A bill to be entitled

An act relating to personal injury protection insurance; amending s. 26.012, F.S.; providing that the circuit court has exclusive original jurisdiction in actions involving challenges to arbitration decisions under the Florida Motor Vehicle No-Fault Law; amending s. 627.4137, F.S.; requiring requests made to a self-insured corporation for disclosure of certain information to be by certified mail; creating s. 627.7311, F.S.; providing for the effect of specified statutory provisions, schedules, and procedures on insurance policies; amending s. 627.736, F.S.; requiring an insured seeking benefits to comply with policy terms as a condition precedent to receiving benefits; revising a reference to Medicare Part B payments as the schedule for an insurer's discretionary use when limiting reimbursement of certain medical services, supplies, and care; specifying the Medicare fee schedule or payment limitation that is to be used by an insurer to limit reimbursements for certain medical services, supplies, and care; requiring that an insurer under certain circumstances notify a provider of an improperly completed form and provide an opportunity to submit a completed form within a specified time; requiring any assignee of benefits or payments to cooperate under the terms of the policy; requiring a provider who is assigned the benefits of an insured to submit to examination under oath under certain circumstances; requiring a provider to produce certain knowledgeable individuals for examination

under oath under certain circumstances; requiring certain records be provided by claimants for inspection if requested by an insurer; authorizing methods for recording examinations under oath; providing that certain actions by an insurer constitute an unfair and deceptive trade practice; subjecting insurers to penalties for an unfair and deceptive trade practice; creating a presumption relating to failing to appear for an examination; specifying that submitting to an examination is a condition precedent to receiving benefits; providing for application relating to attorney's fees; limiting the amount of recoverable attorney's fees; prohibiting the use of a contingency risk multiplier when calculating attorney's fees; authorizing binding arbitration as a policy provision for dispute resolution; providing requirements and procedures relating to arbitration; providing for the recovery of specified attorney's fees and costs in arbitration; providing for a judicial challenge of an arbitration decision; providing for the scope of review relating to such challenge; providing that s. 627.428, F.S., relating to attorneys' fees, does not apply to a challenge of an arbitration decision; prohibiting the accrual of interest during litigation of such challenge under certain circumstances; providing an effective date.

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

Section 1. Subsection (2) of section 26.012, Florida Statutes, is amended to read:

26.012 Jurisdiction of circuit court.—

(2) The circuit court ~~They~~ shall have exclusive original jurisdiction:

(a) In all actions at law not cognizable by the county courts.~~;~~

(b) Of proceedings relating to the settlement of the estates of decedents and minors, the granting of letters testamentary, guardianship, involuntary hospitalization, the determination of incompetency, and other jurisdiction usually pertaining to courts of probate.~~;~~

(c) In all cases in equity including all cases relating to juveniles except traffic offenses as provided in chapters 316 and 985.~~;~~

(d) Of all felonies and of all misdemeanors arising out of the same circumstances as a felony which is also charged.~~;~~

(e) In all cases involving legality of any tax assessment or toll or denial of refund, except as provided in s. 72.011.~~;~~

(f) In actions of ejectment.~~; and~~

(g) In all actions involving the title and boundaries of real property.

(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, where arbitration is initiated pursuant to s. 627.736(18) and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant to this section shall be sent by certified mail to the registered agent of the disclosing entity.

Section 3. Section 627.7311, Florida Statutes, is created to read:

627.7311 Effect of law on policies.—The provisions, schedules, and procedures authorized in ss. 627.730-627.7405 shall be implemented by the insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Law. These provisions, schedules, and procedures have full force and effect regardless of their express inclusion in an insurance policy, and an insurer is not required to amend its policy to implement and apply such provisions, schedules, or procedures.

Section 4. Paragraph (i) is added to subsection (4) of section 627.736, Florida Statutes, paragraphs (a) and (d) of subsection (5), paragraph (b) of subsection (6), paragraph (b) of subsection (7), and subsection (8) of that section are amended, and subsections (17) and (18) are added to that section, to read:

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

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are

covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(i) In all circumstances, an insured seeking benefits under ss. 627.730-627.7405 must comply with the terms of the policy, which includes, but is not limited to, submitting to examinations under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)~~1.~~ Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such ~~a~~ charge may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. When

determining ~~With respect to a determination of~~ whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1.~~2.~~ The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

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

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

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

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

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

outpatient services.

f. For all other medical services, supplies, and care, including durable medical equipment, care, and services rendered by a clinical laboratory, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, or if the care and services are rendered in an ambulatory surgical center, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on January 1 of the year in which ~~at the time~~ the services, supplies, or care was rendered and for the area in which such services were rendered, and shall apply throughout the remainder of the year, notwithstanding any subsequent changes made to such fee schedule or payment limitation, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply any limitation on the number of treatments or other

utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. ~~2.~~ must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is ~~would be~~ entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

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

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology

(CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A ~~No~~ statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~ considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein. If an insurer denies a claim under this section due to the failure of a provider to provide a properly completed form required by this paragraph, the insurer shall notify the provider as to the provisions that were improperly completed and shall give the provider 15 days to submit a completed form.

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if~~; provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial. Such sworn statement must ~~shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs

connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~ overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

1. If an insured seeking to recover benefits under ss. 627.730-627.7405 assigns the contractual right to those benefits or the payment of those benefits to any person or entity, the assignee shall comply with the terms of the policy. In all circumstances, the assignee shall be obligated to cooperate under the policy, which includes, but is not limited to, participation in an examination under oath. For time spent in an examination under oath, the assignee is entitled to reasonable compensation from the insurer. Compliance with this paragraph is a condition precedent to the recovery of benefits under ss. 627.730-627.7405. If an insurer requests an examination under oath of a medical provider, the provider must produce those individuals with the most knowledge of the issues identified by

the insurer in the request for examination under oath. All claimants must produce and provide for inspection all documents requested by the insurer that are reasonably obtainable by the claimant. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof.

2. Prior to requesting that an assignee participate in an examination under oath, the insurer must provide a written request of the assignee for all information that the insurer believes is necessary to the processing of the claim, including the information contemplated in subparagraph 1. An assignee is not relieved from the provisions of this subparagraph simply by providing the information contemplated in subparagraph 1.

3. Any insurer that, as a general practice, requests examinations under oath without a reasonable basis is engaging in an unfair and deceptive trade practice.

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

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

examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for ~~subsequent~~ personal injury protection benefits incurred after the date of the requested examination. Failure to appear for an examination raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to receiving benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.—With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 ~~shall~~ apply, except as provided in subsections (10) and (15) and except that any attorney's fees recovered are limited to the lesser of $10,000 or three times any disputed amount recovered by the attorney under ss. 627.730-627.7405. Attorney's fees in a class action under ss. 627.730-627.7405 are limited to the lesser of $50,000 or three times the total of any disputed amount recovered in the class action proceeding.

(17) ATTORNEY'S FEES.—Notwithstanding s. 627.428, the attorney's fees recovered under ss. 627.730-627.7405 shall be calculated without regard to any contingency risk multiplier.

(18) ARBITRATION.—In order to provide for an expedited,

cost-effective, and fair resolution of disputes arising from contracts for personal injury protection benefits, an insurer may offer a policy that requires or allows the insurer or claimant to demand arbitration of any claims dispute involving personal injury protection benefits prior to filing a lawsuit and in lieu of litigation. Arbitration is subject to the Florida Arbitration Code, except as otherwise provided in this section. In addition:

(a) A demand for arbitration must be made in writing by certified mail, and the arbitration must be held within 60 days after the receipt of a request for arbitration. The 60-day period may not be tolled for discovery of documents pursuant to paragraph (d).

(b) Arbitration shall take place in the county in which the treatment was rendered. If treatment was rendered outside the state, arbitration shall take place in the county in which the insured resides unless the parties agree to another location.

(c) The arbitration shall be conducted by a single arbitrator selected by the chief judge of the judicial circuit in which the arbitration is being held.

(d)1. The claimant shall make available for inspection or copying the medical and other records on which the claimant intends to rely at arbitration, upon written request by the insurer or his or her attorney, within 15 days after receipt of such request.

2. The insurer shall make available for inspection or copying all documents, records, or information upon which it is

relying in adjusting or rejecting the claim, upon written request by the claimant or his or her attorney, within 10 days after receipt of such request.

3. Discovery of insurer documents, records, or information shall be limited to those relating to insurance coverage. The insurer is not required to produce claims-privileged items, underwriting files, or documents that it does not intend to rely on at arbitration.

4. There shall be no discovery relating to general claims-handling practices.

(e) The decision of the arbitrator shall be set forth in writing and furnished to each party within 30 days after the arbitration. The decision shall be binding on each party unless challenged pursuant to paragraph (g). An arbitration award may not exceed the applicable limits of coverage remaining on the policy.

(f) The claimant is entitled to reimbursement of attorney's fees directly associated with the arbitration, subject to subsection (8). The award of fees must be set forth in the arbitration decision. The insurer shall bear all reasonable costs directly associated with the arbitration process.

(g)1. A party may challenge the arbitration decision by filing a complaint in circuit court within 20 days after the receipt of the arbitration decision.

2. Review of the arbitration shall be de novo.

3. Section 627.428 does not apply, and interest on the amount in dispute may not accrue during the course of

litigation, if the insurer has tendered payment of the amount of the arbitration award to the claimant.

Section 5. This act shall take effect July 1, 2011.