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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/13/2011	.	
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	.	
	.	

The Committee on Banking and Insurance (Bogdanoff) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Subsection (1) of section 316.066, Florida
6 Statutes, is amended to read:
7 316.066 Written reports of crashes.—
8 (1)(a) A Florida Traffic Crash Report, Long Form, must ~~is~~
9 ~~required to~~ be completed and submitted to the department within
10 10 days after ~~completing~~ an investigation is completed by the
11 ~~every~~ law enforcement officer who in the regular course of duty
12 investigates a motor vehicle crash:

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13 1. That resulted in death, ~~or~~ personal injury, or any
14 indication of complaints of pain or discomfort by any of the
15 parties or passengers involved in the crash;~~.~~
16 2. That involved one or more passengers, other than the
17 drivers of the vehicles, in any of the vehicles involved in the
18 crash;
19 3.~~2.~~ That involved a violation of s. 316.061(1) or s.
20 316.193; or~~.~~
21 4.~~3.~~ In which a vehicle was rendered inoperative to a
22 degree that required a wrecker to remove it from traffic, if
23 such action is appropriate, in the officer's discretion.
24 (b) In every crash for which a Florida Traffic Crash
25 Report, Long Form, is not required by this section, the law
26 enforcement officer may complete a short-form crash report or
27 provide a short-form crash report to be completed by each party
28 involved in the crash. Short-form crash reports prepared by the
29 law enforcement officer shall be maintained by the officer's
30 agency.
31 (c) The long-form and the short-form report must include:
32 1. The date, time, and location of the crash.
33 2. A description of the vehicles involved.
34 3. The names and addresses of the parties involved.
35 4. The names and addresses of all passengers in all
36 vehicles involved in the crash, each clearly identified as being
37 a passenger and the identification of the vehicle in which they
38 were a passenger.
39 5.~~4.~~ The names and addresses of witnesses.
40 6.~~5.~~ The name, badge number, and law enforcement agency of
41 the officer investigating the crash.

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42 7.~~6.~~ The names of the insurance companies for the
43 respective parties involved in the crash.
44 (d)~~(c)~~ Each party to the crash must ~~shall~~ provide the law
45 enforcement officer with proof of insurance, which must ~~to~~ be
46 included in the crash report. If a law enforcement officer
47 submits a report on the accident, proof of insurance must be
48 provided to the officer by each party involved in the crash. Any
49 party who fails to provide the required information commits a
50 noncriminal traffic infraction, punishable as a nonmoving
51 violation as provided in chapter 318, unless the officer
52 determines that due to injuries or other special circumstances
53 such insurance information cannot be provided immediately. If
54 the person provides the law enforcement agency, within 24 hours
55 after the crash, proof of insurance that was valid at the time
56 of the crash, the law enforcement agency may void the citation.
57 (e)~~(d)~~ The driver of a vehicle that was in any manner
58 involved in a crash resulting in damage to any vehicle or other
59 property in an amount of $500 or more~~,~~ which ~~crash~~ was not
60 investigated by a law enforcement agency, shall, within 10 days
61 after the crash, submit a written report of the crash to the
62 department or traffic records center. The entity receiving the
63 report may require witnesses of the crash ~~crashes~~ to render
64 reports and may require any driver of a vehicle involved in a
65 crash of which a written report must be made ~~as provided in this~~
66 ~~section~~ to file supplemental written reports if ~~whenever~~ the
67 original report is deemed insufficient by the receiving entity.
68 (f) The investigating law enforcement officer may testify
69 at trial or provide a signed affidavit to confirm or supplement
70 the information included on the long-form or short-form report.

71 ~~(c) Short-form crash reports prepared by law enforcement~~
72 ~~shall be maintained by the law enforcement officer's agency.~~
73 Section 2. Subsection (6) is added to section 400.991,
74 Florida Statutes, to read:
75 400.991 License requirements; background screenings;
76 prohibitions.—
77 (6) All forms that constitute part of the application for
78 licensure or exemption from licensure under this part must
79 contain the following statement:
80
81 INSURANCE FRAUD NOTICE.—Submitting a false,
82 misleading, or fraudulent application or other
83 document when applying for licensure as a health care
84 clinic, when seeking an exemption from licensure as a
85 health care clinic, or when demonstrating compliance
86 with part X of chapter 400, Florida Statutes, is a
87 fraudulent insurance act, as defined in s. 626.989 or
88 s. 817.234, Florida Statutes, subject to investigation
89 by the Division of Insurance Fraud, and is grounds for
90 discipline by the appropriate licensing board of the
91 Florida Department of Health.
92 Section 3. Section 626.9894, Florida Statutes, is created
93 to read:
94 626.9894 Motor vehicle insurance fraud direct-support
95 organization.—
96 (1) DEFINITIONS.—As used in this section, the term:
97 (a) "Division" means the Division of Insurance Fraud of the
98 Department of Financial Services.
99 (b) "Motor vehicle insurance fraud" means any act defined

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100 as a "fraudulent insurance act" under s. 626.989, which relates
101 to the coverage of motor vehicle insurance as described in part
102 XI of chapter 627.
103 (c) "Organization" means the direct-support organization
104 established under this section.
105 (2) ORGANIZATION ESTABLISHED.—The division may establish a
106 direct-support organization, to be known as the "Automobile
107 Insurance Fraud Strike Force," whose sole purpose is to support
108 the prosecution, investigation, and prevention of motor vehicle
109 insurance fraud. The organization shall:
110 (a) Be a not-for-profit corporation incorporated under
111 chapter 617 and approved by the Department of State.
112 (b) Be organized and operated to conduct programs and
113 activities; to raise funds; to request and receive grants,
114 gifts, and bequests of money; to acquire, receive, hold, invest,
115 and administer, in its own name, securities, funds, objects of
116 value, or other property, real or personal; and to make grants
117 and expenditures to or for the direct or indirect benefit of the
118 division, state attorneys' offices, the statewide prosecutor,
119 the Agency for Health Care Administration, and the Department of
120 Health to the extent that such grants and expenditures are to be
121 used exclusively to advance the purpose of prosecuting,
122 investigating, or preventing motor vehicle insurance fraud.
123 Grants and expenditures may include the cost of salaries or
124 benefits of dedicated motor vehicle insurance fraud
125 investigators, prosecutors, or support personnel if such grants
126 and expenditures do not interfere with prosecutorial
127 independence or otherwise create conflicts of interest which
128 threaten the success of prosecutions.

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129 (c) Be determined by the division to operate in a manner
130 that promotes the goals of laws relating to motor vehicle
131 insurance fraud, that is in the best interest of the state, and
132 that is in accordance with the adopted goals and mission of the
133 division.
134 (d) Use all of its grants and expenditures solely for the
135 purpose of preventing and decreasing motor vehicle insurance
136 fraud, and not for the purpose of lobbying as defined in s.
137 11.045.
138 (e) Be subject to an annual financial audit in accordance
139 with s. 215.981.
140 (3) CONTRACT.—The organization shall operate under written
141 contract with the division. The contract must provide for:
142 (a) Approval of the articles of incorporation and bylaws of
143 the organization by the division.
144 (b) Submission of an annual budget for the approval of the
145 division. The budget must require the organization to minimize
146 costs to the division and its members at all times by using
147 existing personnel and property and allowing for telephonic
148 meetings when appropriate.
149 (c) Certification by the division that the direct-support
150 organization is complying with the terms of the contract and in
151 a manner consistent with the goals and purposes of the
152 department and in the best interest of the state. Such
153 certification must be made annually and reported in the official
154 minutes of a meeting of the organization.
155 (d) Allocation of funds to address motor vehicle insurance
156 fraud.
157 (e) Reversion of moneys and property held in trust by the

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158 organization for motor vehicle insurance fraud prosecution,
159 investigation, and prevention to the division if the
160 organization is no longer approved to operate for the department
161 or if the organization ceases to exist, or to the state if the
162 division ceases to exist.
163 (f) Specific criteria to be used by the organization's
164 board of directors to evaluate the effectiveness of funding used
165 to combat motor vehicle insurance fraud.
166 (g) The fiscal year of the organization, which begins July
167 1 of each year and ends June 30 of the following year.
168 (h) Disclosure of the material provisions of the contract,
169 and distinguishing between the department and the organization
170 to donors of gifts, contributions, or bequests, including
171 providing such disclosure on all promotional and fundraising
172 publications.
173 (4) BOARD OF DIRECTORS.—The board of directors of the
174 organization shall consist of the following seven members:
175 (a) The Chief Financial Officer, or designee, who shall
176 serve as chair.
177 (b) Two state attorneys, one of whom shall be appointed by
178 the Chief Financial Officer and one of whom shall be appointed
179 by the Attorney General.
180 (c) Two representatives of motor vehicle insurers appointed
181 by the Chief Financial Officer.
182 (d) Two representatives of local law enforcement agencies,
183 both of whom shall be appointed by the Chief Financial Officer.
184
185 The officer who appointed a member of the board may remove that
186 member for cause. The term of office of an appointed member

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187 expires at the same time as the term of the officer who
188 appointed him or her or at such earlier time as the person
189 ceases to be qualified.
190 (5) USE OF PROPERTY.—The department may authorize, without
191 charge, appropriate use of fixed property and facilities of the
192 division by the organization, subject to this subsection.
193 (a) The department may prescribe any condition with which
194 the organization must comply in order to use the division's
195 property or facilities.
196 (b) The department may not authorize the use of the
197 division's property or facilities if the organization does not
198 provide equal membership and employment opportunities to all
199 persons regardless of race, religion, sex, age, or national
200 origin.
201 (c) The department shall adopt rules prescribing the
202 procedures by which the organization is governed and any
203 conditions with which the organization must comply to use the
204 division's property or facilities.
205 (6) CONTRIBUTIONS.—Any contributions made by an insurer to
206 the organization shall be allowed as appropriate business
207 expenses for all regulatory purposes.
208 (7) DEPOSITORY.—Any moneys received by the organization may
209 be held in a separate depository account in the name of the
210 organization and subject to the provisions of the contract with
211 the division.
212 (8) DIVISION'S RECEIPT OF PROCEEDS.—If the division
213 receives proceeds from the organization, those proceeds shall be
214 deposited into the Insurance Regulatory Trust Fund.
215 Section 4. Subsection (3) is added to section 627.4137,

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216 Florida Statutes, to read:
217 627.4137 Disclosure of certain information required.—
218 (3) Any request made to a self-insured corporation pursuant
219 to this section shall be sent by certified mail to the
220 registered agent of the disclosing entity.
221 Section 5. Section 627.730, Florida Statutes, is amended to
222 read:
223 627.730 Florida Motor Vehicle No-Fault Law.—Sections
224 627.730-627.7407 ~~627.730-627.7405~~ may be cited and known as the
225 "Florida Motor Vehicle No-Fault Law."
226 Section 6. Section 627.731, Florida Statutes, is amended to
227 read:
228 627.731 Purpose; legislative intent.—The purpose of the no-
229 fault law ~~ss. 627.730-627.7405~~ is to provide for medical,
230 surgical, funeral, and disability insurance benefits without
231 regard to fault, and to require motor vehicle insurance securing
232 such benefits, for motor vehicles required to be registered in
233 this state and, with respect to motor vehicle accidents, a
234 limitation on the right to claim damages for pain, suffering,
235 mental anguish, and inconvenience.
236 (1) The Legislature finds that automobile insurance fraud
237 remains a major problem for state consumers and insurers.
238 According to the National Insurance Crime Bureau, in recent
239 years this state has been among those states that have the
240 highest number of fraudulent and questionable claims.
241 (2) The Legislature intends to balance the insured's
242 interest in prompt payment of valid claims for insurance
243 benefits under the no-fault law with the public's interest in
244 reducing fraud, abuse, and overuse of the no-fault system. To

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245 that end, the Legislature intends that the investigation and
246 prevention of fraudulent insurance acts in this state be
247 enhanced, that additional sanctions for such acts be imposed,
248 and that the no-fault law be revised to remove incentives for
249 fraudulent insurance acts. The Legislature intends that the no-
250 fault law be construed according to the plain language of the
251 statutory provisions, which are designed to meet these goals.
252 (3) The Legislature intends that:
253 (a) Insurers properly investigate claims, and as such, be
254 allowed to obtain examinations under oath and sworn statements
255 from any claimant seeking no-fault insurance benefits, and to
256 request mental and physical examinations of persons seeking
257 personal injury protection coverage or benefits.
258 (b) Any false, misleading, or otherwise fraudulent activity
259 associated with a claim renders any claim brought by a claimant
260 engaging in such activity invalid. An insurer must be able to
261 raise fraud as a defense to a claim for no-fault insurance
262 benefits irrespective of any prior adjudication of guilt or
263 determination of fraud by the Department of Financial Services.
264 (c) Insurers toll the payment or denial of a claim, with
265 respect to any portion of a claim for which the insurer has a
266 reasonable belief that a fraudulent insurance act, as defined in
267 s. 626.989, has been committed.
268 (d) Insurers discover the names of all passengers involved
269 in an automobile accident before paying claims or benefits
270 pursuant to an insurance policy governed by the no-fault law. A
271 rebuttable presumption must be established that a person was not
272 involved in the event giving rise to the claim if that person’s
273 name does not appear on the police report.

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274 (e) The insured's interest in obtaining competent counsel
275 must be balanced with the public's interest in preventing a no-
276 fault system that encourages litigation by allowing for
277 exorbitant attorney's fees. Courts should limit attorney fee
278 awards so as to eliminate the incentive for attorneys to
279 manufacture unnecessary litigation.
280 Section 7. Section 627.732, Florida Statutes, is reordered
281 and amended to read:
282 627.732 Definitions.—As used in the no-fault law ~~ss.~~
283 ~~627.730-627.7405~~, the term:
284 (1) "Broker" means any person not possessing a license
285 under chapter 395, chapter 400, chapter 429, chapter 458,
286 chapter 459, chapter 460, chapter 461, or chapter 641 who
287 charges or receives compensation for any use of medical
288 equipment and is not the 100-percent owner or the 100-percent
289 lessee of such equipment. For purposes of this section, such
290 owner or lessee may be an individual, a corporation, a
291 partnership, or any other entity and any of its 100-percent-
292 owned affiliates and subsidiaries. For purposes of this
293 subsection, the term "lessee" means a long-term lessee under a
294 capital or operating lease, but does not include a part-time
295 lessee. The term "broker" does not include a hospital or
296 physician management company whose medical equipment is
297 ancillary to the practices managed, a debt collection agency, or
298 an entity that has contracted with the insurer to obtain a
299 discounted rate for such services; or ~~nor does the term include~~
300 a management company that has contracted to provide general
301 management services for a licensed physician or health care
302 facility and whose compensation is not materially affected by

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303 the usage or frequency of usage of medical equipment or an
304 entity that is 100-percent owned by one or more hospitals or
305 physicians. The term “broker” does not include a person or
306 entity that certifies, upon request of an insurer, that:
307 (a) It is a clinic licensed under ss. 400.990-400.995;
308 (b) It is a 100-percent owner of medical equipment; and
309 (c) The owner’s only part-time lease of medical equipment
310 for personal injury protection patients is on a temporary basis,
311 not to exceed 30 days in a 12-month period, and such lease is
312 solely for the purposes of necessary repair or maintenance of
313 the 100-percent-owned medical equipment or pending the arrival
314 and installation of the newly purchased or a replacement for the
315 100-percent-owned medical equipment, or for patients for whom,
316 because of physical size or claustrophobia, it is determined by
317 the medical director or clinical director to be medically
318 necessary that the test be performed in medical equipment that
319 is open-style. The leased medical equipment may not ~~cannot~~ be
320 used by patients who are not patients of the registered clinic
321 ~~for medical treatment of services~~. Any person or entity making a
322 false certification under this subsection commits insurance
323 fraud as defined in s. 817.234. However, the 30-day period
324 ~~provided in this paragraph~~ may be extended for an additional 60
325 days as applicable to magnetic resonance imaging equipment if
326 the owner certifies that the extension otherwise complies with
327 this paragraph.
328 (9) ~~(2)~~ “Medically necessary” refers to a medical service or
329 supply that a prudent physician would provide for the purpose of
330 preventing, diagnosing, or treating an illness, injury, disease,
331 or symptom in a manner that is:

332 (a) In accordance with generally accepted standards of
333 medical practice;
334 (b) Clinically appropriate in terms of type, frequency,
335 extent, site, and duration; and
336 (c) Not primarily for the convenience of the patient,
337 physician, or other health care provider.
338 (10) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
339 with four or more wheels which is of a type both designed and
340 required to be licensed for use on the highways of this state,
341 and any trailer or semitrailer designed for use with such
342 vehicle, and includes:
343 (a) A "private passenger motor vehicle," which is any motor
344 vehicle that ~~which~~ is a sedan, station wagon, or jeep-type
345 vehicle and, if not used primarily for occupational,
346 professional, or business purposes, a motor vehicle of the
347 pickup, panel, van, camper, or motor home type.
348 (b) A "commercial motor vehicle," which is any motor
349 vehicle that ~~which~~ is not a private passenger motor vehicle.
350
351 The term ~~"motor vehicle"~~ does not include a mobile home or any
352 motor vehicle that ~~which~~ is used in mass transit, other than
353 public school transportation, and designed to transport more
354 than five passengers exclusive of the operator of the motor
355 vehicle and that ~~which~~ is owned by a municipality, a transit
356 authority, or a political subdivision of the state.
357 (11) ~~(4)~~ "Named insured" means a person, usually the owner
358 of a vehicle, identified in a policy by name as the insured
359 under the policy.
360 (12) "No-fault law" means the Florida Motor Vehicle No-

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361 Fault Law codifed at ss. 627.730-627.7407.
362 (13)~~(5)~~ "Owner" means a person who holds the legal title to
363 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
364 subject of a security agreement or lease with an option to
365 purchase with the debtor or lessee having the right to
366 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
367 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.
368 (15)~~(6)~~ "Relative residing in the same household" means a
369 relative of any degree by blood or by marriage who usually makes
370 her or his home in the same family unit, whether or not
371 temporarily living elsewhere.
372 (2)~~(7)~~ "Certify" means to swear or attest to being true or
373 represented in writing.
374 (3) "Claimant" means the person, organization, or entity
375 seeking benefits, including all assignees.
376 (5)~~(8)~~ "Immediate personal supervision," as it relates to
377 the performance of medical services by nonphysicians not in a
378 hospital, means that an individual licensed to perform the
379 medical service or provide the medical supplies must be present
380 within the confines of the physical structure where the medical
381 services are performed or where the medical supplies are
382 provided such that the licensed individual can respond
383 immediately to any emergencies if needed.
384 (6)~~(9)~~ "Incident," with respect to services considered as
385 incident to a physician's professional service, for a physician
386 licensed under chapter 458, chapter 459, chapter 460, or chapter
387 461, if not furnished in a hospital, means ~~such~~ services that
388 are ~~must be~~ an integral, even if incidental, part of a covered
389 physician's service.

390 (7)~~(10)~~ “Knowingly” means that a person, with respect to
391 information, has actual knowledge of the information,~~;~~ acts in
392 deliberate ignorance of the truth or falsity of the
393 information,~~;~~ or acts in reckless disregard of the information.~~,~~
394 ~~and~~ Proof of specific intent to defraud is not required.
395 (8)~~(11)~~ “Lawful” or “lawfully” means in substantial
396 compliance with all relevant applicable criminal, civil, and
397 administrative requirements of state and federal law related to
398 the provision of medical services or treatment.
399 (4)~~(12)~~ “Hospital” means a facility that, at the time
400 services or treatment were rendered, was licensed under chapter
401 395.
402 (14)~~(13)~~ “Properly completed” means providing truthful,
403 substantially complete, and substantially accurate responses ~~as~~
404 to all material elements of ~~to~~ each applicable request for
405 information or statement by a means that may lawfully be
406 provided and that complies with this section, or as agreed by
407 the parties.
408 (17)~~(14)~~ “Upcoding” means submitting ~~an action that submits~~
409 a billing code that would result in payment greater in amount
410 than would be paid using a billing code that accurately
411 describes the services performed. The term does not include an
412 otherwise lawful bill by a magnetic resonance imaging facility,
413 which globally combines both technical and professional
414 components, if the amount of the global bill is not more than
415 the components if billed separately; however, payment of such a
416 bill constitutes payment in full for all components of such
417 service.
418 (16)~~(15)~~ “Unbundling” means submitting ~~an action that~~

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419 ~~submits~~ a billing code that is properly billed under one billing
420 code, but that has been separated into two or more billing
421 codes~~,~~ and would result in payment greater than the ~~in~~ amount
422 that ~~than~~ would be paid using one billing code.
423 Section 8. Subsections (1) and (4) of section 627.736,
424 Florida Statutes, are amended, subsections (5) through (16) of
425 that section are redesignated as subsections (6) through (17),
426 respectively, a new subsection (5) is added to that section,
427 present subsection (5), paragraph (b) of present subsection (6),
428 paragraph (b) of present subsection (7), and present subsections
429 (8), (9), and (10) of that section are amended, to read:
430 627.736 Required personal injury protection benefits;
431 exclusions; priority; claims.—
432 (1) REQUIRED BENEFITS.—Every insurance policy complying
433 with the security requirements of s. 627.733 must ~~shall~~ provide
434 personal injury protection to the named insured, relatives
435 residing in the same household, persons operating the insured
436 motor vehicle, passengers in such motor vehicle, and other
437 persons struck by such motor vehicle and suffering bodily injury
438 while not an occupant of a self-propelled vehicle, subject to
439 ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(e),~~ to
440 a limit of $10,000 for loss sustained by ~~any~~ such person as a
441 result of bodily injury, sickness, disease, or death arising out
442 of the ownership, maintenance, or use of a motor vehicle as
443 follows:
444 (a) *Medical benefits.*—Eighty percent of all reasonable
445 expenses, charged pursuant to subsection (6), for medically
446 necessary medical, surgical, X-ray, dental, and rehabilitative
447 services, including prosthetic devices, and for medically

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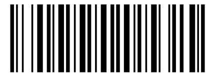
448 necessary ambulance, hospital, and nursing services. However,
449 the medical benefits ~~shall~~ provide reimbursement only for such
450 services and care that are lawfully provided, supervised,
451 ordered, or prescribed by a physician licensed under chapter 458
452 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a
453 chiropractic physician licensed under chapter 460, or an
454 acupuncturist licensed under chapter 457 exclusively to provide
455 oriental medicine as defined in s. 457.102, or that are provided
456 by any of the following ~~persons or entities~~:
457 1. A hospital or ambulatory surgical center licensed under
458 chapter 395.
459 2. A person or entity licensed under part III of chapter
460 401 which ~~ss. 401.2101-401.45 that~~ provides emergency
461 transportation and treatment.
462 3. An entity wholly owned by one or more physicians
463 licensed under chapter 458 or chapter 459, chiropractic
464 physicians licensed under chapter 460, or dentists licensed
465 under chapter 466 or by such ~~practitioner or~~ practitioners and
466 the spouse, parent, child, or sibling of such ~~that practitioner~~
467 ~~or those~~ practitioners.
468 4. An entity wholly owned, directly or indirectly, by a
469 hospital or hospitals.
470 5. A health care clinic licensed under part X of chapter
471 400 which ~~ss. 400.990-400.995 that~~ is:
472 a. Accredited by the Joint Commission on Accreditation of
473 Healthcare Organizations, the American Osteopathic Association,
474 the Commission on Accreditation of Rehabilitation Facilities, or
475 the Accreditation Association for Ambulatory Health Care, Inc.;
476 or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477 b. A health care clinic that:
478 (I) Has a medical director licensed under chapter 458,
479 chapter 459, or chapter 460;
480 (II) Has been continuously licensed for more than 3 years
481 or is a publicly traded corporation that issues securities
482 traded on an exchange registered with the United States
483 Securities and Exchange Commission as a national securities
484 exchange; and
485 (III) Provides at least four of the following medical
486 specialties:
487 (A) General medicine.
488 (B) Radiography.
489 (C) Orthopedic medicine.
490 (D) Physical medicine.
491 (E) Physical therapy.
492 (F) Physical rehabilitation.
493 (G) Prescribing or dispensing outpatient prescription
494 medication.
495 (H) Laboratory services.
496
497 If any services under this paragraph are provided by an entity
498 or clinic described in subparagraph 3., subparagraph 4., or
499 subparagraph 5., the entity or clinic must provide the insurer
500 at the initial submission of the claim with a form adopted by
501 the Department of Financial Services which documents that the
502 entity or clinic meets applicable criteria for such entity or
503 clinic and includes a sworn statement or affidavit to that
504 effect. Any change in ownership requires the filing of a new
505 form within 10 days after the date of the change in ownership.

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506 ~~The Financial Services Commission shall adopt by rule the form~~
507 ~~that must be used by an insurer and a health care provider~~
508 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
509 ~~5. to document that the health care provider meets the criteria~~
510 ~~of this paragraph, which rule must include a requirement for a~~
511 ~~sworn statement or affidavit.~~
512 (b) *Disability benefits.*—Sixty percent of any loss of gross
513 income and loss of earning capacity per individual from
514 inability to work proximately caused by the injury sustained by
515 the injured person, plus all expenses reasonably incurred in
516 obtaining from others ordinary and necessary services in lieu of
517 those that, but for the injury, the injured person would have
518 performed without income for the benefit of his or her
519 household. All disability benefits payable under this provision
520 must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.
521 (c) *Death benefits.*—Death benefits equal to the lesser of
522 $5,000 or the remainder of unused personal injury protection
523 benefits per individual. The insurer may pay such benefits to
524 the executor or administrator of the deceased, to any of the
525 deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection~~
526 ~~by~~ marriage, or to any person appearing to the insurer to be
527 equitably entitled thereto.
528
529 Only insurers writing motor vehicle liability insurance in this
530 state may provide the required benefits of this section, and ~~no~~
531 such insurers may not ~~insurer shall~~ require the purchase of any
532 other motor vehicle coverage other than the purchase of property
533 damage liability coverage as required by s. 627.7275 as a
534 condition for providing such ~~required~~ benefits. Insurers may not

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535 require that property damage liability insurance in an amount
536 greater than $10,000 be purchased in conjunction with personal
537 injury protection. Such insurers shall make benefits and
538 required property damage liability insurance coverage available
539 through normal marketing channels. An ~~Any~~ insurer writing motor
540 vehicle liability insurance in this state who fails to comply
541 with such availability requirement as a general business
542 practice violates ~~shall be deemed to have violated~~ part IX of
543 chapter 626, and such violation constitutes ~~shall constitute~~ an
544 unfair method of competition or an unfair or deceptive act or
545 practice involving the business of insurance. An~~; and any such~~
546 insurer committing such violation is ~~shall be~~ subject to the
547 penalties afforded in such part, as well as those that are ~~which~~
548 ~~may be~~ afforded elsewhere in the insurance code.
549 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
550 the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary,
551 except that benefits received under any workers' compensation
552 law shall be credited against the benefits provided by
553 subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~
554 upon the receipt of reasonable proof of such loss and the amount
555 of expenses and loss incurred which are covered by the policy
556 issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the
557 Agency for Health Care Administration provides, pays, or becomes
558 liable for medical assistance under the Medicaid program related
559 to injury, sickness, disease, or death arising out of the
560 ownership, maintenance, or use of a motor vehicle, the benefits
561 are ~~under ss. 627.730-627.7405 shall be~~ subject to the
562 provisions of the Medicaid program.
563 (a) An insurer may require written notice to be given as

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564 soon as practicable after an accident involving a motor vehicle
565 with respect to which the policy affords the security required
566 by the no-fault law ~~ss. 627.730-627.7405~~.
567 (b) Personal injury protection insurance benefits paid
568 pursuant to this section are ~~shall be~~ overdue if not paid within
569 30 days after the insurer is furnished written notice of the
570 fact of a covered loss and of the amount of same. If ~~such~~
571 written notice is not furnished to the insurer as to the entire
572 claim, any partial amount supported by written notice is overdue
573 if not paid within 30 days after the ~~such~~ written notice is
574 furnished to the insurer. Any part or all of the remainder of
575 the claim that is subsequently supported by written notice is
576 overdue if not paid within 30 days after ~~such~~ written notice is
577 furnished to the insurer. For the purpose of calculating the
578 extent to which benefits are overdue, payment shall be
579 considered made on the date a draft or other valid instrument
580 that is equivalent to payment is placed in the United States
581 mail in a properly addressed, postpaid envelope, or, if not so
582 posted, on the date of delivery.
583 (c) If ~~When~~ an insurer pays only a portion of a claim or
584 rejects a claim, the insurer shall provide at the time of the
585 partial payment or rejection an itemized specification of each
586 item that the insurer had reduced, omitted, or declined to pay
587 and any information that the insurer desires the claimant to
588 consider related to the medical necessity of the denied
589 treatment or to explain the reasonableness of the reduced
590 charge, provided that this does ~~shall~~ not limit the introduction
591 of evidence at trial.~~; and~~ The insurer must ~~shall~~ include the
592 name and address of the person to whom the claimant should

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593 respond and a claim number to be referenced in future
594 correspondence. An insurer's failure to send an itemized
595 specification or explanation of benefits does not waive other
596 grounds for rejecting an invalid claim.
597 (d) A ~~However, notwithstanding the fact that written notice~~
598 ~~has been furnished to the insurer, Any~~ payment is ~~shall~~ not ~~be~~
599 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~
600 ~~establish~~ that the insurer is not responsible for ~~the~~ payment.
601 An insurer may obtain evidence and assert any ground for
602 adjustment or rejection of a ~~For the purpose of calculating the~~
603 ~~extent to which any benefits are overdue, payment shall be~~
604 ~~treated as being made on the date a draft or other valid~~
605 ~~instrument which is equivalent to payment was placed in the~~
606 ~~United States mail in a properly addressed, postpaid envelope~~
607 ~~or, if not so posted, on the date of delivery. This paragraph~~
608 ~~does not preclude or limit the ability of the insurer to assert~~
609 ~~that the~~ claim that is ~~was~~ unrelated, ~~was~~ not medically
610 necessary, ~~or was~~ unreasonable, or submitted ~~that the amount of~~
611 ~~the charge was in excess of that permitted under, or~~ in
612 violation of~~,~~ subsection (6) ~~(5). Such assertion by the insurer~~
613 ~~may be made~~ at any time, including after payment of the claim,
614 ~~or~~ after the 30-day ~~time~~ period for payment set forth in ~~this~~
615 paragraph (b), or after the filing of a lawsuit.
616 (e) The 30-day period for payment is tolled while the
617 insurer investigates a fraudulent insurance act, as defined in
618 s. 626.989, with respect to any portion of a claim for which the
619 insurer has a reasonable belief that a fraudulent insurance act
620 has been committed. The insurer must notify the claimant in
621 writing that it is investigating a fraudulent insurance act

622 within 30 days after the date it has a reasonable belief that
623 such act has been committed. The insurer must pay or deny the
624 claim, in full or in part, within 90 days after the date the
625 written notice of the fact of a covered loss and of the amount
626 of the loss was provided to the insurer. However, no payment is
627 due to a claimant that has violated paragraph (k).
628 (f)~~(c)~~ Notwithstanding any local lien law, upon receiving
629 notice of an accident that is potentially covered by personal
630 injury protection benefits, the insurer must reserve $5,000 of
631 personal injury protection benefits for payment to physicians
632 licensed under chapter 458 or chapter 459 or dentists licensed
633 under chapter 466 who provide emergency services and care, as
634 defined in s. 395.002~~(9)~~, or who provide hospital inpatient
635 care. The amount required to be held in reserve may be used only
636 to pay claims from such physicians or dentists until 30 days
637 after the date the insurer receives notice of the accident.
638 After the 30-day period, any amount of the reserve for which the
639 insurer has not received notice of such ~~a~~ claim ~~from a physician~~
640 ~~or dentist who provided emergency services and care or who~~
641 ~~provided hospital inpatient care~~ may ~~then~~ be used by the insurer
642 to pay other claims. The time periods specified in paragraph (b)
643 for ~~required~~ payment of personal injury protection benefits are
644 ~~shall be~~ tolled for the period of time that an insurer is
645 required ~~by this paragraph~~ to hold payment of a claim that is
646 not from a physician or dentist who provided emergency services
647 and care or who provided hospital inpatient care to the extent
648 that the personal injury protection benefits not held in reserve
649 are insufficient to pay the claim. This paragraph does not
650 require an insurer to establish a claim reserve for insurance

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651 accounting purposes.
652 (g) ~~(d)~~ All overdue payments ~~shall~~ bear simple interest at
653 the rate established under s. 55.03 or the rate established in
654 the insurance contract, whichever is greater, for the year in
655 which the payment became overdue, calculated from the date the
656 insurer was furnished with written notice of the amount of
657 covered loss. Interest is ~~shall be~~ due at the time payment of
658 the overdue claim is made. However, interest on a payment that
659 is overdue pursuant to paragraph (e) shall be calculated from
660 the date the payment is due pursuant to paragraph (b).
661 (h) ~~(e)~~ The insurer of the owner of a motor vehicle shall
662 pay personal injury protection benefits for:
663 1. Accidental bodily injury sustained in this state by the
664 owner while occupying a motor vehicle, or while not an occupant
665 of a self-propelled vehicle if the injury is caused by physical
666 contact with a motor vehicle.
667 2. Accidental bodily injury sustained outside this state,
668 but within the United States of America or its territories or
669 possessions or Canada, by the owner while occupying the owner's
670 motor vehicle.
671 3. Accidental bodily injury sustained by a relative of the
672 owner residing in the same household, under the circumstances
673 described in subparagraph 1. or subparagraph 2. if~~, provided~~ the
674 relative at the time of the accident is domiciled in the owner's
675 household and is not ~~himself or herself~~ the owner of a motor
676 vehicle with respect to which security is required under the no-
677 fault law ~~ss. 627.730-627.7405~~.
678 4. Accidental bodily injury sustained in this state by any
679 other person while occupying the owner's motor vehicle or, if a

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680 resident of this state, while not an occupant of a self-
681 propelled vehicle, if the injury is caused by physical contact
682 with such motor vehicle if~~, provided~~ the injured person is not
683 ~~himself or herself~~:
684 a. The owner of a motor vehicle with respect to which
685 security is required under the no-fault law ~~ss. 627.730-~~
686 ~~627.7405~~; or
687 b. Entitled to personal injury benefits from the insurer of
688 the owner ~~or owners~~ of such a motor vehicle.
689 (i)~~(f)~~ If two or more insurers are liable to pay personal
690 injury protection benefits for the same injury to any one
691 person, the maximum payable is ~~shall be~~ as specified in
692 subsection (1), and any insurer paying the benefits is ~~shall be~~
693 entitled to recover from each of the other insurers an equitable
694 pro rata share of the benefits paid and expenses incurred in
695 processing the claim.
696 (j)~~(g)~~ It is a violation of the insurance code for an
697 insurer to fail to timely provide benefits as required by this
698 section with such frequency as to constitute a general business
699 practice.
700 (k)~~(h)~~ Benefits are ~~shall~~ not ~~be~~ due or payable to a
701 claimant who knowingly: ~~or on the behalf of an insured person if~~
702 ~~that person has~~
703 1. Submits a false or misleading statement, document,
704 record, or bill;
705 2. Submits false or misleading information; or
706 3. Has otherwise committed or attempted to commit a
707 fraudulent insurance act as defined in s. 626.989.
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709 A claimant that violates this paragraph is not entitled to any
710 personal injury protection benefits or payment for any bills and
711 services, regardless of whether a portion of the claim may be
712 legitimate. However, a claimant that does not violate this
713 paragraph may not be denied benefits solely due to a violation
714 by another claimant.
715 (l) Notwithstanding any remedies afforded by law, the
716 insurer may recover from a claimant who violates paragraph (k)
717 any sums previously paid to that claimant and may bring any
718 available common law and statutory causes of action. A claimant
719 has violated paragraph (k) ~~committed, by a material act or~~
720 ~~omission, any insurance fraud relating to personal injury~~
721 ~~protection coverage under his or her policy,~~ if the fraud is
722 admitted to in a sworn statement ~~by the insured~~ or ~~if it is~~
723 established in a court of competent jurisdiction. Any insurance
724 fraud voids ~~shall void~~ all coverage arising from the claim
725 related to ~~such fraud under the personal injury protection~~
726 ~~coverage of~~ the claimant ~~insured person~~ who committed the fraud,
727 irrespective of whether a portion of the insured person's claim
728 may be legitimate, and any benefits paid before ~~prior to~~ the
729 discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~
730 recoverable by the insurer from the claimant ~~person~~ who
731 committed insurance fraud in their entirety. The prevailing
732 party is entitled to its costs and attorney's fees in any action
733 in which it prevails in an insurer's action to enforce its right
734 of recovery under this paragraph. This paragraph does not
735 preclude or limit an insurer's right to deny a claim based on
736 other evidence of fraud or affect an insurer's right to plead
737 and prove a claim or defense of fraud under common law. If a

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738 physician, hospital, clinic, or other medical institution
739 violates paragraph (k), the injured party is not liable for, and
740 the physician, hospital, clinic, or other medical institution
741 may not bill the insured for, charges that are unpaid because of
742 failure to comply with paragraph (k). Any agreement requiring
743 the injured person or insured to pay for such charges is
744 unenforceable.
745 (5) INSURER INVESTIGATIONS.—An insurer has the right and
746 duty to conduct a reasonable investigation of a claim. In the
747 course of the insurer's investigation of a claim:
748 (a) The insurer may require the insured, claimant, or
749 medical provider to provide copies of the treatment and
750 examination records. Any records review need not be based on a
751 physical examination and may be obtained at any time, including
752 after reduction or denial of the claim.
753 1. The records review must be conducted by a practitioner
754 within the same licensing chapter as the medical provider whose
755 records are being reviewed.
756 2. The 30-day period for payment under paragraph (4)(b) is
757 tolled from the date the insurer sends its request for treatment
758 records to the date that the insurer receives the treatment
759 records.
760 3. The insured, claimant, or medical provider may impose a
761 reasonable, cost-based fee that includes only the cost of
762 copying and postage. The cost of copying may not exceed 15 cents
763 per one-sided copy or 20 cents per two-sided copy and may not
764 include the cost of labor for copying.
765 (b) In all circumstances, an insured seeking benefits under
766 the no-fault law must comply with the terms of the policy, which

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767 includes, but is not limited to, submitting to examinations
768 under oath. Compliance with this paragraph is a condition
769 precedent to receiving benefits.
770 (c) An insurer may deny benefits if the insured, claimant,
771 or medical provider fails to:
772 1. Cooperate in the insurer's investigation;
773 2. Commits a fraud or material misrepresentation; or
774 3. Comply with this subsection.
775 (6)~~(5)~~ CHARGES FOR TREATMENT OF INJURED PERSONS.—
776 (a)~~1.~~ Any physician, hospital, clinic, or other person or
777 institution lawfully rendering treatment to an injured person
778 for a bodily injury covered by personal injury protection
779 insurance may charge the insurer and injured party only a
780 reasonable amount pursuant to this section for the services and
781 supplies rendered, and the insurer providing ~~such~~ coverage may
782 pay for such charges directly to the ~~such~~ person or institution
783 lawfully rendering such treatment~~,~~ if the insured receiving such
784 treatment or his or her guardian has countersigned the properly
785 completed invoice, bill, or claim form approved by the office
786 upon which such charges are to be paid for as having actually
787 been rendered, to the best knowledge of the insured or his or
788 her guardian. ~~In no event,~~ However, ~~may~~ such charges may not
789 exceed ~~a charge be in excess of~~ the amount the person or
790 institution customarily charges for like services or supplies.
791 In determining ~~With respect to a determination of~~ whether a
792 charge for a particular service, treatment, or otherwise is
793 reasonable, consideration may be given to evidence of usual and
794 customary charges and payments accepted by the provider involved
795 in the dispute, ~~and~~ reimbursement levels in the community, ~~and~~

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796 various federal and state medical fee schedules applicable to
797 automobile and other insurance coverages, and other information
798 relevant to the reasonableness of the reimbursement for the
799 service, treatment, or supply. However, such charges may not
800 exceed the reimbursement schedule under this paragraph.
801 1.~~2.~~ The insurer may limit reimbursement to no more than 80
802 percent of the following schedule of maximum charges:
803 a. For emergency transport and treatment by providers
804 licensed under chapter 401, 200 percent of Medicare.
805 b. For emergency services and care provided by a hospital
806 licensed under chapter 395, 75 percent of the hospital's usual
807 and customary charges.
808 c. For emergency services and care as defined by s.
809 395.002~~(9)~~ provided in a facility licensed under chapter 395
810 rendered by a physician or dentist, and related hospital
811 inpatient services rendered by a physician or dentist, the usual
812 and customary charges in the community.
813 d. For hospital inpatient services, other than emergency
814 services and care, 200 percent of the Medicare Part A
815 prospective payment applicable to the specific hospital
816 providing the inpatient services.
817 e. For hospital outpatient services, other than emergency
818 services and care, 200 percent of the Medicare Part A Ambulatory
819 Payment Classification for the specific hospital providing the
820 outpatient services.
821 f. For all other medical services, ~~supplies, and care,~~ 200
822 percent of the allowable amount under the participating
823 physicians schedule of Medicare Part B. For all other supplies
824 and care, including durable medical equipment and care and

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825 services rendered by ambulatory surgical centers and clinical
826 laboratories, 200 percent of the allowable amount under Medicare
827 Part B. However, if such services, supplies, or care is not
828 reimbursable under Medicare Part B, the insurer may limit
829 reimbursement to 80 percent of the maximum reimbursable
830 allowance under workers' compensation, as determined under s.
831 440.13 and rules adopted thereunder which are in effect at the
832 time such services, supplies, or care is provided. Services,
833 supplies, or care that is not reimbursable under Medicare or
834 workers' compensation is not required to be reimbursed by the
835 insurer.
836 2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee
837 schedule or payment limitation under Medicare is the fee
838 schedule or payment limitation in effect on January 1 of the
839 year in which ~~at the time~~ the services, supplies, or care was
840 rendered and for the area in which such services were rendered,
841 which shall apply throughout the remainder of the year
842 notwithstanding any subsequent changes made to the fee schedule
843 or payment limitation, except that it may not be less than the
844 allowable amount under the participating physicians schedule of
845 Medicare Part B for 2007 for medical services, supplies, and
846 care subject to Medicare Part B.
847 3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply
848 any limitation on the number of treatments or other utilization
849 limits that apply under Medicare or workers' compensation. An
850 insurer that applies the allowable payment limitations of
851 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully
852 provided care or treatment under the scope of his or her
853 license~~,~~ regardless of whether such provider is ~~would be~~

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854 entitled to reimbursement under Medicare due to restrictions or
855 limitations on the types or discipline of health care providers
856 who may be reimbursed for particular procedures or procedure
857 codes.
858 4.~~5.~~ If an insurer limits payment as authorized by
859 subparagraph 1. ~~2.~~, the person providing such services,
860 supplies, or care may not bill or attempt to collect from the
861 insured any amount in excess of such limits, except for amounts
862 that are not covered by the insured's personal injury protection
863 coverage due to the coinsurance amount or maximum policy limits.
864 5. Effective January 1, 2012, an insurer may limit
865 reimbursement pursuant to this paragraph only if the insurance
866 policy includes the schedule of charges specified in this
867 paragraph.
868 (b)1. An insurer or insured is not required to pay a claim
869 or charges:
870 a. Made by a broker or by a person making a claim on behalf
871 of a broker;
872 b. For any service or treatment that was not lawful at the
873 time rendered;
874 c. To any person who knowingly submits a false or
875 misleading statement relating to the claim or charges;
876 d. With respect to a bill or statement that does not
877 ~~substantially~~ meet the ~~applicable~~ requirements of paragraphs
878 (c), ~~paragraph~~ (d), and (e);
879 e. Except for emergency treatment and care, if the insured
880 failed to countersign a billing form or patient log related to
881 such claim or charges. Failure to submit a countersigned billing
882 form or patient log creates a rebuttable presumption that the

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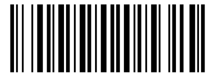
883 insured did not receive the alleged treatment. The insurer is
884 not considered to have been furnished with notice of the subject
885 treatment and loss until the insurer is able to verify that the
886 insured received the alleged treatment. As used in this sub-
887 subparagraph, the term “countersigned” means a second or
888 verifying signature, as on a previously signed document, and is
889 not satisfied by the statement “signature on file” or any
890 similar statement;
891 f.~~e.~~ For any treatment or service that is upcoded, or that
892 is unbundled if ~~when~~ such treatment or services should be
893 bundled, in accordance with paragraph (d). To facilitate prompt
894 payment of lawful services, an insurer may change codes that it
895 determines to have been improperly or incorrectly upcoded or
896 unbundled, and may make payment based on the changed codes,
897 without affecting the right of the provider to dispute the
898 change by the insurer if~~, provided that~~ before doing so, the
899 insurer contacts ~~must contact~~ the health care provider and
900 discusses ~~discuss~~ the reasons for the insurer’s change and the
901 health care provider’s reason for the coding, or makes ~~make~~ a
902 reasonable good faith effort to do so, as documented in the
903 insurer’s file; and
904 g.~~f.~~ For medical services or treatment billed by a
905 physician and not provided in a hospital unless such services
906 are rendered by the physician or are incident to his or her
907 professional services and are included on the physician’s bill,
908 including documentation verifying that the physician is
909 responsible for the medical services that were rendered and
910 billed.
911 2. The Department of Health, in consultation with the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912 appropriate professional licensing boards, shall adopt, by rule,
913 a list of diagnostic tests deemed not to be medically necessary
914 for use in the treatment of persons sustaining bodily injury
915 covered by personal injury protection benefits under this
916 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
917 ~~and~~ shall be revised from time to time as determined by the
918 Department of Health, in consultation with the respective
919 professional licensing boards. Inclusion of a test on the list
920 must ~~of invalid diagnostic tests shall~~ be based on lack of
921 demonstrated medical value and a level of general acceptance by
922 the relevant provider community and may ~~shall~~ not be dependent
923 for results entirely upon subjective patient response.
924 Notwithstanding its inclusion on a fee schedule in this
925 subsection, an insurer or insured is not required to pay any
926 charges or reimburse claims for any invalid diagnostic test as
927 determined by the Department of Health.
928 (c)~~1.~~ With respect to any treatment or service, other than
929 medical services billed by a hospital or other provider for
930 emergency services as defined in s. 395.002 or inpatient
931 services rendered at a hospital-owned facility, the statement of
932 charges must be furnished to the insurer by the provider and may
933 not include, and the insurer is not required to pay, charges for
934 treatment or services rendered more than 35 days before the
935 postmark date or electronic transmission date of the statement,
936 except for past due amounts previously billed on a timely basis
937 under this paragraph, and except that, if the provider submits
938 to the insurer a notice of initiation of treatment within 21
939 days after its first examination or treatment of the claimant,
940 the statement may include charges for treatment or services

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941 rendered up to, but not more than, 75 days before the postmark
942 date of the statement. The injured party is not liable for, and
943 the provider may ~~shall~~ not bill the injured party for, charges
944 that are unpaid because of the provider's failure to comply with
945 this paragraph. Any agreement requiring the injured person or
946 insured to pay for such charges is unenforceable.
947 1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider
948 with the correct name and address of the insured's personal
949 injury protection insurer, the provider has 35 days from the
950 date the provider obtains the correct information to furnish the
951 insurer with a statement of the charges. The insurer is not
952 required to pay for such charges unless the provider includes
953 with the statement documentary evidence that was provided by the
954 insured during the 35-day period demonstrating that the provider
955 reasonably relied on erroneous information from the insured and
956 either:
957 a. A denial letter from the incorrect insurer; or
958 b. Proof of mailing, which may include an affidavit under
959 penalty of perjury, reflecting timely mailing to the incorrect
960 address or insurer.
961 2.~~3.~~ For emergency services and care as defined in s.
962 395.002 rendered in a hospital emergency department or for
963 transport and treatment rendered by an ambulance provider
964 licensed pursuant to part III of chapter 401, the provider is
965 not required to furnish the statement of charges within the time
966 periods established by this paragraph,~~;~~ and the insurer is ~~shall~~
967 not ~~be~~ considered to have been furnished with notice of the
968 amount of covered loss for purposes of paragraph (4)(b) until it
969 receives a statement complying with paragraph (d), or copy

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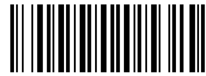
970 thereof, which specifically identifies the place of service to
971 be a hospital emergency department or an ambulance in accordance
972 with billing standards recognized by the Centers for Medicare
973 and Medicaid Services ~~Health Care Finance Administration~~.
974 3.~~4.~~ Each notice of the insured's rights under s. 627.7401
975 must include the following statement in type no smaller than 12
976 points:
977
978 BILLING REQUIREMENTS.—Florida Statutes provide that
979 with respect to any treatment or services, other than
980 certain hospital and emergency services, the statement
981 of charges furnished to the insurer by the provider
982 may not include, and the insurer and the injured party
983 are not required to pay, charges for treatment or
984 services rendered more than 35 days before the
985 postmark date of the statement, except for past due
986 amounts previously billed on a timely basis, and
987 except that, if the provider submits to the insurer a
988 notice of initiation of treatment within 21 days after
989 its first examination or treatment of the claimant,
990 the first billing cycle statement may include charges
991 for treatment or services rendered up to, but not more
992 than, 75 days before the postmark date of the
993 statement.
994
995 (d) All statements and bills for medical services rendered
996 by any physician, hospital, clinic, or other person or
997 institution shall be submitted to the insurer on a properly
998 completed Centers for Medicare and Medicaid Services (CMS) 1500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999 form, UB 92 forms, or any other standard form approved by the
1000 office or adopted by the commission for purposes of this
1001 paragraph. All billings for such services rendered by providers
1002 must ~~shall~~, to the extent applicable, follow the Physicians'
1003 Current Procedural Terminology (CPT) or Healthcare Correct
1004 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1005 year in which services are rendered and comply with the ~~Centers~~
1006 ~~for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions
1007 and the American Medical Association Current Procedural
1008 Terminology (CPT) Editorial Panel and Healthcare Correct
1009 Procedural Coding System (HCPCS). All providers other than
1010 hospitals shall include on the applicable claim form the
1011 professional license number of the provider in the line or space
1012 provided for "Signature of Physician or Supplier, Including
1013 Degrees or Credentials." In determining compliance with
1014 applicable CPT and HCPCS coding, guidance shall be provided by
1015 the Physicians' Current Procedural Terminology (CPT) or the
1016 Healthcare Correct Procedural Coding System (HCPCS) in effect
1017 for the year in which services were rendered, the Office of the
1018 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1019 other authoritative treatises designated by rule by the Agency
1020 for Health Care Administration. A ~~No~~ statement of medical
1021 services may not include charges for medical services of a
1022 person or entity that performed such services without possessing
1023 the valid licenses required to perform such services. For
1024 purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~
1025 considered to have been furnished with notice of the amount of
1026 covered loss or medical bills due unless the statements or bills
1027 comply with this paragraph, and unless the statements or bills

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1028 are ~~comply with this paragraph, and unless the statements or~~
1029 ~~bills are~~ properly completed in their entirety as to all
1030 material provisions, with all relevant information being
1031 provided therein. If an insurer denies a claim due to a
1032 provider's failure to submit a properly completed statement or
1033 bill, the insurer shall notify the provider as to the provisions
1034 that were improperly completed, and the provider shall have 15
1035 days after the receipt of such notice to submit a properly
1036 completed statement or bill. If the provider fails to comply
1037 with this requirement, the insurer is not required to pay for
1038 improperly billed services.
1039 (e)1. At the initial treatment or service provided, each
1040 physician, other licensed professional, clinic, or other medical
1041 institution providing medical services upon which a claim for
1042 personal injury protection benefits is based shall require an
1043 insured person, or his or her guardian, to execute a disclosure
1044 and acknowledgment form, which reflects at a minimum that:
1045 a. The insured, or his or her guardian, must countersign
1046 the form attesting to the fact that the services set forth
1047 therein were actually rendered. Listing CPT codes or other
1048 coding on the disclosure and acknowledgment form does not
1049 satisfy this requirement;
1050 b. The insured, or his or her guardian, has both the right
1051 and affirmative duty to confirm that the services were actually
1052 rendered;
1053 c. The insured, or his or her guardian, was not solicited
1054 by any person to seek any services from the medical provider;
1055 d. The physician, other licensed professional, clinic, or
1056 other medical institution rendering services for which payment

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1057 is being claimed explained the services to the insured or his or
1058 her guardian; and
1059 e. If the insured notifies the insurer in writing of a
1060 billing error, the insured may be entitled to a certain
1061 percentage of a reduction in the amounts paid by the insured's
1062 motor vehicle insurer.
1063 2. The physician, other licensed professional, clinic, or
1064 other medical institution rendering services for which payment
1065 is being claimed has the affirmative duty to explain the
1066 services rendered to the insured, or his or her guardian, so
1067 that the insured, or his or her guardian, countersigns the form
1068 with informed consent.
1069 3. Countersignature by the insured, or his or her guardian,
1070 is not required for the reading of diagnostic tests or other
1071 services that are of such a nature that they are not required to
1072 be performed in the presence of the insured.
1073 4. The licensed medical professional rendering treatment
1074 for which payment is being claimed must sign, by his or her own
1075 hand, the form complying with this paragraph.
1076 5. An insurer is not considered to have been furnished with
1077 notice of the amount of a covered loss or medical bills unless
1078 the original completed disclosure and acknowledgment form is
1079 ~~shall be~~ furnished to the insurer pursuant to paragraph (4)(b)
1080 and sub-subparagraph 1.a. The disclosure and acknowledgement
1081 form may not be electronically furnished. A disclosure and
1082 acknowledgement form that does not meet the minimum requirements
1083 of sub-subparagraph 1.a. does not provide an insurer with notice
1084 of the amount of a covered loss or medical bills due.
1085 6. This disclosure and acknowledgment form is not required

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1086 for services billed by a provider for emergency services as
1087 defined in s. 395.002, for emergency services and care as
1088 defined in s. 395.002 rendered in a hospital emergency
1089 department, or for transport and treatment rendered by an
1090 ambulance provider licensed pursuant to part III of chapter 401.
1091 7. The Financial Services Commission shall adopt~~,~~ by rule~~,~~
1092 a standard disclosure and acknowledgment form to ~~that shall~~ be
1093 used to fulfill the requirements of this paragraph~~, effective 90~~
1094 ~~days after such form is adopted and becomes final~~. ~~The~~
1095 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1096 ~~the rule is final, the provider may use a form of its own which~~
1097 ~~otherwise complies with the requirements of this paragraph.~~
1098 8. As used in this paragraph, the term “countersigned” or
1099 “countersignature” means a second or verifying signature, as on
1100 a previously signed document, and is not satisfied by the
1101 statement “signature on file” or any similar statement.
1102 9. The requirements of this paragraph apply only with
1103 respect to the initial treatment or service of the insured by a
1104 provider. For subsequent treatments or service, the provider
1105 must maintain a patient log signed by the patient, in
1106 chronological order by date of service, that is consistent with
1107 the services being rendered to the patient as claimed. Listing
1108 CPT codes or other coding on the patient log does not satisfy
1109 this requirement. The provider must provide copies of the
1110 patient log to the insurer within 30 days after receiving a
1111 written request from the insurer. Failure to maintain a patient
1112 log renders the treatment unlawful and noncompensable. The
1113 requirements ~~of this subparagraph~~ for maintaining a patient log
1114 signed by the patient may be met by a hospital that maintains

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1115 medical records as required by s. 395.3025 and applicable rules
1116 and makes such records available to the insurer upon request.
1117 (f) Upon written notification by any person, an insurer
1118 shall investigate any claim of improper billing by a physician
1119 or other medical provider. The insurer shall determine if the
1120 insured was properly billed for only those services and
1121 treatments that the insured actually received. If the insurer
1122 determines that the insured has been improperly billed, the
1123 insurer shall notify the insured, the person making the written
1124 notification<u>,</u> and the provider of its findings and ~~shall~~ reduce
1125 the amount of payment to the provider by the amount determined
1126 to be improperly billed. If a reduction is made due to such
1127 written notification by any person, the insurer shall pay to the
1128 person 20 percent of the amount of the reduction, up to $500. If
1129 the provider is arrested due to the improper billing, ~~then~~ the
1130 insurer shall pay to the person 40 percent of the amount of the
1131 reduction, up to $500.
1132 (g) An insurer may not systematically downcode with the
1133 intent to deny reimbursement otherwise due. Such action
1134 constitutes a material misrepresentation under s.
1135 626.9541(1)(i)2.
1136 <u>(7)</u>~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1137 DISPUTES.—
1138 (b) Every physician, hospital, clinic, or other medical
1139 institution providing, before or after bodily injury upon which
1140 a claim for personal injury protection insurance benefits is
1141 based, any products, services, or accommodations in relation to
1142 that or any other injury, or in relation to a condition claimed
1143 to be connected with that or any other injury, shall, if

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1144 requested to do so by the insurer against whom the claim has
1145 been made, permit the insurer or the insurer's representative to
1146 conduct an onsite physical review and examination of the
1147 treatment location, treatment apparatuses, diagnostic devices,
1148 and any other medical equipment used for the services rendered
1149 within 10 days after the insurer's request, and furnish
1150 ~~forthwith~~ a written report of the history, condition, treatment,
1151 dates, and costs of such treatment of the injured person and why
1152 the items identified by the insurer were reasonable in amount
1153 and medically necessary, together with a sworn statement that
1154 the treatment or services rendered were reasonable and necessary
1155 with respect to the bodily injury sustained and identifying
1156 which portion of the expenses for such treatment or services was
1157 incurred as a result of such bodily injury, and produce
1158 forthwith, and permit the inspection and copying of, his or her
1159 or its records regarding such history, condition, treatment,
1160 dates, and costs of treatment if~~; provided that~~ this does ~~shall~~
1161 not limit the introduction of evidence at trial. Such sworn
1162 statement must ~~shall~~ read as follows: "Under penalty of perjury,
1163 I declare that I have read the foregoing, and the facts alleged
1164 are true, to the best of my knowledge and belief." A ~~No~~ cause of
1165 action for violation of the physician-patient privilege or
1166 invasion of the right of privacy may not be brought ~~shall be~~
1167 ~~permitted~~ against any physician, hospital, clinic, or other
1168 medical institution complying with ~~the provisions of~~ this
1169 section. The person requesting such records and such sworn
1170 statement shall pay all reasonable costs connected therewith.
1171 1. If an insurer makes a written request for documentation
1172 or information under this paragraph within 30 days after having

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1173 received notice of the amount of a covered loss under paragraph
1174 (4)(a), the amount or the partial amount that ~~which~~ is the
1175 subject of the insurer’s inquiry is ~~shall become~~ overdue if the
1176 insurer does not pay in accordance with paragraph (4)(b) or
1177 within 10 days after the insurer’s receipt of the requested
1178 documentation or information, whichever occurs later. For
1179 purposes of this subparagraph ~~paragraph~~, the term “receipt”
1180 includes, but is not limited to, inspection and copying pursuant
1181 to this paragraph. An ~~Any~~ insurer that requests documentation or
1182 information pertaining to reasonableness of charges or medical
1183 necessity under this paragraph without a reasonable basis for
1184 such requests as a general business practice is engaging in an
1185 unfair trade practice under the insurance code.
1186 2. If an insured seeking to recover benefits pursuant to
1187 the no-fault law assigns the contractual right to those benefits
1188 or payment of those benefits to any person or entity, the
1189 assignee must comply with the terms of the policy. In all
1190 circumstances, the assignee is obligated to cooperate under the
1191 policy, which includes, but is not limited to, participating in
1192 an examination under oath. Examinations under oath may be
1193 recorded by audio, video, court reporter, or any combination
1194 thereof. Compliance with this paragraph is a condition precedent
1195 to recovery of benefits pursuant to the no-fault law.
1196 a. If an insurer requests an examination under oath of a
1197 medical provider, the provider must produce the persons having
1198 the most knowledge of the issues identified by the insurer in
1199 the request for examination under oath. All claimants must
1200 produce and allow for the inspection all documents requested by
1201 the insurer which are relevant to the services rendered and

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1202 reasonably obtainable by the claimant. The insurer must pay the
1203 medical provider reasonable compensation for attending the
1204 examination under oath; however, expert witness fees are not
1205 reasonable compensation. The medical provider may have an
1206 attorney present at the examination under oath at the provider's
1207 own expense.
1208 b. Before requesting that an assignee participate in an
1209 examination under oath, the insurer must send a written request
1210 to the assignee requesting all information that the insurer
1211 believes is necessary to process the claim and relevant to the
1212 services rendered, including the information contemplated under
1213 this subparagraph.
1214 c. An insurer that, as a general practice, requests
1215 examinations under oath of an assignee without a reasonable
1216 basis is engaging in an unfair and deceptive trade practice.
1217 (8) ~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1218 REPORTS.—
1219 (b) If requested by the person examined, a party causing an
1220 examination to be made shall deliver to him or her a copy of
1221 every written report concerning the examination rendered by an
1222 examining physician, at least one of which reports must set out
1223 the examining physician's findings and conclusions in detail.
1224 After such request and delivery, the party causing the
1225 examination to be made is entitled, upon request, to receive
1226 from the person examined every written report available to him
1227 or her or his or her representative concerning any examination,
1228 previously or thereafter made, of the same mental or physical
1229 condition. By requesting and obtaining a report of the
1230 examination so ordered, or by taking the deposition of the

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1231 examiner, the person examined waives any privilege he or she may
1232 have, in relation to the claim for benefits, regarding the
1233 testimony of every other person who has examined, or may
1234 thereafter examine, him or her in respect to the same mental or
1235 physical condition. If a person fails to appear for ~~unreasonably~~
1236 ~~refuses to submit to~~ an examination, the personal injury
1237 protection carrier is not required to pay ~~no longer liable~~ for
1238 ~~subsequent~~ personal injury protection benefits incurred after
1239 the date of the first requested examination until the insured
1240 appears for the examination. Failure to appear for two scheduled
1241 examinations raises a rebuttable presumption that such failure
1242 was unreasonable. Submission to an examination is a condition
1243 precedent to the recovery of benefits.
1244 (9) ~~(8)~~ APPLICABILITY OF PROVISION REGULATING ATTORNEY’S
1245 FEES.—With respect to any dispute ~~under the provisions of ss.~~
1246 ~~627.730-627.7405~~ between the insured and the insurer under the
1247 no-fault law, or between an assignee of an insured’s rights and
1248 the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as
1249 provided in subsections (11) and (16) ~~(10) and (15)~~.
1250 (10) ~~(9)~~ PREFERRED PROVIDERS.—An insurer may negotiate and
1251 enter into contracts with preferred ~~licensed health care~~
1252 providers for the benefits described in this section, ~~referred~~
1253 ~~to in this section as “preferred providers,”~~ which include ~~shall~~
1254 ~~include~~ health care providers licensed under chapter 457,
1255 chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or
1256 chapter ~~and~~ 463.
1257 (a) The insurer may provide an option to an insured to use
1258 a preferred provider at the time of purchase of the policy for
1259 personal injury protection benefits~~,~~ if the requirements of this

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1260 subsection are met. However, if the insurer offers a preferred
1261 provider option, it must also offer a nonpreferred provider
1262 policy. If the insured elects to use a provider who is not a
1263 preferred provider, whether the insured purchased a preferred
1264 provider policy or a nonpreferred provider policy, the medical
1265 benefits provided by the insurer must ~~shall~~ be as required by
1266 this section.
1267 (b) If the insured elects the ~~to use a provider who is a~~
1268 preferred provider option, the insurer may pay medical benefits
1269 in excess of the benefits required by this section and may waive
1270 or lower the amount of any deductible that applies to such
1271 medical benefits. As an alternative, or in addition to such
1272 benefits, waiver, or reduction, the insurer may provide an
1273 actuarially appropriate premium discount as specified in an
1274 approved rate filing to an insured who selects the preferred
1275 provider option. If the preferred provider option provides a
1276 premium discount, the insured forfeits the premium discount
1277 effective on the date that the insured elects to use a provider
1278 who is not a preferred provider and who renders nonemergency
1279 services, unless there is no member of the preferred provider
1280 network located within 15 miles of the insured's place of
1281 residence whose scope of practice includes the required
1282 services, or unless the nonemergency services are rendered in
1283 the emergency room of a hospital licensed under chapter 395. ~~If~~
1284 ~~the insurer offers a preferred provider policy to a policyholder~~
1285 ~~or applicant, it must also offer a nonpreferred provider policy.~~
1286 (c) The insurer shall provide each insured ~~policyholder~~
1287 with a current roster of preferred providers in the county in
1288 which the insured resides at the time of purchasing ~~purchase of~~

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1289 such policy, and ~~shall~~ make such list available for public
1290 inspection during regular business hours at the insurer's
1291 principal office ~~of the insurer~~ within the state. The insurer
1292 may contract with a health insurer to use an existing preferred
1293 provider network to implement the preferred provider option. All
1294 providers and entities that are eligible to receive
1295 reimbursement pursuant to paragraph (1)(a) may provide services
1296 through a preferred provider network. Any other arrangement is
1297 subject to the approval of the Office of Insurance Regulation.
1298 (11)~~(10)~~ DEMAND LETTER.—
1299 (a) As a condition precedent to filing any action for
1300 benefits under this section, the claimant filing suit must
1301 provide the insurer ~~must be provided~~ with written notice of an
1302 intent to initiate litigation. Such notice may not be sent until
1303 the claim is overdue, including any additional time the insurer
1304 has to pay the claim pursuant to paragraph (4)(b). A premature
1305 demand letter is defective and cannot be cured unless the court
1306 first abates the action or the claimant first voluntarily
1307 dismisses the action.
1308 (b) The ~~notice~~ required notice must ~~shall~~ state that it is
1309 a "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with
1310 specificity:
1311 1. The name of the insured upon which such benefits are
1312 being sought, including a copy of the assignment giving rights
1313 to the claimant if the claimant is not the insured.
1314 2. The claim number or policy number upon which such claim
1315 was originally submitted to the insurer.
1316 3. To the extent applicable, the name of any medical
1317 provider who rendered to an insured the treatment, services,

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1318 accommodations, or supplies that form the basis of such claim;
1319 and an itemized statement specifying each exact amount, the date
1320 of treatment, service, or accommodation, and the type of benefit
1321 claimed to be due. A completed form satisfying the requirements
1322 of paragraph (6)~~(5)~~(d) or the lost-wage statement previously
1323 submitted may be used as the itemized statement. ~~To the extent~~
1324 ~~that the demand involves an insurer's withdrawal of payment~~
1325 ~~under paragraph (7)(a) for future treatment not yet rendered,~~
1326 ~~the claimant shall attach a copy of the insurer's notice~~
1327 ~~withdrawing such payment and an itemized statement of the type,~~
1328 ~~frequency, and duration of future treatment claimed to be~~
1329 ~~reasonable and medically necessary.~~
1330 (c) Each notice required by this subsection must be
1331 delivered to the insurer by United States certified or
1332 registered mail, return receipt requested. Such postal costs
1333 shall be reimbursed by the insurer if ~~so~~ requested by the
1334 claimant in the notice~~,~~ when the insurer pays the claim. Such
1335 notice must be sent to the person and address specified by the
1336 insurer for the purposes of receiving notices under this
1337 subsection. Each licensed insurer, whether domestic, foreign, or
1338 alien, shall file with the office designation of the name and
1339 address of the person to whom notices must ~~pursuant to this~~
1340 ~~subsection shall~~ be sent which the office shall make available
1341 on its Internet website. The name and address on file with the
1342 office pursuant to s. 624.422 shall be deemed the authorized
1343 representative to accept notice pursuant to this subsection if
1344 ~~in the event~~ no other designation has been made.
1345 (d) If, within 30 days after receipt of notice by the
1346 insurer, the overdue claim specified in the notice is paid by

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1347 the insurer together with applicable interest and a penalty of
1348 10 percent of the overdue amount paid by the insurer, subject to
1349 a maximum penalty of $250, no action may be brought against the
1350 insurer. If ~~the demand involves an insurer’s withdrawal of~~
1351 ~~payment under paragraph (7)(a) for future treatment not yet~~
1352 ~~rendered, no action may be brought against the insurer if,~~
1353 ~~within 30 days after its receipt of the notice, the insurer~~
1354 ~~mails to the person filing the notice a written statement of the~~
1355 ~~insurer’s agreement to pay for such treatment in accordance with~~
1356 ~~the notice and to pay a penalty of 10 percent, subject to a~~
1357 ~~maximum penalty of $250, when it pays for such future treatment~~
1358 ~~in accordance with the requirements of this section. To the~~
1359 ~~extent~~ the insurer determines not to pay any amount demanded,
1360 the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action.
1361 For purposes of this subsection, payment or the insurer’s
1362 agreement is ~~shall be~~ treated as being made on the date a draft
1363 or other valid instrument that is equivalent to payment, or the
1364 insurer’s written statement of agreement, is placed in the
1365 United States mail in a properly addressed, postpaid envelope,
1366 or if not so posted, on the date of delivery. The insurer is not
1367 obligated to pay any attorney’s fees if the insurer pays the
1368 claim or mails its agreement to pay for future treatment within
1369 the time prescribed by this subsection.
1370 (e) The applicable statute of limitation for an action
1371 under this section shall be tolled for ~~a period of~~ 30 business
1372 days by the mailing of the notice required by this subsection.
1373 (f) A demand letter that does not meet the minimum
1374 requirements set forth in this subsection or that is sent during
1375 the pendency of the lawsuit is defective. A defective demand

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1376 letter cannot be cured unless the court first abates the action
1377 or the claimant first voluntarily dismisses the action.
1378 (g) ~~(f)~~ An ~~Any~~ insurer making a general business practice of
1379 not paying valid claims until receipt of the notice required by
1380 this subsection is engaging in an unfair trade practice under
1381 the insurance code.
1382 (h) If the insurer pays in response to a demand letter and
1383 the claimant disputes the amount paid, the claimant must send a
1384 second demand letter by certified or registered mail stating the
1385 exact amount that the claimant believes the insurer owes and why
1386 the claimant believes the amount paid is incorrect. The insurer
1387 has an additional 10 days after receipt of the second letter to
1388 issue any additional payment that is owed. The purpose of this
1389 provision is to avoid unnecessary litigation over miscalculated
1390 payments.
1391 (i) Demand letters may not be used to request the
1392 production of claim documents or other records from the insurer.
1393 Section 9. Paragraph (c) of subsection (7), and subsections
1394 (10) through (12) of section 817.234, Florida Statutes, are
1395 amended to read:
1396 817.234 False and fraudulent insurance claims.—
1397 (7)
1398 (c) An insurer, or any person acting at the direction of or
1399 on behalf of an insurer, may not change an opinion in a mental
1400 or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or
1401 direct the physician preparing the report to change such
1402 opinion; however, this provision does not preclude the insurer
1403 from calling to the attention of the physician errors of fact in
1404 the report based upon information in the claim file. Any person

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1405 who violates this paragraph commits a felony of the third
1406 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1407 775.084.
1408 ~~(10) As used in this section, the term "insurer" means any~~
1409 ~~insurer, health maintenance organization, self-insurer, self-~~
1410 ~~insurance fund, or other similar entity or person regulated~~
1411 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~
1412 ~~Regulation under the Florida Insurance Code.~~
1413 (10) ~~(11)~~ If the value of any property involved in a
1414 violation of this section:
1415 (a) Is less than $20,000, the offender commits a felony of
1416 the third degree, punishable as provided in s. 775.082, s.
1417 775.083, or s. 775.084.
1418 (b) Is $20,000 or more, but less than $100,000, the
1419 offender commits a felony of the second degree, punishable as
1420 provided in s. 775.082, s. 775.083, or s. 775.084.
1421 (c) Is $100,000 or more, the offender commits a felony of
1422 the first degree, punishable as provided in s. 775.082, s.
1423 775.083, or s. 775.084.
1424 (11) In addition to any criminal liability, a person
1425 convicted of violating any provision of this section for the
1426 purpose of receiving insurance proceeds from a motor vehicle
1427 insurance contract is subject to a civil penalty.
1428 (a) Except for a violation of subsection (9), the civil
1429 penalty shall be:
1430 1. A fine up to $5,000 for a first offense.
1431 2. A fine greater than $5,000, but not to exceed $10,000,
1432 for a second offense.
1433 3. A fine greater than $10,000, but not to exceed $15,000,

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1434 for a third or subsequent offense.
1435 (b) The civil penalty for a violation of subsection (9)
1436 must be at least $15,000, but may not exceed $50,000.
1437 (c) The civil penalty shall be paid to the Insurance
1438 Regulatory Trust Fund within the Department of Financial
1439 Services and used by the department for the investigation and
1440 prosecution of insurance fraud.
1441 (d) This subsection does not prohibit a state attorney from
1442 entering into a written agreement in which the person charged
1443 with the violation does not admit to or deny the charges but
1444 consents to payment of the civil penalty.
1445 (12) As used in this section, the term:
1446 (a) "Insurer" means any insurer, health maintenance
1447 organization, self-insurer, self-insurance fund, or similar
1448 entity or person regulated under chapter 440 or chapter 641 or
1449 by the Office of Insurance Regulation under the Florida
1450 Insurance Code.
1451 (b)(a) "Property" means property as defined in s. 812.012.
1452 (c)(b) "Value" has the same meaning means value as defined
1453 in s. 812.012.
1454 Section 10. Subsection (1) of section 324.021, Florida
1455 Statutes, is amended to read:
1456 324.021 Definitions; minimum insurance required.—The
1457 following words and phrases when used in this chapter shall, for
1458 the purpose of this chapter, have the meanings respectively
1459 ascribed to them in this section, except in those instances
1460 where the context clearly indicates a different meaning:
1461 (1) MOTOR VEHICLE.—Every self-propelled vehicle that which
1462 is designed and required to be licensed for use upon a highway,

1463 including trailers and semitrailers designed for use with such
1464 vehicles, except traction engines, road rollers, farm tractors,
1465 power shovels, and well drillers, and every vehicle that ~~which~~
1466 is propelled by electric power obtained from overhead wires but
1467 not operated upon rails, but not including any bicycle or moped.
1468 However, the term does ~~"motor vehicle" shall~~ not include a ~~any~~
1469 motor vehicle as defined in s. 627.732~~(3)~~ if ~~when~~ the owner of
1470 such vehicle has complied with the no-fault law ~~requirements of~~
1471 ~~ss. 627.730-627.7405, inclusive~~, unless the provisions of s.
1472 324.051 apply; and, in such case, the applicable proof of
1473 insurance provisions of s. 320.02 apply.
1474 Section 11. Paragraph (k) of subsection (2) of section
1475 456.057, Florida Statutes, is amended to read:
1476 456.057 Ownership and control of patient records; report or
1477 copies of records to be furnished.—
1478 (2) As used in this section, the terms "records owner,"
1479 "health care practitioner," and "health care practitioner's
1480 employer" do not include any of the following persons or
1481 entities; furthermore, the following persons or entities are not
1482 authorized to acquire or own medical records, but are authorized
1483 under the confidentiality and disclosure requirements of this
1484 section to maintain those documents required by the part or
1485 chapter under which they are licensed or regulated:
1486 (k) Persons or entities practicing under s. 627.736(8)
1487 ~~627.736(7)~~.
1488 Section 12. Paragraph (b) of subsection (1) of section
1489 627.7401, Florida Statutes, is amended to read:
1490 627.7401 Notification of insured's rights.—
1491 (1) The commission, by rule, shall adopt a form for the

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1492 notification of insureds of their right to receive personal
1493 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1494 fault law. Such notice shall include:
1495 (b) An advisory informing insureds that:
1496 1. Pursuant to s. 626.9892, the Department of Financial
1497 Services may pay rewards of up to $25,000 to persons providing
1498 information leading to the arrest and conviction of persons
1499 committing crimes investigated by the Division of Insurance
1500 Fraud arising from violations of s. 440.105, s. 624.15, s.
1501 626.9541, s. 626.989, or s. 817.234.
1502 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
1503 insured notifies the insurer of a billing error, the insured may
1504 be entitled to a certain percentage of a reduction in the amount
1505 paid by the insured’s motor vehicle insurer.
1506 Section 13. This act shall take effect July 1, 2011.
1507
1508 ================ T I T L E A M E N D M E N T ================
1509 And the title is amended as follows:
1510 Delete everything before the enacting clause
1511 and insert:
1512 A bill to be entitled
1513 An act relating to motor vehicle personal injury
1514 protection insurance; amending s. 316.066, F.S.;
1515 revising provisions relating to the contents of
1516 written reports of motor vehicle crashes; requiring
1517 short-form crash reports by a law enforcement officer
1518 to be maintained by the officer’s agency; authorizing
1519 the investigation officer to testify at trial or
1520 provide an affidavit concerning the content of the

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1521 reports; amending s. 400.991, F.S.; requiring that an
1522 application for licensure as a mobile clinic include a
1523 statement regarding insurance fraud; creating s.
1524 626.9894, F.S.; providing definitions; authorizing the
1525 Division of Insurance Fraud to establish a direct-
1526 support organization for the purpose of prosecuting,
1527 investigating, and preventing motor vehicle insurance
1528 fraud; providing requirements for the organization and
1529 the organization's contract with the division;
1530 providing for a board of directors; authorizing the
1531 organization to use the division's property and
1532 facilities subject to certain requirements;
1533 authorizing contributions from insurers; providing
1534 that any moneys received by the organization may be
1535 held in a separate depository account in the name of
1536 the organization; requiring the division to deposit
1537 certain proceeds into the Insurance Regulatory Trust
1538 Fund; amending s. 627.4137, F.S.; requiring a
1539 claimant's request about insurance coverage to be
1540 appropriately served upon the disclosing entity;
1541 amending s. 627.730, F.S.; conforming a cross-
1542 reference; amending s. 627.731, F.S.; providing
1543 legislative intent with respect to the Florida Motor
1544 Vehicle No-Fault Law; amending s. 627.732, F.S.;
1545 defining the terms "claimant" and "no-fault law";
1546 amending s. 627.736, F.S.; conforming a cross-
1547 reference; adding licensed acupuncturists to the list
1548 of practitioners authorized to provide, supervise,
1549 order, or prescribe services; requiring certain

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1550 entities providing medical services to document that
1551 they meet required criteria; revising requirements
1552 relating to the form that must be submitted by
1553 providers; requiring an entity or clinic to file a new
1554 form within a specified period after the date of a
1555 change of ownership; revising provisions relating to
1556 when payment for a benefit is due; providing that an
1557 insurer’s failure to send certain specification or
1558 explanation does not waive other grounds for rejecting
1559 an invalid claim; authorizing an insurer to obtain
1560 evidence and assert any ground for adjusting or
1561 rejecting a claim; providing that the time period for
1562 paying a claim is tolled during the investigation of a
1563 fraudulent insurance act; specifying when benefits are
1564 not payable; preempting local lien laws with respect
1565 to payment of benefits to medical providers; providing
1566 that a claimant that violates certain provisions is
1567 not entitled to any payment, regardless of whether a
1568 portion of the claim may be legitimate; authorizing an
1569 insurer to recover payments and bring a cause of
1570 action to recover payments; providing that an insurer
1571 may deny any claim based on other evidence of fraud;
1572 forbidding a physician, hospital, clinic, or other
1573 medical institution that fails to comply with certain
1574 provisions from billing the injured person or the
1575 insured; providing that an insurer has a right to
1576 conduct reasonable investigations of claims;
1577 authorizing an insurer to require a claimant to
1578 provide certain records; requiring a records review to

1579 be conducted by the same type of practitioner as the
1580 medical provider whose records are being reviewed;
1581 specifying when the period for payment is tolled;
1582 authorizing an insurer to deny benefits if an insured,
1583 claimant, or medical provider fails to comply with
1584 certain provisions; revising the insurer's
1585 reimbursement limitation; providing a limit on the
1586 amount of reimbursement if the insurance policy
1587 includes a schedule of charges; creating a rebuttable
1588 presumption that the insured did not receive the
1589 alleged treatment if the insured does not countersign
1590 the patient log; authorizing the insurer to deny a
1591 claim if the provider does not submit a properly
1592 completed statement or bill within a certain time;
1593 specifying requirements for furnishing the insured
1594 with notice of the amount of covered loss; deleting an
1595 obsolete provision; requiring the provider to provide
1596 copies of the patient log within a certain time if
1597 requested by the insurer; providing that failure to
1598 maintain a patient log renders the treatment unlawful
1599 and noncompensable; revising requirements relating to
1600 discovery; authorizing the insurer to conduct a
1601 physical review of the treatment location; requiring
1602 the insured and assignee to comply with certain
1603 provisions to recover benefits; requiring the provider
1604 to produce persons having the most knowledge in
1605 specified circumstances; requiring the insurer to pay
1606 reasonable compensation to the provider for attending
1607 the examination; requiring the insurer to request

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1608 certain information before requesting an assignee to
1609 participate in an examination under oath; providing
1610 that an insurer that requests an examination under
1611 oath without a reasonable basis is engaging in an
1612 unfair and deceptive trade practice; providing that
1613 failure to appear for scheduled examinations
1614 establishes a rebuttable presumption that such failure
1615 was unreasonable; authorizing an insurer to contract
1616 with a preferred provider network; authorizing an
1617 insurer to provide a premium discount to an insured
1618 who selects a preferred provider; authorizing an
1619 insurance policy to not pay for nonemergency services
1620 performed by a nonpreferred provider in specified
1621 circumstances; authorizing an insurer to use a
1622 preferred provider network; revising requirements
1623 relating to demand letters in an action for benefits;
1624 specifying when a demand letter is defective;
1625 requiring a second demand letter under certain
1626 circumstances; deleting obsolete provisions; providing
1627 that a demand letter may not be used to request the
1628 production of claim documents or records from the
1629 insurer; amending s. 817.234, F.S.; conforming a
1630 cross-reference; providing civil penalties for
1631 fraudulent insurance claims; amending ss. 324.021,
1632 456.057, and 627.7401, F.S.; conforming cross-
1633 references; providing an effective date.