A bill to be entitled

An act relating to expenses of motor vehicle crashes; creating s. 324.0221, F.S.; prohibiting an owner or operator of a motor vehicle from recovering noneconomic damages if proof of financial responsibility is not established; providing exceptions; amending s. 400.990, F.S.; providing additional legislative findings; amending s. 400.9905, F.S.; redefining the term "clinic" for purposes of the Health Care Clinic Act to include certain additional providers; excluding certain facilities owned by publicly traded corporations; defining the term "specialty clinic"; including certain facilities owned by publicly traded corporations excluded by the definition of the term "clinic"; defining the terms "infusion therapy" and "fraud"; amending s. 400.991, F.S.; requiring specialty clinics to be subject to licensure requirements; requiring additional persons to be subject to background screening; revising certain requirements for applying for licensure as a health care clinic; creating additional requirements for applying for licensure as a specialty clinic; providing additional grounds under which an applicant may be denied licensure due to a finding of guilt for committing a felony; providing grounds for the denial of specialty clinic licensure; amending s. 400.9925, F.S.; providing the agency with rulemaking authority regarding specialty clinics; amending s. 400.993, F.S.; including specialty clinics within provisions regarding unlicensed clinics; amending s.

400.9935, F.S.; including specialty clinics within provisions regarding clinic responsibilities; revising the responsibilities of the medical director and the clinic director; requiring clinic health care service providers to comply with the licensure laws and rules under which they are licensed; providing for a certificate of exemption from licensure as a clinic to expire within a specified period; providing for renewal of the certificate of exemption; revising the application procedures for a certificate of exemption; providing grounds for the denial, withdrawal, or emergency suspension of a certificate of exemption by the Agency for Health Care Administration; providing criminal penalties for an applicant who submits fraudulent or material and misleading information to the agency; requiring a specialty clinic to file an audited report with the agency no less frequently than annually; requiring a specialty clinic to maintain compliance with specified provisions; requiring health care clinics and specialty clinics to display signs containing certain information relating to insurance fraud; authorizing compliance inspections by the Division of Insurance Fraud; requiring clinics to allow inspection access; amending s. 400.995, F.S.; granting the agency authority to impose administrative penalties against a specialty clinic; creating s. 400.996, F.S.; creating a process whereby the agency receives, documents, and processes complaints about specialty clinics; requiring the agency to request that complaints regarding

billing fraud by a specialty clinic be made by sworn affidavit; requiring the agency to refer to the Office of Fiscal Integrity within the Department of Financial Services any sworn affidavit asserting billing fraud by a specialty clinic; requiring the department to report findings regarding billing fraud by a specialty clinic to the agency; requiring the department to refer an investigation to prosecutorial authorities and provide investigative assistance under certain circumstances; providing criminal penalties for submission of an affidavit asserting billing fraud by a specialty clinic that is without any factual basis; allowing the department to conduct unannounced reviews, investigations, analyses, and audits to investigate complaints of billing fraud by a specialty clinic; authorizing the department to enter upon the premises of a specialty clinic and immediately secure copies of certain documents; requiring a specialty clinic to allow full and immediate access to the premises and records of the clinic to a department officer or employee under specified provisions; providing that failure to provide such access is a ground for emergency suspension of the license of the specialty clinic; permitting the agency to assess a fee against a specialty clinic equal to the cost of conducting a review, investigation, analysis, or audit performed by the agency or the department; providing that all investigators designated by the Chief Financial Officer to perform specified duties are law enforcement officers of the state; amending s. 456.072,

F.S.; providing that intentionally providing false information in an application for a certificate of exemption from clinic licensure constitutes grounds for which disciplinary action may be taken; providing appropriations; authorizing positions and a salary rate; reviving and reenacting ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S., the Florida Motor Vehicle No-Fault Law, notwithstanding the repeal of such law provided in s. 19, chapter 2003-411, Laws of Florida; providing legislative intent concerning the application of the act; requiring insurers to deliver revised notices of premium and policy changes to certain policyholders; requiring insurers to cancel the policy and return any unearned premium if the insured fails to timely respond to the notice; providing for calculating the amount of unearned premium; providing that a person purchasing a motor vehicle insurance policy without personal injury protection coverage is exempt from the requirement for such coverage and is not subject to certain liability provisions for a specified period; requiring that insurers provide notice of the requirement for personal injury protection coverage or add an endorsement to the policy providing such coverage; providing for the future repeal of the Florida Motor Vehicle No-Fault Law, ss. 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, F.S.; providing an effective date.

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

Section 1. Section 324.0221, Florida Statutes, is created to read:

324.0221 Proof of responsibility required to recover noneconomic damages.--In any action to recover damages arising out of the operation or use of a motor vehicle, a person may not recover noneconomic damages to compensate for pain, suffering, inconvenience, or other noneconomic loss or damages if the person was the owner or operator of a vehicle involved in the accident and cannot establish that he or she maintained proof of financial responsibility at the time of the accident by one of the methods specified in s. 324.031. However, this restriction shall not apply to noneconomic damages recovered from a person who intentionally caused, or who acted in a grossly negligent manner in causing, the injury giving rise to the noneconomic damages.

Section 2. Section 400.990, Florida Statutes, is amended to read:

400.990 Short title; legislative findings.--

(1) This part~~, consisting of ss. 400.990 400.995,~~ may be cited as the "Health Care Clinic Act."

(2) The Legislature finds that the regulation of health care clinics must be strengthened to prevent significant cost and harm to consumers. The purpose of this part is to provide for the licensure, establishment, and enforcement of basic standards for health care clinics and to provide administrative

oversight by the Agency for Health Care Administration.

(3) The Legislature further finds the additional regulation of specialty health care clinics is necessary to prevent significant fraudulent practices in the provision of infusion therapy services in this state.

(4) The purpose of this part is to provide for the licensure, establishment, and enforcement of basic standards for health care clinics and to provide administrative oversight by the Agency for Health Care Administration.

Section 3. Subsection (4) of section 400.9905, Florida Statutes, is amended, and subsections (8), (9), and (10) are added to that section, to read:

400.9905 Definitions.--

(4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; or entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42

C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services or other health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; or entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; or entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42

C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; or entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part X, chapter 429, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees not less than two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state

government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, ~~or~~ corporation, or other legal entity that provides health care services by physicians and physician assistants licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 ~~physicians covered by s. 627.419~~, that is directly supervised by one or more of such physicians or physician assistants, and that is wholly owned by one or more of those physicians or physician assistants or by a physician or physician assistant and the spouse, parent, child, or sibling of that that physician or physician assistant.

(g) A sole proprietorship, group practice, partnership, ~~or~~ corporation, or other legal entity that provides health care services by licensed health care practitioners under chapter 457, ~~chapter 458, chapter 459, chapter 460, chapter 461,~~ chapter 462, chapter 463, ~~chapter 466,~~ chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which entities are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the health care services ~~business activities~~ and is legally responsible for the entity's compliance with all federal and state laws. However, ~~a~~ health care services provided may not exceed the scope of the licensed owner's health care

~~practitioner may not supervise services beyond the scope of the practitioner's~~ license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

(i) Entities that provide ~~only~~ oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange.

(j) Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education at which training is provided for chiropractic students.

(k) Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services in facilities licensed under chapter 395 and that derive at least 90 percent of their gross annual revenues from the provision of such services. Entities claiming an exemption from licensure under this paragraph must provide documentation demonstrating compliance.

(l) ~~Orthotic or prosthetic~~ Clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that

issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange.

(8) "Specialty clinic" means a clinic, as defined in subsection (4), and includes those entities exempt under that subsection that are not licensed as home health agencies that provide infusion therapy services to treat conditions caused by or related to HIV or AIDS to outpatients who remain less than 24 hours at the facility or to patients who receive such services where they reside. The term does not include:

(a) Entities licensed under part II or part III;

(b) Entities licensed under part IV that provide infusion therapy to patients only in the home or residence of the patient; or

(c) Entities licensed under chapter 395.

(9) "Infusion therapy" includes, but is not limited to, the therapeutic infusion of substances into, or the injection of substances through, the venous peripheral system, consisting of activity that includes: observing, initiating, monitoring, discontinuing, maintaining, regulating, adjusting, documenting, planning, intervening, and evaluating. This definition embraces the administration of nutrition, antibiotic therapy, and fluid and electrolyte repletion.

(10) "Fraud" means deception or misrepresentation made by a person or business entity with the intent that the deception will likely result in an unauthorized benefit to himself or herself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Section 4. Section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.--

(1)(a) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the agency pursuant to this part. A license issued by the agency is required in order to operate a clinic or specialty clinic in this state. Each clinic or specialty clinic location shall be licensed separately regardless of whether the clinic or specialty clinic is operated under the same business name or management as another clinic.

(b) Each mobile clinic or specialty clinic must obtain a separate health care clinic license and must provide to the agency, at least quarterly, its projected street location to enable the agency to locate and inspect such clinic or specialty clinic. A portable equipment provider must obtain a health care clinic license for a single administrative office and is not required to submit quarterly projected street locations.

~~(2) The initial clinic license application shall be filed with the agency by all clinics, as defined in s. 400.9905, on or before July 1, 2004.~~

(2)(a)~~(3)~~ The license application shall contain information that includes, but need not be limited to, information pertaining to the name, residence and business address, phone number, social security number, and license number of the medical or clinic director and of the licensed

medical providers employed or under contract with the clinic.

(b) Any person or entity that has a pecuniary interest in the clinic or specialty clinic who may or may not own stock or an equivalent interest in the clinic or specialty clinic, but nonetheless has control over or the authority to approve, directly or indirectly, clinic billing, policy, business activities, or personnel decisions, including, but not limited to, contracted or employed third-party billing persons or entities, managers, and management companies, and persons and entities, directly or indirectly, that lend or give money of any denomination or any thing of value exceeding an aggregate of $5,000, for clinic use, with or without an expectation of a return of the money or thing of value, and regardless of profit motive, are subject to background screening requirements under this part.

(c) The agency may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this subsection.

(3) An application for a specialty clinic shall contain, in addition to the information required in subsection (4):

(a) The correct business name of each business entity and the full name of each individual holding any ownership interest of 5 percent or more, or any pecuniary interest of $5,000 or more, in any legal entity that owns or operates any specialty clinic seeking licensure, whether such ownership or pecuniary interest arose out of a contract, loan, gift, investment, inheritance, or any other source. Individual possession of an ownership or pecuniary interest in any subject specialty clinic includes, but is not limited to, a direct or indirect interest

in:

1. The business operation, equipment, or legend pharmaceuticals used in the clinic;

2. The premises in which the clinic provides its services; or

3. Any legal entity that owns any such interest, directly or indirectly, in the business operation of the clinic; the equipment used in providing infusion therapy services at the clinic; the legend pharmaceuticals used at the clinic; or the premises in which the clinic provides its services.

(b) In the case of an incorporated business entity that holds any ownership interest of 5 percent or more, or any pecuniary interest of $5,000 or more, in the specialty clinic, copies of the articles of incorporation and bylaws, and the names and addresses of all officers and directors of the corporation.

(c) On a form furnished by the agency, a sworn notarized statement by each business entity and individual that holds any ownership interest of 5 percent or more, or any pecuniary interest of $5,000 or more, in the subject specialty clinic that discloses the nature and degree of each such ownership or pecuniary interest and that discloses the source of funds that gave rise to each such ownership or pecuniary interest.

(d) On a form furnished by the agency, a sworn notarized statement by each individual and business entity that holds any ownership interest of 5 percent or more, or any pecuniary interest of $5,000 or more, in the subject specialty clinic that discloses whether he or she has been an owner or part owner,

individually or through any business entity, of any business entity whose health care license has been revoked or suspended in any jurisdiction.

(e) On a form furnished by the agency, an estimate of the costs for establishing the specialty clinic and the source of funds for payment of those costs and for sustaining the operation of the clinic until its operation produces a positive cash flow.

For purposes of this subsection, the term "ownership or pecuniary interest" does not include any individual whose interest in a specialty clinic arises only out of his or her interest in a lending company, insurance company, or banking institution licensed by this state or any other state of the United States; a company regularly trading on a national stock exchange of the United States; or a governmental entity in the United States.

(4) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic or specialty clinic is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of each professional staff member to be employed; and

(c) Proof of financial ability to operate as required under s. 408.810(8). As an alternative to submitting proof of

financial ability to operate as required under s. 408.810(8), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic or specialty clinic will act in full conformity with all legal requirements for operating a clinic or specialty clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.

(5) Each applicant for licensure shall comply with the following requirements:

(a) As used in this subsection, the term "applicant" means an individual ~~individuals~~ owning or controlling, directly or indirectly, 5 percent or more of an interest in a clinic or an individual owning or controlling, directly or indirectly, any interest in a specialty clinic; the medical or clinic director, or a similarly titled person who is responsible for the day-to-day operation of the licensed clinic; the financial officer or similarly titled individual who is responsible for the financial operation of the clinic; and licensed health care practitioners at the clinic.

(b) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in paragraph (d) ~~chapter 435~~. Proof of compliance with the level 2 background screening requirements of paragraph (d) ~~chapter 435~~ which has been submitted within the previous 5 years in compliance with the ~~any other~~ health care licensure requirements of this part ~~state~~ is acceptable in fulfillment of this paragraph. Applicants who own less than 10 percent of a health care clinic are not required to submit

fingerprints under this section.

(c) Each applicant must submit to the agency, with the application, a description and explanation of any exclusions, permanent suspensions, or terminations of an applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interest under the Medicaid or Medicare programs may be accepted in lieu of this submission. The description and explanation may indicate whether such exclusions, suspensions, or terminations were voluntary or not voluntary on the part of the applicant. The agency may deny or revoke licensure based on information received under this paragraph.

(d) A license may not be granted to a clinic or specialty clinic if the applicant, or a person or entity identified in paragraph (3)(b), has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435; any felony under chapter 400, chapter 408, chapter 409, chapter 440, chapter 624, chapter 626, chapter 627, chapter 812, chapter 817, chapter 831, chapter 837, chapter 838, chapter 895, or chapter 896; or any substantially comparable offense or crime of another state or of the United States, if a felony in that jurisdiction, within the past 10 years. Each person required to provide background screening shall disclose to the agency any arrest for any crime for which any court disposition other than dismissal has been made within the past 10 years. Failure to provide such information shall be considered a material omission in the

application process~~, or a violation of insurance fraud under s. 817.234, within the past 5 years~~. ~~If the applicant has been convicted of an offense prohibited under the level 2 standards or insurance fraud in any jurisdiction, the applicant must show that his or her civil rights have been restored prior to submitting an application.~~

(e) Each applicant that performs the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and also provides the professional components of such services through an employee or independent contractor, must provide to the agency, on a form provided by the agency, the name and address of the clinic, the serial or operating number of each magnetic resonance imaging, static radiograph, computed tomography, and positron emission tomography machine, the name of the manufacturer of the machine, and such other information as required by the agency to identify the machine. The information must be provided to the agency upon renewal of the clinic's licensure and within 30 days after a clinic begins using a machine for which it has not provided the information to the agency.

(f) The agency shall deny or revoke a specialty clinic license if an applicant has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any felony involving dishonesty or making a false statement in any jurisdiction within the preceding 10 years.

(g) The agency shall deny a specialty clinic license application when any business entity or individual possessing an ownership or pecuniary interest in the specialty clinic also

possessed an ownership or pecuniary interest, individually or through any business entity, in any health care facility whose license was revoked in any jurisdiction during the pendency of that interest.

(h) The agency may not issue a specialty clinic license to any applicant to whom the agency has sent notice that there is a pending question as to whether one or more of the individuals with an ownership of 5 percent or more or with a pecuniary interest of $5,000 or more in the clinic has a disqualifying criminal record. The agency notice shall request the applicant to submit any additional information necessary to resolve the pending criminal background question within 21 days after receipt of the notice. The agency shall deny a specialty clinic license application when the applicant has failed to resolve a criminal background screening issue pertaining to an individual who is required to meet criminal background screening requirements of this part, and the agency raised such background screening issue by notice as set forth in this part.

Section 5. Subsections (1) and (2) of section 400.9925, Florida Statutes, are amended to read:

400.9925 Rulemaking authority; license fees.--

(1) The agency shall adopt rules necessary to administer the clinic and specialty clinic administration, regulation, and licensure program, including rules pursuant to this part and part II of chapter 408, establishing the specific licensure requirements, procedures, forms, and fees. It shall adopt rules establishing a procedure for the biennial renewal of licenses. The agency may issue initial licenses for less than the full 2-

year period by charging a prorated licensure fee and specifying a different renewal date than would otherwise be required for biennial licensure. The rules shall specify the expiration dates of licenses, the process of tracking compliance with financial responsibility requirements, and any other conditions of renewal required by law or rule.

(2) The agency shall adopt rules specifying limitations on the number of licensed clinics and specialty clinics and licensees for which a medical director or a clinic director may assume responsibility for purposes of this part. In determining the quality of supervision a medical director or a clinic or specialty clinic director can provide, the agency shall consider the number of clinic or specialty clinic employees, the clinic or specialty clinic location, and the health care services provided by the clinic or specialty clinic.

Section 6. Subsection (3) of section 400.993, Florida Statutes, is amended to read:

400.993 Unlicensed clinics; reporting.--

(3) In addition to the requirements of part II of chapter 408, any health care provider who is aware of the operation of an unlicensed clinic or specialty clinic shall report that facility to the agency. Failure to report a clinic or specialty clinic that the provider knows or has reasonable cause to suspect is unlicensed shall be reported to the provider's licensing board.

Section 7. Section 400.9935, Florida Statutes, is amended to read:

400.9935 Clinic responsibilities.--

(1) Each clinic and specialty clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

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

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

(c) Review any patient referral contracts or agreements executed by the clinic.

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

(e) Ensure that all health care practitioners at the clinic provide health care services in accordance with the requirements of subsection (5).

(f) ~~(e)~~ Serve as the clinic records owner as defined in s. 456.057.

(g) ~~(f)~~ Ensure compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of chapter 456, the respective practice acts, and rules adopted under this part and part II of chapter 408.

(h) ~~(g)~~ Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic

director shall take immediate corrective action. If the clinic performs only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, and the American College of Radiology; and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to all personal injury protection insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume the responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

(i) ~~(h)~~ Not refer a patient to the clinic if the clinic performs magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography. The term "refer a patient" means the referral of one or more patients of the medical or clinical director or a member of the medical or clinical director's group practice to the clinic for magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography. A medical director who is found to violate this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(j) Serve in that capacity for no more than five health care clinics that have a cumulative total of no more than 200 employees and persons under contract with the health care clinic

at a given time. A medical or clinic director may not supervise a health care clinic more than 200 miles away from any other health care clinic supervised by the same medical or clinic director. The agency may waive the limitations of this paragraph upon a showing of good cause and a determination by the agency that the medical director will be able to adequately perform the requirements of this subsection.

(2) Any contract to serve as a medical director or a clinic director entered into or renewed by a physician or a licensed health care practitioner in violation of this part is void as contrary to public policy. This subsection shall apply to contracts entered into or renewed on or after March 1, 2004.

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

(4) In addition to the requirements of s. 408.812, any person establishing, operating, or managing an unlicensed clinic or specialty clinic otherwise required to be licensed under this part or part II of chapter 408, or any person who knowingly files a false or misleading license application or license renewal application, or false or misleading information related to such application or department rule, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(5) Each licensed person providing health care services to an individual must comply with the licensure laws and rules

under which he or she is licensed to provide the services or as otherwise provided by law.

(6) ~~(5)~~ Any licensed health care provider who violates this part is subject to discipline in accordance with this chapter and his or her respective practice act.

(7) ~~(6)~~ Any person or entity providing health care services which is not a clinic or specialty clinic, as defined under s. 400.9905, may voluntarily apply for a certificate of exemption from licensure under its exempt status. Other than certificates of exemption granted pursuant to an exemption under s. 400.9905(4)(f), certificates of exemption shall expire in 2 years and may be renewed ~~with the agency on a form that sets forth its name or names and addresses, a statement of the reasons why it cannot be defined as a clinic, and other information deemed necessary by the agency~~. ~~An exemption is not transferable. The agency may charge an applicant for a certificate of exemption in an amount equal to $100 or the actual cost of processing the certificate, whichever is less.~~

(a) The agency shall provide a form that requires the name, address, a statement of the reasons why the applicant is exempt from licensure as a health care clinic or specialty clinic, and any other information deemed necessary by the agency. The signature on an application for a certificate of exemption must be notarized and signed by persons having knowledge of the truth of its contents. An exemption is not transferable and is valid only for the reasons, location, persons, and entity set forth on the application form. A person or entity claiming an exemption under this part or issued a

current certificate of exemption must be exempt from the licensing provisions of this part at all times, or such claim or certificate shall be invalid from the date that such person or entity is not exempt.

(b) The agency shall charge an applicant a fee of $100 for a certificate of exemption to cover the cost of processing the certificate or the actual cost of processing the certificate, whichever is less.

(c) An application for the renewal of a certificate of exemption must be submitted to the agency prior to the expiration of the certificate of exemption. The agency may investigate any applicant, person, or entity claiming an exemption for purposes of determining compliance when a certificate of exemption is sought. Authorized personnel of the agency shall have access to the premises of any certificateholder, applicant, or specialty clinic, other than a person or entity who is exempt pursuant to s. 400.9905(4)(f), for the sole purpose of determining compliance with an exemption under this part. The agency shall have access to all billings and records indicated in s. 400.9915(2) or in agency rules. The agency may deny or withdraw a certificate of exemption when a person or entity does not qualify under this part.

(d) A certificate of exemption is considered withdrawn when the agency determines that an exempt status cannot be confirmed. The provisions applicable to the unlicensed operation of a health care clinic or specialty clinic apply to any health care provider that self-determines or claims an exemption or that is issued a certificate of exemption if, in fact, such

clinic does not meet the exemption claimed.

(e) Any person or entity that submits an application for a certificate of exemption that contains fraudulent or material and misleading information commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(f) A response to a request in writing for additional information or clarification must be filed with the agency no later than 21 days after receipt of the request or the application shall be denied.

(g) The agency shall grant or deny an application for a certificate of exemption in accordance with s. 120.60(1).

(h) A person or entity that qualifies as a health care clinic or specialty clinic and has been denied a certificate of exemption must file an initial application and pay the fee. A certificate of exemption is valid only when issued and current.

(i) The agency shall issue an emergency order of suspension of a certificate of exemption when the agency finds that the applicant has provided false or misleading material information or omitted any material fact from the application for a certificate of exemption which is permitted or required by this part or has submitted false or misleading information to the agency when self-determining an exempt status and materially misleading the agency as to such status.

(8) ~~(7)~~ (a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, within 1 year after licensure. However, a clinic

may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic can not be accredited within 1 year after licensure, and that such accreditation will be completed within the 6-month extension. After obtaining accreditation as required by this subsection, each such clinic must maintain accreditation as a condition of renewal of its license.

(b) The agency may deny the application or revoke the license of any entity formed for the purpose of avoiding compliance with the accreditation provisions of this subsection and whose principals were previously principals of an entity that was unable to meet the accreditation requirements within the specified timeframes. The agency may adopt rules as to the accreditation of magnetic resonance imaging clinics.

(9) ~~(8)~~ The agency shall give full faith and credit pertaining to any past variance and waiver granted to a magnetic resonance imaging clinic from rule 64-2002, Florida Administrative Code, by the Department of Health, until September 2004. After that date, such clinic must request a variance and waiver from the agency under s. 120.542.

(10) ~~(9)~~ In addition to the requirements of part II of chapter 408, the clinic shall display a sign in a conspicuous location within the clinic readily visible to all patients indicating that, pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s.

624.15, s. 626.9541, s. 626.989, or s. 817.234. An authorized employee of the Division of Insurance Fraud may make unannounced inspections of a clinic licensed under this part as necessary to determine whether the clinic is in compliance with this subsection. A licensed clinic shall allow full and complete access to the premises to such authorized employee of the division who makes an inspection to determine compliance with this subsection.

(11) Every licensed specialty clinic shall file with the agency, upon forms to be furnished by the agency, no less frequently than annually, including concurrently with the filing of any change of ownership application, an audited report showing the following information:

(a) The number of patients served by the specialty clinic during the previous 12-month period, which report may exclude any partial month for the month when the report was prepared.

(b) Total specialty clinic operating expenses.

(c) Gross patient charges by payor category, including Medicare, Medicaid, county indigent programs, any other governmental programs, private insurance, self-paying patients, nonpaying patients, and other payees.

(d) The cost of operation of the specialty clinic during the previous 12-month period, excluding any partial month during which time the report was prepared.

(e) Unless the specialty clinic can demonstrate that the clinic already has furnished the required information regarding a particular subject individual, the full name of any individual who became an owner or became possessed of any pecuniary

interest in the subject clinic since the last report to the agency, along with the disclosure of the information required by s. 400.991(5) as to such individual.

(f) A current statement of the source of funds for payment of the costs of establishing the specialty clinic and for sustaining the operation of the specialty clinic until its operation produces a positive cash flow.

(12) Every licensee of a specialty clinic has a continuing obligation to comply with this part and to report to the agency a change of circumstance related to the clinic's continuing compliance with this part. Such a change of circumstance includes, but is not limited to, any change in the ownership of the specialty clinic, the addition of any individual or business entity possessing a pecuniary interest in the specialty clinic, the employment of any individual as a member of the specialty clinic's staff who would be required to undergo a criminal background screening if such individual had been an employee at the time of the initial licensure, and any change in the medical or clinic director. The specialty clinic shall furnish the information required about such an individual under this subsection and s. 400.991 within 30 days of the occurrence of the change of circumstance.

(13)(a) The clinic or specialty clinic shall display a sign in a conspicuous location within the clinic readily visible to all patients indicating that, pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the

Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) An authorized employee of the Division of Insurance Fraud may make an unannounced inspection of a clinic or specialty clinic licensed under this part when necessary to determine whether the clinic is in compliance with this subsection, and the clinic shall allow the division's authorized employee full and complete access to the clinic's premises for that purpose.

Section 8. Section 400.995, Florida Statutes, is amended to read:

400.995 Agency administrative penalties.--

(1) In addition to the requirements of part II of chapter 408, the agency may deny the application for a license renewal, revoke and suspend the license, and impose administrative fines of up to $5,000 per violation for violations of ~~the requirements of~~ this part or rules of the agency. In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a patient will result or has resulted, the severity of the action or potential harm, and the extent to which the ~~provisions of the~~ applicable laws or rules were violated.

(b) Actions taken by the owner, medical director, or clinic director to correct violations.

(c) Any previous violations.

(d) The financial benefit to the clinic or specialty

clinic of committing or continuing the violation.

(2) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(3) Any action taken to correct a violation shall be documented in writing by the owner, medical director, or clinic director of the clinic or specialty clinic and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated clinic or specialty clinic, revoke or deny a clinic's license when a clinic medical director or clinic director knowingly misrepresents actions taken to correct a violation.

(4) Any licensed clinic or specialty clinic whose owner, medical director, or clinic director concurrently operates an unlicensed clinic shall be subject to an administrative fine of $5,000 per day.

(5) Any clinic or specialty clinic whose owner fails to apply for a change-of-ownership license in accordance with part II of chapter 408 ~~s. 400.992~~ and operates the clinic or specialty clinic under the new ownership is subject to a fine of $5,000.

(6) The agency, as an alternative to or in conjunction with an administrative action against a clinic or specialty clinic for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner, medical director, or clinic director of the clinic or specialty clinic, prior to written notification. The agency, instead of fixing a period within

which the clinic or specialty clinic shall enter into compliance with standards, may request a plan of corrective action from the clinic or specialty clinic which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

Section 9. Section 400.996, Florida Statutes, is created to read:

400.996 Specialty clinics; complaints; audits; referrals.--

(1) The agency shall receive, document, and process complaints about specialty clinics. Upon receipt of any complaint that asserts the existence of facts evidencing possible billing fraud by a specialty clinic or by any employee of a specialty clinic, the agency shall request the complainant to make such assertions by sworn affidavit.

(2) Upon receipt of any sworn affidavit that asserts the existence of facts evidencing possible billing fraud by a specialty clinic or any of its employees, the agency shall refer the complaint to the Office of Fiscal Integrity within the Department of Financial Services.

(3) The Department of Financial Services shall report findings to the agency for any appropriate licensure action. Such report shall include a statement of facts as determined by the Department of Financial Services to exist, specifically with regard to the possible violations of licensure requirements. If, during an investigation, the department has reason to believe that any criminal law of this state has or may have been violated, the department shall refer such investigation to

appropriate prosecutorial agencies and shall provide investigative assistance to those agencies as required.

(4) The investigating authority and the agency shall cooperate with each other with respect to preparing a record and sharing information from which the agency may determine if any action for sanctions under this part by the agency is warranted.

(5) Any person submitting a sworn complaint that initiates a complaint investigation pursuant to this section, which sworn complaint is determined to be totally without any factual basis to support the assertions made in the complaint that facts existed evidencing possible fraudulent practices by a specialty clinic or any of its employees, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(6) The Office of Fiscal Integrity within the Department of Financial Services shall conduct unannounced reviews, investigations, analyses, and audits to investigate complaints and, as necessary, to determine whether specialty clinic billings are fraudulent or unlawful. The Department of Financial Services is expressly authorized to enter upon the premises of the clinic during regular business hours and demand and immediately secure copies of billing and other records of the clinic that will enable the Department of Financial Services to investigate complaints or determine whether specialty clinic billings are fraudulent or unlawful.

(7) A licensed specialty clinic shall allow full, complete, and immediate access to the premises and to billing records or information to any such officer or employee who

conducts a review, investigation, analysis, or audit to determine compliance with this part and with applicable rules. Failure to allow full, complete, and immediate access to the premises and to billing records or information to any representative of the agency or Department of Financial Services who attempts to conduct a review, investigation, analysis, or audit to determine compliance with this part constitutes a ground for emergency suspension of the license by the agency pursuant to s. 120.60(6).

(8) In addition to any administrative fines imposed, the agency may assess a fee equal to the cost of conducting any review, investigation, analysis, or audit performed by the agency or the department.

(9) All investigators designated by the Chief Financial Officer to perform duties under this part and who are certified under s. 943.1395 are law enforcement officers of the state. Such investigators have the authority to conduct criminal investigations, bear arms, make arrests, and apply for, serve, and execute search warrants, arrest warrants, capias, and other process throughout the state pertaining to fraud investigations under this section.

Section 10. Paragraph (ii) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.--

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

(ii) Intentionally providing false information on an

application for a certificate of exemption from clinic licensure under part X of chapter 400.

Section 11. For the 2007-2008 fiscal year, the sums of $510,276 in recurring funds and $111,455 in nonrecurring funds are appropriated from the Insurance Regulatory Trust Fund of the Department of Financial Services to the Division of Insurance Fraud within the department for the purpose of providing a new fraud unit within the division consisting of six sworn law enforcement officers, one nonsworn investigator, one crime analyst, and one clerical position. A total of nine full-time equivalent positions and associated salary rate of 381,500 are authorized. This appropriation is for the purposes provided in s. 626.989, Florida Statutes.

Section 12. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.730, Florida Statutes, is revived and reenacted to read:

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

Section 13. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.731, Florida Statutes, is revived and reenacted to read:

627.731 Purpose.--The purpose of ss. 627.730-627.7405 is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles

required to be registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience.

Section 14. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.732, Florida Statutes, is revived and reenacted to read:

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

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; nor does the term include a management company that has contracted to provide general management services for a licensed physician or health care facility and whose compensation is not materially affected by

the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment cannot be used by patients who are not patients of the registered clinic for medical treatment of services. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period provided in this paragraph may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(2) "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of

preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

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

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

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

(3) "Motor vehicle" means any self-propelled vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of this state and any trailer or semitrailer designed for use with such vehicle and includes:

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

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

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

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

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

(6) "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere.

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

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

(9) "Incident," with respect to services considered as incident to a physician's professional service, for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means such services must be

an integral, even if incidental, part of a covered physician's service.

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

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

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

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

(14) "Upcoding" means an action that submits a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed. The term does not include an otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if

billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

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

Section 15. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.733, Florida Statutes, is revived and reenacted to read:

627.733 Required security.--

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

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

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

(3) Such security shall be provided:

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

(b) By any other method authorized by s. 324.031(2), (3), or (4) and approved by the Department of Highway Safety and Motor Vehicles as affording security equivalent to that afforded by a policy of insurance or by self-insuring as authorized by s. 768.28(16). The person filing such security shall have all of the obligations and rights of an insurer under ss. 627.730-627.7405.

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

(5) In addition to other persons who are not required to provide required security as required under this section and s. 324.022, the owner or registrant of a motor vehicle is exempt from such requirements if she or he is a member of the United States Armed Forces and is called to or on active duty outside the United States in an emergency situation. The exemption

provided by this subsection applies only as long as the member of the armed forces is on such active duty outside the United States and applies only while the vehicle covered by the security required by this section and s. 324.022 is not operated by any person. Upon receipt of a written request by the insured to whom the exemption provided in this subsection applies, the insurer shall cancel the coverages and return any unearned premium or suspend the security required by this section and s. 324.022. Notwithstanding subsection (6), the Department of Highway Safety and Motor Vehicles may not suspend the registration or operator's license of any owner or registrant of a motor vehicle during the time she or he qualifies for an exemption under this subsection. Any owner or registrant of a motor vehicle who qualifies for an exemption under this subsection shall immediately notify the department prior to and at the end of the expiration of the exemption.

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

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

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

(7) Any operator or owner whose driver's license or registration has been suspended pursuant to this section or s. 316.646 may effect its reinstatement upon compliance with the requirements of this section and upon payment to the Department of Highway Safety and Motor Vehicles of a nonrefundable reinstatement fee of $150 for the first reinstatement. Such reinstatement fee shall be $250 for the second reinstatement and $500 for each subsequent reinstatement during the 3 years following the first reinstatement. Any person reinstating her or his insurance under this subsection must also secure noncancelable coverage as described in ss. 324.021(8), 324.023, and 627.7275(2) and present to the appropriate person proof that the coverage is in force on a form promulgated by the Department of Highway Safety and Motor Vehicles, such proof to be maintained for 2 years. If the person does not have a second reinstatement within 3 years after her or his initial reinstatement, the reinstatement fee shall be $150 for the first reinstatement after that 3-year period. In the event that a person's license and registration are suspended pursuant to this section or s. 316.646, only one reinstatement fee shall be paid to reinstate the license and the registration. All fees shall be collected by the Department of Highway Safety and Motor Vehicles at the time of reinstatement. The Department of Highway Safety and Motor Vehicles shall issue proper receipts for such fees and shall promptly deposit those fees in the Highway Safety Operating Trust Fund. One-third of the fee collected under this subsection shall be distributed from the Highway Safety Operating Trust Fund to the local government entity or state

agency which employed the law enforcement officer who seizes a license plate pursuant to s. 324.201. Such funds may be used by the local government entity or state agency for any authorized purpose.

Section 16. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.734, Florida Statutes, is revived and reenacted to read:

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

(1) The provisions of chapter 324 which pertain to the method of giving and maintaining proof of financial responsibility and which govern and define a motor vehicle liability policy shall apply to filing and maintaining proof of security required by ss. 627.730-627.7405.

(2) Any person who:

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

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

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

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

Section 17. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.736, Florida Statutes, is revived and reenacted to read:

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

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

(a) Medical benefits.--Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. Such benefits shall also include necessary remedial treatment and services recognized and permitted under the laws of the state for an injured person who relies upon spiritual means through prayer alone for healing, in accordance with his or her religious beliefs; however, this sentence does

not affect the determination of what other services or procedures are medically necessary.

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

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

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through

normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

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

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

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

1. Causing injury to himself or herself intentionally; or

2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle

prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

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

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

the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for medically

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

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

5. Allowable amounts that may be charged to a personal injury protection insurance insurer and insured for magnetic resonance imaging services shall not exceed 175 percent of the allowable amount under the participating physician fee schedule of Medicare Part B for year 2001, for the area in which the treatment was rendered, adjusted annually on August 1 to reflect

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

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

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

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

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

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

a. A denial letter from the incorrect insurer; or

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

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

with billing standards recognized by the Health Care Finance Administration.

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

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

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural

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

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical

institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

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

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

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

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

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

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

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or

other services that are of such a nature that they are not required to be performed in the presence of the insured.

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

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

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

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

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

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider

must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

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

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

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

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts

alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

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

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

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

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

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

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

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

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

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

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

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

(9)(a) Each insurer which has issued a policy providing personal injury protection benefits shall report the renewal, cancellation, or nonrenewal thereof to the Department of Highway Safety and Motor Vehicles within 45 days from the effective date of the renewal, cancellation, or nonrenewal. Upon the issuance of a policy providing personal injury protection benefits to a named insured not previously insured by the insurer thereof during that calendar year, the insurer shall report the issuance of the new policy to the Department of Highway Safety and Motor Vehicles within 30 days. The report shall be in such form and format and contain such information as may be required by the

Department of Highway Safety and Motor Vehicles which shall include a format compatible with the data processing capabilities of said department, and the Department of Highway Safety and Motor Vehicles is authorized to adopt rules necessary with respect thereto. Failure by an insurer to file proper reports with the Department of Highway Safety and Motor Vehicles as required by this subsection or rules adopted with respect to the requirements of this subsection constitutes a violation of the Florida Insurance Code. Reports of cancellations and policy renewals and reports of the issuance of new policies received by the Department of Highway Safety and Motor Vehicles are confidential and exempt from the provisions of s. 119.07(1). These records are to be used for enforcement and regulatory purposes only, including the generation by the department of data regarding compliance by owners of motor vehicles with financial responsibility coverage requirements. In addition, the Department of Highway Safety and Motor Vehicles shall release, upon a written request by a person involved in a motor vehicle accident, by the person's attorney, or by a representative of the person's motor vehicle insurer, the name of the insurance company and the policy number for the policy covering the vehicle named by the requesting party. The written request must include a copy of the appropriate accident form as provided in s. 316.065, s. 316.066, or s. 316.068.

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

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

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

provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(11) DEMAND LETTER.--

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

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

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

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

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent

that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.

(d) If, within 15 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet

rendered, no action may be brought against the insurer if, within 15 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty shall not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer shall not be obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

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

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

(12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo

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

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

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

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

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

Section 18. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.737, Florida Statutes, is revived and reenacted to read:

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

(1) Every owner, registrant, operator, or occupant of a motor vehicle with respect to which security has been provided as required by ss. 627.730-627.7405, and every person or organization legally responsible for her or his acts or omissions, is hereby exempted from tort liability for damages because of bodily injury, sickness, or disease arising out of the ownership, operation, maintenance, or use of such motor vehicle in this state to the extent that the benefits described in s. 627.736(1) are payable for such injury, or would be payable but for any exclusion authorized by ss. 627.730-

627.7405, under any insurance policy or other method of security complying with the requirements of s. 627.733, or by an owner personally liable under s. 627.733 for the payment of such benefits, unless a person is entitled to maintain an action for pain, suffering, mental anguish, and inconvenience for such injury under the provisions of subsection (2).

(2) In any action of tort brought against the owner, registrant, operator, or occupant of a motor vehicle with respect to which security has been provided as required by ss. 627.730-627.7405, or against any person or organization legally responsible for her or his acts or omissions, a plaintiff may recover damages in tort for pain, suffering, mental anguish, and inconvenience because of bodily injury, sickness, or disease arising out of the ownership, maintenance, operation, or use of such motor vehicle only in the event that the injury or disease consists in whole or in part of:

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

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

(c) Significant and permanent scarring or disfigurement.

(d) Death.

(3) When a defendant, in a proceeding brought pursuant to ss. 627.730-627.7405, questions whether the plaintiff has met the requirements of subsection (2), then the defendant may file an appropriate motion with the court, and the court shall, on a one-time basis only, 30 days before the date set for the trial or the pretrial hearing, whichever is first, by examining the

pleadings and the evidence before it, ascertain whether the plaintiff will be able to submit some evidence that the plaintiff will meet the requirements of subsection (2). If the court finds that the plaintiff will not be able to submit such evidence, then the court shall dismiss the plaintiff's claim without prejudice.

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

Section 19. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.739, Florida Statutes, is revived and reenacted to read:

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

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

(2) Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, and $1,000. The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736. After the deductible is met, each insured is eligible to receive up to $10,000 in total benefits described in s. 627.736(1). However, this subsection

shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

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

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

(5) All such offers shall be made in clear and unambiguous language at the time the initial application is taken and prior to each annual renewal and shall indicate that a premium reduction will result from each election. At the option of the insurer, the requirements of the preceding sentence are met by using forms of notice approved by the office, or by providing the following notice in 10-point type in the insurer's application for initial issuance of a policy of motor vehicle insurance and the insurer's annual notice of renewal premium:

For personal injury protection insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named

insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

Section 20. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.7401, Florida Statutes, is revived and reenacted to read:

627.7401 Notification of insured's rights.--

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

(a) A description of the benefits provided by personal injury protection, including, but not limited to, the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions from and limitations on personal injury protection benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, penalties and interest that may be imposed on insurers for failure to make timely payments of benefits, and rights of parties regarding disputes as to benefits.

(b) An advisory informing insureds that:

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

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

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

(2) Each insurer issuing a policy in this state providing personal injury protection benefits must mail or deliver the notice as specified in subsection (1) to an insured within 21 days after receiving from the insured notice of an automobile accident or claim involving personal injury to an insured who is covered under the policy. The office may allow an insurer additional time to provide the notice specified in subsection (1) not to exceed 30 days, upon a showing by the insurer that an emergency justifies an extension of time.

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

Section 21. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.7403, Florida Statutes, is revived and reenacted to read:

627.7403 Mandatory joinder of derivative claim.--In any action brought pursuant to the provisions of s. 627.737 claiming

personal injuries, all claims arising out of the plaintiff's injuries, including all derivative claims, shall be brought together, unless good cause is shown why such claims should be brought separately.

Section 22. Notwithstanding the repeal of the Florida Motor Vehicle No-Fault Law, which occurred on October 1, 2007, section 627.7405, Florida Statutes, is revived and reenacted to read:

627.7405 Insurers' right of reimbursement.--Notwithstanding any other provisions of ss. 627.730-627.7405, any insurer providing personal injury protection benefits on a private passenger motor vehicle shall have, to the extent of any personal injury protection benefits paid to any person as a benefit arising out of such private passenger motor vehicle insurance, a right of reimbursement against the owner or the insurer of the owner of a commercial motor vehicle, if the benefits paid result from such person having been an occupant of the commercial motor vehicle or having been struck by the commercial motor vehicle while not an occupant of any self-propelled vehicle.

Section 23. This act revives and reenacts the Florida Motor Vehicle No-Fault Law, which expired by operation of law on October 1, 2007. This act is intended to be remedial and curative in nature. Therefore, the Florida Motor Vehicle No-Fault Law shall continue to be codified as ss. 627.730-627.7405, Florida Statutes, notwithstanding the repeal of those sections contained in s. 19, chapter 2003-411, Laws of Florida.

Section 24. (1) The Legislature intends that the

provisions of this act reviving and reenacting the Florida Motor Vehicle No-Fault Law apply to policies issued on or after the effective date of this act.

(2) Each insurer that issued coverage for a motor vehicle that is subject to the Florida Motor Vehicle No-Fault Law shall, within 30 days after the effective date of this act, mail or deliver a revised notice of the premium and policy changes to each policyholder whose policy has an effective date on or after the effective date of this act and who was previously issued a motor vehicle insurance policy or sent a renewal notice based on the assumption that the Florida Motor Vehicle No-Fault Law would be repealed on October 1, 2007. For a renewal policy, the coverage must provide the same limits of personal injury protection coverage, the same deductible from personal injury protection coverage, and the same limits of medical payments coverage as provided in the prior policy, unless the policyholder elects different limits that are available. The effective date of the revised policy or renewal shall be the same as the effective date specified in the prior notice. The revised notice of premium and coverage changes are exempt from the requirements of ss. 627.7277, 627.728, and 627.7282, Florida Statutes. The policyholder has a period of 30 days, or a longer period if specified by the insurer, following receipt of the revised notice within which to pay any additional amount of premium due and thereby maintain the policy in force as specified in this section. Alternatively, the policyholder may cancel the policy within this time period and obtain a refund of the unearned premium. If the policyholder fails to timely

respond to the notice, the insurer must cancel the policy and return any unearned premium to the insured. The date on which the policy will be canceled shall be stated in the notice and may not be less than 35 days after the date of the notice. The amount of unearned premium due to the policyholder shall be calculated on a pro rata basis. The failure of an insurer to timely mail or deliver a revised notice as required by this subsection does not affect the other requirements of this section.

(3) The Legislature recognizes that some persons have been issued a motor vehicle insurance policy effective on or after October 1, 2007, and before the effective date of this act, which does not include personal injury protection, based upon the expected repeal of the Florida Motor Vehicle No-Fault Law on October 1, 2007, pursuant to s. 19, chapter 2003-411, Laws of Florida. Any such person:

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

(b) Is not subject to the provisions of s. 627.737, Florida Statutes, relating to the exemption from tort liability with respect to injuries sustained by the person in a motor vehicle crash occurring while the policy without personal injury protection coverage is in effect but not later than November 30, 2007. This paragraph also applies during such period to any

person who would have been covered under a personal injury protection policy if such a policy had been maintained on such motor vehicle.

(4) Each insurer shall, by October 31, 2007, provide written notification to each insured referred to in subsection (3) informing the insured that he or she must obtain personal injury protection coverage that takes effect no later than December 1, 2007. Such notice must include the premium for such coverage and the premium credit, if any, which will be provided for other coverage, such as bodily injury liability coverage or uninsured motorist coverage. Alternatively, the insurer may add an endorsement to the policy to provide personal injury protection coverage as required by law, effective no later than December 1, 2007, without requiring any additional payment from the insured and shall provide written notification to the insured of such endorsement by October 31, 2007.

Section 25. Effective January 1, 2009, sections 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes, constituting the Florida Motor Vehicle No-Fault Law, are repealed, unless reviewed and reenacted by the Legislature before that date.

Section 26. This act shall take effect upon becoming a law.