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1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; providing a short title; providing
4 legislative intent; amending s. 316.066, F.S.; revising
5 provisions relating to the contents of written reports of
6 motor vehicle crashes; authorizing the investigating
7 officer to testify at trial or provide an affidavit
8 concerning the content of the reports; amending s.
9 400.991, F.S.; requiring that an application for licensure
10 as a mobile clinic include a statement regarding insurance
11 fraud; creating s. 626.9894, F.S.; providing definitions;
12 authorizing the Division of Insurance Fraud to establish a
13 direct-support organization for the purpose of
14 prosecuting, investigating, and preventing motor vehicle
15 insurance fraud; providing requirements for the
16 organization and the organization's contract with the
17 division; providing for a board of directors; authorizing
18 the organization to use the division's property and
19 facilities subject to certain requirements; authorizing
20 contributions from insurers; providing that any moneys
21 received by the organization may be held in a separate
22 depository account in the name of the organization;
23 requiring the division to deposit certain proceeds into
24 the Insurance Regulatory Trust Fund; amending s. 627.730,
25 F.S.; conforming a cross-reference; amending s. 627.731,
26 F.S.; providing legislative intent with respect to the
27 Florida Motor Vehicle No-Fault Law; amending s. 627.732,
28 F.S.; defining the terms "claimant" and "no-fault law";

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

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29 | amending s. 627.736, F.S.; conforming a cross-reference;
30 | requiring certain entities providing medical services to
31 | document that they meet required criteria; revising
32 | requirements relating to the form that must be submitted
33 | by providers; requiring an entity or clinic to file a new
34 | form within a specified period after the date of a change
35 | of ownership; revising provisions relating to when payment
36 | for a benefit is due; providing that the time period for
37 | paying or denying a claim is tolled during the
38 | investigation of a fraudulent insurance act; specifying
39 | when benefits are not payable; providing that a claimant
40 | that violates certain provisions is not entitled to any
41 | payment, regardless of whether a portion of the claim may
42 | be legitimate; authorizing an insurer to recover payments
43 | and bring a cause of action to recover payments;
44 | forbidding a physician, hospital, clinic, or other medical
45 | institution that fails to comply with certain provisions
46 | from billing the injured person or the insured; providing
47 | that an insurer has a right to conduct reasonable
48 | investigations of claims; authorizing an insurer to
49 | require a claimant to provide certain records; revising
50 | the insurer's reimbursement limitation; deleting an
51 | obsolete provision; revising requirements relating to
52 | discovery; authorizing an insurer to conduct examinations
53 | of claimants under oath or sworn statement; requiring the
54 | provider to produce persons having the most knowledge in
55 | specified circumstances; providing that an insurer that
56 | requests an examination under oath without a reasonable

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57 | basis is engaging in an unfair and deceptive trade
 58 | practice; authorizing the insurer to conduct a physical
 59 | review of the treatment location; authorizing an insurer
 60 | to contract with a preferred provider network; authorizing
 61 | an insurer to provide a premium discount to an insured who
 62 | selects a preferred provider; authorizing an insurance
 63 | policy not to pay for nonemergency services performed by a
 64 | nonpreferred provider in specified circumstances;
 65 | authorizing an insurer to contract with a health insurer
 66 | in specified circumstances; amending s. 817.234, F.S.;
 67 | conforming a cross-reference; providing civil penalties
 68 | for criminal acts that result in the unlawful receipt of
 69 | insurance proceeds from a motor vehicle insurance
 70 | contract; amending ss. 324.021, 456.057, 627.7295,
 71 | 627.733, 627.734, 627.737, 627.7401, 627.7405, 627.7407,
 72 | and 628.909, F.S.; conforming cross-references; providing
 73 | an effective date.

74 |

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

76 |

77 | Section 1. (1) SHORT TITLE.—This act may be cited as the
 78 | "Comprehensive Insurance Fraud Investigation and Prevention
 79 | Act."

80 | (2) FINDINGS AND INTENT.—The Legislature intends to
 81 | balance the insured's interest in prompt payment of valid claims
 82 | for insurance benefits under the no-fault law with the public's
 83 | interest in reducing fraud, abuse, and overuse of the no-fault
 84 | system. To that end, the Legislature intends that the

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85 investigation and prevention of fraudulent insurance acts in
86 this state be enhanced, that additional sanctions for such acts
87 be imposed, and that the no-fault law be revised to remove
88 incentives for fraudulent insurance acts. The Legislature
89 intends that the no-fault law be construed according to the
90 plain language of the statutory provisions, which are designed
91 to meet these goals.

92 (a) The Legislature finds that:

93 1. Motor vehicle insurance fraud remains a major problem
94 for state consumers and insurers. According to the National
95 Insurance Crime Bureau, in recent years this state has been
96 among those states that have the highest number of fraudulent
97 and questionable claims.

98 2. The current regulatory process for health care clinics
99 under part X of chapter 400, Florida Statutes, which was
100 originally enacted to reduce motor vehicle insurance fraud, is
101 not adequately preventing fraudulent insurance acts with respect
102 to licensure exemptions and compliance with that part.

103 (b) The Legislature intends that:

104 1. Insurers properly investigate claims, and as such, this
105 act clarifies that insurers are allowed to obtain examinations
106 under oath and sworn statements from any claimant seeking no-
107 fault insurance benefits and to request mental and physical
108 examinations of persons seeking personal injury protection
109 coverage or benefits.

110 2. Any false, misleading, or otherwise fraudulent activity
111 associated with a claim render the entire claim invalid. An
112 insurer must be able to raise fraud as a defense to a claim for

113 no-fault insurance benefits irrespective of any prior
 114 adjudication of guilt or determination of fraud by the
 115 Department of Financial Services.

116 3. Insurers toll the payment or denial of a claim with
 117 respect to any portion of a claim for which the insurer has a
 118 reasonable belief that a fraudulent insurance act, as defined in
 119 s. 626.989 or s. 817.234, Florida Statutes, has been committed.

120 4. Insurers discover the names of all passengers involved
 121 in a motor vehicle crash before paying claims or benefits
 122 pursuant to an insurance policy governed by the no-fault law. A
 123 rebuttable presumption must be established that a person was not
 124 involved in the event giving rise to the claim if that person's
 125 name does not appear on the police report.

126 Section 2. Subsection (1) of section 316.066, Florida
 127 Statutes, is amended to read:

128 316.066 Written reports of crashes.-

129 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~
 130 ~~required to~~ be completed and submitted to the department within
 131 10 days after ~~completing~~ an investigation is completed by the
 132 every law enforcement officer who in the regular course of duty
 133 investigates a motor vehicle crash:

134 1. That resulted in death of, ~~or~~ personal injury to, or
 135 any indication of complaints of pain or discomfort by any of the
 136 parties or passengers involved in the crash;

137 2. That involved one or more passengers, other than the
 138 drivers of the vehicles, in any of the vehicles involved in the
 139 crash;-

140 3.2- That involved a violation of s. 316.061(1) or s.

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141 316.193; or-

142 ~~4.3-~~ In which a vehicle was rendered inoperative to a
 143 degree that required a wrecker to remove it from traffic, if
 144 such action is appropriate, in the officer's discretion.

145 (b) The long form must include:

146 1. The date, time, and location of the crash.

147 2. A description of the vehicles involved.

148 3. The names and addresses of the parties involved.

149 4. The names and addresses of witnesses.

150 5. The name, badge number, and law enforcement agency of
 151 the officer investigating the crash.

152 6. The names of the insurance companies for the respective
 153 parties involved in the crash.

154 7. The names and addresses of all passengers in all
 155 vehicles involved in the crash, each clearly identified as being
 156 a passenger, including the identification of the vehicle in
 157 which each was a passenger.

158 ~~(c)-(b)~~ In every crash for which a Florida Traffic Crash
 159 Report, Long Form, is not required ~~by this section~~, the law
 160 enforcement officer may complete a short-form crash report or
 161 provide a short-form crash report to be completed by each party
 162 involved in the crash. The short-form report must include all of
 163 the items listed in subparagraphs (b)1.-6. Short-form crash
 164 reports prepared by the law enforcement officer shall be
 165 maintained by the officer's agency.†

166 ~~1. The date, time, and location of the crash.~~

167 ~~2. A description of the vehicles involved.~~

168 ~~3. The names and addresses of the parties involved.~~

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- 169 4. ~~The names and addresses of witnesses.~~
- 170 5. ~~The name, badge number, and law enforcement agency of~~
- 171 ~~the officer investigating the crash.~~
- 172 6. ~~The names of the insurance companies for the respective~~
- 173 ~~parties involved in the crash.~~

174 (d)~~(e)~~ Each party to the crash must ~~shall~~ provide the law
 175 enforcement officer with proof of insurance, which must ~~to~~ be
 176 included in the crash report. If a law enforcement officer
 177 submits a report on the accident, proof of insurance must be
 178 provided to the officer by each party involved in the crash. Any
 179 party who fails to provide the required information commits a
 180 noncriminal traffic infraction, punishable as a nonmoving
 181 violation as provided in chapter 318, unless the officer
 182 determines that due to injuries or other special circumstances
 183 such insurance information cannot be provided immediately. If
 184 the person provides the law enforcement agency, within 24 hours
 185 after the crash, proof of insurance that was valid at the time
 186 of the crash, the law enforcement agency may void the citation.

187 (e)~~(d)~~ The driver of a vehicle that was in any manner
 188 involved in a crash resulting in damage to any vehicle or other
 189 property in an amount of \$500 or more, ~~which crash~~ was not
 190 investigated by a law enforcement agency, ~~shall~~ shall, within 10 days
 191 after the crash, submit a written report of the crash to the
 192 department or traffic records center. The entity receiving the
 193 report may require witnesses of the crash ~~crashes~~ to render
 194 reports and may require any driver of a vehicle involved in the
 195 ~~a crash of which a written report must be made as provided in~~
 196 ~~this section~~ to file supplemental written reports if ~~whenever~~

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197 the original report is deemed insufficient by the receiving
 198 entity.

199 (f) The investigating law enforcement officer may testify
 200 at trial or provide a signed affidavit to confirm or supplement
 201 the information included on the long-form or short-form report.

202 ~~(e) Short form crash reports prepared by law enforcement~~
 203 ~~shall be maintained by the law enforcement officer's agency.~~

204 Section 3. Subsection (6) is added to section 400.991,
 205 Florida Statutes, to read:

206 400.991 License requirements; background screenings;
 207 prohibitions.—

208 (6) All forms that constitute part of the application for
 209 licensure or exemption from licensure under this part must
 210 contain the following statement:

211
 212 INSURANCE FRAUD NOTICE.—Submitting a false,
 213 misleading, or fraudulent application or other
 214 document when applying for licensure as a health care
 215 clinic, when seeking an exemption from licensure as a
 216 health care clinic, or when demonstrating compliance
 217 with part X of chapter 400, Florida Statutes, is a
 218 criminal act under s. 817.234, Florida Statutes, or a
 219 fraudulent insurance act as defined in s. 626.989,
 220 Florida Statutes, subject to investigation by the
 221 Division of Insurance Fraud, and is grounds for
 222 discipline by the appropriate licensing board of the
 223 Florida Department of Health.

224 Section 4. Section 626.9894, Florida Statutes, is created

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225 to read:

226 626.9894 Motor vehicle insurance fraud direct-support
 227 organization.-

228 (1) DEFINITIONS.-As used in this section, the term:

229 (a) "Division" means the Division of Insurance Fraud of
 230 the Department of Financial Services.

231 (b) "Motor vehicle insurance fraud" means any act defined
 232 as a "fraudulent insurance act" under s. 626.989 that relates to
 233 the coverage of motor vehicle insurance as described in part XI
 234 of chapter 627.

235 (c) "Organization" means the direct-support organization
 236 established under this section.

237 (2) ORGANIZATION ESTABLISHED.-The division may establish a
 238 direct-support organization, to be known as the "Fight Auto
 239 Fraud Fund," whose sole purpose is to support the prosecution,
 240 investigation, and prevention of motor vehicle insurance fraud.
 241 The organization shall:

242 (a) Be a not-for-profit corporation incorporated under
 243 chapter 617 and approved by the Department of State.

244 (b) Be organized and operated to conduct programs and
 245 activities; to raise funds; to request and receive grants,
 246 gifts, and bequests of money; to acquire, receive, hold, invest,
 247 and administer, in its own name, securities, funds, objects of
 248 value, or other real or personal property; and to make grants
 249 and expenditures to or for the direct or indirect benefit of the
 250 division, state attorneys' offices, the statewide prosecutor,
 251 the Agency for Health Care Administration, and the Department of
 252 Health, to the extent that such grants and expenditures are used

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253 exclusively to advance the purpose of prosecuting,
254 investigating, or preventing motor vehicle insurance fraud.
255 Grants and expenditures may include the cost of salaries or
256 benefits of dedicated motor vehicle insurance fraud
257 investigators, prosecutors, or support personnel if such grants
258 and expenditures do not interfere with prosecutorial
259 independence or otherwise create conflicts of interest that
260 threaten the success of prosecutions.

261 (c) Be determined by the division to operate in a manner
262 that promotes the goals of laws relating to motor vehicle
263 insurance fraud, that is in the best interest of the state, and
264 that is in accordance with the adopted goals and mission of the
265 division.

266 (d) Use all of its grants and expenditures solely for the
267 purpose of preventing and decreasing motor vehicle insurance
268 fraud and not for the purpose of lobbying as defined in s.
269 11.045.

270 (e) Be subject to an annual financial audit in accordance
271 with s. 215.981.

272 (3) CONTRACT.—The organization shall operate under written
273 contract with the division. The contract must provide for:

274 (a) Approval of the articles of incorporation and bylaws
275 of the organization by the division.

276 (b) Submission of an annual budget for the approval of the
277 division.

278 (c) Certification by the division that the direct-support
279 organization is complying with the terms of the contract and in
280 a manner consistent with the goals and purposes of the

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281 department and in the best interest of the state. Such
 282 certification must be made annually and reported in the official
 283 minutes of a meeting of the organization.

284 (d) Allocation of funds to address motor vehicle insurance
 285 fraud.

286 (e) Reversion of moneys and property held in trust by the
 287 organization for motor vehicle insurance fraud prosecution,
 288 investigation, and prevention to the division if the
 289 organization is no longer approved to operate by the department
 290 or if the organization ceases to exist, or to the state if the
 291 division ceases to exist.

292 (f) Specific criteria to be used by the organization's
 293 board of directors to evaluate the effectiveness of funding used
 294 to combat motor vehicle insurance fraud.

295 (g) The fiscal year of the organization, which begins July
 296 1 of each year and ends June 30 of the following year.

297 (h) Disclosure of the material provisions of the contract,
 298 and distinguishing between the department and the organization
 299 to donors of gifts, contributions, or bequests, including
 300 providing such disclosure on all promotional and fundraising
 301 publications.

302 (4) BOARD OF DIRECTORS.—The board of directors of the
 303 organization shall consist of the following seven members:

304 (a) The Chief Financial Officer, or his or her designee,
 305 who shall serve as chair.

306 (b) Two state attorneys, one of whom shall be appointed by
 307 the Chief Financial Officer and one of whom shall be appointed
 308 by the Attorney General.

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309 (c) Two representatives of motor vehicle insurers
310 appointed by the Chief Financial Officer.

311 (d) Two representatives of local law enforcement agencies,
312 both of whom shall be appointed by the Chief Financial Officer.

313
314 The officer who appointed a member of the board may remove that
315 member for cause. The term of office of an appointed member may
316 not exceed 4 years and expires at the same time as the term of
317 the officer who appointed him or her or at such earlier time as
318 the member ceases to be qualified.

319 (5) USE OF PROPERTY.—The department may authorize, without
320 charge, appropriate use of fixed property and facilities of the
321 division by the organization, subject to this subsection.

322 (a) The department may prescribe by rule any condition
323 with which the organization must comply in order to use the
324 division's property or facilities.

325 (b) The department may not authorize the use of the
326 division's property or facilities if the organization does not
327 provide equal membership and employment opportunities to all
328 persons regardless of race, religion, sex, age, or national
329 origin.

330 (c) The department shall adopt rules prescribing the
331 procedures by which the organization is governed.

332 (6) CONTRIBUTIONS.—Any contributions made by an insurer to
333 the organization shall be allowed as appropriate business
334 expenses for all regulatory purposes.

335 (7) DEPOSITORY.—Any moneys received by the organization
336 may be held in a separate depository account in the name of the

337 organization and subject to the provisions of the contract with
 338 the division.

339 (8) DIVISION'S RECEIPT OF PROCEEDS.-If the division
 340 receives proceeds from the organization, those proceeds shall be
 341 deposited into the Insurance Regulatory Trust Fund.

342 Section 5. Section 627.730, Florida Statutes, is amended
 343 to read:

344 627.730 Florida Motor Vehicle No-Fault Law.—Sections
 345 627.730-627.7407 ~~627.730-627.7405~~ may be cited ~~and known~~ as the
 346 "Florida Motor Vehicle No-Fault Law."

347 Section 6. Section 627.731, Florida Statutes, is amended
 348 to read:

349 627.731 Purpose; legislative intent.—

350 (1) The purpose of the no-fault law ~~ss. 627.730-627.7405~~
 351 is to provide for medical, surgical, funeral, and disability
 352 insurance benefits without regard to fault, and to require motor
 353 vehicle insurance securing such benefits, for motor vehicles
 354 required to be registered in this state and, with respect to
 355 motor vehicle accidents, a limitation on the right to claim
 356 damages for pain, suffering, mental anguish, and inconvenience.

357 (2) The Legislature intends that the provisions,
 358 schedules, and procedures authorized under the no-fault law be
 359 implemented by the insurers offering policies pursuant to the
 360 no-fault law. These provisions, schedules, and procedures have
 361 full force and effect regardless of their express inclusion in
 362 an insurance policy, and an insurer is not required to amend its
 363 policy to implement and apply such provisions, schedules, or
 364 procedures.

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365 Section 7. Section 627.732, Florida Statutes, is amended
 366 to read:

367 627.732 Definitions.—As used in the no-fault law ss.
 368 ~~627.730–627.7405~~, the term:

369 (1) "Broker" means any person not possessing a license
 370 under chapter 395, chapter 400, chapter 429, chapter 458,
 371 chapter 459, chapter 460, chapter 461, or chapter 641 who
 372 charges or receives compensation for any use of medical
 373 equipment and is not the 100-percent owner or the 100-percent
 374 lessee of such equipment. For purposes of this section, such
 375 owner or lessee may be an individual, a corporation, a
 376 partnership, or any other entity and any of its 100-percent-
 377 owned affiliates and subsidiaries. For purposes of this
 378 subsection, the term "lessee" means a long-term lessee under a
 379 capital or operating lease, but does not include a part-time
 380 lessee. The term "broker" does not include a hospital or
 381 physician management company whose medical equipment is
 382 ancillary to the practices managed, a debt collection agency, or
 383 an entity that has contracted with the insurer to obtain a
 384 discounted rate for such services; or ~~nor does the term include~~
 385 a management company that has contracted to provide general
 386 management services for a licensed physician or health care
 387 facility and whose compensation is not materially affected by
 388 the usage or frequency of usage of medical equipment or an
 389 entity that is 100-percent owned by one or more hospitals or
 390 physicians. The term "broker" does not include a person or
 391 entity that certifies, upon request of an insurer, that:

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

393 (b) It is a 100-percent owner of medical equipment; and
 394 (c) The owner's only part-time lease of medical equipment
 395 for personal injury protection patients is on a temporary basis,
 396 not to exceed 30 days in a 12-month period, and such lease is
 397 solely for the purposes of necessary repair or maintenance of
 398 the 100-percent-owned medical equipment or pending the arrival
 399 and installation of the newly purchased or a replacement for the
 400 100-percent-owned medical equipment, or for patients for whom,
 401 because of physical size or claustrophobia, it is determined by
 402 the medical director or clinical director to be medically
 403 necessary that the test be performed in medical equipment that
 404 is open-style. The leased medical equipment may not ~~cannot~~ be
 405 used by patients who are not patients of the registered clinic
 406 ~~for medical treatment of services~~. Any person or entity making a
 407 false certification under this subsection commits insurance
 408 fraud as defined in s. 817.234. However, the 30-day period
 409 ~~provided in this paragraph~~ may be extended for an additional 60
 410 days as applicable to magnetic resonance imaging equipment if
 411 the owner certifies that the extension otherwise complies with
 412 this paragraph.

413 (2) ~~(7)~~ "Certify" means to swear or attest to being true or
 414 represented in writing.

415 (3) "Claimant" means the person, organization, or entity
 416 seeking benefits, including all assignees.

417 (4) ~~(12)~~ "Hospital" means a facility that, at the time
 418 services or treatment were rendered, was licensed under chapter
 419 395.

420 (5) ~~(8)~~ "Immediate personal supervision," as it relates to

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421 the performance of medical services by nonphysicians not in a
422 hospital, means that an individual licensed to perform the
423 medical service or provide the medical supplies must be present
424 within the confines of the physical structure where the medical
425 services are performed or where the medical supplies are
426 provided such that the licensed individual can respond
427 immediately to any emergencies if needed.

428 ~~(6)-(9)~~ "Incident," with respect to services considered as
429 incident to a physician's professional service, for a physician
430 licensed under chapter 458, chapter 459, chapter 460, or chapter
431 461, if not furnished in a hospital, means ~~such~~ services that
432 are ~~must be~~ an integral, even if incidental, part of a covered
433 physician's service.

434 ~~(7)-(10)~~ "Knowingly" means that a person, with respect to
435 information, has actual knowledge of the information, and acts in
436 deliberate ignorance of the truth or falsity of the
437 information, and or acts in reckless disregard of the information, and
438 ~~and~~ Proof of specific intent to defraud is not required.

439 ~~(8)-(11)~~ "Lawful" or "lawfully" means in substantial
440 compliance with all relevant applicable criminal, civil, and
441 administrative requirements of state and federal law related to
442 the provision of medical services or treatment.

443 ~~(9)-(2)~~ "Medically necessary" refers to a medical service
444 or supply that a prudent physician would provide for the purpose
445 of preventing, diagnosing, or treating an illness, injury,
446 disease, or symptom in a manner that is:

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

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

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

453 (10)~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
 454 with four or more wheels that ~~which~~ is of a type both designed
 455 and required to be licensed for use on the highways of this
 456 state, and any trailer or semitrailer designed for use with such
 457 vehicle, and includes:

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

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

465
 466 The term "motor vehicle" does not include a mobile home or any
 467 motor vehicle that ~~which~~ is used in mass transit, other than
 468 public school transportation, and designed to transport more
 469 than five passengers exclusive of the operator of the motor
 470 vehicle and that ~~which~~ is owned by a municipality, a transit
 471 authority, or a political subdivision of the state.

472 (11)~~(4)~~ "Named insured" means a person, usually the owner
 473 of a vehicle, identified in a policy by name as the insured
 474 under the policy.

475 (12) "No-fault law" means the Florida Motor Vehicle No-
 476 Fault Law, ss. 627.730-627.7407.

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477 ~~(13)-(5)~~ "Owner" means a person who holds the legal title
 478 to a motor vehicle; or, ~~if in the event~~ a motor vehicle is the
 479 subject of a security agreement or lease with an option to
 480 purchase with the debtor or lessee having the right to
 481 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
 482 owner for the purposes of the no-fault law ss. 627.730-627.7405.

483 ~~(14)-(13)~~ "Properly completed" means providing truthful,
 484 substantially complete, and substantially accurate responses ~~as~~
 485 to all material elements of ~~to~~ each applicable request for
 486 information or statement by a means that may lawfully be
 487 provided and that complies with this section, or as agreed by
 488 the parties.

489 ~~(15)-(6)~~ "Relative residing in the same household" means a
 490 relative of any degree by blood or by marriage who usually makes
 491 her or his home in the same family unit, whether or not
 492 temporarily living elsewhere.

493 ~~(16)-(15)~~ "Unbundling" means submitting ~~an action that~~
 494 ~~submits~~ a billing code that is properly billed under one billing
 495 code, but that has been separated into two or more billing
 496 codes, and would result in payment greater than the ~~in~~ amount
 497 that ~~than~~ would be paid using one billing code.

498 ~~(17)-(14)~~ "Upcoding" means submitting ~~an action that~~
 499 ~~submits~~ a billing code that would result in payment greater than
 500 the ~~in~~ amount that ~~than~~ would be paid using a billing code that
 501 accurately describes the services performed. The term does not
 502 include an otherwise lawful bill by a magnetic resonance imaging
 503 facility, which globally combines both technical and
 504 professional components, if the amount of the global bill is not

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505 more than the components if billed separately; however, payment
 506 of such a bill constitutes payment in full for all components of
 507 such service.

508 Section 8. Subsections (1), (3), and (4) of section
 509 627.736, Florida Statutes, are amended, subsections (5) through
 510 (16) of that section are renumbered as subsections (6) through
 511 (17), respectively, a new subsection (5) is added to that
 512 section, and present subsections (5), (6), (8), and (9),
 513 paragraph (b) of present subsection (7), and present subsection
 514 (16) of that section are amended, to read:

515 627.736 Required personal injury protection benefits;
 516 exclusions; priority; claims.—

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

529 (a) Medical benefits.—Eighty percent of ~~all reasonable~~
 530 expenses for medically necessary medical, surgical, X-ray,
 531 dental, and rehabilitative services, including prosthetic
 532 devices, and for medically necessary ambulance, hospital, and

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533 nursing services. However, the medical benefits ~~shall~~ provide
 534 reimbursement only for such services and care that are lawfully
 535 provided, supervised, ordered, or prescribed by a physician
 536 licensed under chapter 458 or chapter 459, a dentist licensed
 537 under chapter 466, or a chiropractic physician licensed under
 538 chapter 460 or that are provided by any of the following ~~persons~~
 539 ~~or entities~~:

540 1. A hospital or ambulatory surgical center licensed under
 541 chapter 395.

542 2. A person or entity licensed under part III of chapter
 543 401 that ~~ss. 401.2101-401.45 that~~ provides emergency
 544 transportation and treatment.

545 3. An entity wholly owned by one or more physicians
 546 licensed under chapter 458 or chapter 459, chiropractic
 547 physicians licensed under chapter 460, or dentists licensed
 548 under chapter 466 or by such ~~practitioner or practitioners and~~
 549 the spouses, parents, children, or siblings ~~spouse, parent,~~
 550 ~~child, or sibling of such that practitioner or those~~
 551 practitioners.

552 4. An entity wholly owned, directly or indirectly, by a
 553 hospital or hospitals.

554 5. A health care clinic licensed under part X of chapter
 555 400 ~~ss. 400.990-400.995~~ that is:

556 a. Accredited by the Joint Commission on Accreditation of
 557 Healthcare Organizations, the American Osteopathic Association,
 558 the Commission on Accreditation of Rehabilitation Facilities, or
 559 the Accreditation Association for Ambulatory Health Care, Inc. ;
 560 or

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- 561 b. A health care clinic that:
- 562 (I) Has a medical director licensed under chapter 458,
- 563 chapter 459, or chapter 460;
- 564 (II) Has been continuously licensed for more than 3 years
- 565 or is a publicly traded corporation that issues securities
- 566 traded on an exchange registered with the United States
- 567 Securities and Exchange Commission as a national securities
- 568 exchange; and
- 569 (III) Provides at least four of the following medical
- 570 specialties:
- 571 (A) General medicine.
- 572 (B) Radiography.
- 573 (C) Orthopedic medicine.
- 574 (D) Physical medicine.
- 575 (E) Physical therapy.
- 576 (F) Physical rehabilitation.
- 577 (G) Prescribing or dispensing outpatient prescription
- 578 medication.
- 579 (H) Laboratory services.

581 If any services under this paragraph are provided by an entity

582 or clinic described in subparagraph 3., subparagraph 4., or

583 subparagraph 5., the entity or clinic must provide the insurer

584 at the initial submission of the claim with a form adopted by

585 the Department of Financial Services that documents that the

586 entity or clinic meets applicable criteria for such entity or

587 clinic and includes a sworn statement or affidavit to that

588 effect. Any change in ownership requires the filing of a new

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589 form within 10 days after the date of the change in ownership.
 590 ~~The Financial Services Commission shall adopt by rule the form~~
 591 ~~that must be used by an insurer and a health care provider~~
 592 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
 593 ~~5. to document that the health care provider meets the criteria~~
 594 ~~of this paragraph, which rule must include a requirement for a~~
 595 ~~sworn statement or affidavit.~~

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

606 (c) Death benefits.—Death benefits equal to the lesser of
 607 \$5,000 or the remainder of unused personal injury protection
 608 benefits per individual. The insurer may pay such benefits to
 609 the executor or administrator of the deceased, to any of the
 610 deceased's relatives by blood, or ~~or~~ legal adoption, or ~~connection~~
 611 ~~by~~ marriage, or to any person appearing to the insurer to be
 612 equitably entitled thereto.

613
 614 Only insurers writing motor vehicle liability insurance in this
 615 state may provide the required benefits of this section, and ~~no~~
 616 such insurers may not ~~insurer shall~~ require the purchase of any

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617 other motor vehicle coverage other than the purchase of property
 618 damage liability coverage as required by s. 627.7275 as a
 619 condition for providing such ~~required~~ benefits. Insurers may not
 620 require that property damage liability insurance in an amount
 621 greater than \$10,000 be purchased in conjunction with personal
 622 injury protection. Such insurers shall make benefits and
 623 required property damage liability insurance coverage available
 624 through normal marketing channels. An ~~Any~~ insurer writing motor
 625 vehicle liability insurance in this state who fails to comply
 626 with such availability requirement as a general business
 627 practice violates ~~shall be deemed to have violated~~ part IX of
 628 chapter 626, and such violation constitutes ~~shall constitute~~ an
 629 unfair method of competition or an unfair or deceptive act or
 630 practice involving the business of insurance. An; ~~and any such~~
 631 insurer committing such violation is ~~shall be~~ subject to the
 632 penalties afforded in such part, as well as those that are ~~which~~
 633 ~~may be~~ afforded elsewhere in the insurance code.

634 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN
 635 TORT CLAIMS.-An ~~No~~ insurer shall not have a lien on any recovery
 636 in tort by judgment, settlement, or otherwise for personal
 637 injury protection benefits, whether suit has been filed or
 638 settlement has been reached without suit. An injured party who
 639 is entitled to bring suit under the no-fault law provisions of
 640 ~~ss. 627.730-627.7405~~, or his or her legal representative, shall
 641 have no right to recover any damages for which personal injury
 642 protection benefits are paid or payable. The plaintiff may prove
 643 all of his or her special damages notwithstanding this
 644 limitation, but if special damages are introduced in evidence,

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645 the trier of facts, whether judge or jury, shall not award
646 damages for personal injury protection benefits paid or payable.
647 In all cases in which a jury is required to fix damages, the
648 court shall instruct the jury that the plaintiff shall not
649 recover such special damages for personal injury protection
650 benefits paid or payable.

651 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
652 the no-fault law are ss. 627.730-627.7405 shall be primary,
653 except that benefits received under any workers' compensation
654 law shall be credited against the benefits provided by
655 subsection (1) and are ~~shall be~~ due and payable as loss accrues,
656 upon the receipt of reasonable proof of such loss and the amount
657 of expenses and loss incurred that ~~which~~ are covered by the
658 policy issued under the no-fault law ss. 627.730-627.7405. If
659 ~~When~~ the Agency for Health Care Administration provides, pays,
660 or becomes liable for medical assistance under the Medicaid
661 program related to injury, sickness, disease, or death arising
662 out of the ownership, maintenance, or use of a motor vehicle,
663 the benefits are ~~under ss. 627.730-627.7405~~ shall be subject to
664 the provisions of the Medicaid program.

665 (a) An insurer may require written notice to be given as
666 soon as practicable after an accident involving a motor vehicle
667 with respect to which the policy affords the security required
668 by the no-fault law ss. 627.730-627.7405.

669 (b) Personal injury protection insurance benefits paid
670 pursuant to this section are ~~shall be~~ overdue if not paid within
671 30 days after the insurer is furnished written notice of the
672 fact of a covered loss and of the amount of same. If such

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673 written notice is not furnished to the insurer as to the entire
 674 claim, any partial amount supported by written notice is overdue
 675 if not paid within 30 days after such written notice is
 676 furnished to the insurer. Any part or all of the remainder of
 677 the claim that is subsequently supported by written notice is
 678 overdue if not paid within 30 days after such written notice is
 679 furnished to the insurer.

680 (c) ~~If when~~ an insurer pays only a portion of a claim or
 681 rejects a claim, the insurer shall provide at the time of the
 682 partial payment or rejection an itemized specification of each
 683 item that the insurer had reduced, omitted, or declined to pay
 684 and any information that the insurer desires the claimant to
 685 consider related to the medical necessity of the denied
 686 treatment or to explain the reasonableness of the reduced
 687 charge, provided that this does ~~shall~~ not limit the introduction
 688 of evidence at trial. ~~and~~ The insurer must ~~shall~~ include the
 689 name and address of the person to whom the claimant should
 690 respond and a claim number to be referenced in future
 691 correspondence.

692 (d) ~~A However, notwithstanding the fact that written~~
 693 ~~notice has been furnished to the insurer, Any payment is shall~~
 694 ~~not be deemed~~ overdue if ~~when~~ the insurer has reasonable proof
 695 ~~to establish~~ that the insurer is not responsible for ~~the~~
 696 payment. For the purpose of calculating the extent to which any
 697 benefits are overdue, payment shall be treated as being made on
 698 the date a draft or other valid instrument ~~which is~~ equivalent
 699 to payment was placed in the United States mail in a properly
 700 addressed, postpaid envelope or, if not so posted, on the date

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701 of delivery. This paragraph does not preclude or limit the
 702 ability of the insurer to assert that the claim is ~~was~~
 703 unrelated, ~~was~~ not medically necessary, ~~or was~~ unreasonable, or
 704 submitted that the amount of the charge was in excess of that
 705 permitted under, or in violation of, subsection (6) (5). Such
 706 ~~assertion by the insurer may be made~~ at any time, including
 707 after payment of the claim or after the 30-day ~~time~~ period for
 708 payment set forth in ~~this~~ paragraph (b). The 30-day period for
 709 payment or denial is tolled with respect to any portion of a
 710 claim for which the insurer has a reasonable belief that a
 711 fraudulent insurance act as defined in s. 626.989 has been
 712 committed while the insurer investigates such act. The insurer
 713 must notify the claimant in writing that it is investigating a
 714 fraudulent insurance act within 30 days after the date it has a
 715 reasonable belief that such act has been committed. The insurer
 716 must pay or deny the claim, in full or in part, within 120 days
 717 after the date the written notice of the fact of a covered loss
 718 and of the amount of the loss was provided to the insurer.

719 (e) (e) Upon receiving notice of an accident that is
 720 potentially covered by personal injury protection benefits, the
 721 insurer must reserve \$5,000 of personal injury protection
 722 benefits for payment to physicians licensed under chapter 458 or
 723 chapter 459 or dentists licensed under chapter 466 who provide
 724 emergency services and care, as defined in s. 395.002~~(9)~~, or who
 725 provide hospital inpatient care. The amount required to be held
 726 in reserve may be used only to pay claims from such physicians
 727 or dentists until 30 days after the date the insurer receives
 728 notice of the accident. After the 30-day period, any amount of

729 the reserve for which the insurer has not received notice of
 730 such a claim ~~from a physician or dentist who provided emergency~~
 731 ~~services and care or who provided hospital inpatient care~~ may
 732 ~~then~~ be used by the insurer to pay other claims. The time
 733 periods specified in paragraph (b) for ~~required~~ payment of
 734 personal injury protection benefits are ~~shall be~~ tolled for the
 735 period of time that an insurer is required ~~by this paragraph~~ to
 736 hold payment of a claim that is not from a physician or dentist
 737 who provided emergency services and care or who provided
 738 hospital inpatient care to the extent that the personal injury
 739 protection benefits not held in reserve are insufficient to pay
 740 the claim. This paragraph does not require an insurer to
 741 establish a claim reserve for insurance accounting purposes.

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

749 (g) ~~(e)~~ The insurer of the owner of a motor vehicle shall
 750 pay personal injury protection benefits for:

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

755 2. Accidental bodily injury sustained outside this state,
 756 but within the United States of America or its territories or

757 possessions or Canada, by the owner while occupying the owner's
758 motor vehicle.

759 3. Accidental bodily injury sustained by a relative of the
760 owner residing in the same household, under the circumstances
761 described in subparagraph 1. or subparagraph 2. if, ~~provided~~ the
762 relative at the time of the accident is domiciled in the owner's
763 household and is not ~~himself or herself~~ the owner of a motor
764 vehicle with respect to which security is required under the no-
765 fault law ss. 627.730-627.7405.

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

772 a. The owner of a motor vehicle with respect to which
773 security is required under the no-fault law ss. 627.730-
774 627.7405; or

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

777 (h) ~~(f)~~ If two or more insurers are liable to pay personal
778 injury protection benefits for the same injury to any one
779 person, the maximum payable is ~~shall be~~ as specified in
780 subsection (1), and any insurer paying the benefits is ~~shall be~~
781 entitled to recover from each of the other insurers an equitable
782 pro rata share of the benefits paid and expenses incurred in
783 processing the claim.

784 (i) ~~(g)~~ It is a violation of the insurance code for an

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785 insurer to fail to timely provide benefits as required by this
 786 section with such frequency as to constitute a general business
 787 practice.

788 ~~(j)(h)~~ Benefits are ~~shall not be~~ due or payable to or on
 789 the behalf of a claimant who: ~~an insured person if that person~~
 790 ~~has~~

791 1. Submits a false or misleading statement, document,
 792 record, or bill;

793 2. Submits any other false or misleading information; or

794 3. Has otherwise committed or attempted to commit a
 795 fraudulent insurance act as defined in s. 626.989.

796
 797 A claimant who violates this paragraph is not entitled to any
 798 personal injury protection benefits or payment for any bills and
 799 services, regardless of whether a portion of the claim may be
 800 legitimate.

801 (k) Notwithstanding any remedies afforded by law, the
 802 insurer may recover from a claimant who has violated paragraph
 803 (j) any sums previously paid to the claimant and may bring any
 804 available common law and statutory causes of action committed,
 805 ~~by a material act or omission, any insurance fraud relating to~~
 806 ~~personal injury protection coverage under his or her policy, if~~
 807 ~~the fraud is admitted to in a sworn statement by the insured or~~
 808 ~~if it is established in a court of competent jurisdiction. If a~~
 809 physician, hospital, clinic, or other medical institution
 810 violates paragraph (j), the injured party is not liable for, and
 811 the physician, hospital, clinic, or other medical institution
 812 may not bill the insured for, charges that are unpaid because of

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813 failure to comply with paragraph (j). Any agreement requiring
814 the injured person or insured to pay for such charges is
815 unenforceable. Any insurance fraud shall void all coverage
816 arising from the claim related to such fraud under the personal
817 injury protection coverage of the insured person who committed
818 the fraud, irrespective of whether a portion of the insured
819 person's claim may be legitimate, and any benefits paid prior to
820 the discovery of the insured person's insurance fraud shall be
821 recoverable by the insurer from the person who committed
822 insurance fraud in their entirety. The prevailing party is
823 entitled to its costs and attorney's fees in any action in which
824 it prevails in an insurer's action to enforce its right of
825 recovery under this paragraph.

826 (5) INSURER INVESTIGATIONS.—An insurer has the right and
827 duty to conduct a reasonable investigation of a claim. In the
828 course of the investigation, the insurer may require the
829 insured, claimant, or medical provider to provide copies of the
830 treatment and examination records so that the insurer can
831 provide such records to a physician for a records review. A
832 records review need not be based on a physical examination and
833 may be obtained at any time, including after reduction or denial
834 of the claim. The 30-day period for payment under paragraph
835 (4) (b) is tolled from the date the insurer sends its request for
836 treatment records to the date that the insurer receives the
837 treatment records. The claim may be denied or reduced if the
838 medical provider fails to keep adequate records such that the
839 insurer is unable to obtain a records review.

840 (6)-(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

841 (a)~~1~~. Any physician, hospital, clinic, or other person or
 842 institution lawfully rendering treatment to an injured person
 843 for a bodily injury covered by personal injury protection
 844 insurance may charge the insurer and injured party only an a
 845 ~~reasonable~~ amount pursuant to this section for the services and
 846 supplies rendered, and the insurer providing such coverage may
 847 pay for such charges directly to such person or institution
 848 lawfully rendering such treatment~~,~~ if the insured receiving such
 849 treatment or his or her guardian has countersigned the properly
 850 completed invoice, bill, or claim form approved by the office
 851 upon which such charges are to be paid for as having actually
 852 been rendered, to the best knowledge of the insured or his or
 853 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
 854 exceed ~~be in excess of~~ the amount the person or institution
 855 customarily charges for like services or supplies. When
 856 determining ~~With respect to a determination of~~ whether a charge
 857 for a particular service, treatment, or otherwise is reasonable,
 858 consideration may be given to evidence of usual and customary
 859 charges and payments accepted by the provider involved in the
 860 dispute, ~~and~~ reimbursement levels in the community and various
 861 federal and state medical fee schedules applicable to automobile
 862 and other insurance coverages, and other information relevant to
 863 the reasonableness of the reimbursement for the service,
 864 treatment, or supply.

865 1.2. The insurer may limit reimbursement to 80 percent of
 866 the following schedule of maximum charges:

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

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

872 c. For emergency services and care as defined by s.
873 395.002(9) provided in a facility licensed under chapter 395
874 rendered by a physician or dentist, and related hospital
875 inpatient services rendered by a physician or dentist, the usual
876 and customary charges in the community.

877 d. For hospital inpatient services, other than emergency
878 services and care, 200 percent of the Medicare Part A
879 prospective payment applicable to the specific hospital
880 providing the inpatient services.

881 e. For hospital outpatient services, other than emergency
882 services and care, 200 percent of the Medicare Part A Ambulatory
883 Payment Classification for the specific hospital providing the
884 outpatient services.

885 f. For all other medical services, supplies, and care, 200
886 percent of the allowable amount under the participating
887 physicians schedule of Medicare Part B. However, if such
888 services, supplies, or care is not reimbursable under Medicare
889 Part B, the insurer may limit reimbursement to 80 percent of the
890 maximum reimbursable allowance under workers' compensation, as
891 determined under s. 440.13 and rules adopted thereunder which
892 are in effect at the time such services, supplies, or care is
893 provided. Services, supplies, or care that is not reimbursable
894 under Medicare or workers' compensation is not required to be
895 reimbursed by the insurer.

896 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable

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897 fee schedule or payment limitation under Medicare is the fee
898 schedule or payment limitation in effect on January 1 of the
899 year in which ~~at the time~~ the services, supplies, or care was
900 rendered and for the area in which such services were rendered,
901 notwithstanding any subsequent changes made to such fee schedule
902 or payment limitation, except that it may not be less than the
903 allowable amount under the participating physicians schedule of
904 Medicare Part B for 2007 for medical services, supplies, and
905 care subject to Medicare Part B.

906 ~~3.4.~~ Subparagraph 1. 2. does not allow the insurer to
907 apply any limitation on the number of treatments or other
908 utilization limits that apply under Medicare or workers'
909 compensation. An insurer that applies the allowable payment
910 limitations of subparagraph 1. 2. must reimburse a provider who
911 lawfully provided care or treatment under the scope of his or
912 her license~~7~~, regardless of whether such provider is ~~would be~~
913 entitled to reimbursement under Medicare due to restrictions or
914 limitations on the types or discipline of health care providers
915 who may be reimbursed for particular procedures or procedure
916 codes.

917 ~~4.5.~~ If an insurer limits payment as authorized by
918 subparagraph 1. 2., the person providing such services,
919 supplies, or care may not bill or attempt to collect from the
920 insured any amount in excess of such limits, except for amounts
921 that are not covered by the insured's personal injury protection
922 coverage due to the coinsurance amount or maximum policy limits.

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

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- 925 a. Made by a broker or by a person making a claim on
 926 behalf of a broker;
- 927 b. For any service or treatment that was not lawful at the
 928 time rendered;
- 929 c. To any person who knowingly submits a false or
 930 misleading statement relating to the claim or charges;
- 931 d. With respect to a bill or statement that does not
 932 ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs (c)
 933 and paragraph (d);
- 934 e. For any treatment or service that is upcoded, or that
 935 is unbundled if ~~when~~ such treatment or services should be
 936 bundled, in accordance with paragraph (d). To facilitate prompt
 937 payment of lawful services, an insurer may change codes that it
 938 determines to have been improperly or incorrectly upcoded or
 939 unbundled, and may make payment based on the changed codes,
 940 without affecting the right of the provider to dispute the
 941 change by the insurer if, ~~provided that~~ before doing so, the
 942 insurer contacts ~~must contact~~ the health care provider and
 943 discusses ~~discuss~~ the reasons for the insurer's change and the
 944 health care provider's reason for the coding, or makes ~~make~~ a
 945 reasonable good faith effort to do so, as documented in the
 946 insurer's file; and
- 947 f. For medical services or treatment billed by a physician
 948 and not provided in a hospital unless such services are rendered
 949 by the physician or are incident to his or her professional
 950 services and are included on the physician's bill, including
 951 documentation verifying that the physician is responsible for
 952 the medical services that were rendered and billed.

953 2. The Department of Health, in consultation with the
 954 appropriate professional licensing boards, shall adopt, by rule,
 955 a list of diagnostic tests deemed not to be medically necessary
 956 for use in the treatment of persons sustaining bodily injury
 957 covered by personal injury protection benefits under this
 958 section. The ~~initial list shall be adopted by January 1, 2004,~~
 959 ~~and~~ shall be revised from time to time as determined by the
 960 Department of Health, in consultation with the respective
 961 professional licensing boards. Inclusion of a test on the list
 962 must ~~of invalid diagnostic tests shall~~ be based on lack of
 963 demonstrated medical value and a level of general acceptance by
 964 the relevant provider community and may ~~shall~~ not be dependent
 965 for results entirely upon subjective patient response.
 966 Notwithstanding its inclusion on a fee schedule in this
 967 subsection, an insurer or insured is not required to pay any
 968 charges or reimburse claims for any invalid diagnostic test as
 969 determined by the Department of Health.

970 (c)~~1.~~ With respect to any treatment or service, other than
 971 medical services billed by a hospital or other provider for
 972 emergency services as defined in s. 395.002 or inpatient
 973 services rendered at a hospital-owned facility, the statement of
 974 charges must be furnished to the insurer by the provider and may
 975 not include, and the insurer is not required to pay, charges for
 976 treatment or services rendered more than 35 days before the
 977 postmark date or electronic transmission date of the statement,
 978 except for past due amounts previously billed on a timely basis
 979 under this paragraph, and except that, if the provider submits
 980 to the insurer a notice of initiation of treatment within 21

981 days after its first examination or treatment of the claimant,
 982 the statement may include charges for treatment or services
 983 rendered up to, but not more than, 75 days before the postmark
 984 date of the statement. The injured party is not liable for, and
 985 the provider may ~~shall~~ not bill the injured party for, charges
 986 that are unpaid because of the provider's failure to comply with
 987 this paragraph. Any agreement requiring the injured person or
 988 insured to pay for such charges is unenforceable.

989 1.2. ~~If, however,~~ the insured fails to furnish the
 990 provider with the correct name and address of the insured's
 991 personal injury protection insurer, the provider has 35 days
 992 from the date the provider obtains the correct information to
 993 furnish the insurer with a statement of the charges. The insurer
 994 is not required to pay for such charges unless the provider
 995 includes with the statement documentary evidence that was
 996 provided by the insured during the 35-day period demonstrating
 997 that the provider reasonably relied on erroneous information
 998 from the insured and either:

- 999 a. A denial letter from the incorrect insurer; or
- 1000 b. Proof of mailing, which may include an affidavit under
- 1001 penalty of perjury, reflecting timely mailing to the incorrect
- 1002 address or insurer.

1003 2.3. For emergency services and care as defined in s.
 1004 395.002 rendered in a hospital emergency department or for
 1005 transport and treatment rendered by an ambulance provider
 1006 licensed pursuant to part III of chapter 401, the provider is
 1007 not required to furnish the statement of charges within the time
 1008 periods established by this paragraph, ~~and~~ and the insurer is ~~shall~~

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1009 | not ~~be~~ considered to have been furnished with notice of the
 1010 | amount of covered loss for purposes of paragraph (4)(b) until it
 1011 | receives a statement complying with paragraph (d), or copy
 1012 | thereof, which specifically identifies the place of service to
 1013 | be a hospital emergency department or an ambulance in accordance
 1014 | with billing standards recognized by the Centers for Medicare
 1015 | and Medicaid Services (CMS) Health Care Finance Administration.

1016 | ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
 1017 | must include the following statement in type no smaller than 12
 1018 | points:

1019 |
 1020 | BILLING REQUIREMENTS.—Florida Statutes provide that
 1021 | with respect to any treatment or services, other than
 1022 | certain hospital and emergency services, the statement
 1023 | of charges furnished to the insurer by the provider
 1024 | may not include, and the insurer and the injured party
 1025 | are not required to pay, charges for treatment or
 1026 | services rendered more than 35 days before the
 1027 | postmark date of the statement, except for past due
 1028 | amounts previously billed on a timely basis, and
 1029 | except that, if the provider submits to the insurer a
 1030 | notice of initiation of treatment within 21 days after
 1031 | its first examination or treatment of the claimant,
 1032 | the first billing cycle statement may include charges
 1033 | for treatment or services rendered up to, but not more
 1034 | than, 75 days before the postmark date of the
 1035 | statement.

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1037 (d) All statements and bills for medical services rendered
 1038 by any physician, hospital, clinic, or other person or
 1039 institution shall be submitted to the insurer on a properly
 1040 completed Centers for Medicare and Medicaid Services (CMS) 1500
 1041 form, UB 92 forms, or any other standard form approved by the
 1042 office or adopted by the commission for purposes of this
 1043 paragraph. All billings for such services rendered by providers
 1044 must ~~shall~~, to the extent applicable, follow the Physicians'
 1045 Current Procedural Terminology (CPT) or Healthcare Correct
 1046 Procedural Coding System (HCPCS), or ICD-9 in effect for the
 1047 year in which services are rendered and comply with the ~~Centers~~
 1048 ~~for Medicare and Medicaid Services (CMS)~~ 1500 form instructions
 1049 and the American Medical Association Current Procedural
 1050 Terminology (CPT) Editorial Panel and Healthcare Correct
 1051 Procedural Coding System (HCPCS). All providers other than
 1052 hospitals shall include on the applicable claim form the
 1053 professional license number of the provider in the line or space
 1054 provided for "Signature of Physician or Supplier, Including
 1055 Degrees or Credentials." In determining compliance with
 1056 applicable CPT and HCPCS coding, guidance shall be provided by
 1057 the Physicians' Current Procedural Terminology (CPT) or the
 1058 Healthcare Correct Procedural Coding System (HCPCS) in effect
 1059 for the year in which services were rendered, the Office of the
 1060 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
 1061 other authoritative treatises designated by rule by the Agency
 1062 for Health Care Administration. A ~~No~~ statement of medical
 1063 services may not include charges for medical services of a
 1064 person or entity that performed such services without possessing

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1065 the valid licenses required to perform such services. For
 1066 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
 1067 considered to have been furnished with notice of the amount of
 1068 covered loss or medical bills due unless the statements or bills
 1069 comply with this paragraph, and unless the statements or bills
 1070 are properly completed in their entirety as to all material
 1071 provisions, with all relevant information ~~being~~ provided
 1072 ~~therein~~.

1073 (e)1. At the initial treatment or service provided, each
 1074 physician, other licensed professional, clinic, or other medical
 1075 institution providing medical services upon which a claim for
 1076 personal injury protection benefits is based shall require an
 1077 insured person, or his or her guardian, to execute a disclosure
 1078 and acknowledgment form, which reflects at a minimum that:

1079 a. The insured, or his or her guardian, must countersign
 1080 the form attesting to the fact that the services set forth
 1081 therein were actually rendered;

1082 b. The insured, or his or her guardian, has both the right
 1083 and affirmative duty to confirm that the services were actually
 1084 rendered;

1085 c. The insured, or his or her guardian, was not solicited
 1086 by any person to seek any services from the medical provider;

1087 d. The physician, other licensed professional, clinic, or
 1088 other medical institution rendering services for which payment
 1089 is being claimed explained the services to the insured or his or
 1090 her guardian; and

1091 e. If the insured notifies the insurer in writing of a
 1092 billing error, the insured may be entitled to a certain

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1093 percentage of a reduction in the amounts paid by the insured's
 1094 motor vehicle insurer.

1095 2. The physician, other licensed professional, clinic, or
 1096 other medical institution rendering services for which payment
 1097 is being claimed has the affirmative duty to explain the
 1098 services rendered to the insured, or his or her guardian, so
 1099 that the insured, or his or her guardian, countersigns the form
 1100 with informed consent.

1101 3. Countersignature by the insured, or his or her
 1102 guardian, is not required for the reading of diagnostic tests or
 1103 other services that are of such a nature that they are not
 1104 required to be performed in the presence of the insured.

1105 4. The licensed medical professional rendering treatment
 1106 for which payment is being claimed must sign, by his or her own
 1107 hand, the form complying with this paragraph.

1108 5. The original completed disclosure and acknowledgment
 1109 form is ~~shall be~~ furnished to the insurer pursuant to paragraph
 1110 (4) (b) and may not be electronically furnished.

1111 6. This disclosure and acknowledgment form is not required
 1112 for services billed by a provider for emergency services as
 1113 defined in s. 395.002, for emergency services and care as
 1114 defined in s. 395.002 rendered in a hospital emergency
 1115 department, or for transport and treatment rendered by an
 1116 ambulance provider licensed pursuant to part III of chapter 401.

1117 7. The Financial Services Commission shall adopt, ~~by rule,~~
 1118 a standard disclosure and acknowledgment form to ~~that shall~~ be
 1119 used to fulfill the requirements of this paragraph, ~~effective 90~~
 1120 ~~days after such form is adopted and becomes final.~~ The

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1121 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1122 ~~the rule is final, the provider may use a form of its own which~~
1123 ~~otherwise complies with the requirements of this paragraph.~~

1124 8. As used in this paragraph, the term "countersigned" or
1125 "countersignature" means a second or verifying signature, as on
1126 a previously signed document, and is not satisfied by the
1127 statement "signature on file" or any similar statement.

1128 9. The requirements of this paragraph apply only with
1129 respect to the initial treatment or service of the insured by a
1130 provider. For subsequent treatments or service, the provider
1131 must maintain a patient log signed by the patient, in
1132 chronological order by date of service, that is consistent with
1133 the services being rendered to the patient as claimed. The
1134 requirements ~~of this subparagraph~~ for maintaining a patient log
1135 signed by the patient may be met by a hospital that maintains
1136 medical records as required by s. 395.3025 and applicable rules
1137 and makes such records available to the insurer upon request.

1138 (f) Upon written notification by any person, an insurer
1139 shall investigate any claim of improper billing by a physician
1140 or other medical provider. The insurer shall determine if the
1141 insured was properly billed for only those services and
1142 treatments that the insured actually received. If the insurer
1143 determines that the insured has been improperly billed, the
1144 insurer shall notify the insured, the person making the written
1145 notification, and the provider of its findings and shall reduce
1146 the amount of payment to the provider by the amount determined
1147 to be improperly billed. If a reduction is made due to such
1148 written notification by any person, the insurer shall pay to the

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1149 person 20 percent of the amount of the reduction, up to \$500. If
 1150 the provider is arrested due to the improper billing, ~~then~~ the
 1151 insurer shall pay to the person 40 percent of the amount of the
 1152 reduction, up to \$500.

1153 (g) An insurer may not systematically downcode with the
 1154 intent to deny reimbursement otherwise due. Such action
 1155 constitutes a material misrepresentation under s.
 1156 626.9541(1)(i)2.

1157 ~~(7)(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
 1158 DISPUTES.—

1159 (a) An insurer may require a claimant to submit to an
 1160 examination under oath or sworn statement as often as reasonably
 1161 requested by an insurer and at any reasonable location
 1162 designated by the insurer. Submission to an examination under
 1163 oath or sworn statement is a condition precedent to recovery or
 1164 filing suit. The insurer is not liable for benefits under the
 1165 no-fault law if the claimant fails to fully and truthfully
 1166 answer all questions asked or violates any provision of
 1167 paragraph (4)(j).

1168 1. The insurer may conduct the examination outside the
 1169 presence of any other person seeking coverage.

1170 2. If an insurer requests an examination of a claimant
 1171 that is in a hospital, clinic, or other medical institution,
 1172 such claimant shall produce the persons with the most knowledge
 1173 relating to the issues set forth by the insurer in the notice of
 1174 examination.

1175 3. The claimant must provide the insurer at the
 1176 examination with all documents, papers, receipts, invoices,

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1177 bills, records, or other tangible items requested by the
 1178 insurer.

1179 4. The examination may be recorded by audio, video, or
 1180 court report or any combination thereof. The claimant may record
 1181 the examination at the claimant's expense.

1182 5. The claimant may have an attorney present at the
 1183 examination at the claimant's expense.

1184 6. An insurer that unreasonably requests an examination
 1185 without a reasonable basis as a general business practice is
 1186 engaging in an unfair insurance trade practice pursuant to s.
 1187 626.9541.

1188 ~~(a) Every employer shall, if a request is made by an~~
 1189 ~~insurer providing personal injury protection benefits under ss.~~
 1190 ~~627.730-627.7405 against whom a claim has been made, furnish~~
 1191 ~~forthwith, in a form approved by the office, a sworn statement~~
 1192 ~~of the earnings, since the time of the bodily injury and for a~~
 1193 ~~reasonable period before the injury, of the person upon whose~~
 1194 ~~injury the claim is based.~~

1195 (b) Every physician, hospital, clinic, or other medical
 1196 institution providing, before or after bodily injury upon which
 1197 a claim for personal injury protection insurance benefits is
 1198 based, any products, services, or accommodations in relation to
 1199 that or any other injury, or in relation to a condition claimed
 1200 to be connected with that or any other injury, shall, if
 1201 requested to do so by the insurer against whom the claim has
 1202 been made, permit the insurer or the insurer's representative to
 1203 conduct an onsite physical review and examination of the
 1204 treatment location, treatment apparatuses, diagnostic devices,

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1205 and any other medical equipment used for the services rendered
 1206 within 10 days after the insurer's request and furnish forthwith
 1207 a written report of the history, condition, treatment, dates,
 1208 and costs of such treatment of the injured person and why the
 1209 items identified by the insurer were reasonable in amount and
 1210 medically necessary, together with a sworn statement that the
 1211 treatment or services rendered were reasonable and necessary
 1212 with respect to the bodily injury sustained and identifying
 1213 which portion of the expenses for such treatment or services was
 1214 incurred as a result of such bodily injury, and produce
 1215 ~~forthwith,~~ and permit the inspection and copying of, his or her
 1216 or its records regarding such history, condition, treatment,
 1217 dates, and costs of treatment if; ~~provided that~~ this does shall
 1218 not limit the introduction of evidence at trial. Such sworn
 1219 statement must shall read as follows: "Under penalty of perjury,
 1220 I declare that I have read the foregoing, and the facts alleged
 1221 are true, to the best of my knowledge and belief." A No cause of
 1222 action for violation of the physician-patient privilege or
 1223 invasion of the right of privacy may not be brought shall be
 1224 ~~permitted~~ against any physician, hospital, clinic, or other
 1225 medical institution complying with ~~the provisions of~~ this
 1226 section. The person requesting such records and such sworn
 1227 statement shall pay all reasonable costs connected therewith. If
 1228 an insurer makes a written request for documentation or
 1229 information under this paragraph within 30 days after having
 1230 received notice of the amount of a covered loss under paragraph
 1231 (4) (a), the amount or the partial amount that which is the
 1232 subject of the insurer's inquiry is shall become overdue if the

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1233 insurer does not pay in accordance with paragraph (4) (b) or
 1234 within 10 days after the insurer's receipt of the requested
 1235 documentation or information, whichever occurs later. For
 1236 purposes of this paragraph, the term "receipt" includes, but is
 1237 not limited to, inspection and copying pursuant to this
 1238 paragraph. An ~~Any~~ insurer that requests documentation or
 1239 information pertaining to reasonableness of charges or medical
 1240 necessity under this paragraph without a reasonable basis for
 1241 such requests as a general business practice is engaging in an
 1242 unfair trade practice under the insurance code.

1243 (c) If a request is made by an insurer, an employer must
 1244 furnish, in a form approved by the office, a sworn statement of
 1245 the earnings of the person upon whose injury a claim is based
 1246 since the time of the bodily injury and for a reasonable period
 1247 before the injury.

1248 (d) ~~(e)~~ If there is a ~~In the event of any~~ dispute regarding
 1249 an insurer's right to discovery of facts under this section, the
 1250 insurer may petition the ~~a~~ court ~~of competent jurisdiction~~ to
 1251 enter an order permitting such discovery. The order may be made
 1252 only on motion for good cause shown and upon notice to all
 1253 persons having an interest, and must ~~it shall~~ specify the time,
 1254 place, manner, conditions, and scope of the discovery. The ~~Such~~
 1255 court may, in order to protect against annoyance, embarrassment,
 1256 or oppression, as justice requires, enter an order refusing
 1257 discovery or specifying conditions of discovery and ~~may~~ order
 1258 payments of costs and expenses of the proceeding, including
 1259 reasonable fees for the appearance of attorneys at the
 1260 proceedings, as justice requires.

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1261 (8)~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
 1262 REPORTS.—

1263 (b) If requested by the person examined, a party causing
 1264 an examination to be made shall deliver to him or her a copy of
 1265 every written report concerning the examination rendered by an
 1266 examining physician, at least one of which reports must set out
 1267 the examining physician's findings and conclusions in detail.
 1268 After such request and delivery, the party causing the
 1269 examination to be made is entitled, upon request, to receive
 1270 from the person examined every written report available to him
 1271 or her or his or her representative concerning any examination,
 1272 previously or thereafter made, of the same mental or physical
 1273 condition. By requesting and obtaining a report of the
 1274 examination so ordered, or by taking the deposition of the
 1275 examiner, the person examined waives any privilege he or she may
 1276 have, in relation to the claim for benefits, regarding the
 1277 testimony of every other person who has examined, or may
 1278 thereafter examine, him or her in respect to the same mental or
 1279 physical condition. If a person unreasonably refuses to submit
 1280 to an examination, the personal injury protection carrier is no
 1281 longer liable for ~~subsequent~~ personal injury protection benefits
 1282 incurred after the date of the first request for examination.
 1283 Failure to appear for an examination raises a rebuttable
 1284 presumption that such failure was unreasonable. Submission to an
 1285 examination is a condition precedent to the recovery of
 1286 benefits.

1287 (9)~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY'S
 1288 FEES.—With respect to any dispute ~~under the provisions of ss.~~

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1289 ~~627.730-627.7405~~ between the insured and the insurer under the
 1290 no-fault law,~~7~~ or between an assignee of an insured's rights and
 1291 the insurer, ~~the provisions of s. 627.428 applies shall apply,~~
 1292 except as provided in subsections (11) and (16) ~~(10) and (15)~~.

1293 ~~(10)-(9)~~ PREFERRED PROVIDERS.-An insurer may negotiate and
 1294 enter into contracts with preferred licensed health care
 1295 providers for the benefits described in this section, ~~referred~~
 1296 ~~to in this section as "preferred providers,"~~ which shall include
 1297 health care providers licensed under chapter chapters 458,
 1298 chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463.

1299 (a) The insurer may provide an option to an insured to use
 1300 a preferred provider at the time of purchase of the policy for
 1301 personal injury protection benefits,~~7~~ if the requirements of this
 1302 subsection are met. However, if the insurer offers a preferred
 1303 provider option, it must also offer a nonpreferred provider
 1304 policy. If the insured elects to use a provider who is not a
 1305 preferred provider, whether the insured purchased a preferred
 1306 provider policy or a nonpreferred provider policy, the medical
 1307 benefits provided by the insurer shall be as required by this
 1308 section.

1309 (b) If the insured elects the ~~to use a provider who is a~~
 1310 preferred provider option, the insurer may pay medical benefits
 1311 in excess of the benefits required by this section and may waive
 1312 or lower the amount of any deductible that applies to such
 1313 medical benefits. As an alternative, or in addition to such
 1314 benefits, waiver, or reduction, the insurer may provide an
 1315 actuarially appropriate premium discount as specified in an
 1316 approved rate filing to an insured who selects the preferred

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1317 provider option. If the preferred provider option provides a
1318 premium discount, the policy may provide that charges for
1319 nonemergency services provided within this state are payable
1320 only if performed by members of the preferred provider network
1321 unless there is no member of the preferred provider network
1322 located within 15 miles of the insured's place of residence
1323 whose scope of practice includes the required services. If the
1324 ~~insurer offers a preferred provider policy to a policyholder or~~
1325 ~~applicant, it must also offer a nonpreferred provider policy.~~

1326 (c) The insurer shall provide each insured policyholder
1327 with a current roster of preferred providers in the county in
1328 which the insured resides at the time of purchasing purchase of
1329 such policy, and shall make such list available for public
1330 inspection during regular business hours at the insurer's
1331 principal office of the insurer within the state. The insurer
1332 may contract with another health insurer for the right to use an
1333 existing preferred provider network to implement the preferred
1334 provider option. Any other arrangement is subject to the
1335 approval of the Office of Insurance Regulation.

1336 (17)-(16) SECURE ELECTRONIC DATA TRANSFER.—If all parties
1337 mutually and expressly agree, a notice, documentation,
1338 transmission, or communication of any kind required or
1339 authorized under the no-fault law ss. 627.730–627.7405 may be
1340 transmitted electronically if it is transmitted by secure
1341 electronic data transfer that is consistent with state and
1342 federal privacy and security laws.

1343 Section 9. Paragraph (c) of subsection (7) of section
1344 817.234, Florida Statutes, is amended, present subsection (12)

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1345 of that section is renumbered as subsection (13), and a new
 1346 subsection (12) is added to that section, to read:

1347 817.234 False and fraudulent insurance claims.—

1348 (7)

1349 (c) An insurer, or any person acting at the direction of
 1350 or on behalf of an insurer, may not change an opinion in a
 1351 mental or physical report prepared under s. 627.736(8)
 1352 ~~627.736(7)~~ or direct the physician preparing the report to
 1353 change such opinion; however, this provision does not preclude
 1354 the insurer from calling to the attention of the physician
 1355 errors of fact in the report based upon information in the claim
 1356 file. Any person who violates this paragraph commits a felony of
 1357 the third degree, punishable as provided in s. 775.082, s.
 1358 775.083, or s. 775.084.

1359 (12) In addition to any criminal liability, a person
 1360 convicted of violating any provision of this section for the
 1361 purpose of receiving insurance proceeds from a motor vehicle
 1362 insurance contract is subject to a civil penalty.

1363 (a) Except for a violation of subsection (9), the civil
 1364 penalty shall be:

1365 1. A fine up to \$5,000 for a first offense.

1366 2. A fine greater than \$5,000, but not to exceed \$10,000,
 1367 for a second offense.

1368 3. A fine greater than \$10,000, but not to exceed \$15,000,
 1369 for a third or subsequent offense.

1370 (b) The civil penalty for a violation of subsection
 1371 (9) must be at least \$15,000 but may not exceed \$50,000.

1372 (c) The civil penalty shall be paid to the Insurance

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1373 Regulatory Trust Fund within the Department of Financial
 1374 Services and used by the department for the investigation and
 1375 prosecution of insurance fraud.

1376 (d) This subsection does not prohibit a state attorney
 1377 from entering into a written agreement in which the person
 1378 charged with the violation does not admit to or deny the charges
 1379 but consents to payment of the civil penalty.

1380 Section 10. Subsection (1) of section 324.021, Florida
 1381 Statutes, is amended to read:

1382 324.021 Definitions; minimum insurance required.—The
 1383 following words and phrases when used in this chapter shall, for
 1384 the purpose of this chapter, have the meanings respectively
 1385 ascribed to them in this section, except in those instances
 1386 where the context clearly indicates a different meaning:

1387 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
 1388 is designed and required to be licensed for use upon a highway,
 1389 including trailers and semitrailers designed for use with such
 1390 vehicles, except traction engines, road rollers, farm tractors,
 1391 power shovels, and well drillers, and every vehicle that ~~which~~
 1392 is propelled by electric power obtained from overhead wires but
 1393 not operated upon rails, but not including any bicycle or moped.
 1394 However, the term does ~~"motor vehicle"~~ shall not include a ~~any~~
 1395 motor vehicle as defined in s. 627.732(3) ~~if when~~ the owner of
 1396 such vehicle has complied with the no-fault law ~~requirements of~~
 1397 ~~ss. 627.730–627.7405, inclusive,~~ unless the provisions of s.
 1398 324.051 apply; and, in such case, the applicable proof of
 1399 insurance provisions of s. 320.02 apply.

1400 Section 11. Paragraph (k) of subsection (2) of section

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1401 456.057, Florida Statutes, is amended to read:

1402 456.057 Ownership and control of patient records; report
 1403 or copies of records to be furnished.—

1404 (2) As used in this section, the terms "records owner,"
 1405 "health care practitioner," and "health care practitioner's
 1406 employer" do not include any of the following persons or
 1407 entities; furthermore, the following persons or entities are not
 1408 authorized to acquire or own medical records, but are authorized
 1409 under the confidentiality and disclosure requirements of this
 1410 section to maintain those documents required by the part or
 1411 chapter under which they are licensed or regulated:

1412 (k) Persons or entities practicing under s. 627.736(8)
 1413 ~~627.736(7)~~.

1414 Section 12. Subsection (7) of section 627.7295, Florida
 1415 Statutes, is amended to read:

1416 627.7295 Motor vehicle insurance contracts.—

1417 (7) A policy of private passenger motor vehicle insurance
 1418 or a binder for such a policy may be initially issued in this
 1419 state only if the insurer or agent has collected from the
 1420 insured an amount equal to 2 months' premium. An insurer, agent,
 1421 or premium finance company may not, directly or indirectly, take
 1422 any action resulting in the insured having paid from the
 1423 insured's own funds an amount less than the 2 months' premium
 1424 required by this subsection. This subsection applies without
 1425 regard to whether the premium is financed by a premium finance
 1426 company or is paid pursuant to a periodic payment plan of an
 1427 insurer or an insurance agent. This subsection does not apply if
 1428 an insured or member of the insured's family is renewing or

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1429 replacing a policy or a binder for such policy written by the
 1430 same insurer or a member of the same insurer group. This
 1431 subsection does not apply to an insurer that issues private
 1432 passenger motor vehicle coverage primarily to active duty or
 1433 former military personnel or their dependents. This subsection
 1434 does not apply if all policy payments are paid pursuant to a
 1435 payroll deduction plan or an automatic electronic funds transfer
 1436 payment plan from the policyholder, provided that the first
 1437 policy payment is made by cash, cashier's check, check, or a
 1438 money order. This subsection and subsection (4) do not apply if
 1439 all policy payments to an insurer are paid pursuant to an
 1440 automatic electronic funds transfer payment plan from an agent,
 1441 a managing general agent, or a premium finance company and if
 1442 the policy includes, at a minimum, personal injury protection
 1443 pursuant to ss. 627.730-627.7407 ~~627.730-627.7405~~; motor vehicle
 1444 property damage liability pursuant to s. 627.7275; and bodily
 1445 injury liability in at least the amount of \$10,000 because of
 1446 bodily injury to, or death of, one person in any one accident
 1447 and in the amount of \$20,000 because of bodily injury to, or
 1448 death of, two or more persons in any one accident. This
 1449 subsection and subsection (4) do not apply if an insured has had
 1450 a policy in effect for at least 6 months, the insured's agent is
 1451 terminated by the insurer that issued the policy, and the
 1452 insured obtains coverage on the policy's renewal date with a new
 1453 company through the terminated agent.

1454 Section 13. Subsections (3) and (4) of section 627.733,
 1455 Florida Statutes, are amended to read:
 1456 627.733 Required security.—

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1457 (3) Such security shall be provided:
 1458 (a) By an insurance policy delivered or issued for
 1459 delivery in this state by an authorized or eligible motor
 1460 vehicle liability insurer which provides the benefits and
 1461 exemptions contained in the no-fault law ~~ss. 627.730-627.7405~~.
 1462 Any policy of insurance represented or sold as providing the
 1463 security required hereunder shall be deemed to provide insurance
 1464 for the payment of the required benefits; or
 1465 (b) By any other method authorized by s. 324.031(2), (3),
 1466 or (4) and approved by the Department of Highway Safety and
 1467 Motor Vehicles as affording security equivalent to that afforded
 1468 by a policy of insurance or by self-insuring as authorized by s.
 1469 768.28(16). The person filing such security shall have all of
 1470 the obligations and rights of an insurer under the no-fault law
 1471 ~~ss. 627.730-627.7405~~.
 1472 (4) An owner of a motor vehicle with respect to which
 1473 security is required by this section who fails to have such
 1474 security in effect at the time of an accident shall have no
 1475 immunity from tort liability, but shall be personally liable for
 1476 the payment of benefits under s. 627.736. With respect to such
 1477 benefits, such an owner shall have all of the rights and
 1478 obligations of an insurer under the no-fault law ~~ss. 627.730-~~
 1479 ~~627.7405~~.
 1480 Section 14. Section 627.734, Florida Statutes, is amended
 1481 to read:
 1482 627.734 Proof of security; security requirements;
 1483 penalties.—
 1484 (1) The provisions of chapter 324 that ~~which~~ pertain to

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1485 the method of giving and maintaining proof of financial
 1486 responsibility and that ~~which~~ govern and define a motor vehicle
 1487 liability policy shall apply to filing and maintaining proof of
 1488 security required by the no-fault law ~~ss. 627.730-627.7405~~.

1489 (2) Any person who:

1490 (a) Gives information required in a report or otherwise as
 1491 provided for in the no-fault law ~~ss. 627.730-627.7405~~, knowing
 1492 or having reason to believe that such information is false;

1493 (b) Forges or, without authority, signs any evidence of
 1494 proof of security; or

1495 (c) Files, or offers for filing, any such evidence of
 1496 proof, knowing or having reason to believe that it is forged or
 1497 signed without authority,

1498
 1499 commits ~~is guilty of~~ a misdemeanor of the first degree,
 1500 punishable as provided in s. 775.082 or s. 775.083.

1501 Section 15. Subsections (1), (2), and (3) of section
 1502 627.737, Florida Statutes, are amended to read:

1503 627.737 Tort exemption; limitation on right to damages;
 1504 punitive damages.—

1505 (1) Every owner, registrant, operator, or occupant of a
 1506 motor vehicle with respect to which security has been provided
 1507 as required by the no-fault law ~~ss. 627.730-627.7405~~, and every
 1508 person or organization legally responsible for her or his acts
 1509 or omissions, is hereby exempted from tort liability for damages
 1510 because of bodily injury, sickness, or disease arising out of
 1511 the ownership, operation, maintenance, or use of such motor
 1512 vehicle in this state to the extent that the benefits described

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1513 in s. 627.736(1) are payable for such injury, or would be
 1514 payable but for any exclusion authorized by the no-fault law ~~ss.~~
 1515 ~~627.730-627.7405~~, under any insurance policy or other method of
 1516 security complying with the requirements of s. 627.733, or by an
 1517 owner personally liable under s. 627.733 for the payment of such
 1518 benefits, unless a person is entitled to maintain an action for
 1519 pain, suffering, mental anguish, and inconvenience for such
 1520 injury under ~~the provisions of~~ subsection (2).

1521 (2) In any action of tort brought against the owner,
 1522 registrant, operator, or occupant of a motor vehicle with
 1523 respect to which security has been provided as required by the
 1524 no-fault law ~~ss. 627.730-627.7405~~, or against any person or
 1525 organization legally responsible for her or his acts or
 1526 omissions, a plaintiff may recover damages in tort for pain,
 1527 suffering, mental anguish, and inconvenience because of bodily
 1528 injury, sickness, or disease arising out of the ownership,
 1529 maintenance, operation, or use of such motor vehicle only in the
 1530 event that the injury or disease consists in whole or in part
 1531 of:

1532 (a) Significant and permanent loss of an important bodily
 1533 function.

1534 (b) Permanent injury within a reasonable degree of medical
 1535 probability, other than scarring or disfigurement.

1536 (c) Significant and permanent scarring or disfigurement.

1537 (d) Death.

1538 (3) When a defendant, in a proceeding brought pursuant to
 1539 the no-fault law ~~ss. 627.730-627.7405~~, questions whether the
 1540 plaintiff has met the requirements of subsection (2), ~~then~~ the

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1541 defendant may file an appropriate motion with the court, and the
 1542 court shall, on a one-time basis only, 30 days before the date
 1543 set for the trial or the pretrial hearing, whichever is first,
 1544 by examining the pleadings and the evidence before it, ascertain
 1545 whether the plaintiff will be able to submit some evidence that
 1546 the plaintiff will meet the requirements of subsection (2). If
 1547 the court finds that the plaintiff will not be able to submit
 1548 such evidence, ~~then~~ the court shall dismiss the plaintiff's
 1549 claim without prejudice.

1550 Section 16. Subsection (1) of section 627.7401, Florida
 1551 Statutes, is amended to read:

1552 627.7401 Notification of insured's rights.—

1553 (1) The commission, by rule, shall adopt a form for the
 1554 notification of insureds of their right to receive personal
 1555 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
 1556 fault law. Such notice shall include:

1557 (a) A description of the benefits provided by personal
 1558 injury protection, including, but not limited to, the specific
 1559 types of services for which medical benefits are paid,
 1560 disability benefits, death benefits, significant exclusions from
 1561 and limitations on personal injury protection benefits, when
 1562 payments are due, how benefits are coordinated with other
 1563 insurance benefits that the insured may have, penalties and
 1564 interest that may be imposed on insurers for failure to make
 1565 timely payments of benefits, and rights of parties regarding
 1566 disputes as to benefits.

1567 (b) An advisory informing insureds that:

1568 1. Pursuant to s. 626.9892, the Department of Financial

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1569 Services may pay rewards of up to \$25,000 to persons providing
 1570 information leading to the arrest and conviction of persons
 1571 committing crimes investigated by the Division of Insurance
 1572 Fraud arising from violations of s. 440.105, s. 624.15, s.
 1573 626.9541, s. 626.989, or s. 817.234.

1574 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
 1575 insured notifies the insurer of a billing error, the insured may
 1576 be entitled to a certain percentage of a reduction in the amount
 1577 paid by the insured's motor vehicle insurer.

1578 (c) A notice that solicitation of a person injured in a
 1579 motor vehicle crash for purposes of filing personal injury
 1580 protection or tort claims could be a violation of s. 817.234, s
 1581 817.505, or the rules regulating The Florida Bar and should be
 1582 immediately reported to the Division of Insurance Fraud if such
 1583 conduct has taken place.

1584 Section 17. Section 627.7405, Florida Statutes, is amended
 1585 to read:

1586 627.7405 Insurers' right of reimbursement.—Notwithstanding
 1587 any other provisions of the no-fault law ~~ss. 627.730-627.7405,~~
 1588 any insurer providing personal injury protection benefits on a
 1589 private passenger motor vehicle has ~~shall have~~, to the extent of
 1590 any personal injury protection benefits paid to any person as a
 1591 benefit arising out of such private passenger motor vehicle
 1592 insurance, a right of reimbursement against the owner or the
 1593 insurer of the owner of a commercial motor vehicle, if the
 1594 benefits paid result from such person having been an occupant of
 1595 the commercial motor vehicle or having been struck by the
 1596 commercial motor vehicle while not an occupant of any self-

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1597 propelled vehicle.

1598 Section 18. Subsection (1) of section 627.7407, Florida
 1599 Statutes, is amended to read:

1600 627.7407 Application of the Florida Motor Vehicle No-Fault
 1601 Law.—

1602 (1) Any person subject to the requirements of ~~ss. 627.730-~~
 1603 ~~627.7405,~~ the Florida Motor Vehicle No-Fault Law, as revived and
 1604 amended by this act, must maintain security for personal injury
 1605 protection as required by the Florida Motor Vehicle No-Fault
 1606 Law, as revived and amended by this act, beginning on January 1,
 1607 2008.

1608 Section 19. Paragraph (d) of subsection (2) and paragraph
 1609 (d) of subsection (3) of section 628.909, Florida Statutes, are
 1610 amended to read:

1611 628.909 Applicability of other laws.—

1612 (2) The following provisions of the Florida Insurance Code
 1613 shall apply to captive insurers who are not industrial insured
 1614 captive insurers to the extent that such provisions are not
 1615 inconsistent with this part:

1616 (d) Sections 627.730-627.7407 ~~627.730-627.7405,~~ when no-
 1617 fault coverage is provided.

1618 (3) The following provisions of the Florida Insurance Code
 1619 shall apply to industrial insured captive insurers to the extent
 1620 that such provisions are not inconsistent with this part:

1621 (d) Sections 627.730-627.7407 ~~627.730-627.7405~~ when no-
 1622 fault coverage is provided.

1623 Section 20. This act shall take effect July 1, 2011.