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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
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.

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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 appointed by the Attorney General.
178 (c) Two representatives of motor vehicle insurers appointed
179 by the Chief Financial Officer.
180 (d) Two representatives of local law enforcement agencies,
181 one of whom shall be appointed by the Chief Financial Officer,
182 and one of whom shall be appointed by the Attorney General.
183
184 The officer who appointed a member of the board may remove that
185 member for cause. The term of office of an appointed member
186 expires at the same time as the term of the officer who

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

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

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

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274 must be balanced with the public’s interest in preventing a no-
275 fault system that encourages litigation by allowing for
276 exorbitant attorney’s fees. Courts should limit attorney fee
277 awards so as to eliminate the incentive for attorneys to
278 manufacture unnecessary litigation.
279 Section 7. Section 627.7311, Florida Statutes, is created
280 to read:
281 627.7311 Implementation of no-fault law.—The provisions,
282 schedules, and procedures authorized under the no-fault law
283 shall be implemented by insurers and have full force and effect
284 regardless of their express inclusion in an insurance policy,
285 and an insurer is not required to amend its policy to implement
286 such provisions, schedules, or procedures.
287 Section 8. Section 627.732, Florida Statutes, is reordered
288 and amended to read:
289 627.732 Definitions.—As used in the no-fault law ~~ss.~~
290 ~~627.730-627.7405~~, the term:
291 (1) “Broker” means any person not possessing a license
292 under chapter 395, chapter 400, chapter 429, chapter 458,
293 chapter 459, chapter 460, chapter 461, or chapter 641 who
294 charges or receives compensation for any use of medical
295 equipment and is not the 100-percent owner or the 100-percent
296 lessee of such equipment. For purposes of this section, such
297 owner or lessee may be an individual, a corporation, a
298 partnership, or any other entity and any of its 100-percent-
299 owned affiliates and subsidiaries. For purposes of this
300 subsection, the term “lessee” means a long-term lessee under a
301 capital or operating lease, but does not include a part-time
302 lessee. The term “broker” does not include a hospital or

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303 physician management company whose medical equipment is
304 ancillary to the practices managed, a debt collection agency, or
305 an entity that has contracted with the insurer to obtain a
306 discounted rate for such services; or ~~nor does the term include~~
307 a management company that has contracted to provide general
308 management services for a licensed physician or health care
309 facility and whose compensation is not materially affected by
310 the usage or frequency of usage of medical equipment or an
311 entity that is 100-percent owned by one or more hospitals or
312 physicians. The term “broker” does not include a person or
313 entity that certifies, upon request of an insurer, that:
314 (a) It is a clinic licensed under ss. 400.990-400.995;
315 (b) It is a 100-percent owner of medical equipment; and
316 (c) The owner’s only part-time lease of medical equipment
317 for personal injury protection patients is on a temporary basis,
318 not to exceed 30 days in a 12-month period, and such lease is
319 solely for the purposes of necessary repair or maintenance of
320 the 100-percent-owned medical equipment or pending the arrival
321 and installation of the newly purchased or a replacement for the
322 100-percent-owned medical equipment, or for patients for whom,
323 because of physical size or claustrophobia, it is determined by
324 the medical director or clinical director to be medically
325 necessary that the test be performed in medical equipment that
326 is open-style. The leased medical equipment may not ~~cannot~~ be
327 used by patients who are not patients of the registered clinic
328 ~~for medical treatment of services~~. Any person or entity making a
329 false certification under this subsection commits insurance
330 fraud as defined in s. 817.234. However, the 30-day period
331 ~~provided in this paragraph~~ may be extended for an additional 60

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332 days as applicable to magnetic resonance imaging equipment if
333 the owner certifies that the extension otherwise complies with
334 this paragraph.
335 (9)~~(2)~~ "Medically necessary" refers to a medical service or
336 supply that a prudent physician would provide for the purpose of
337 preventing, diagnosing, or treating an illness, injury, disease,
338 or symptom in a manner that is:
339 (a) In accordance with generally accepted standards of
340 medical practice;
341 (b) Clinically appropriate in terms of type, frequency,
342 extent, site, and duration; and
343 (c) Not primarily for the convenience of the patient,
344 physician, or other health care provider.
345 (10)~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle
346 with four or more wheels which is of a type both designed and
347 required to be licensed for use on the highways of this state,
348 and any trailer or semitrailer designed for use with such
349 vehicle, and includes:
350 (a) A "private passenger motor vehicle," which is any motor
351 vehicle that ~~which~~ is a sedan, station wagon, or jeep-type
352 vehicle and, if not used primarily for occupational,
353 professional, or business purposes, a motor vehicle of the
354 pickup, panel, van, camper, or motor home type.
355 (b) A "commercial motor vehicle," which is any motor
356 vehicle that ~~which~~ is not a private passenger motor vehicle.
357
358 The term ~~"motor vehicle"~~ does not include a mobile home or any
359 motor vehicle that ~~which~~ is used in mass transit, other than
360 public school transportation, and designed to transport more

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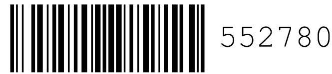
361 than five passengers exclusive of the operator of the motor
362 vehicle and that ~~which~~ is owned by a municipality, a transit
363 authority, or a political subdivision of the state.
364 (11)~~(4)~~ “Named insured” means a person, usually the owner
365 of a vehicle, identified in a policy by name as the insured
366 under the policy.
367 (12) “No-fault law” means the Florida Motor Vehicle No-
368 Fault Law codifed at ss. 627.730-627.7407.
369 (13)~~(5)~~ “Owner” means a person who holds the legal title to
370 a motor vehicle; or, if ~~in the event~~ a motor vehicle is the
371 subject of a security agreement or lease with an option to
372 purchase with the debtor or lessee having the right to
373 possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the
374 owner for the purposes of the no-fault law ~~ss. 627.730-627.7405~~.
375 (15)~~(6)~~ “Relative residing in the same household” means a
376 relative of any degree by blood or by marriage who usually makes
377 her or his home in the same family unit, whether or not
378 temporarily living elsewhere.
379 (2)~~(7)~~ “Certify” means to swear or attest to being true or
380 represented in writing.
381 (3) “Claimant” means the person, organization, or entity
382 seeking benefits, including all assignees.
383 (5)~~(8)~~ “Immediate personal supervision,” as it relates to
384 the performance of medical services by nonphysicians not in a
385 hospital, means that an individual licensed to perform the
386 medical service or provide the medical supplies must be present
387 within the confines of the physical structure where the medical
388 services are performed or where the medical supplies are
389 provided such that the licensed individual can respond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390 immediately to any emergencies if needed.
391 (6)~~(9)~~ “Incident,” with respect to services considered as
392 incident to a physician’s professional service, for a physician
393 licensed under chapter 458, chapter 459, chapter 460, or chapter
394 461, if not furnished in a hospital, means ~~such~~ services that
395 are ~~must be~~ an integral, even if incidental, part of a covered
396 physician’s service.
397 (7)~~(10)~~ “Knowingly” means that a person, with respect to
398 information, has actual knowledge of the information,~~;~~ acts in
399 deliberate ignorance of the truth or falsity of the
400 information,~~;~~ or acts in reckless disregard of the information.~~,~~
401 ~~and~~ Proof of specific intent to defraud is not required.
402 (8)~~(11)~~ “Lawful” or “lawfully” means in substantial
403 compliance with all relevant applicable criminal, civil, and
404 administrative requirements of state and federal law related to
405 the provision of medical services or treatment.
406 (4)~~(12)~~ “Hospital” means a facility that, at the time
407 services or treatment were rendered, was licensed under chapter
408 395.
409 (14)~~(13)~~ “Properly completed” means providing truthful,
410 substantially complete, and substantially accurate responses ~~as~~
411 to all material elements of ~~to~~ each applicable request for
412 information or statement by a means that may lawfully be
413 provided and that complies with this section, or as agreed by
414 the parties.
415 (17)~~(14)~~ “Upcoding” means submitting ~~an action that submits~~
416 a billing code that would result in payment greater in amount
417 than would be paid using a billing code that accurately
418 describes the services performed. The term does not include an

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419 otherwise lawful bill by a magnetic resonance imaging facility,
420 which globally combines both technical and professional
421 components, if the amount of the global bill is not more than
422 the components if billed separately; however, payment of such a
423 bill constitutes payment in full for all components of such
424 service.
425 (16)~~(15)~~ “Unbundling” means submitting ~~an action that~~
426 ~~submits~~ a billing code that is properly billed under one billing
427 code, but that has been separated into two or more billing
428 codes~~,~~ and would result in payment greater than the ~~in~~ amount
429 that ~~than~~ would be paid using one billing code.
430 Section 9. Subsections (1) and (4) of section 627.736,
431 Florida Statutes, are amended, subsections (5) through (16) of
432 that section are redesignated as subsections (6) through (17),
433 respectively, a new subsection (5) is added to that section,
434 present subsection (5), paragraph (b) of present subsection (6),
435 paragraph (b) of present subsection (7), and present subsections
436 (8), (9), and (10) of that section are amended, to read:
437 627.736 Required personal injury protection benefits;
438 exclusions; priority; claims.—
439 (1) REQUIRED BENEFITS.—Every insurance policy complying
440 with the security requirements of s. 627.733 must ~~shall~~ provide
441 personal injury protection to the named insured, relatives
442 residing in the same household, persons operating the insured
443 motor vehicle, passengers in such motor vehicle, and other
444 persons struck by such motor vehicle and suffering bodily injury
445 while not an occupant of a self-propelled vehicle, subject to
446 ~~the provisions of~~ subsection (2) and paragraph (4)(h) ~~(4)(e),~~ to
447 a limit of $10,000 for loss sustained by ~~any~~ such person as a

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448 result of bodily injury, sickness, disease, or death arising out
449 of the ownership, maintenance, or use of a motor vehicle as
450 follows:
451 (a) *Medical benefits.*—Eighty percent of all reasonable
452 expenses, charged pursuant to subsection (6), for medically
453 necessary medical, surgical, X-ray, dental, and rehabilitative
454 services, including prosthetic devices, and for medically
455 necessary ambulance, hospital, and nursing services. However,
456 the medical benefits ~~shall~~ provide reimbursement only for such
457 services and care that are lawfully provided, supervised,
458 ordered, or prescribed by a physician licensed under chapter 458
459 or chapter 459, a dentist licensed under chapter 466, or a
460 chiropractic physician licensed under chapter 460 or that are
461 provided by any of the following ~~persons or entities~~:
462 1. A hospital or ambulatory surgical center licensed under
463 chapter 395.
464 2. A person or entity licensed under part III of chapter
465 401 which ~~ss. 401.2101-401.45 that~~ provides emergency
466 transportation and treatment.
467 3. An entity wholly owned by one or more physicians
468 licensed under chapter 458 or chapter 459, chiropractic
469 physicians licensed under chapter 460, or dentists licensed
470 under chapter 466 or by such ~~practitioner or~~ practitioners and
471 the spouse, parent, child, or sibling of such ~~that practitioner~~
472 ~~or those~~ practitioners.
473 4. An entity wholly owned, directly or indirectly, by a
474 hospital or hospitals.
475 5. A health care clinic licensed under part X of chapter
476 400 which ~~ss. 400.990-400.995 that~~ is:

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477 a. Accredited by the Joint Commission on Accreditation of
478 Healthcare Organizations, the American Osteopathic Association,
479 the Commission on Accreditation of Rehabilitation Facilities, or
480 the Accreditation Association for Ambulatory Health Care, Inc.;
481 or
482 b. A health care clinic that:
483 (I) Has a medical director licensed under chapter 458,
484 chapter 459, or chapter 460;
485 (II) Has been continuously licensed for more than 3 years
486 or is a publicly traded corporation that issues securities
487 traded on an exchange registered with the United States
488 Securities and Exchange Commission as a national securities
489 exchange; and
490 (III) Provides at least four of the following medical
491 specialties:
492 (A) General medicine.
493 (B) Radiography.
494 (C) Orthopedic medicine.
495 (D) Physical medicine.
496 (E) Physical therapy.
497 (F) Physical rehabilitation.
498 (G) Prescribing or dispensing outpatient prescription
499 medication.
500 (H) Laboratory services.
501 6. An acupuncturist licensed under chapter 457.
502
503 If any services under this paragraph are provided by an entity
504 or clinic described in subparagraph 3., subparagraph 4., or
505 subparagraph 5., the entity or clinic must provide the insurer

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506 at the initial submission of the claim with a form adopted by
507 the Department of Financial Services which documents that the
508 entity or clinic meets applicable criteria for such entity or
509 clinic and includes a sworn statement or affidavit to that
510 effect. Any change in ownership requires the filing of a new
511 form within 10 days after the date of the change in ownership.
512 ~~The Financial Services Commission shall adopt by rule the form~~
513 ~~that must be used by an insurer and a health care provider~~
514 ~~specified in subparagraph 3., subparagraph 4., or subparagraph~~
515 ~~5. to document that the health care provider meets the criteria~~
516 ~~of this paragraph, which rule must include a requirement for a~~
517 ~~sworn statement or affidavit.~~
518 (b) *Disability benefits.*—Sixty percent of any loss of gross
519 income and loss of earning capacity per individual from
520 inability to work proximately caused by the injury sustained by
521 the injured person, plus all expenses reasonably incurred in
522 obtaining from others ordinary and necessary services in lieu of
523 those that, but for the injury, the injured person would have
524 performed without income for the benefit of his or her
525 household. All disability benefits payable under this provision
526 must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.
527 (c) *Death benefits.*—Death benefits equal to the lesser of
528 $5,000 or the remainder of unused personal injury protection
529 benefits per individual. The insurer may pay such benefits to
530 the executor or administrator of the deceased, to any of the
531 deceased's relatives by blood, ~~or~~ legal adoption, or ~~connection~~
532 ~~by~~ marriage, or to any person appearing to the insurer to be
533 equitably entitled thereto.
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535 Only insurers writing motor vehicle liability insurance in this
536 state may provide the required benefits of this section, and ~~no~~
537 such insurers may not ~~insurer shall~~ require the purchase of any
538 other motor vehicle coverage other than the purchase of property
539 damage liability coverage as required by s. 627.7275 as a
540 condition for providing such ~~required~~ benefits. Insurers may not
541 require that property damage liability insurance in an amount
542 greater than $10,000 be purchased in conjunction with personal
543 injury protection. Such insurers shall make benefits and
544 required property damage liability insurance coverage available
545 through normal marketing channels. An ~~Any~~ insurer writing motor
546 vehicle liability insurance in this state who fails to comply
547 with such availability requirement as a general business
548 practice violates ~~shall be deemed to have violated~~ part IX of
549 chapter 626, and such violation constitutes ~~shall constitute~~ an
550 unfair method of competition or an unfair or deceptive act or
551 practice involving the business of insurance. An~~; and any such~~
552 insurer committing such violation is ~~shall be~~ subject to the
553 penalties afforded in such part, as well as those that are ~~which~~
554 ~~may be~~ afforded elsewhere in the insurance code.
555 (4) BENEFITS; WHEN DUE.—Benefits due from an insurer under
556 the no-fault law are ~~ss. 627.730-627.7405 shall be~~ primary,
557 except that benefits received under any workers' compensation
558 law shall be credited against the benefits provided by
559 subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~
560 upon the receipt of reasonable proof of such loss and the amount
561 of expenses and loss incurred which are covered by the policy
562 issued under the no-fault law ~~ss. 627.730-627.7405~~. If ~~When~~ the
563 Agency for Health Care Administration provides, pays, or becomes

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564 liable for medical assistance under the Medicaid program related
565 to injury, sickness, disease, or death arising out of the
566 ownership, maintenance, or use of a motor vehicle, the benefits
567 are ~~under ss. 627.730-627.7405 shall be~~ subject to the
568 provisions of the Medicaid program.
569 (a) An insurer may require written notice to be given as
570 soon as practicable after an accident involving a motor vehicle
571 with respect to which the policy affords the security required
572 by the no-fault law ~~ss. 627.730-627.7405~~.
573 (b) Personal injury protection insurance benefits paid
574 pursuant to this section are ~~shall be~~ overdue if not paid within
575 30 days after the insurer is furnished written notice of the
576 fact of a covered loss and of the amount of same. If such
577 written notice is not furnished to the insurer as to the entire
578 claim, any partial amount supported by written notice is overdue
579 if not paid within 30 days after such written notice is
580 furnished to the insurer. Any part or all of the remainder of
581 the claim that is subsequently supported by written notice is
582 overdue if not paid within 30 days after such written notice is
583 furnished to the insurer.
584 (c) If ~~When~~ an insurer pays only a portion of a claim or
585 rejects a claim, the insurer shall provide at the time of the
586 partial payment or rejection an itemized specification of each
587 item that the insurer had reduced, omitted, or declined to pay
588 and any information that the insurer desires the claimant to
589 consider related to the medical necessity of the denied
590 treatment or to explain the reasonableness of the reduced
591 charge, provided that this does ~~shall~~ not limit the introduction
592 of evidence at trial.~~; and~~ The insurer must ~~shall~~ include the

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

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

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

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680 other person while occupying the owner's motor vehicle or, if a
681 resident of this state, while not an occupant of a self-
682 propelled vehicle, if the injury is caused by physical contact
683 with such motor vehicle if~~, provided~~ the injured person is not
684 ~~himself or herself~~:
685 a. The owner of a motor vehicle with respect to which
686 security is required under the no-fault law ~~ss. 627.730-~~
687 ~~627.7405~~; or
688 b. Entitled to personal injury benefits from the insurer of
689 the owner ~~or owners~~ of such a motor vehicle.
690 (i)~~(f)~~ If two or more insurers are liable to pay personal
691 injury protection benefits for the same injury to any one
692 person, the maximum payable is ~~shall be~~ as specified in
693 subsection (1), and any insurer paying the benefits is ~~shall be~~
694 entitled to recover from each of the other insurers an equitable
695 pro rata share of the benefits paid and expenses incurred in
696 processing the claim.
697 (j)~~(g)~~ It is a violation of the insurance code for an
698 insurer to fail to timely provide benefits as required by this
699 section with such frequency as to constitute a general business
700 practice.
701 (k)~~(h)~~ Benefits are ~~shall~~ not ~~be~~ due or payable to a
702 claimant who knowingly: ~~or on the behalf of an insured person if~~
703 ~~that person has~~
704 1. Submits a false or misleading statement, document,
705 record, or bill;
706 2. Submits false or misleading information; or
707 3. Has otherwise committed or attempted to commit a
708 fraudulent insurance act as defined in s. 626.989.

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709
710 A claimant that violates this paragraph is not entitled to any
711 personal injury protection benefits or payment for any bills and
712 services, regardless of whether a portion of the claim may be
713 legitimate. However, a claimant that does not violate this
714 paragraph may not be denied benefits solely due to a violation
715 by another claimant.
716 (l) Notwithstanding any remedies afforded by law, the
717 insurer may recover from a claimant who violates paragraph (k)
718 any sums previously paid to a claimant and may bring any
719 available common law and statutory causes of action. A claimant
720 has violated paragraph (k) ~~committed, by a material act or~~
721 ~~omission, any insurance fraud relating to personal injury~~
722 ~~protection coverage under his or her policy,~~ if the fraud is
723 admitted to in a sworn statement ~~by the insured~~ or ~~if it is~~
724 established in a court of competent jurisdiction. Any insurance
725 fraud voids ~~shall void~~ all coverage arising from the claim
726 related to ~~such fraud under the personal injury protection~~
727 ~~coverage of~~ the claimant ~~insured person~~ who committed the fraud,
728 irrespective of whether a portion of the insured person’s claim
729 may be legitimate, and any benefits paid before ~~prior to~~ the
730 discovery of the ~~insured person’s insurance~~ fraud is ~~shall be~~
731 recoverable by the insurer from the claimant ~~person~~ who
732 committed insurance fraud in their entirety. The prevailing
733 party is entitled to its costs and attorney’s fees in any action
734 in which it prevails in an insurer’s action to enforce its right
735 of recovery under this paragraph. This paragraph does not
736 preclude or limit an insurer’s right to deny a claim based on
737 other evidence of fraud or affect an insurer’s right to plead

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738 and prove a claim or defense of fraud under common law. If a
739 physician, hospital, clinic, or other medical institution
740 violates paragraph (k), the injured party is not liable for, and
741 the physician, hospital, clinic, or other medical institution
742 may not bill the insured for, charges that are unpaid because of
743 failure to comply with paragraph (k). Any agreement requiring
744 the injured person or insured to pay for such charges is
745 unenforceable.
746 (5) INSURER INVESTIGATIONS.—An insurer has the right and
747 duty to conduct a reasonable investigation of a claim. In the
748 course of the insurer’s investigation of a claim:
749 (a) Any records review need not be based on a physical
750 examination and may be obtained at any time, including after
751 reduction or denial of the claim.
752 1. The records review must be conducted by a practitioner
753 within the same licensing chapter as the medical provider whose
754 records are being reviewed unless the records review is
755 performed by a physician licensed under chapter 458 or chapter
756 459.
757 2. The 30-day period for payment under paragraph (4)(b) is
758 tolled from the date the insurer sends its request for treatment
759 records to the date that the insurer receives the treatment
760 records.
761 3. The insured, claimant, or medical provider may impose a
762 reasonable, cost-based fee that includes only the cost of
763 copying and postage and not the cost of labor for copying.
764 (b) In all circumstances, an insured seeking benefits under
765 the no-fault law must comply with the terms of the policy, which
766 includes, but is not limited to, submitting to examinations

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

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796 ~~accepted by the provider involved in the dispute, and~~
797 ~~reimbursement levels in the community and various federal and~~
798 ~~state medical fee schedules applicable to automobile and other~~
799 ~~insurance coverages, and other information relevant to the~~
800 ~~reasonableness of the reimbursement for the service, treatment,~~
801 ~~or supply.~~
802 1.~~2.~~ The insurer shall ~~may~~ limit reimbursement to no more
803 than 80 percent of the following schedule of maximum charges:
804 a. For emergency transport and treatment by providers
805 licensed under chapter 401, 200 percent of Medicare.
806 b. For emergency services and care provided by a hospital
807 licensed under chapter 395, 75 percent of the hospital's usual
808 and customary charges.
809 c. For emergency services and care as defined by s.
810 395.002~~(9)~~ provided in a facility licensed under chapter 395
811 rendered by a physician or dentist, and related hospital
812 inpatient services rendered by a physician or dentist, the usual
813 and customary charges in the community.
814 d. For hospital inpatient services, other than emergency
815 services and care, 200 percent of the Medicare Part A
816 prospective payment applicable to the specific hospital
817 providing the inpatient services.
818 e. For hospital outpatient services, other than emergency
819 services and care, 200 percent of the Medicare Part A Ambulatory
820 Payment Classification for the specific hospital providing the
821 outpatient services.
822 f. For all other medical services, ~~supplies, and care,~~ 200
823 percent of the allowable amount under the participating
824 physicians schedule of Medicare Part B. For all other supplies

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

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

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883 insured received the alleged treatment. As used in this sub-
884 subparagraph, the term "countersigned" means a second or
885 verifying signature, as on a previously signed document, and is
886 not satisfied by the statement "signature on file" or any
887 similar statement;
888 f.~~e.~~ For any treatment or service that is upcoded, or that
889 is unbundled if ~~when~~ such treatment or services should be
890 bundled, in accordance with paragraph (d). To facilitate prompt
891 payment of lawful services, an insurer may change codes that it
892 determines to have been improperly or incorrectly upcoded or
893 unbundled, and may make payment based on the changed codes,
894 without affecting the right of the provider to dispute the
895 change by the insurer if~~, provided that~~ before doing so, the
896 insurer contacts ~~must contact~~ the health care provider and
897 discusses ~~discuss~~ the reasons for the insurer's change and the
898 health care provider's reason for the coding, or makes ~~make~~ a
899 reasonable good faith effort to do so, as documented in the
900 insurer's file; and
901 g.~~f.~~ For medical services or treatment billed by a
902 physician and not provided in a hospital unless such services
903 are rendered by the physician or are incident to his or her
904 professional services and are included on the physician's bill,
905 including documentation verifying that the physician is
906 responsible for the medical services that were rendered and
907 billed.
908 2. The Department of Health, in consultation with the
909 appropriate professional licensing boards, shall adopt, by rule,
910 a list of diagnostic tests deemed not to be medically necessary
911 for use in the treatment of persons sustaining bodily injury

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912 covered by personal injury protection benefits under this
913 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
914 ~~and~~ shall be revised from time to time as determined by the
915 Department of Health, in consultation with the respective
916 professional licensing boards. Inclusion of a test on the list
917 <u>must</u> ~~of invalid diagnostic tests shall~~ be based on lack of
918 demonstrated medical value and a level of general acceptance by
919 the relevant provider community and <u>may</u> ~~shall~~ not be dependent
920 for results entirely upon subjective patient response.
921 Notwithstanding its inclusion on a fee schedule in this
922 subsection, an insurer or insured is not required to pay any
923 charges or reimburse claims for any invalid diagnostic test as
924 determined by the Department of Health.
925 (c)~~1.~~ With respect to any treatment or service, other than
926 medical services billed by a hospital or other provider for
927 emergency services as defined in s. 395.002 or inpatient
928 services rendered at a hospital-owned facility, the statement of
929 charges must be furnished to the insurer by the provider and may
930 not include, and the insurer is not required to pay, charges for
931 treatment or services rendered more than 35 days before the
932 postmark date or electronic transmission date of the statement,
933 except for past due amounts previously billed on a timely basis
934 under this paragraph, and except that, if the provider submits
935 to the insurer a notice of initiation of treatment within 21
936 days after its first examination or treatment of the claimant,
937 the statement may include charges for treatment or services
938 rendered up to, but not more than, 75 days before the postmark
939 date of the statement. The injured party is not liable for, and
940 the provider <u>may</u> ~~shall~~ not bill the injured party for, charges

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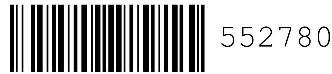
941 that are unpaid because of the provider’s failure to comply with
942 this paragraph. Any agreement requiring the injured person or
943 insured to pay for such charges is unenforceable.
944 1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider
945 with the correct name and address of the insured’s personal
946 injury protection insurer, the provider has 35 days from the
947 date the provider obtains the correct information to furnish the
948 insurer with a statement of the charges. The insurer is not
949 required to pay for such charges unless the provider includes
950 with the statement documentary evidence that was provided by the
951 insured during the 35-day period demonstrating that the provider
952 reasonably relied on erroneous information from the insured and
953 either:
954 a. A denial letter from the incorrect insurer; or
955 b. Proof of mailing, which may include an affidavit under
956 penalty of perjury, reflecting timely mailing to the incorrect
957 address or insurer.
958 2.~~3.~~ For emergency services and care as defined in s.
959 395.002 rendered in a hospital emergency department or for
960 transport and treatment rendered by an ambulance provider
961 licensed pursuant to part III of chapter 401, the provider is
962 not required to furnish the statement of charges within the time
963 periods established by this paragraph,~~;~~ and the insurer is ~~shall~~
964 not ~~be~~ considered to have been furnished with notice of the
965 amount of covered loss for purposes of paragraph (4)(b) until it
966 receives a statement complying with paragraph (d), or copy
967 thereof, which specifically identifies the place of service to
968 be a hospital emergency department or an ambulance in accordance
969 with billing standards recognized by the Centers for Medicare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970 and Medicaid Services ~~Health Care Finance Administration~~.
971 3. ~~4.~~ Each notice of the insured's rights under s. 627.7401
972 must include the following statement in type no smaller than 12
973 points:
974
975 BILLING REQUIREMENTS.—Florida Statutes provide that
976 with respect to any treatment or services, other than
977 certain hospital and emergency services, the statement
978 of charges furnished to the insurer by the provider
979 may not include, and the insurer and the injured party
980 are not required to pay, charges for treatment or
981 services rendered more than 35 days before the
982 postmark date of the statement, except for past due
983 amounts previously billed on a timely basis, and
984 except that, if the provider submits to the insurer a
985 notice of initiation of treatment within 21 days after
986 its first examination or treatment of the claimant,
987 the first billing cycle statement may include charges
988 for treatment or services rendered up to, but not more
989 than, 75 days before the postmark date of the
990 statement.
991
992 (d) All statements and bills for medical services rendered
993 by any physician, hospital, clinic, or other person or
994 institution shall be submitted to the insurer on a properly
995 completed Centers for Medicare and Medicaid Services (CMS) 1500
996 form, UB 92 forms, or any other standard form approved by the
997 office or adopted by the commission for purposes of this
998 paragraph. All billings for such services rendered by providers

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999 must ~~shall~~, to the extent applicable, follow the Physicians'
1000 Current Procedural Terminology (CPT) or Healthcare Correct
1001 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1002 year in which services are rendered and comply with the ~~Centers~~
1003 ~~for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions
1004 and the American Medical Association Current Procedural
1005 Terminology (CPT) Editorial Panel and Healthcare Correct
1006 Procedural Coding System (HCPCS). All providers other than
1007 hospitals shall include on the applicable claim form the
1008 professional license number of the provider in the line or space
1009 provided for "Signature of Physician or Supplier, Including
1010 Degrees or Credentials." In determining compliance with
1011 applicable CPT and HCPCS coding, guidance shall be provided by
1012 the Physicians' Current Procedural Terminology (CPT) or the
1013 Healthcare Correct Procedural Coding System (HCPCS) in effect
1014 for the year in which services were rendered, the Office of the
1015 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1016 other authoritative treatises designated by rule by the Agency
1017 for Health Care Administration. A ~~No~~ statement of medical
1018 services may not include charges for medical services of a
1019 person or entity that performed such services without possessing
1020 the valid licenses required to perform such services. For
1021 purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~
1022 considered to have been furnished with notice of the amount of
1023 covered loss or medical bills due unless the statements or bills
1024 comply with this paragraph, and unless the statements or bills
1025 are ~~comply with this paragraph, and unless the statements or~~
1026 ~~bills are~~ properly completed in their entirety as to all
1027 material provisions, with all relevant information being

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

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

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1086 <u>of the amount of a covered loss or medical bills due.</u>
1087 6. This disclosure and acknowledgment form is not required
1088 for services billed by a provider for emergency services as
1089 defined in s. 395.002, for emergency services and care as
1090 defined in s. 395.002 rendered in a hospital emergency
1091 department, or for transport and treatment rendered by an
1092 ambulance provider licensed pursuant to part III of chapter 401.
1093 7. The Financial Services Commission shall adopt~~,~~ by rule~~,~~
1094 a standard disclosure and acknowledgment form <u>to</u> ~~that shall~~ be
1095 used to fulfill the requirements of this paragraph~~, effective 90~~
1096 ~~days after such form is adopted and becomes final~~. ~~The~~
1097 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1098 ~~the rule is final, the provider may use a form of its own which~~
1099 ~~otherwise complies with the requirements of this paragraph.~~
1100 8. As used in this paragraph, <u>the term</u> “countersigned” <u>or</u>
1101 <u>“countersignature”</u> means a second or verifying signature, as on
1102 a previously signed document, and is not satisfied by the
1103 statement “signature on file” or any similar statement.
1104 9. The requirements of this paragraph apply only with
1105 respect to the initial treatment or service of the insured by a
1106 provider. For subsequent treatments or service, the provider
1107 must maintain a patient log signed by the patient, in
1108 chronological order by date of service, <u>which describes the</u>
1109 <u>treatment rendered in a language readable by the insured</u> ~~that is~~
1110 ~~consistent with the services being rendered to the patient as~~
1111 ~~claimed~~. <u>Listing CPT codes or other coding on the patient log</u>
1112 <u>does not satisfy this requirement. The provider must provide</u>
1113 <u>copies of the patient log to the insurer within 30 days after</u>
1114 <u>receiving a written request from the insurer. Failure to</u>

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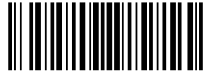
1115 maintain a patient log renders the treatment unlawful and
1116 noncompensable. The requirements ~~of this subparagraph~~ for
1117 maintaining a patient log signed by the patient may be met by a
1118 hospital that maintains medical records as required by s.
1119 395.3025 and applicable rules and makes such records available
1120 to the insurer upon request.
1121 (f) Upon written notification by any person, an insurer
1122 shall investigate any claim of improper billing by a physician
1123 or other medical provider. The insurer shall determine if the
1124 insured was properly billed for only those services and
1125 treatments that the insured actually received. If the insurer
1126 determines that the insured has been improperly billed, the
1127 insurer shall notify the insured, the person making the written
1128 notification, and the provider of its findings and ~~shall~~ reduce
1129 the amount of payment to the provider by the amount determined
1130 to be improperly billed. If a reduction is made due to such
1131 written notification by any person, the insurer shall pay to the
1132 person 20 percent of the amount of the reduction, up to $500. If
1133 the provider is arrested due to the improper billing, ~~then~~ the
1134 insurer shall pay to the person 40 percent of the amount of the
1135 reduction, up to $500.
1136 (g) An insurer may not systematically downcode with the
1137 intent to deny reimbursement otherwise due. Such action
1138 constitutes a material misrepresentation under s.
1139 626.9541(1)(i)2.
1140 (7) ~~(6)~~ DISCOVERY OF FACTS ABOUT AN INJURED PERSON;
1141 DISPUTES.—
1142 (b) Every physician, hospital, clinic, or other medical
1143 institution providing, before or after bodily injury upon which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1144 a claim for personal injury protection insurance benefits is
1145 based, any products, services, or accommodations in relation to
1146 that or any other injury, or in relation to a condition claimed
1147 to be connected with that or any other injury, shall, if
1148 requested to do so by the insurer against whom the claim has
1149 been made, permit the insurer or the insurer’s representative to
1150 conduct an onsite physical review and examination of the
1151 treatment location, treatment apparatuses, diagnostic devices,
1152 and any other medical equipment used for the services rendered
1153 within 10 days after the insurer’s request, and furnish
1154 ~~forthwith~~ a written report of the history, condition, treatment,
1155 dates, and costs of such treatment of the injured person and why
1156 the items identified by the insurer were reasonable in amount
1157 and medically necessary, together with a sworn statement that
1158 the treatment or services rendered were reasonable and necessary
1159 with respect to the bodily injury sustained and identifying
1160 which portion of the expenses for such treatment or services was
1161 incurred as a result of such bodily injury, and produce
1162 forthwith, and permit the inspection and copying of, his or her
1163 or its records regarding such history, condition, treatment,
1164 dates, and costs of treatment if~~; provided that~~ this does ~~shall~~
1165 not limit the introduction of evidence at trial. Such sworn
1166 statement must ~~shall~~ read as follows: “Under penalty of perjury,
1167 I declare that I have read the foregoing, and the facts alleged
1168 are true, to the best of my knowledge and belief.” A ~~No~~ cause of
1169 action for violation of the physician-patient privilege or
1170 invasion of the right of privacy may not be brought ~~shall be~~
1171 ~~permitted~~ against any physician, hospital, clinic, or other
1172 medical institution complying with ~~the provisions of~~ this

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1173 section. The person requesting such records and such sworn
1174 statement shall pay all reasonable costs connected therewith.
1175 1. If an insurer makes a written request for documentation
1176 or information under this paragraph within 30 days after having
1177 received notice of the amount of a covered loss under paragraph
1178 (4)(a), the amount or the partial amount that ~~which~~ is the
1179 subject of the insurer's inquiry is ~~shall become~~ overdue if the
1180 insurer does not pay in accordance with paragraph (4)(b) or
1181 within 10 days after the insurer's receipt of the requested
1182 documentation or information, whichever occurs later. For
1183 purposes of this subparagraph ~~paragraph~~, the term "receipt"
1184 includes, but is not limited to, inspection and copying pursuant
1185 to this paragraph. An ~~Any~~ insurer that requests documentation or
1186 information pertaining to reasonableness of charges or medical
1187 necessity under this paragraph without a reasonable basis for
1188 such requests as a general business practice is engaging in an
1189 unfair trade practice under the insurance code.
1190 2. If an insured seeking to recover benefits pursuant to
1191 the no-fault law assigns the contractual right to those benefits
1192 or payment of those benefits to any person or entity, the
1193 assignee must comply with the terms of the policy. In all
1194 circumstances, the assignee is obligated to cooperate under the
1195 policy, which includes, but is not limited to, participating in
1196 an examination under oath. Examinations under oath may be
1197 recorded by audio, video, court reporter, or any combination
1198 thereof. Compliance with this paragraph is a condition precedent
1199 to recovery of benefits pursuant to the no-fault law.
1200 a. If an insurer requests an examination under oath of a
1201 medical provider, the provider must produce the persons having

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1202 the most knowledge of the issues identified by the insurer in
1203 the request for examination under oath. All claimants must
1204 produce and provide for inspection all documents requested by
1205 the insurer which are reasonably obtainable by the claimant.
1206 b. Before requesting that an assignee participate in an
1207 examination under oath, the insurer must send a written request
1208 to the assignee requesting all information that the insurer
1209 believes is necessary to process the claim, including the
1210 information contemplated under this subparagraph.
1211 c. An insurer that, as a general practice, requests
1212 examinations under oath of an assignee without a reasonable
1213 basis is engaging in an unfair and deceptive trade practice.
1214 (8) ~~(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1215 REPORTS.—
1216 (b) If requested by the person examined, a party causing an
1217 examination to be made shall deliver to him or her a copy of
1218 every written report concerning the examination rendered by an
1219 examining physician, at least one of which reports must set out
1220 the examining physician's findings and conclusions in detail.
1221 After such request and delivery, the party causing the
1222 examination to be made is entitled, upon request, to receive
1223 from the person examined every written report available to him
1224 or her or his or her representative concerning any examination,
1225 previously or thereafter made, of the same mental or physical
1226 condition. By requesting and obtaining a report of the
1227 examination so ordered, or by taking the deposition of the
1228 examiner, the person examined waives any privilege he or she may
1229 have, in relation to the claim for benefits, regarding the
1230 testimony of every other person who has examined, or may

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

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1260 ~~preferred provider, whether the insured purchased a preferred~~
1261 ~~provider policy or a nonpreferred provider policy, the medical~~
1262 ~~benefits provided by the insurer shall be as required by this~~
1263 ~~section.~~
1264 (b) If the insured elects the ~~to use a provider who is a~~
1265 preferred provider option, the insurer may pay medical benefits
1266 in excess of the benefits required by this section and may waive
1267 or lower the amount of any deductible that applies to such
1268 medical benefits. As an alternative, or in addition to such
1269 benefits, waiver, or reduction, the insurer may provide an
1270 actuarially appropriate premium discount as specified in an
1271 approved rate filing to an insured who selects the preferred
1272 provider option. If the preferred provider option provides a
1273 premium discount, the policy may provide that charges for
1274 nonemergency services provided within this state are payable
1275 only if performed by members of the preferred provider network
1276 unless there is no member of the preferred provider network
1277 located within 15 miles of the insured's place of residence
1278 whose scope of practice includes the required services, or
1279 unless the nonemergency services are rendered in the emergency
1280 room of a hospital licensed under chapter 395. ~~If the insurer~~
1281 ~~offers a preferred provider policy to a policyholder or~~
1282 ~~applicant, it must also offer a nonpreferred provider policy.~~
1283 (c) The insurer shall provide each insured ~~policyholder~~
1284 with a current roster of preferred providers in the county in
1285 which the insured resides at the time of purchasing ~~purchase of~~
1286 such policy, and ~~shall~~ make such list available for public
1287 inspection during regular business hours at the insurer's
1288 principal office ~~of the insurer~~ within the state. The insurer

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1289 may contract with a health insurer for the right to use an
1290 existing preferred provider network to implement the preferred
1291 provider option. Any other arrangement is subject to the
1292 approval of the Office of Insurance Regulation.
1293 (11) ~~(10)~~ DEMAND LETTER.—
1294 (a) As a condition precedent to filing any action for
1295 benefits under this section, the claimant filing suit must
1296 provide the insurer ~~must be provided~~ with written notice of an
1297 intent to initiate litigation. Such notice may not be sent until
1298 the claim is overdue, including any additional time the insurer
1299 has to pay the claim pursuant to paragraph (4)(b). A premature
1300 demand letter is defective and cannot be cured unless the court
1301 first abates the action or the claimant first voluntarily
1302 dismisses the action.
1303 (b) The ~~notice~~ required notice must ~~shall~~ state that it is
1304 a "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with
1305 specificity:
1306 1. The name of the insured upon which such benefits are
1307 being sought, including a copy of the assignment giving rights
1308 to the claimant if the claimant is not the insured.
1309 2. The claim number or policy number upon which such claim
1310 was originally submitted to the insurer.
1311 3. To the extent applicable, the name of any medical
1312 provider who rendered to an insured the treatment, services,
1313 accommodations, or supplies that form the basis of such claim;
1314 and an itemized statement specifying each exact amount, the date
1315 of treatment, service, or accommodation, and the type of benefit
1316 claimed to be due. A completed form satisfying the requirements
1317 of paragraph (6)~~(5)~~(d) or the lost-wage statement previously

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1318 submitted may be used as the itemized statement. ~~To the extent~~
1319 ~~that the demand involves an insurer’s withdrawal of payment~~
1320 ~~under paragraph (7)(a) for future treatment not yet rendered,~~
1321 ~~the claimant shall attach a copy of the insurer’s notice~~
1322 ~~withdrawing such payment and an itemized statement of the type,~~
1323 ~~frequency, and duration of future treatment claimed to be~~
1324 ~~reasonable and medically necessary.~~
1325 (c) Each notice required by this subsection must be
1326 delivered to the insurer by United States certified or
1327 registered mail, return receipt requested. Such postal costs
1328 shall be reimbursed by the insurer if ~~so~~ requested by the
1329 claimant in the notice~~,~~ when the insurer pays the claim. Such
1330 notice must be sent to the person and address specified by the
1331 insurer for the purposes of receiving notices under this
1332 subsection. Each licensed insurer, whether domestic, foreign, or
1333 alien, shall file with the office designation of the name and
1334 address of the person to whom notices must ~~pursuant to this~~
1335 ~~subsection shall~~ be sent which the office shall make available
1336 on its Internet website. The name and address on file with the
1337 office pursuant to s. 624.422 shall be deemed the authorized
1338 representative to accept notice pursuant to this subsection if
1339 ~~in the event~~ no other designation has been made.
1340 (d) If, within 30 days after receipt of notice by the
1341 insurer, the overdue claim specified in the notice is paid by
1342 the insurer together with applicable interest and a penalty of
1343 10 percent of the overdue amount paid by the insurer, subject to
1344 a maximum penalty of $250, no action may be brought against the
1345 insurer. If ~~the demand involves an insurer’s withdrawal of~~
1346 ~~payment under paragraph (7)(a) for future treatment not yet~~

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

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1376 the insurance code.
1377 (h) If the insurer pays in response to a demand letter and
1378 the claimant disputes the amount paid, the claimant must send a
1379 second demand letter by certified or registered mail stating the
1380 exact amount that the claimant believes the insurer owes and why
1381 the claimant believes the amount paid is incorrect. The insurer
1382 has an additional 10 days after receipt of the second letter to
1383 issue any additional payment that is owed. The purpose of this
1384 provision is to avoid unnecessary litigation over miscalculated
1385 payments.
1386 (i) Demand letters may not be used to request the
1387 production of claim documents or other records from the insurer.
1388 Section 10. Paragraph (c) of subsection (7), and
1389 subsections (10) through (12) of section 817.234, Florida
1390 Statutes, are amended to read:
1391 817.234 False and fraudulent insurance claims.—
1392 (7)
1393 (c) An insurer, or any person acting at the direction of or
1394 on behalf of an insurer, may not change an opinion in a mental
1395 or physical report prepared under s. 627.736(8) ~~627.736(7)~~ or
1396 direct the physician preparing the report to change such
1397 opinion; however, this provision does not preclude the insurer
1398 from calling to the attention of the physician errors of fact in
1399 the report based upon information in the claim file. Any person
1400 who violates this paragraph commits a felony of the third
1401 degree, punishable as provided in s. 775.082, s. 775.083, or s.
1402 775.084.
1403 ~~(10) As used in this section, the term “insurer” means any~~
1404 ~~insurer, health maintenance organization, self-insurer, self-~~

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1405 ~~insurance fund, or other similar entity or person regulated~~
1406 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~
1407 ~~Regulation under the Florida Insurance Code.~~
1408 (10) ~~(11)~~ If the value of any property involved in a
1409 violation of this section:
1410 (a) Is less than $20,000, the offender commits a felony of
1411 the third degree, punishable as provided in s. 775.082, s.
1412 775.083, or s. 775.084.
1413 (b) Is $20,000 or more, but less than $100,000, the
1414 offender commits a felony of the second degree, punishable as
1415 provided in s. 775.082, s. 775.083, or s. 775.084.
1416 (c) Is $100,000 or more, the offender commits a felony of
1417 the first degree, punishable as provided in s. 775.082, s.
1418 775.083, or s. 775.084.
1419 (11) In addition to any criminal liability, a person
1420 convicted of violating any provision of this section for the
1421 purpose of receiving insurance proceeds from a motor vehicle
1422 insurance contract is subject to a civil penalty.
1423 (a) Except for a violation of subsection (9), the civil
1424 penalty shall be:
1425 1. A fine up to $5,000 for a first offense.
1426 2. A fine greater than $5,000, but not to exceed $10,000,
1427 for a second offense.
1428 3. A fine greater than $10,000, but not to exceed $15,000,
1429 for a third or subsequent offense.
1430 (b) The civil penalty for a violation of subsection (9)
1431 must be at least $15,000, but may not exceed $50,000.
1432 (c) The civil penalty shall be paid to the Insurance
1433 Regulatory Trust Fund within the Department of Financial

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1434 Services and used by the department for the investigation and
1435 prosecution of insurance fraud.
1436 (d) This subsection does not prohibit a state attorney from
1437 entering into a written agreement in which the person charged
1438 with the violation does not admit to or deny the charges but
1439 consents to payment of the civil penalty.
1440 (12) As used in this section, the term:
1441 (a) “Insurer” means any insurer, health maintenance
1442 organization, self-insurer, self-insurance fund, or similar
1443 entity or person regulated under chapter 440 or chapter 641 or
1444 by the Office of Insurance Regulation under the Florida
1445 Insurance Code.
1446 (b)~~(a)~~ “Property” means property as defined in s. 812.012.
1447 (c)~~(b)~~ “Value” has the same meaning ~~means value~~ as ~~defined~~
1448 in s. 812.012.
1449 Section 11. Subsection (1) of section 324.021, Florida
1450 Statutes, is amended to read:
1451 324.021 Definitions; minimum insurance required.—The
1452 following words and phrases when used in this chapter shall, for
1453 the purpose of this chapter, have the meanings respectively
1454 ascribed to them in this section, except in those instances
1455 where the context clearly indicates a different meaning:
1456 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
1457 is designed and required to be licensed for use upon a highway,
1458 including trailers and semitrailers designed for use with such
1459 vehicles, except traction engines, road rollers, farm tractors,
1460 power shovels, and well drillers, and every vehicle that ~~which~~
1461 is propelled by electric power obtained from overhead wires but
1462 not operated upon rails, but not including any bicycle or moped.

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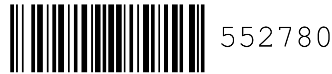
1463 However, the term does ~~“motor vehicle” shall~~ not include a ~~any~~
1464 motor vehicle as defined in s. 627.732~~(3)~~ if ~~when~~ the owner of
1465 such vehicle has complied with the no-fault law ~~requirements of~~
1466 ~~ss. 627.730-627.7405, inclusive~~, unless the provisions of s.
1467 324.051 apply; and, in such case, the applicable proof of
1468 insurance provisions of s. 320.02 apply.
1469 Section 12. Paragraph (k) of subsection (2) of section
1470 456.057, Florida Statutes, is amended to read:
1471 456.057 Ownership and control of patient records; report or
1472 copies of records to be furnished.—
1473 (2) As used in this section, the terms “records owner,”
1474 “health care practitioner,” and “health care practitioner’s
1475 employer” do not include any of the following persons or
1476 entities; furthermore, the following persons or entities are not
1477 authorized to acquire or own medical records, but are authorized
1478 under the confidentiality and disclosure requirements of this
1479 section to maintain those documents required by the part or
1480 chapter under which they are licensed or regulated:
1481 (k) Persons or entities practicing under s. 627.736(8)
1482 ~~627.736(7)~~.
1483 Section 13. Paragraph (b) of subsection (1) of section
1484 627.7401, Florida Statutes, is amended to read:
1485 627.7401 Notification of insured’s rights.—
1486 (1) The commission, by rule, shall adopt a form for the
1487 notification of insureds of their right to receive personal
1488 injury protection benefits under the ~~Florida Motor Vehicle~~ no-
1489 fault law. Such notice shall include:
1490 (b) An advisory informing insureds that:
1491 1. Pursuant to s. 626.9892, the Department of Financial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1492 Services may pay rewards of up to $25,000 to persons providing
1493 information leading to the arrest and conviction of persons
1494 committing crimes investigated by the Division of Insurance
1495 Fraud arising from violations of s. 440.105, s. 624.15, s.
1496 626.9541, s. 626.989, or s. 817.234.
1497 2. Pursuant to s. 627.736(6)(e)1. ~~627.736(5)(e)1.~~, if the
1498 insured notifies the insurer of a billing error, the insured may
1499 be entitled to a certain percentage of a reduction in the amount
1500 paid by the insured's motor vehicle insurer.
1501 Section 14. This act shall take effect July 1, 2011.
1502
1503 ================= T I T L E A M E N D M E N T ================
1504 And the title is amended as follows:
1505 Delete everything before the enacting clause
1506 and insert:
1507 A bill to be entitled
1508 An act relating to motor vehicle personal injury
1509 protection insurance; amending s. 316.066, F.S.;
1510 revising provisions relating to the contents of
1511 written reports of motor vehicle crashes; requiring
1512 short-form crash reports by a law enforcement officer
1513 to be maintained by the officer's agency; authorizing
1514 the investigation officer to testify at trial or
1515 provide an affidavit concerning the content of the
1516 reports; amending s. 400.991, F.S.; requiring that an
1517 application for licensure as a mobile clinic include a
1518 statement regarding insurance fraud; creating s.
1519 626.9894, F.S.; providing definitions; authorizing the
1520 Division of Insurance Fraud to establish a direct-

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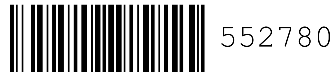
1521 support organization for the purpose of prosecuting,
1522 investigating, and preventing motor vehicle insurance
1523 fraud; providing requirements for the organization and
1524 the organization's contract with the division;
1525 providing for a board of directors; authorizing the
1526 organization to use the division's property and
1527 facilities subject to certain requirements;
1528 authorizing contributions from insurers; providing
1529 that any moneys received by the organization may be
1530 held in a separate depository account in the name of
1531 the organization; requiring the division to deposit
1532 certain proceeds into the Insurance Regulatory Trust
1533 Fund; amending s. 627.4137, F.S.; requiring a
1534 claimant's request about insurance coverage to be
1535 appropriately served upon the disclosing entity;
1536 amending s. 627.730, F.S.; conforming a cross-
1537 reference; amending s. 627.731, F.S.; providing
1538 legislative intent with respect to the Florida Motor
1539 Vehicle No-Fault Law; creating s. 627.7311, F.S.;
1540 requiring the provisions, schedules, and procedures of
1541 the no-fault law to be implemented by insurers
1542 regardless of whether they are expressly stated in the
1543 policy; amending s. 627.732, F.S.; defining the terms
1544 "claimant" and "no-fault law"; amending s. 627.736,
1545 F.S.; conforming a cross-reference; adding
1546 acupuncturists to the list of authorized
1547 practitioners; requiring certain entities providing
1548 medical services to document that they meet required
1549 criteria; revising requirements relating to the form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1550 that must be submitted by providers; requiring an
1551 entity or clinic to file a new form within a specified
1552 period after the date of a change of ownership;
1553 revising provisions relating to when payment for a
1554 benefit is due; providing that an insurer’s failure to
1555 send certain specification or explanation does not
1556 waive other grounds for rejecting an invalid claim;
1557 authorizing an insurer to obtain evidence and assert
1558 any ground for adjusting or rejecting a claim;
1559 providing that the time period for paying a claim is
1560 tolled during the investigation of a fraudulent
1561 insurance act; specifying when benefits are not
1562 payable; preempting local lien laws with respect to
1563 payment of benefits to medical providers; providing
1564 that a claimant that violates certain provisions is
1565 not entitled to any payment, regardless of whether a
1566 portion of the claim may be legitimate; authorizing an
1567 insurer to recover payments and bring a cause of
1568 action to recover payments; providing that an insurer
1569 may deny any claim based on other evidence of fraud;
1570 forbidding a physician, hospital, clinic, or other
1571 medical institution that fails to comply with certain
1572 provisions from billing the injured person or the
1573 insured; providing that an insurer has a right to
1574 conduct reasonable investigations of claims;
1575 authorizing an insurer to require a claimant to
1576 provide certain records; requiring a records review to
1577 be conducted by the same type of practitioner as the
1578 medical provider whose records are being reviewed or

1579 by a physician; specifying when the period for payment
1580 is tolled; authorizing an insurer to deny benefits if
1581 an insured, claimant, or medical provider fails to
1582 comply with certain provisions; forbidding the
1583 claimant from filing suit unless the claimant complies
1584 with the act; revising the insurer’s reimbursement
1585 limitation; providing a limit on the amount of
1586 reimbursement; creating a rebuttable presumption that
1587 the insured did not receive the alleged treatment if
1588 the insured does not countersign the patient log;
1589 authorizing the insurer to deny a claim if the
1590 provider does not properly complete the required form
1591 within a certain time; requiring the provider to
1592 ensure that the insured understands the services being
1593 provided; specifying requirements for furnishing the
1594 insured with notice of the amount of covered loss;
1595 deleting an obsolete provision; requiring the provider
1596 to provide copies of the patient log within a certain
1597 time if requested by the insurer; providing that
1598 failure to maintain a patient log renders the
1599 treatment unlawful and noncompensable; revising
1600 requirements relating to discovery; authorizing the
1601 insurer to conduct a physical review of the treatment
1602 location; requiring the insured and assignee to comply
1603 with certain provisions to recover benefits; requiring
1604 the provider to produce persons having the most
1605 knowledge in specified circumstances; requiring the
1606 insurer to request certain information before
1607 requesting an assignee to participate in an

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