307 furnished to the insurer by the provider may not include, and
 2308 the insurer and the injured party are not required to pay,
 2309 charges for treatment or services rendered more than 35 days
 2310 before the postmark date of the statement, except for past due
 2311 amounts previously billed on a timely basis, and except that, if
 2312 the provider submits to the insurer a notice of initiation of
 2313 treatment within 21 days after its first examination or
 2314 treatment of the claimant, the statement may include charges for
 2315 treatment or services rendered up to, but not more than, 75 days
 2316 before the postmark date of the statement.

2317 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 2318 FEES.--With respect to any dispute under the provisions of ss.
 2319 627.730-627.7405 between the insured and the insurer, or between
 2320 an assignee of an insured's rights and the insurer, the
 2321 provisions of s. 627.428 shall apply, except:

2322 (a) As provided in subsections ~~subsection~~ (10) and (15).

2323 (b) That attorney's fees chargeable under this subsection
 2324 shall be calculated without regard to any contingency risk

2325 multiplier.

2326 (c) That any attorney's fees recovered under ss. 627.730-
 2327 627.7405 shall be limited to the greater of \$10,000 or three
 2328 times the amount of benefits secured by the attorney under ss.
 2329 627.730-627.7405.

2330 (10) DEMAND LETTER.--

2331 (d) If, within 30 ~~15~~ days after receipt of notice by the
 2332 insurer, the overdue claim specified in the notice is paid by
 2333 the insurer together with applicable interest and a penalty of
 2334 10 percent of the overdue amount paid by the insurer, subject to
 2335 a maximum penalty of \$250, no action may be brought against the
 2336 insurer. If the demand involves an insurer's withdrawal of
 2337 payment under paragraph (7) (a) for future treatment not yet
 2338 rendered, no action may be brought against the insurer if,
 2339 within 30 ~~15~~ days after its receipt of the notice, the insurer
 2340 mails to the person filing the notice a written statement of the
 2341 insurer's agreement to pay for such treatment in accordance with
 2342 the notice and to pay a penalty of 10 percent, subject to a
 2343 maximum penalty of \$250, when it pays for such future treatment
 2344 in accordance with the requirements of this section. To the
 2345 extent the insurer determines not to pay any amount demanded,
 2346 the penalty shall not be payable in any subsequent action. For
 2347 purposes of this subsection, payment or the insurer's agreement
 2348 shall be treated as being made on the date a draft or other
 2349 valid instrument that is equivalent to payment, or the insurer's
 2350 written statement of agreement, is placed in the United States
 2351 mail in a properly addressed, postpaid envelope, or if not so
 2352 posted, on the date of delivery. The insurer is ~~shall~~ not be

2353 obligated to pay any attorney's fees if the insurer pays the
 2354 claim or mails its agreement to pay for future treatment within
 2355 the time prescribed by this subsection.

2356 (e) The applicable statute of limitation for an action
 2357 under this section shall be tolled for a period of 30 ~~45~~
 2358 business days by the mailing of the notice required by this
 2359 subsection.

2360 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
 2361 PRACTICE.--

2362 (a) If an insurer fails to pay valid claims for personal
 2363 injury protection with such frequency so as to indicate a
 2364 general business practice, the insurer is engaging in a
 2365 prohibited unfair or deceptive practice that is subject to the
 2366 penalties provided in s. 626.9521 and the office has the powers
 2367 and duties specified in ss. 626.9561-626.9601 with respect
 2368 thereto.

2369 (b) Notwithstanding s. 501.212, the Department of Legal
 2370 Affairs may investigate and initiate actions for a violation of
 2371 this subsection, including, but not limited to, the powers and
 2372 duties specified in part II of chapter 501.

2373 (15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.--In any civil
 2374 action to recover personal injury protection benefits brought by
 2375 a claimant pursuant to this section against an insurer, all
 2376 claims related to the same health care provider for the same
 2377 injured person shall be brought in one action, unless good cause
 2378 is shown why such claims should be brought separately. If the
 2379 court determines that a civil action is filed for a claim that
 2380 should have been brought in a prior civil action, the court may

2381 not award attorney's fees to the claimant.

2382 (16) SECURE ELECTRONIC DATA TRANSFER.--If all parties
 2383 mutually and expressly agree, a notice, documentation,
 2384 transmission, or communication of any kind required or
 2385 authorized under ss. 627.730-627.7405 may be transmitted
 2386 electronically if it is transmitted by secure electronic data
 2387 transfer that is consistent with state and federal privacy and
 2388 security laws.

2389 Section 21. (1) The Legislature intends that the
 2390 provisions of this act reviving and reenacting the Florida Motor
 2391 Vehicle No-Fault Law apply to policies issued on or after the
 2392 effective date of this act.

2393 (2) Each insurer that issued coverage for a motor vehicle
 2394 that is subject to the Florida Motor Vehicle No-Fault Law shall,
 2395 within 30 days after the effective date of this act, mail or
 2396 deliver a revised notice of the premium and policy changes to
 2397 each policyholder whose policy has an effective date on or after
 2398 the effective date of this act and who was previously issued a
 2399 motor vehicle insurance policy or sent a renewal notice based on
 2400 the assumption that the Florida Motor Vehicle No-Fault Law would
 2401 be repealed on October 1, 2007. For a renewal policy, the
 2402 coverage must provide the same limits of personal injury
 2403 protection coverage, the same deductible from personal injury
 2404 protection coverage, and the same limits of medical payments
 2405 coverage as provided in the prior policy, unless the
 2406 policyholder elects different limits that are available. The
 2407 effective date of the revised policy or renewal shall be the
 2408 same as the effective date specified in the prior notice. The

2409 revised notice of premium and coverage changes is exempt from
2410 the requirements of ss. 627.7277, 627.728, and 627.7282, Florida
2411 Statutes. The policyholder has a period of 30 days, or a longer
2412 period if specified by the insurer, following receipt of the
2413 revised notice within which to pay any additional amount of
2414 premium due and thereby maintain the policy in force as
2415 specified in this section. Alternatively, the policyholder may
2416 cancel the policy within this time period and obtain a refund of
2417 the unearned premium. If the policyholder fails to timely
2418 respond to the notice, the insurer must cancel the policy and
2419 return any unearned premium to the insured. The date on which
2420 the policy will be canceled shall be stated in the notice and
2421 may not be less than 35 days after the date of the notice. The
2422 amount of unearned premium due to the policyholder shall be
2423 calculated on a pro rata basis. The failure of an insurer to
2424 timely mail or deliver a revised notice as required by this
2425 subsection does not affect the other requirements of this
2426 section.

2427 (3) With respect to a policy providing personal injury
2428 protection coverage having an effective date between the
2429 effective date of this act and January 14, 2008, inclusive, the
2430 insurer shall use the forms and rates it had in effect on
2431 September 30, 2007, for all coverages in that policy unless the
2432 insurer makes a new rate or form filing that is approved by the
2433 Office of Insurance Regulation or otherwise legally allowed.

2434 (4) The Legislature recognizes that some persons have been
2435 issued a motor vehicle insurance policy effective on or after
2436 October 1, 2007, and before the effective date of this act,

2437 which does not include personal injury protection, based upon
 2438 the expected repeal of the Florida Motor Vehicle No-Fault Law on
 2439 October 1, 2007, pursuant to s. 19, chapter 2003-411, Laws of
 2440 Florida. Any such person:

2441 (a) May continue to own and operate a motor vehicle in
 2442 this state without being subject to any sanction for failing to
 2443 maintain personal injury protection coverage if that person
 2444 continues to meet statutory requirements relating to property
 2445 damage liability coverage and obtains personal injury protection
 2446 coverage that takes effect no later than December 1, 2007.

2447 (b) Is not subject to the provisions of s. 627.737,
 2448 Florida Statutes, relating to the exemption from tort liability
 2449 with respect to injuries sustained by the person in a motor
 2450 vehicle crash occurring while the policy without personal injury
 2451 protection coverage is in effect but not later than November 30,
 2452 2007. This paragraph also applies during such period to any
 2453 person who would have been covered under a personal injury
 2454 protection policy if such a policy had been maintained on such
 2455 motor vehicle.

2456 (5) Each insurer shall, by October 31, 2007, provide
 2457 written notification to each insured referred to in subsection
 2458 (4) informing the insured that he or she must obtain personal
 2459 injury protection coverage that takes effect no later than
 2460 December 1, 2007. Such notice must include the premium for such
 2461 coverage and the premium credit, if any, which will be provided
 2462 for other coverage, such as bodily injury liability coverage or
 2463 uninsured motorist coverage, as required by subsection (4).
 2464 Alternatively, the insurer may add an endorsement to the policy

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2465 to provide personal injury protection coverage as required by
2466 law, effective no later than December 1, 2007, without requiring
2467 any additional payment from the insured, and shall provide
2468 written notification to the insured of such endorsement by
2469 October 31, 2007.

2470 Section 22. Except as otherwise expressly provided in this
2471 act, this act shall take effect upon becoming a law.