The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	SB 1930
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1930 revises the Florida Motor Vehicle No-Fault Law (No-Fault Law) and related statutory provisions. The bill:

- Requires law enforcement officers to use the *Florida Traffic Crash Report—Long Form* in accidents involving passengers or passenger complains of pain or discomfort.
- Requires an "Insurance Fraud Notice" to be included within the application for health care clinic licensure.
- Establishes the Fight Auto Fraud Fund direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud.
- Requires requests for the disclosure of liability insurance information made to a self-insured corporation to be sent by certified mail to the entity's registered agent.
- Creates additional language expressing the Legislative intent of the Florida Motor Vehicle No-Fault Law.
- Defines "Claimant" to mean the person, organization, or entity seeking benefits, including all assignees.
- Revises provisions regarding Personal Injury Protection (PIP) policies offering a Preferred Provider (PPO) option for medical benefits. The bill authorizes motor vehicle insurers to contract with a health insurer to use its existing PPO network. The bill authorizes insurers to offer a discount to policyholders that select a policy that uses a PPO network to provide PIP benefits and specify that reimbursement will only be provided to network providers.
- Requires a clinic or entity that initially submits a PIP claim to an insurer to include a sworn affidavit that documents it is eligible to receive reimbursement.

- Requires the insured and a medical provider that accepts an assignment of no-fault benefits to comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO).
- Revises provisions related to demand letters.
    - The claimant filing suit must submit the demand letter.
    - A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - Demand letters may not be used to request record production from the insurer.
    - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are properly completed in their entirety.
- Requires health care providers to provide disclosures and patient logs to the injured person describing treatment in readable language. The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer.
- Clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.
- States that the insurer may define in the insurance policy what constitutes "reasonable proof" that the insurer is not liable to provide PIP benefits.
- Tolls the 30-day period for payment if the insurer reasonably believes a fraudulent insurance act was committed. The insurer must investigate and reach a claims decision within 120 days.
- Prohibits a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate.
- Prohibits a provider from billing the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts.
- Authorizes the insurer to require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer.
- Creates a rebuttable presumption that the injured party's failure to appear for a mental or physical examination was unreasonable. The insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination.
- Authorizes an insurer to conduct an on-site physical review and examination of the treatment location.
- Specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider.
- Prohibits a claimant from filing suit until it complies with the insurer's investigation.
- Provides that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement.

The bill is effective upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.991, 627.4137, 627.730, 627.731, 627.732, 627.736, 324, 324.021, 456.057, 627.7401, and 817.234.

This bill creates the following section of the Florida Statutes: 626.9894

II. Present Situation:

Florida Motor Vehicle No-Fault Law
Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[1] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation
- or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

[1] (Chapter 2007-324, L.O.F.)

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[4]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 hundred PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] The NICB defines a "questionable claim" as one in which indications of the behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[4] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies with law enforcement

description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division of Insurance Fraud have identified the following as sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,[5] that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers and that. A dissent in the case stated that the policy required the medical provider to submit to an examination under oath because the State Farm policy clearly stated that the medical provider must submit to an EUO under the State

[5] *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Demand Letter

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of an intent to initiate litigation. The notice must include an itemized statement detailing the exact amount and type of treatment asserted to be due. If the insurer pays the claim within 30 days (with interest and penalty) after receiving the demand letter then no action may be brought against the insurer. A suit may not be filed to obtain benefits and potentially collect attorney's fees until the end of this 30-day period.

Florida Uniform Crash Reports

Section 316.066, F.S., provides that a Florida Traffic Crash Report-Long Form must be completed and submitted to the Department within 10 days after an investigation by every law enforcement who, in the regular course of duty, investigates a motor vehicle crash that resulted in death or personal injury, that involved a violation of s. 316.061(1), F.S., or s. 316.193, F.S., and in which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if the action is appropriate, in the officer's discretion. For every crash for which a Florida traffic crash report long form is not required by s. 316.066, F.S., the law enforcement officer may complete a short form crash report or provide a short form crash report to be completed by each party involved in the crash.

Health Care Clinic Licensure

The Health Care Clinic Licensure Act (ss. 400.990-400.995, F.S.) was enacted by the 2003 Legislature for the purpose of preventing cost and harm to consumers by providing for the licensure, establishment and enforcement of basic standards for health care clinics. The definition of a health care "clinic" is expansive: "an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider."[6] However, the statute contains a multitude of exemptions from licensure. For instance, an entity owned by a Florida-licensed health care practitioner or by a Florida-licensed health care facility is exempt from the clinic licensure requirements. Furthermore, clinic exemptions are voluntary and the Agency for Health Care Administration (AHCA) has no statutory authority to verify that an entity qualifies for an exemption as claimed. As of January 20, 2011, there were 3,417 licensed health care clinics and 7,956 exemptions from licensure.

An applicant[7] for clinic licensure must submit to and pass a level 2 background screening pursuant to section 435.04, Florida Statutes, which requires taking fingerprints of each applicant and conducting a statewide criminal history check through the Department of Law Enforcement (FDLE) and national criminal history check through the Federal Bureau of Investigation (FBI).

[6] Section 400.9905(4), F.S.
[7] An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.

AHCA also reviews the finances of the proposed clinic and inspects the facility to verify that the proposed clinic complies with licensure requirements.

Direct Support Organizations

A direct service organization (DSO) collects funds through grants, donations and other sources, and distributes them to entities that will use the funds to further a legislative purpose. Florida's nondelegation doctrine derives from Article II, Section 3 of the Florida Constitution and prohibits one branch of government from encroaching on another branch's power and also prohibits any branch from delegating its constitutionally assigned powers to another branch.[8] Accordingly, a DSO cannot exceed its grant of statutory authority. Additionally, as a statutorily created organization, the DSO is subject to the Government in the Sunshine law under ch. 119, F.S.[9] Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within five months after the end of the fiscal year.[10]

III. Effect of Proposed Changes:

Section 1. Amends s. 316.066(1), F.S., to require the law enforcement officer investigating a motor vehicle crash to use the *Florida Traffic Crash Report—Long Form* if passengers are in any of the vehicles involved in the crash or any party or passenger complains of pain or discomfort. The long-form and short-form crash report must also list the names and addresses of all passengers involved in the crash and identify the vehicle where the passenger was located. The bill also specifies that the investigating officer may testify at trial or provide a signed affidavit to confirm or supplement the information on the long-form or short-form report.

Section 2. Amends s. 400.991(6), F.S., to require an "Insurance Fraud Notice" to be included within the application for health care clinic licensure and the application for an exemption from such licensure. The notice states that submitting a false, misleading, or fraudulent application or document when applying for health care clinic licensure, seeking an exemption from licensure, or demonstrating compliance with Part X of ch. 400, F.S. (the Health Care Clinic Act) is a fraudulent insurance act pursuant to s. 626.989, F.S. Such act is subject to investigation by the Division of Insurance Fraud and grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Creates s. 626.9894, F.S., establishing the Fight Auto Fraud Fund (Fund) direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The Fund will operate under a written contract with the Division of Insurance Fraud that requires the division to approve the Fund's articles of incorporation and bylaws, approve the annual budget, and certify that the Fund is complying with the terms of the contract

[8] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla.2005)
[9] *See* s. 119.011(2), F.S. (defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, *or other separate unit of government created or established by law including, for the purposes of this chapter*, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, *and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency*.") (emphasis added). See also *Crespo v. Florida Entertainment Direct Support Organization, Inc*., 674 So.2d 154 (Fla. 3rd DCA 1996).
[10] *See* ss. 11.45, 215.981, F.S.

and consistent with the goals of the DFS and best interests of the state. The Fund's contract with the Division of Insurance Fraud must provide for the allocation of monies to address motor vehicle fraud and the reversion of money and property held in trust by the Fund if it ceases to exist.

The Fund must be a not-for-profit corporation under ch. 617, F.S., and use all of its grants and expenditures solely to prevent and decrease motor vehicle insurance fraud. The fund is authorized to obtain money and property necessary to conduct its mission to allocate monies to address motor vehicle fraud in the following ways:

- Raise funds;
- Request and receive grants, gifts, and bequests of money; and
- Acquire, receive, hold, invest, and administer securities, funds, and real or personal property.

The Fund may make grants and expenditures that directly or indirectly benefit the Division of Insurance Fraud, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration (AHCA), and the Department of Health. Grants or expenditures made by the Fund must be used exclusively to prevent, investigate, and prosecute motor vehicle insurance fraud. Proper grants and expenditure include the salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel so long as the money does not interfere with prosecutorial independence or create conflicts of interest that threaten the prosecution's success.

Moneys received by the Fund may be held in a separate depository account in the Fund's name but are subject to the written contract with the Division of Insurance Fraud. The DFS is authorized to permit the Fund to use department property without expense and is granted rulemaking authority to prescribe the procedures and conditions for use of department property. Use of grants or expenditures to lobby is prohibited and the Fund is subject to an annual financial audit. All contributions made by an insurer are allowed as an appropriate business expense for regulatory purposes.

The Fund will have a 7-member board of directors consisting of the Chief Financial Officer (or designee), two state attorney's appointed by the Attorney General, two representatives of motor vehicle insurers appointed by the Chief Financial Officer, and two representatives of local law enforcement agencies (the CFO and Attorney General each get one appointment). Board-members serve a 4 year term, until the appointing officer leaves office, or until the member ceases to be qualified. The Fund's contract must provide criteria for use by the Fund's board of directors to evaluate the effectiveness of the Fund's spending to combat fraud.

Section 4. Amends s. 627.4137, F.S., which requires an insurer to provide a sworn disclosure setting forth information regarding each known policy providing liability insurance that may be available to pay a claim. The sworn statement must include the names of the insurer and each insured, the liability coverage limits, a copy of the policy, and a statement of all defenses the insurer reasonably believes it has. The bill requires requests for the disclosure made to a self-insured corporation must be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Amends s. 627.730, F.S., to clarify that s. 627.7407, F.S., is part of the Florida Motor Vehicle No-Fault Law.

Section 6. Amends s. 627.731, F.S., to create additional intent language for the Florida Motor Vehicle No-Fault Law. Current law states that the purpose of the no-fault law is to require motor vehicle insurance that provides specified benefits without regard to fault, to require the registration of motor vehicles, and create a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. The bill expands upon this language by stating that the Legislature intends to balance the insured's interest in prompt claim payment with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. Accordingly, the investigation and prevention of fraudulent insurance acts must be enhanced, additional sanctions for such acts must be imposed. The intent language also specifies how the Legislature intends the no-fault law to be interpreted. The no-fault law should be construed according to the plain language of the statutory provisions, which are designed to meet the goals specified by the legislature.

The Legislature provides two findings of fact within the intent language. The first is that automobile insurance fraud remains a major problem for state consumers, as evidenced by the National Insurance Crime Bureau's finding that the state is amongst those with the highest number of fraudulent and questionable clams. The second finding of fact is that the current regulatory process for health care clinics is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance.

The intent language concludes with statements of legislative intent regarding various provisions of the bill:

- The provisions, schedules and procedures authorized under the no fault law are effective regardless of their express inclusion in an insurance policy, and an insurer need not amend its policy to implement them.
- In order to properly investigate a claim, the insurer must be able to take pre-litigation examinations under oath and sworn statements of claimants and request mental and physical examinations of persons seeking PIP coverage or benefits.
- Any false, misleading, or fraudulent activity renders the entire claim invalid. Insurers must be able to raise fraud as a defense to a PIP claim when there has not been an adjudication of guilt or a determination of fraud by the DFS.
- Insurers should toll the payment or denial of a claim if the insurer reasonably believes that a fraudulent insurance act has been committed.
- A rebuttable presumption must be established that a person was not involved in a motor vehicle accident if that person's name is not in the police report.
- Courts should limit attorney fee awards to eliminate the incentive for attorneys to manufacture unnecessary litigation because the insured's interest in obtaining competent counsel should be balanced with the public's interest in a no-fault system that does not encourage unnecessary litigation.

Section 7. Amends s. 627.732, F.S., to define "claimant" and "No-Fault Law" within the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7407, F.S.). "Claimant" means the person, organization, or entity seeking benefits, including all assignees. Medical providers that accept an

assignment of benefits from the insured will be claimants under the No-Fault Law and subject to all statutory provisions related to a claimant under the law.

Section 8. Amends s. 627.736, F.S., which contains the statutory provisions governing the provision of Personal Injury Protection insurance coverage. The bill makes numerous revisions, which are detailed and explained herein.

Benefits – No-Fault Preferred Provider Networks [s. 627.736(10), F.S.]

Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" (PPO) option. However, if the insured uses an "out-of-network" provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law. The current PPO option does little to reduce PIP costs because there is no incentive for the insured to utilize network providers and thus little incentive for medical providers to contract with the PIP insurer. Additionally, many motor vehicle insurance carriers lack the expertise to create the medical provider network necessary to offer a preferred provider option.

The bill modifies the no-fault preferred provider option by authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider. If a premium discount is provided, the insurer may restrict reimbursement of non-emergency services to members of the preferred provider network unless there are no network providers within 15 miles of the insured's place of residence. The insurer may contract with a health insurer to use an existing preferred provider network, with any other arrangement subject to OIR approval.

Assignment of Benefits [s. 627.736(7)(b), F.S.]

The bill states that a medical provider that accepts an assignment of no-fault benefits from an insured, the medical provider and the insured must comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO). Compliance is a condition precedent to recovering benefits under the no-fault law.

Provider Billing Submissions – Notice of Licensure Compliance [s. 627.736(1)(a), F.S.]

A clinic or entity that initially submits a PIP claim to an insurer must include a sworn affidavit that documents that the entity or clinic is eligible to receive reimbursement for the treatment of bodily injuries covered by PIP insurance. The following entities must execute the affidavit:

- An entity that is wholly owned by one or more licensed physicians, chiropractors, or dentists or by the spouse, parent, child, or sibling of such medical practitioners.
- Wholly owned by a hospital or hospitals.
- A licensed health care clinic.

The affidavit must be executed on a form adopted by the DFS. If the entity or clinic changes ownership, a new sworn affidavit must be provided to the insurer within 10 days.

Provider Billing Submissions – Proper Submission of Billing Required for Insurer to Have Notice [s. 627.736(6)(d), F.S.]

The bill specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are submitted on an approved form, follow the proper coding requirements, and contain the professional license number of the provider. The remaining portions of statements and bills must be properly completed in their entirety. Current law contains a less stringent standard requiring bills and statements to be properly completed in their entirety "as to all material provisions, with all relevant information being provided therein."

Section 627.736(6)(c), F.S., generally requires health care providers to submit a statement of charges within 35 days of when the treatment was rendered. If a provider fails to submit the billing within the time frame, the insurer is not required to provide payment. Accordingly, if a provider fails to meet the bill's requirement to property submit a bill, the insurer will not be considered to have notice of the bill and the provider may be unable to obtain reimbursement for such services.

Provider Billing Submissions – Initial Disclosure Form and Patient Treatment Log [s. 627.736(6)(e), F.S.]

Current law requires a medical provider providing treatment for bodily injury covered by PIP insurance to obtain at the initial treatment a disclosure form of the insured's rights that details the treatment to be provided and is signed by the injured person and subsequently countersigned by the injured person verifying that the treatment was rendered. The disclosure and acknowledgement form is not required for emergency services or for ambulance transport and treatment. For subsequent treatments, the provider must maintain a patient log of services rendered in chronological order.

The bill states that the insurer does not have notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgement form is provided to the insurer with the countersignature of the insured and accurately describes the services rendered as required by s. 627.736(6)(e)1.a., F.S. The services rendered must be described on the form in a in a manner readable by the insured; listing billing codes is not allowed. The provider must determine whether the insured can read the disclosure. If not, the provider must verify, under penalty of perjury, that the services were verbally explained to the insured.

The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer. If the provider does not maintain a patient log, the treatment is unlawful and noncompensable. The patient log must describe subsequent services rendered in readable language; listing billing codes is not allowed.

Claim Payments – PIP Fee Schedule [s. 627.736(6)(a)2., F.S.]

The bill clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.

Claim Payments – Reasonable Proof [s. 627.736(4)(d), F.S.]

Under current law, a claims payment is not overdue if the insurer has reasonable proof that it is not responsible for payment. "Reasonable proof" is not defined in statute. The bill states that "reasonable proof" may be defined in the insurance policy and says an insurer may request information that will aid it in its claim investigation.

Insurer Investigation of Possible Fraudulent Insurance Acts [s. 627.736(4)(d), F.S.]

The 30-day period for payment is tolled during the insurer's investigation of a fraudulent insurance act, as defined in s. 626.989, F.S., for any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify that claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date the insurer has a reasonable belief the act was committed. The insurer must pay or deny the claim within 120 days.

Benefits are not due to a claimant who submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate. The insurer may recover sums previously paid to such claimants and bring a common law and statutory cause of action against the claimant if the fraud is admitted to in a sworn statement or established in court. Insurance fraud voids all coverage arising for the claim and all claims for attorneys fees, regardless of whether a portion of the claim is legitimate.

The insurer may recover any benefits or attorney's fees paid before the discovery of fraud. The paragraph does not preclude or limit the insurer's right to deny a claim on other evidence of fraud and to prove a claim or defense of fraud under common law. The injured party is not liable for fraudulent acts committed by a physician, hospital, clinic, or other medical institution. The provider not bill the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts in paragraph (j).

Insurer Investigations – Records Review [s. 627.736(5), F.S.]

The bill states that the insurer had the right and duty to reasonably investigate the claim. As part of the insurer's claim investigation, it may require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer. The insurer's choice of physician to conduct the records review is not limited by the physician's practice area or licensing chapter. The records review tolls the 30-day period for payment from the date the insurer sends a request for treatment records to the date the insurer receives the treatment records.

Insurer Investigations – Examinations Under Oath [s. 627.736(7)(b), F.S.]

A medical provider that accepts an assignment of benefits must submit to an examination under oath upon the request of the insurer. The provider must produce the persons having the most knowledge of the issues identified by the insurer in the EUO request. All claimants (the person

receiving treatment and the provider) must produce and provide for inspection all reasonably obtainable documents requested by the insurer. The EUO may be recorded by audio, video, or court reporter. Unreasonably requesting EUOs as a general practice is an unfair or deceptive trade practice.

Insurer Investigations – Mental & Physical Examination of Insured [s. 627.736(8), F.S.]

Current law authorizes the insurer to require an injured person to submit to a mental or physical examination whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future PIP insurance benefits. The bill specifies that the insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination. The bill also creates a rebuttable presumption that the injured party's failure to appear for an examination was unreasonable.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 53 Fla. L. Weekly S640 (Fla. 2010). In Custer, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Insurer Investigations – On-Site Inspection of Medical Provider [s. 627.736(7)(b), F.S.]

The bill authorizes each insurer to conduct an on-site physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and medical equipment used for services rendered within 10 days of the insurer's request.

Claim Denial – Grounds for Denying a PIP Claim or Refusing a Provider Billing [s. 627.736(5), F.S.]

The bill specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider. The insurer may deny a claim or reduce reimbursement if:

- The medical provider fails to maintain adequate records that would allow the insurer to obtain a records review.
- The insured, claimant, or medical provider fails to comply with the statutory requirements for a records review.
- The insured, claimant, or medical provider fails to cooperate in the insurer's investigation.
- The insured, claimant, or medical provider commits a fraud or material misrepresentation.

The claimant may not file suit:

- Until the records review is completed;

- If the claimant fails to cooperate with the insurer's claim investigation; or
- The claimant commits fraud or makes a material misrepresentation.

Under current law, subsection (6) specifies when the insurer or insured is not required to pay a claim or charges. The bill provides that the insurer or insured is not required to make a payment if the insured has not countersigned the billing forms and patient logs. The bill also states the insurer need not pay a bill or statement that does not comply with the billing requirements of subsections (c), (d), or (e). Subsection (c) generally requires the provider to submit a statement of charges to the insurer within 35 days of providing treatment. Subsection (d) requires the use of specified forms and practice codes when submitting a bill to the insurer. Subsection (e) directs the provider to require the insured person to execute a signed disclosure form during the initial treatment and to obtain the patient's countersignature on a treatment log that describes subsequent treatments.

Claim Denial – Insurer's Itemized Specification of Reduced or Denied Benefits [s. 627.736(4)(c), F.S.]

The bill states that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement. Current law requires an insurer that denies or only pays a portion of a PIP claim to provide an itemized specification of each item the insurer declined to pay or denied. The itemized specification includes information the insurer wants the claimant to consider related to the medical necessity of the treatment or to explain why the insurer was reasonable in reducing the charge, provided the information does not limit the introduction of evidence at trial.

Demand Letters [s. 627.736(11), F.S.]

Under current law, the claimant must provide a written demand letter specifying the PIP benefits and amounts that the claimant asserts are due under the policy prior to filing suit. If the insurer pays the overdue claim specified in the demand letter with interest and a 10 percent penalty, the claimant may not file suit. The bill modifies the demand letter requirement as follows:

- The claimant filing suit must submit the demand letter.
- A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - A defective demand letter cannot be cured unless the court abates the action or the claimant voluntarily dismisses the action.
    - If the insurer pays the benefits during abatement or dismissal, the insurer is not liable for attorney's fees.
- If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Demand letters may not be used to request record production from the insurer.
- Removes the requirement that a demand letter involving future treatment must include the insurer's notice of withdrawing payment for future treatment. Under current law, the insurer

may withdraw patient for a treating physician if the insurer retains a physician under that performs a mental or physical examination of the patient pursuant to s. 627.736(7), F.S., and the physician reports that the treatment is not reasonable, related, or necessary.

Section 9. Amends s. 324.021, F.S., by making technical, conforming changes to the definition of "motor vehicle" in the financial responsibility law.

Section 10. Amends s. 456.057(2)(k), F.S., by making a technical conforming change to a statutory reference.

Section 11. Amends s. 627.7401(1)(b), F.S., by making technical conforming changes to statutory references.

Section 12. Amends s. 817.234(7)(c), F.S., by making a technical conforming change to a statutory reference.

Section 13. The act is effective July 1, 2011.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

To the extent that the bill's provisions are effective in reducing motor vehicle insurance fraud, policyholders will benefit through a reduction in rates for such insurance.

C. Government Sector Impact:

The Fight Auto Fraud direct support organization may increase funding to the Division of Insurance Fraud and other law enforcement agencies to combat motor vehicle insurance fraud.

The Department of Highway Safety and Motor Vehicles states that the requirement to utilize the long-form traffic crash report when passengers are involved in an accident or there are indications that a party to the accident is experiencing pain or discomfort will create additional costs for the department. Based on historical trends, this change could increase the number of long form crash reports received by the department by approximately 90,000 per year. In 2009, the department received 76,258 short form reports that included one or more passengers involved in the accident. Based on estimates and the department's current contract for processing crash reports, the new requirements could cost the department to process the additional reports an estimated $104,687 per year. The department further estimates an additional 45,000 hours per year of time would be needed by officers of the state to complete the long form as opposed to the time it takes to complete the shot form.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.