1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; amending s. 316.066, F.S.;
4 revising the conditions for completing the long-form
5 traffic crash report; revising the information
6 contained in the short-form and long-form reports;
7 revising the requirements relating to the driver's
8 responsibility for submitting a report for crashes not
9 requiring a law enforcement report; amending s.
10 400.9905, F.S.; providing that certain entities exempt
11 from licensure as a health care clinic must
12 nonetheless be licensed in order to receive
13 reimbursement for the provision of personal injury
14 protection benefits; amending s. 400.991, F.S.;
15 requiring that an application for licensure, or
16 exemption from licensure, as a health care clinic
17 include a statement regarding insurance fraud;
18 amending s. 626.989, F.S.; providing that knowingly
19 submitting false, misleading, or fraudulent documents
20 relating to licensure as a health care clinic, or
21 submitting a claim for personal injury protection
22 relating to clinic licensure documents, is a
23 fraudulent insurance act under certain conditions;
24 amending s. 626.9541, F.S.; specifying an additional
25 unfair claim settlement practice; creating s.
26 626.9895, F.S.; providing definitions; authorizing the
27 Division of Insurance Fraud of the Department of
28 Financial Services to establish a direct-support

29 organization for the purpose of prosecuting,
30 investigating, and preventing motor vehicle insurance
31 fraud; providing requirements for, and duties of, the
32 organization; requiring that the organization operate
33 pursuant to a contract with the division; providing
34 for the requirements of the contract; providing for a
35 board of directors; authorizing the organization to
36 use the division's property and facilities subject to
37 certain requirements; requiring that the department
38 adopt rules relating to procedures for the
39 organization's governance and relating to conditions
40 for the use of the division's property or facilities;
41 authorizing contributions from insurers; authorizing
42 any moneys received by the organization to be held in
43 a separate depository account in the name of the
44 organization; requiring that the division deposit
45 certain proceeds into the Insurance Regulatory Trust
46 Fund; creating s. 627.7311, F.S.; specifying the
47 effects of the Florida Motor Vehicle No-Fault Law;
48 requiring compliance with provisions regardless of
49 their expression in policy forms; amending s. 627.732,
50 F.S.; providing definitions; amending s. 627.736,
51 F.S.; revising the cap on benefits to provide that
52 death benefits are in addition to medical and
53 disability benefits; revising medical benefits;
54 distinguishing between initial and followup services;
55 excluding massage and acupuncture from medical
56 benefits that may be reimbursed under the Florida

57 Motor Vehicle No-Fault Law; adding physical therapists
58 to the list of providers that may provide services;
59 requiring that an insurer repay any benefits covered
60 by the Medicaid program; requiring that an insurer
61 provide a claimant an opportunity to revise claims
62 that contain errors; authorizing an insurer to provide
63 notice to the claimant and conduct an investigation if
64 fraud is suspected; requiring that an insurer create
65 and maintain a log of personal injury protection
66 benefits paid and that the insurer provide to the
67 insured or an assignee of the insured, upon request, a
68 copy of the log if litigation is commenced; revising
69 the Medicare fee schedules that an insurer may use as
70 a basis for limiting reimbursement of personal injury
71 protection benefits; providing that the Medicare fee
72 schedule in effect on a specific date applies for
73 purposes of limiting reimbursement; requiring that an
74 insurer that limits payments based on the statutory
75 fee schedule include a notice in insurance policies at
76 the time of issuance or renewal; deleting obsolete
77 provisions; providing that certain entities exempt
78 from licensure as a clinic must nonetheless be
79 licensed to receive reimbursement for the provision of
80 personal injury protection benefits; providing
81 exceptions; requiring that an insurer notify parties
82 in disputes over personal injury protection claims
83 when policy limits are reached; providing that an
84 insured must comply with the terms of the policy,

85 including submission to examinations under oath;
86 requiring that an insured not fail to appear at an
87 examination; providing for a rebuttable presumption
88 that a refusal of or failure to appear at an
89 examination is unreasonable in certain circumstances;
90 providing criteria for the award of attorney fees;
91 providing a presumption regarding the use of a
92 contingency risk multiplier; consolidating provisions
93 relating to unfair or deceptive practices under
94 certain conditions; specifying that claims generated
95 as a result of certain unlawful activities are not
96 reimbursable; eliminating a requirement that all
97 parties mutually and expressly agree to the use of
98 electronic transmission of data; amending s. 627.7405,
99 F.S.; providing an exception from an insurer's right
100 of reimbursement for certain owners or registrants;
101 amending s. 817.234, F.S.; providing that it is
102 insurance fraud to present a claim for personal injury
103 protection benefits payable to a person or entity that
104 knowingly submitted false, misleading, or fraudulent
105 documents relating to licensure as a health care
106 clinic; providing that a licensed health care
107 practitioner guilty of certain insurance fraud loses
108 his or her license and may not receive reimbursement
109 for personal injury protection benefits for a
110 specified period; defining the term "insurer";
111 amending s. 316.065, F.S.; conforming a cross-
112 reference; authorizing the Office of Insurance

113 Regulation to make contracts for certain purposes;
114 requiring a report; requiring insurers writing private
115 passenger automobile personal injury protection
116 insurance to make certain rate filings; providing
117 sanctions for failure to make the filings as required;
118 providing an appropriation; providing for carryforward
119 of any unexpended balance of the appropriation;
120 requiring that the Office of Insurance Regulation
121 perform a data call relating to personal injury
122 protection; prescribing required elements of the data
123 call; providing for severability; providing effective
124 dates.
125
126 Be It Enacted by the Legislature of the State of Florida:
127
128 Section 1. Subsection (1) of section 316.066, Florida
129 Statutes, is amended to read:
130 316.066 Written reports of crashes.—
131 (1)(a) A Florida Traffic Crash Report, Long Form must ~~is~~
132 ~~required to~~ be completed and submitted to the department within
133 10 days after ~~completing~~ an investigation is completed by the
134 ~~every~~ law enforcement officer who in the regular course of duty
135 investigates a motor vehicle crash that:
136 1. Resulted in death of, ~~or~~ personal injury to, or any
137 indication of complaints of pain or discomfort by any of the
138 parties or passengers involved in the crash;~~.~~
139 2. Involved a violation of s. 316.061(1) or s. 316.193;~~.~~

140 3. Rendered a vehicle inoperable to a degree that required
141 a wrecker to remove it from the scene of the crash; or
142 4. Involved a commercial motor vehicle.
143 (b) The Florida Traffic Crash Report, Long Form must
144 include:
145 1. The date, time, and location of the crash.
146 2. A description of the vehicles involved.
147 3. The names and addresses of the parties involved,
148 including all drivers and passengers, and the identification of
149 the vehicle in which each was a driver or a passenger.
150 4. The names and addresses of witnesses.
151 5. The name, badge number, and law enforcement agency of
152 the officer investigating the crash.
153 6. The names of the insurance companies for the respective
154 parties involved in the crash.
155 (c) ~~(b)~~ In any ~~every~~ crash for which a Florida Traffic
156 Crash Report, Long Form is not required by this section and
157 which occurs on the public roadways of this state, the law
158 enforcement officer shall ~~may~~ complete a short-form crash report
159 or provide a driver exchange-of-information form, to be
160 completed by all drivers and passengers ~~each party~~ involved in
161 the crash, which requires the identification of each vehicle
162 that the drivers and passengers were in. The short-form report
163 must include:
164 1. The date, time, and location of the crash.
165 2. A description of the vehicles involved.

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166 3. The names and addresses of the parties involved,
167 including all drivers and passengers, and the identification of
168 the vehicle in which each was a driver or a passenger.
169 4. The names and addresses of witnesses.
170 5. The name, badge number, and law enforcement agency of
171 the officer investigating the crash.
172 6. The names of the insurance companies for the respective
173 parties involved in the crash.
174 (d) ~~(c)~~ Each party to the crash must provide the law
175 enforcement officer with proof of insurance, which must be
176 documented in the crash report. If a law enforcement officer
177 submits a report on the crash, proof of insurance must be
178 provided to the officer by each party involved in the crash. Any
179 party who fails to provide the required information commits a
180 noncriminal traffic infraction, punishable as a nonmoving
181 violation as provided in chapter 318, unless the officer
182 determines that due to injuries or other special circumstances
183 such insurance information cannot be provided immediately. If
184 the person provides the law enforcement agency, within 24 hours
185 after the crash, proof of insurance that was valid at the time
186 of the crash, the law enforcement agency may void the citation.
187 (e) ~~(d)~~ The driver of a vehicle that was in any manner
188 involved in a crash resulting in damage to a ~~any~~ vehicle or
189 other property which does not require a law enforcement report
190 ~~in an amount of $500 or more which was not investigated by a law~~
191 ~~enforcement agency,~~ shall, within 10 days after the crash,
192 submit a written report of the crash to the department. The
193 report shall be submitted on a form approved by the department.

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194 ~~The entity receiving the report may require witnesses of the~~
195 ~~crash to render reports and may require any driver of a vehicle~~
196 ~~involved in a crash of which a written report must be made to~~
197 ~~file supplemental written reports if the original report is~~
198 ~~deemed insufficient by the receiving entity.~~
199 (f) ~~(e)~~ Long-form and short-form crash reports prepared by
200 law enforcement must be submitted to the department and may
201 ~~shall~~ be maintained by the law enforcement officer's agency.
202 Section 2. Subsection (4) of section 400.9905, Florida
203 Statutes, is amended to read:
204 400.9905 Definitions.—
205 (4) "Clinic" means an entity where ~~at which~~ health care
206 services are provided to individuals and which tenders charges
207 for reimbursement for such services, including a mobile clinic
208 and a portable equipment provider. As used in ~~For purposes of~~
209 this part, the term does not include and the licensure
210 requirements of this part do not apply to:
211 (a) Entities licensed or registered by the state under
212 chapter 395; ~~or~~ entities licensed or registered by the state and
213 providing only health care services within the scope of services
214 authorized under their respective licenses ~~granted~~ under ss.
215 383.30-383.335, chapter 390, chapter 394, chapter 397, this
216 chapter except part X, chapter 429, chapter 463, chapter 465,
217 chapter 466, chapter 478, part I of chapter 483, chapter 484, or
218 chapter 651; end-stage renal disease providers authorized under
219 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
220 C.F.R. part 485, subpart B or subpart H; or any entity that
221 provides neonatal or pediatric hospital-based health care

222 services or other health care services by licensed practitioners
223 solely within a hospital licensed under chapter 395.
224 (b) Entities that own, directly or indirectly, entities
225 licensed or registered by the state pursuant to chapter 395; ~~or~~
226 entities that own, directly or indirectly, entities licensed or
227 registered by the state and providing only health care services
228 within the scope of services authorized pursuant to their
229 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
230 390, chapter 394, chapter 397, this chapter except part X,
231 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
232 part I of chapter 483, chapter 484, chapter 651; end-stage renal
233 disease providers authorized under 42 C.F.R. part 405, subpart
234 U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or
235 subpart H; or any entity that provides neonatal or pediatric
236 hospital-based health care services by licensed practitioners
237 solely within a hospital licensed under chapter 395.
238 (c) Entities that are owned, directly or indirectly, by an
239 entity licensed or registered by the state pursuant to chapter
240 395; ~~or~~ entities that are owned, directly or indirectly, by an
241 entity licensed or registered by the state and providing only
242 health care services within the scope of services authorized
243 pursuant to their respective licenses ~~granted~~ under ss. 383.30-
244 383.335, chapter 390, chapter 394, chapter 397, this chapter
245 except part X, chapter 429, chapter 463, chapter 465, chapter
246 466, chapter 478, part I of chapter 483, chapter 484, or chapter
247 651; end-stage renal disease providers authorized under 42
248 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
249 C.F.R. part 485, subpart B or subpart H; or any entity that

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250 provides neonatal or pediatric hospital-based health care
251 services by licensed practitioners solely within a hospital
252 under chapter 395.
253 (d) Entities that are under common ownership, directly or
254 indirectly, with an entity licensed or registered by the state
255 pursuant to chapter 395; ~~or~~ entities that are under common
256 ownership, directly or indirectly, with an entity licensed or
257 registered by the state and providing only health care services
258 within the scope of services authorized pursuant to their
259 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
260 390, chapter 394, chapter 397, this chapter except part X,
261 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
262 part I of chapter 483, chapter 484, or chapter 651; end-stage
263 renal disease providers authorized under 42 C.F.R. part 405,
264 subpart U; ~~or~~ providers certified under 42 C.F.R. part 485,
265 subpart B or subpart H; or any entity that provides neonatal or
266 pediatric hospital-based health care services by licensed
267 practitioners solely within a hospital licensed under chapter
268 395.
269 (e) An entity that is exempt from federal taxation under
270 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
271 under 26 U.S.C. s. 409 that has a board of trustees at least ~~not~~
272 ~~less than~~ two-thirds of which are Florida-licensed health care
273 practitioners and provides only physical therapy services under
274 physician orders, any community college or university clinic,
275 and any entity owned or operated by the federal or state
276 government, including agencies, subdivisions, or municipalities
277 thereof.

278 (f) A sole proprietorship, group practice, partnership, or
279 corporation that provides health care services by physicians
280 covered by s. 627.419, that is directly supervised by one or
281 more of such physicians, and that is wholly owned by one or more
282 of those physicians or by a physician and the spouse, parent,
283 child, or sibling of that physician.
284 (g) A sole proprietorship, group practice, partnership, or
285 corporation that provides health care services by licensed
286 health care practitioners under chapter 457, chapter 458,
287 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
288 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
289 chapter 490, chapter 491, or part I, part III, part X, part
290 XIII, or part XIV of chapter 468, or s. 464.012, and that is
291 ~~which are~~ wholly owned by one or more licensed health care
292 practitioners, or the licensed health care practitioners set
293 forth in this paragraph and the spouse, parent, child, or
294 sibling of a licensed health care practitioner if~~, so long as~~
295 one of the owners who is a licensed health care practitioner is
296 supervising the business activities and is legally responsible
297 for the entity's compliance with all federal and state laws.
298 However, a health care practitioner may not supervise services
299 beyond the scope of the practitioner's license, except that, for
300 the purposes of this part, a clinic owned by a licensee in s.
301 456.053(3)(b) which ~~that~~ provides only services authorized
302 pursuant to s. 456.053(3)(b) may be supervised by a licensee
303 specified in s. 456.053(3)(b).

304 (h) Clinical facilities affiliated with an accredited
305 medical school at which training is provided for medical
306 students, residents, or fellows.
307 (i) Entities that provide only oncology or radiation
308 therapy services by physicians licensed under chapter 458 or
309 chapter 459 or entities that provide oncology or radiation
310 therapy services by physicians licensed under chapter 458 or
311 chapter 459 which are owned by a corporation whose shares are
312 publicly traded on a recognized stock exchange.
313 (j) Clinical facilities affiliated with a college of
314 chiropractic accredited by the Council on Chiropractic Education
315 at which training is provided for chiropractic students.
316 (k) Entities that provide licensed practitioners to staff
317 emergency departments or to deliver anesthesia services in
318 facilities licensed under chapter 395 and that derive at least
319 90 percent of their gross annual revenues from the provision of
320 such services. Entities claiming an exemption from licensure
321 under this paragraph must provide documentation demonstrating
322 compliance.
323 (l) Orthotic or prosthetic clinical facilities that are a
324 publicly traded corporation or that are wholly owned, directly
325 or indirectly, by a publicly traded corporation. As used in this
326 paragraph, a publicly traded corporation is a corporation that
327 issues securities traded on an exchange registered with the
328 United States Securities and Exchange Commission as a national
329 securities exchange.
330

331 Notwithstanding this subsection, an entity shall be deemed a
332 clinic and must be licensed under this part in order to receive
333 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
334 627.730-627.7405, unless exempted under s. 627.736(5)(h).
335 Section 3. Subsection (6) is added to section 400.991,
336 Florida Statutes, to read:
337 400.991 License requirements; background screenings;
338 prohibitions.—
339 (6) All agency forms for licensure application or
340 exemption from licensure under this part must contain the
341 following statement:
342
343 INSURANCE FRAUD NOTICE.—A person who knowingly submits
344 a false, misleading, or fraudulent application or
345 other document when applying for licensure as a health
346 care clinic, seeking an exemption from licensure as a
347 health care clinic, or demonstrating compliance with
348 part X of chapter 400, Florida Statutes, with the
349 intent to use the license, exemption from licensure,
350 or demonstration of compliance to provide services or
351 seek reimbursement under the Florida Motor Vehicle No-
352 Fault Law, commits a fraudulent insurance act, as
353 defined in s. 626.989, Florida Statutes. A person who
354 presents a claim for personal injury protection
355 benefits knowing that the payee knowingly submitted
356 such health care clinic application or document,
357 commits insurance fraud, as defined in s. 817.234,
358 Florida Statutes.

359 Section 4. Subsection (1) of section 626.989, Florida
360 Statutes, is amended to read:
361 626.989 Investigation by department or Division of
362 Insurance Fraud; compliance; immunity; confidential information;
363 reports to division; division investigator's power of arrest.—
364 (1) For the purposes of this section:,
365 (a) A person commits a "fraudulent insurance act" if the
366 person:
367 1. Knowingly and with intent to defraud presents, causes
368 to be presented, or prepares with knowledge or belief that it
369 will be presented, to or by an insurer, self-insurer, self-
370 insurance fund, servicing corporation, purported insurer,
371 broker, or any agent thereof, any written statement as part of,
372 or in support of, an application for the issuance of, or the
373 rating of, any insurance policy, or a claim for payment or other
374 benefit pursuant to any insurance policy, which the person knows
375 to contain materially false information concerning any fact
376 material thereto or if the person conceals, for the purpose of
377 misleading another, information concerning any fact material
378 thereto.
379 2. Knowingly submits:
380 a. A false, misleading, or fraudulent application or other
381 document when applying for licensure as a health care clinic,
382 seeking an exemption from licensure as a health care clinic, or
383 demonstrating compliance with part X of chapter 400 with an
384 intent to use the license, exemption from licensure, or
385 demonstration of compliance to provide services or seek
386 reimbursement under the Florida Motor Vehicle No-Fault Law.

387 b. A claim for payment or other benefit pursuant to a
388 personal injury protection insurance policy under the Florida
389 Motor Vehicle No-Fault Law if the person knows that the payee
390 knowingly submitted a false, misleading, or fraudulent
391 application or other document when applying for licensure as a
392 health care clinic, seeking an exemption from licensure as a
393 health care clinic, or demonstrating compliance with part X of
394 chapter 400. For the purposes of this section,
395 (b) The term "insurer" also includes a any health
396 maintenance organization, and the term "insurance policy" also
397 includes a health maintenance organization subscriber contract.
398 Section 5. Paragraph (i) of subsection (1) of section
399 626.9541, Florida Statutes, is amended to read:
400 626.9541 Unfair methods of competition and unfair or
401 deceptive acts or practices defined.—
402 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
403 ACTS.—The following are defined as unfair methods of competition
404 and unfair or deceptive acts or practices:
405 (i) Unfair claim settlement practices.—
406 1. Attempting to settle claims on the basis of an
407 application, when serving as a binder or intended to become a
408 part of the policy, or any other material document which was
409 altered without notice to, or knowledge or consent of, the
410 insured;
411 2. A material misrepresentation made to an insured or any
412 other person having an interest in the proceeds payable under
413 such contract or policy, for the purpose and with the intent of
414 effecting settlement of such claims, loss, or damage under such

415 contract or policy on less favorable terms than those provided
416 in, and contemplated by, such contract or policy; or
417 3. Committing or performing with such frequency as to
418 indicate a general business practice any of the following:
419 a. Failing to adopt and implement standards for the proper
420 investigation of claims;
421 b. Misrepresenting pertinent facts or insurance policy
422 provisions relating to coverages at issue;
423 c. Failing to acknowledge and act promptly upon
424 communications with respect to claims;
425 d. Denying claims without conducting reasonable
426 investigations based upon available information;
427 e. Failing to affirm or deny full or partial coverage of
428 claims, and, as to partial coverage, the dollar amount or extent
429 of coverage, or failing to provide a written statement that the
430 claim is being investigated, upon the written request of the
431 insured within 30 days after proof-of-loss statements have been
432 completed;
433 f. Failing to promptly provide a reasonable explanation in
434 writing to the insured of the basis in the insurance policy, in
435 relation to the facts or applicable law, for denial of a claim
436 or for the offer of a compromise settlement;
437 g. Failing to promptly notify the insured of any
438 additional information necessary for the processing of a claim;
439 or
440 h. Failing to clearly explain the nature of the requested
441 information and the reasons why such information is necessary.

442 i. Failing to pay personal injury protection insurance
443 claims within the time periods required by s. 627.736(4)(b). The
444 office may order the insurer to pay restitution to a
445 policyholder, medical provider, or other claimant, including
446 interest at a rate consistent with the amount set forth in s.
447 55.03(1), for the time period within which an insurer fails to
448 pay claims as required by law. Restitution is in addition to any
449 other penalties allowed by law, including, but not limited to,
450 the suspension of the insurer's certificate of authority.
451 4. Failing to pay undisputed amounts of partial or full
452 benefits owed under first-party property insurance policies
453 within 90 days after an insurer receives notice of a residential
454 property insurance claim, determines the amounts of partial or
455 full benefits, and agrees to coverage, unless payment of the
456 undisputed benefits is prevented by an act of God, prevented by
457 the impossibility of performance, or due to actions by the
458 insured or claimant that constitute fraud, lack of cooperation,
459 or intentional misrepresentation regarding the claim for which
460 benefits are owed.
461 Section 6. Subsection (5) of section 626.9894, Florida
462 Statutes, is amended to read:
463 626.9894 Gifts and grants.—
464 (5) Notwithstanding ~~the provisions of~~ s. 216.301 and
465 pursuant to s. 216.351, any balance of moneys deposited into the
466 Insurance Regulatory Trust Fund pursuant to this section or s.
467 626.9895 remaining at the end of any fiscal year is ~~shall be~~
468 available for carrying out the duties and responsibilities of
469 the division. The department may request annual appropriations

470 from the grants and donations received pursuant to this section
471 or s. 626.9895 and cash balances in the Insurance Regulatory
472 Trust Fund for the purpose of carrying out its duties and
473 responsibilities related to the division's anti-fraud efforts,
474 including the funding of dedicated prosecutors and related
475 personnel.
476 Section 7. Section 626.9895, Florida Statutes, is created
477 to read:
478 626.9895 Motor vehicle insurance fraud direct-support
479 organization.—
480 (1) DEFINITIONS.—As used in this section, the term:
481 (a) "Division" means the Division of Insurance Fraud of
482 the Department of Financial Services.
483 (b) "Motor vehicle insurance fraud" means any act defined
484 as a "fraudulent insurance act" under s. 626.989, which relates
485 to the coverage of motor vehicle insurance as described in part
486 XI of chapter 627.
487 (c) "Organization" means the direct-support organization
488 established under this section.
489 (2) ORGANIZATION ESTABLISHED.—The division may establish a
490 direct-support organization, to be known as the "Automobile
491 Insurance Fraud Strike Force," whose sole purpose is to support
492 the prosecution, investigation, and prevention of motor vehicle
493 insurance fraud. The organization shall:
494 (a) Be a not-for-profit corporation incorporated under
495 chapter 617 and approved by the Department of State.
496 (b) Be organized and operated to conduct programs and
497 activities; raise funds; request and receive grants, gifts, and

498 bequests of money; acquire, receive, hold, invest, and
499 administer, in its own name, securities, funds, objects of
500 value, or other property, real or personal; and make grants and
501 expenditures to or for the direct or indirect benefit of the
502 division, state attorneys' offices, the statewide prosecutor,
503 the Agency for Health Care Administration, and the Department of
504 Health to the extent that such grants and expenditures are used
505 exclusively to advance the prosecution, investigation, or
506 prevention of motor vehicle insurance fraud. Grants and
507 expenditures may include the cost of salaries or benefits of
508 motor vehicle insurance fraud investigators, prosecutors, or
509 support personnel if such grants and expenditures do not
510 interfere with prosecutorial independence or otherwise create
511 conflicts of interest which threaten the success of
512 prosecutions.
513 (c) Be determined by the division to operate in a manner
514 that promotes the goals of laws relating to motor vehicle
515 insurance fraud, that is in the best interest of the state, and
516 that is in accordance with the adopted goals and mission of the
517 division.
518 (d) Use all of its grants and expenditures solely for the
519 purpose of preventing and decreasing motor vehicle insurance
520 fraud, and not for advertising using the likeness or name of any
521 elected official nor for the purpose of lobbying as defined in
522 s. 11.045.
523 (e) Be subject to an annual financial audit in accordance
524 with s. 215.981.

525 (3) CONTRACT.—The organization shall operate under written
526 contract with the division. The contract must provide for:
527 (a) Approval of the articles of incorporation and bylaws
528 of the organization by the division.
529 (b) Submission of an annual budget for approval of the
530 division. The budget must require the organization to minimize
531 costs to the division and its members at all times by using
532 existing personnel and property and allowing for telephonic
533 meetings if appropriate.
534 (c) Certification by the division that the organization is
535 complying with the terms of the contract and in a manner
536 consistent with the goals and purposes of the department and in
537 the best interest of the state. Such certification must be made
538 annually and reported in the official minutes of a meeting of
539 the organization.
540 (d) Allocation of funds to address motor vehicle insurance
541 fraud.
542 (e) Reversion of moneys and property held in trust by the
543 organization for motor vehicle insurance fraud prosecution,
544 investigation, and prevention to the division if the
545 organization is no longer approved to operate for the department
546 or if the organization ceases to exist, or to the state if the
547 division ceases to exist.
548 (f) Specific criteria to be used by the organization's
549 board of directors to evaluate the effectiveness of funding used
550 to combat motor vehicle insurance fraud.
551 (g) The fiscal year of the organization, which begins July
552 1 of each year and ends June 30 of the following year.

553 (h) Disclosure of the material provisions of the contract,
554 and distinguishing between the department and the organization
555 to donors of gifts, contributions, or bequests, including
556 providing such disclosure on all promotional and fundraising
557 publications.
558 (4) BOARD OF DIRECTORS.—
559 (a) The board of directors of the organization shall
560 consist of the following eleven members:
561 1. The Chief Financial Officer, or designee, who shall
562 serve as chair.
563 2. Two state attorneys, one of whom shall be appointed by
564 the Chief Financial Officer and one of whom shall be appointed
565 by the Attorney General.
566 3. Two representatives of motor vehicle insurers appointed
567 by the Chief Financial Officer.
568 4. Two representatives of local law enforcement agencies,
569 one of whom shall be appointed by the Chief Financial Officer
570 and one of whom shall be appointed by the Attorney General.
571 5. Two representatives of the types of health care
572 providers who regularly make claims for benefits under ss.
573 627.730-627.7405, one of whom shall be appointed by the
574 President of the Senate and one of whom shall be appointed by
575 the Speaker of the House of Representatives. The appointees may
576 not represent the same type of health care provider.
577 6. A private attorney that has experience in representing
578 claimants in actions for benefits under ss. 627.730-627.7405,
579 who shall be appointed by the President of the Senate.

580 7. A private attorney who has experience in representing
581 insurers in actions for benefits under ss. 627.730-627.7405, who
582 shall be appointed by the Speaker of the House of
583 Representatives.
584 (b) The officer who appointed a member of the board may
585 remove that member for any reason. The term of office of an
586 appointed member expires at the same time as the term of the
587 officer who appointed him or her or at such earlier time as the
588 person ceases to be qualified.
589 (5) USE OF PROPERTY.—The department may authorize, without
590 charge, appropriate use of fixed property and facilities of the
591 division by the organization, subject to this subsection.
592 (a) The department may prescribe any condition with which
593 the organization must comply in order to use the division's
594 property or facilities.
595 (b) The department may not authorize the use of the
596 division's property or facilities if the organization does not
597 provide equal membership and employment opportunities to all
598 persons regardless of race, religion, sex, age, or national
599 origin.
600 (c) The department shall adopt rules prescribing the
601 procedures by which the organization is governed and any
602 conditions with which the organization must comply to use the
603 division's property or facilities.
604 (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an
605 insurer to the organization shall be allowed as an appropriate
606 business expense of the insurer for all regulatory purposes.

607 (7) DEPOSITORY ACCOUNT.—Any moneys received by the
608 organization may be held in a separate depository account in the
609 name of the organization and subject to the contract with the
610 division.
611 (8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by
612 the division from the organization shall be deposited into the
613 Insurance Regulatory Trust Fund.
614 Section 8. Section 627.7311, Florida Statutes, is created
615 to read:
616 627.7311 Effect of law on personal injury protection
617 policies.—The provisions and procedures authorized in ss.
618 627.730-627.7405 shall be implemented by insurers offering
619 policies pursuant to the Florida Motor Vehicle No-Fault Law. The
620 Legislature intends that these provisions and procedures have
621 full force and effect regardless of their express inclusion in
622 an insurance policy form, and a specific provision or procedure
623 authorized in ss. 627.730-627.7405 shall control over general
624 provisions in an insurance policy form. An insurer is not
625 required to amend its policy form or to expressly notify
626 providers, claimants, or insureds in order to implement and
627 apply such provisions or procedures.
628 Section 9. Effective January 1, 2013, subsections (16) and
629 (17) are added to section 627.732, Florida Statutes, to read:
630 627.732 Definitions.—As used in ss. 627.730-627.7405, the
631 term:
632 (16) "Emergency medical condition" means a medical
633 condition manifesting itself by acute symptoms of sufficient
634 severity, which may include severe pain, such that the absence

635 of immediate medical attention could reasonably be expected to
636 result in any of the following:
637 (a) Serious jeopardy to patient health.
638 (b) Serious impairment to bodily functions.
639 (c) Serious dysfunction of any bodily organ or part.
640 (17) "Entity wholly owned" means a proprietorship, group
641 practice, partnership, or corporation that provides health care
642 services rendered by licensed health care practitioners and in
643 which licensed health care practitioners are the business owners
644 of all aspects of the business entity, including, but not
645 limited to, being reflected as the business owners on the title
646 or lease of the physical facility, filing taxes as the business
647 owners, being account holders on the entity's bank account,
648 being listed as the principals on all incorporation documents
649 required by this state, and having ultimate authority over all
650 personnel and compensation decisions relating to the entity.
651 However, this definition does not apply to an entity that is
652 wholly owned, directly or indirectly, by a hospital licensed
653 under chapter 395.
654 Section 10. Effective January 1, 2013, subsections (1),
655 (4), (5), (6), (7), (8), (9), (10), and (11) of section 627.736,
656 Florida Statutes, are amended, and subsection (17) is added to
657 that section, to read:
658 627.736 Required personal injury protection benefits;
659 exclusions; priority; claims.—
660 (1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy complying
661 with the security requirements of s. 627.733 must ~~shall~~ provide
662 personal injury protection to the named insured, relatives

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663 residing in the same household, persons operating the insured
664 motor vehicle, passengers in the ~~such~~ motor vehicle, and other
665 persons struck by the ~~such~~ motor vehicle and suffering bodily
666 injury while not an occupant of a self-propelled vehicle,
667 subject to ~~the provisions of~~ subsection (2) and paragraph
668 (4)(e), to a limit of $10,000 in medical and disability benefits
669 and $5,000 in death benefits resulting from ~~for loss sustained~~
670 ~~by any such person as a result of~~ bodily injury, sickness,
671 disease, or death arising out of the ownership, maintenance, or
672 use of a motor vehicle as follows:

673 (a) *Medical benefits.*—Eighty percent of all reasonable
674 expenses for medically necessary medical, surgical, X-ray,
675 dental, and rehabilitative services, including prosthetic
676 devices~~,~~ and medically necessary ambulance, hospital, and
677 nursing services if the individual receives initial services and
678 care pursuant to subparagraph 1. within 14 days after the motor
679 vehicle accident. ~~However,~~ The medical benefits ~~shall~~ provide
680 reimbursement only for: ~~such~~

681 1. Initial services and care that are lawfully provided,
682 supervised, ordered, or prescribed by a physician licensed under
683 chapter 458 or chapter 459, a dentist licensed under chapter
684 466, or a chiropractic physician licensed under chapter 460 or
685 that are provided in a hospital or in a facility that owns, or
686 is wholly owned by, a hospital. Initial services and care may
687 also be provided by a person or entity licensed under part III
688 of chapter 401 which provides emergency transportation and
689 treatment.

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690 2. Upon referral by a provider described in subparagraph
691 1., followup services and care consistent with the underlying
692 medical diagnosis rendered pursuant to subparagraph 1. which may
693 be provided, supervised, ordered, or prescribed only by a
694 physician licensed under chapter 458 or chapter 459, a
695 chiropractic physician licensed under chapter 460, a dentist
696 licensed under chapter 466, or, to the extent permitted by
697 applicable law and under the supervision of such physician,
698 osteopathic physician, chiropractic physician, or dentist, by a
699 physician assistant licensed under chapter 458 or chapter 459 or
700 an advanced registered nurse practitioner licensed under chapter
701 464. Followup services and care may also be provided by any of
702 the following persons or entities:
703 a.1. A hospital or ambulatory surgical center licensed
704 under chapter 395.
705 2. A person or entity licensed under ss. 401.2101-401.45
706 that provides emergency transportation and treatment.
707 b.3. An entity wholly owned by one or more physicians
708 licensed under chapter 458 or chapter 459, chiropractic
709 physicians licensed under chapter 460, or dentists licensed
710 under chapter 466 or by such practitioner or practitioners and
711 the spouse, parent, child, or sibling of such that practitioner
712 or those practitioners.
713 c.4. An entity that owns or is wholly owned, directly or
714 indirectly, by a hospital or hospitals.
715 d. A physical therapist licensed under chapter 486, based
716 upon a referral by a provider described in subparagraph 2.

717 e.~~5.~~ A health care clinic licensed under part X of chapter
718 400 which ~~ss. 400.990-400.995 that~~ is~~:~~
719 ~~a.~~ accredited by the Joint Commission on Accreditation of
720 Healthcare Organizations, the American Osteopathic Association,
721 the Commission on Accreditation of Rehabilitation Facilities, or
722 the Accreditation Association for Ambulatory Health Care, Inc.,~~;~~
723 or
724 ~~b. A health care clinic that~~:
725 (I) Has a medical director licensed under chapter 458,
726 chapter 459, or chapter 460;
727 (II) Has been continuously licensed for more than 3 years
728 or is a publicly traded corporation that issues securities
729 traded on an exchange registered with the United States
730 Securities and Exchange Commission as a national securities
731 exchange; and
732 (III) Provides at least four of the following medical
733 specialties:
734 (A) General medicine.
735 (B) Radiography.
736 (C) Orthopedic medicine.
737 (D) Physical medicine.
738 (E) Physical therapy.
739 (F) Physical rehabilitation.
740 (G) Prescribing or dispensing outpatient prescription
741 medication.
742 (H) Laboratory services.
743 3. Reimbursement for services and care provided in
744 subparagraph 1. or subparagraph 2. up to $10,000 if a physician

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745 licensed under chapter 458 or chapter 459, a dentist licensed
746 under chapter 466, a physician assistant licensed under chapter
747 458 or chapter 459, or an advanced registered nurse practitioner
748 licensed under chapter 464 has determined that the injured
749 person had an emergency medical condition.
750 4. Reimbursement for services and care provided in
751 subparagraph 1. or subparagraph 2. is limited to $2,500 if any
752 provider listed in subparagraph 1. or subparagraph 2. determines
753 that the injured person did not have an emergency medical
754 condition.
755 5. Medical benefits do not include massage as defined in
756 s. 480.033 or acupuncture as defined in s. 457.102, regardless
757 of the person, entity, or licensee providing massage or
758 acupuncture, and a licensed massage therapist or licensed
759 acupuncturist may not be reimbursed for medical benefits under
760 this section.
761 6. The Financial Services Commission shall adopt by rule
762 the form that must be used by an insurer and a health care
763 provider specified in sub-subparagraph 2.b., sub-subparagraph
764 2.c., or sub-subparagraph 2.e. ~~subparagraph 3., subparagraph 4.,~~
765 ~~or subparagraph 5.~~ to document that the health care provider
766 meets the criteria of this paragraph, which rule must include a
767 requirement for a sworn statement or affidavit.
768 (b) *Disability benefits.*—Sixty percent of any loss of
769 gross income and loss of earning capacity per individual from
770 inability to work proximately caused by the injury sustained by
771 the injured person, plus all expenses reasonably incurred in
772 obtaining from others ordinary and necessary services in lieu of

773 those that, but for the injury, the injured person would have
774 performed without income for the benefit of his or her
775 household. All disability benefits payable under this provision
776 must shall be paid at least not less than every 2 weeks.
777 (c) *Death benefits.*—Death benefits equal to the lesser of
778 $5,000 or the remainder of unused personal injury protection
779 benefits per individual. Death benefits are in addition to the
780 medical and disability benefits provided under the insurance
781 policy. The insurer may pay death such benefits to the executor
782 or administrator of the deceased, to any of the deceased's
783 relatives by blood, or legal adoption, or connection by
784 marriage, or to any person appearing to the insurer to be
785 equitably entitled to such benefits thereto.
786
787 Only insurers writing motor vehicle liability insurance in this
788 state may provide the required benefits of this section, and no
789 such insurer may not shall require the purchase of any other
790 motor vehicle coverage other than the purchase of property
791 damage liability coverage as required by s. 627.7275 as a
792 condition for providing such required benefits. Insurers may not
793 require that property damage liability insurance in an amount
794 greater than $10,000 be purchased in conjunction with personal
795 injury protection. Such insurers shall make benefits and
796 required property damage liability insurance coverage available
797 through normal marketing channels. An Any insurer writing motor
798 vehicle liability insurance in this state who fails to comply
799 with such availability requirement as a general business
800 practice violates shall be deemed to have violated part IX of

801 chapter 626, and such violation constitutes ~~shall constitute~~ an
802 unfair method of competition or an unfair or deceptive act or
803 practice involving the business of insurance. An~~; and any such~~
804 insurer committing such violation is ~~shall be~~ subject to the
805 penalties provided under that ~~afforded in such~~ part, as well as
806 those provided ~~which may be afforded~~ elsewhere in the insurance
807 code.
808 (4) PAYMENT OF BENEFITS~~; WHEN DUE~~.—Benefits due from an
809 insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except
810 that benefits received under any workers' compensation law must
811 ~~shall~~ be credited against the benefits provided by subsection
812 (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon
813 receipt of reasonable proof of such loss and the amount of
814 expenses and loss incurred which are covered by the policy
815 issued under ss. 627.730-627.7405. If ~~When~~ the Agency for Health
816 Care Administration provides, pays, or becomes liable for
817 medical assistance under the Medicaid program related to injury,
818 sickness, disease, or death arising out of the ownership,
819 maintenance, or use of a motor vehicle, the benefits under ss.
820 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of~~ the
821 Medicaid program. However, within 30 days after receiving notice
822 that the Medicaid program paid such benefits, the insurer shall
823 repay the full amount of the benefits to the Medicaid program.
824 (a) An insurer may require written notice to be given as
825 soon as practicable after an accident involving a motor vehicle
826 with respect to which the policy affords the security required
827 by ss. 627.730-627.7405.

828 (b) Personal injury protection insurance benefits paid
829 pursuant to this section are ~~shall be~~ overdue if not paid within
830 30 days after the insurer is furnished written notice of the
831 fact of a covered loss and of the amount of same. However:
832 1. If ~~such~~ written notice of the entire claim is not
833 furnished to the insurer ~~as to the entire claim~~, any partial
834 amount supported by written notice is overdue if not paid within
835 30 days after ~~such~~ written notice is furnished to the insurer.
836 Any part or all of the remainder of the claim that is
837 subsequently supported by written notice is overdue if not paid
838 within 30 days after ~~such~~ written notice is furnished to the
839 insurer.
840 2. If ~~When~~ an insurer pays only a portion of a claim or
841 rejects a claim, the insurer shall provide at the time of the
842 partial payment or rejection an itemized specification of each
843 item that the insurer had reduced, omitted, or declined to pay
844 and any information that the insurer desires the claimant to
845 consider related to the medical necessity of the denied
846 treatment or to explain the reasonableness of the reduced charge
847 if~~, provided that~~ this does ~~shall~~ not limit the introduction of
848 evidence at trial.~~; and~~ The insurer must also ~~shall~~ include the
849 name and address of the person to whom the claimant should
850 respond and a claim number to be referenced in future
851 correspondence.
852 3. If an insurer pays only a portion of a claim or rejects
853 a claim due to an alleged error in the claim, the insurer, at
854 the time of the partial payment or rejection, shall provide an
855 itemized specification or explanation of benefits due to the

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856 specified error. Upon receiving the specification or
857 explanation, the person making the claim, at the person's option
858 and without waiving any other legal remedy for payment, has 15
859 days to submit a revised claim, which shall be considered a
860 timely submission of written notice of a claim.
861 4. However, Notwithstanding the fact that written notice
862 has been furnished to the insurer, any payment is shall not be
863 deemed overdue if when the insurer has reasonable proof to
864 establish that the insurer is not responsible for the payment.
865 5. For the purpose of calculating the extent to which any
866 benefits are overdue, payment shall be treated as being made on
867 the date a draft or other valid instrument that which is
868 equivalent to payment was placed in the United States mail in a
869 properly addressed, postpaid envelope or, if not so posted, on
870 the date of delivery.
871 6. This paragraph does not preclude or limit the ability
872 of the insurer to assert that the claim was unrelated, was not
873 medically necessary, or was unreasonable or that the amount of
874 the charge was in excess of that permitted under, or in
875 violation of, subsection (5). Such assertion by the insurer may
876 be made at any time, including after payment of the claim or
877 after the 30-day time period for payment set forth in this
878 paragraph.
879 (c) Upon receiving notice of an accident that is
880 potentially covered by personal injury protection benefits, the
881 insurer must reserve $5,000 of personal injury protection
882 benefits for payment to physicians licensed under chapter 458 or
883 chapter 459 or dentists licensed under chapter 466 who provide

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884 emergency services and care, as defined in s. 395.002~~(9)~~, or who
885 provide hospital inpatient care. The amount required to be held
886 in reserve may be used only to pay claims from such physicians
887 or dentists until 30 days after the date the insurer receives
888 notice of the accident. After the 30-day period, any amount of
889 the reserve for which the insurer has not received notice of
890 <u>such claims</u> ~~a claim from a physician or dentist who provided~~
891 ~~emergency services and care or who provided hospital inpatient~~
892 ~~care~~ may ~~then~~ be used by the insurer to pay other claims. The
893 time periods specified in paragraph (b) for ~~required~~ payment of
894 personal injury protection benefits <u>are</u> ~~shall be~~ tolled for the
895 period of time that an insurer is required ~~by this paragraph~~ to
896 hold payment of a claim that is not from <u>such</u> ~~a~~ physician or
897 dentist ~~who provided emergency services and care or who provided~~
898 ~~hospital inpatient care~~ to the extent that the personal injury
899 protection benefits not held in reserve are insufficient to pay
900 the claim. This paragraph does not require an insurer to
901 establish a claim reserve for insurance accounting purposes.
902 (d) All overdue payments ~~shall~~ bear simple interest at the
903 rate established under s. 55.03 or the rate established in the
904 insurance contract, whichever is greater, for the year in which
905 the payment became overdue, calculated from the date the insurer
906 was furnished with written notice of the amount of covered loss.
907 Interest <u>is</u> ~~shall be~~ due at the time payment of the overdue
908 claim is made.
909 (e) The insurer of the owner of a motor vehicle shall pay
910 personal injury protection benefits for:

911 1. Accidental bodily injury sustained in this state by the
912 owner while occupying a motor vehicle, or while not an occupant
913 of a self-propelled vehicle if the injury is caused by physical
914 contact with a motor vehicle.
915 2. Accidental bodily injury sustained outside this state,
916 but within the United States of America or its territories or
917 possessions or Canada, by the owner while occupying the owner's
918 motor vehicle.
919 3. Accidental bodily injury sustained by a relative of the
920 owner residing in the same household, under the circumstances
921 described in subparagraph 1. or subparagraph 2., if ~~provided~~ the
922 relative at the time of the accident is domiciled in the owner's
923 household and is not ~~himself or herself~~ the owner of a motor
924 vehicle with respect to which security is required under ss.
925 627.730-627.7405.
926 4. Accidental bodily injury sustained in this state by any
927 other person while occupying the owner's motor vehicle or, if a
928 resident of this state, while not an occupant of a self-
929 propelled vehicle~~,~~ if the injury is caused by physical contact
930 with such motor vehicle, if ~~provided~~ the injured person is not
931 ~~himself or herself~~:
932 a. The owner of a motor vehicle with respect to which
933 security is required under ss. 627.730-627.7405; or
934 b. Entitled to personal injury benefits from the insurer
935 of the owner ~~or owners~~ of such a motor vehicle.
936 (f) If two or more insurers are liable for paying ~~to pay~~
937 personal injury protection benefits for the same injury to any
938 one person, the maximum payable is ~~shall be~~ as specified in

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939 subsection (1), and the ~~any~~ insurer paying the benefits is ~~shall~~
940 ~~be~~ entitled to recover from each of the other insurers an
941 equitable pro rata share of the benefits paid and expenses
942 incurred in processing the claim.

943 (g) It is a violation of the insurance code for an insurer
944 to fail to timely provide benefits as required by this section
945 with such frequency as to constitute a general business
946 practice.

947 (h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the
948 behalf of an insured person if that person has committed, by a
949 material act or omission, ~~any~~ insurance fraud relating to
950 personal injury protection coverage under his or her policy, if
951 the fraud is admitted to in a sworn statement by the insured or
952 ~~if it is~~ established in a court of competent jurisdiction. Any
953 insurance fraud voids ~~shall void~~ all coverage arising from the
954 claim related to such fraud under the personal injury protection
955 coverage of the insured person who committed the fraud,
956 irrespective of whether a portion of the insured person's claim
957 may be legitimate, and any benefits paid before ~~prior to~~ the
958 discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~
959 recoverable by the insurer in its entirety from the person who
960 committed insurance fraud ~~in their entirety~~. The prevailing
961 party is entitled to its costs and attorney ~~attorney's~~ fees in
962 any action in which it prevails in an insurer's action to
963 enforce its right of recovery under this paragraph.

964 (i) If an insurer has a reasonable belief that a
965 fraudulent insurance act, for the purposes of s. 626.989 or s.
966 817.234, has been committed, the insurer shall notify the

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967 claimant, in writing, within 30 days after submission of the
968 claim that the claim is being investigated for suspected fraud.
969 Beginning at the end of the initial 30-day period, the insurer
970 has an additional 60 days to conduct its fraud investigation.
971 Notwithstanding subsection (10), no later than 90 days after the
972 submission of the claim, the insurer must deny the claim or pay
973 the claim with simple interest as provided in paragraph (d).
974 Interest shall be assessed from the day the claim was submitted
975 until the day the claim is paid. All claims denied for suspected
976 fraudulent insurance acts shall be reported to the Division of
977 Insurance Fraud.
978 (j) An insurer shall create and maintain for each insured
979 a log of personal injury protection benefits paid by the insurer
980 on behalf of the insured. If litigation is commenced, the
981 insurer shall provide to the insured a copy of the log within 30
982 days after receiving a request for the log from the insured.
983 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
984 (a)~~1.~~ A ~~Any~~ physician, hospital, clinic, or other person
985 or institution lawfully rendering treatment to an injured person
986 for a bodily injury covered by personal injury protection
987 insurance may charge the insurer and injured party only a
988 reasonable amount pursuant to this section for the services and
989 supplies rendered, and the insurer providing such coverage may
990 pay for such charges directly to such person or institution
991 lawfully rendering such treatment~~,~~ if the insured receiving such
992 treatment or his or her guardian has countersigned the properly
993 completed invoice, bill, or claim form approved by the office
994 upon which such charges are to be paid for as having actually

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995 been rendered, to the best knowledge of the insured or his or
996 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
997 exceed ~~be in excess of~~ the amount the person or institution
998 customarily charges for like services or supplies. In
999 determining ~~With respect to a determination of~~ whether a charge
1000 for a particular service, treatment, or otherwise is reasonable,
1001 consideration may be given to evidence of usual and customary
1002 charges and payments accepted by the provider involved in the
1003 dispute, ~~and~~ reimbursement levels in the community and various
1004 federal and state medical fee schedules applicable to motor
1005 vehicle ~~automobile~~ and other insurance coverages, and other
1006 information relevant to the reasonableness of the reimbursement
1007 for the service, treatment, or supply.
1008 1.~~2.~~ The insurer may limit reimbursement to 80 percent of
1009 the following schedule of maximum charges:
1010 a. For emergency transport and treatment by providers
1011 licensed under chapter 401, 200 percent of Medicare.
1012 b. For emergency services and care provided by a hospital
1013 licensed under chapter 395, 75 percent of the hospital's usual
1014 and customary charges.
1015 c. For emergency services and care as defined by s.
1016 395.002~~(9)~~ provided in a facility licensed under chapter 395
1017 rendered by a physician or dentist, and related hospital
1018 inpatient services rendered by a physician or dentist, the usual
1019 and customary charges in the community.
1020 d. For hospital inpatient services, other than emergency
1021 services and care, 200 percent of the Medicare Part A

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1022 prospective payment applicable to the specific hospital
1023 providing the inpatient services.
1024 e. For hospital outpatient services, other than emergency
1025 services and care, 200 percent of the Medicare Part A Ambulatory
1026 Payment Classification for the specific hospital providing the
1027 outpatient services.
1028 f. For all other medical services, supplies, and care, 200
1029 percent of the allowable amount under:
1030 (I) The participating physicians fee schedule of Medicare
1031 Part B, except as provided in sub-sub-subparagraphs (II) and
1032 (III).
1033 (II) Medicare Part B, in the case of services, supplies,
1034 and care provided by ambulatory surgical centers and clinical
1035 laboratories.
1036 (III) The Durable Medical Equipment Prosthetics/Orthotics
1037 and Supplies fee schedule of Medicare Part B, in the case of
1038 durable medical equipment.
1039
1040 However, if such services, supplies, or care is not reimbursable
1041 under Medicare Part B, as provided in this sub-subparagraph, the
1042 insurer may limit reimbursement to 80 percent of the maximum
1043 reimbursable allowance under workers' compensation, as
1044 determined under s. 440.13 and rules adopted thereunder which
1045 are in effect at the time such services, supplies, or care is
1046 provided. Services, supplies, or care that is not reimbursable
1047 under Medicare or workers' compensation is not required to be
1048 reimbursed by the insurer.

1049 2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable
1050 fee schedule or payment limitation under Medicare is the fee
1051 schedule or payment limitation in effect on March 1 of the year
1052 in which ~~at the time~~ the services, supplies, or care is ~~was~~
1053 rendered and for the area in which such services, supplies, or
1054 care is ~~were~~ rendered, and the applicable fee schedule or
1055 payment limitation applies throughout the remainder of that
1056 year, notwithstanding any subsequent change made to the fee
1057 schedule or payment limitation, except that it may not be less
1058 than the allowable amount under the applicable ~~participating~~
1059 ~~physicians~~ schedule of Medicare Part B for 2007 for medical
1060 services, supplies, and care subject to Medicare Part B.
1061 3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to
1062 apply any limitation on the number of treatments or other
1063 utilization limits that apply under Medicare or workers'
1064 compensation. An insurer that applies the allowable payment
1065 limitations of subparagraph 1. ~~2.~~ must reimburse a provider who
1066 lawfully provided care or treatment under the scope of his or
1067 her license, regardless of whether such provider is ~~would be~~
1068 entitled to reimbursement under Medicare due to restrictions or
1069 limitations on the types or discipline of health care providers
1070 who may be reimbursed for particular procedures or procedure
1071 codes. However, subparagraph 1. does not prohibit an insurer
1072 from using the Medicare coding policies and payment
1073 methodologies of the federal Centers for Medicare and Medicaid
1074 Services, including applicable modifiers, to determine the
1075 appropriate amount of reimbursement for medical services,

1076 supplies, or care if the coding policy or payment methodology
1077 does not constitute a utilization limit.
1078 4.5. If an insurer limits payment as authorized by
1079 subparagraph 1. 2., the person providing such services,
1080 supplies, or care may not bill or attempt to collect from the
1081 insured any amount in excess of such limits, except for amounts
1082 that are not covered by the insured's personal injury protection
1083 coverage due to the coinsurance amount or maximum policy limits.
1084 5. Effective July 1, 2012, an insurer may limit payment as
1085 authorized by this paragraph only if the insurance policy
1086 includes a notice at the time of issuance or renewal that the
1087 insurer may limit payment pursuant to the schedule of charges
1088 specified in this paragraph. A policy form approved by the
1089 office satisfies this requirement. If a provider submits a
1090 charge for an amount less than the amount allowed under
1091 subparagraph 1., the insurer may pay the amount of the charge
1092 submitted.
1093 (b)1. An insurer or insured is not required to pay a claim
1094 or charges:
1095 a. Made by a broker or by a person making a claim on
1096 behalf of a broker;
1097 b. For any service or treatment that was not lawful at the
1098 time rendered;
1099 c. To any person who knowingly submits a false or
1100 misleading statement relating to the claim or charges;
1101 d. With respect to a bill or statement that does not
1102 substantially meet the applicable requirements of paragraph (d);

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1103 e. For any treatment or service that is upcoded, or that
1104 is unbundled when such treatment or services should be bundled,
1105 in accordance with paragraph (d). To facilitate prompt payment
1106 of lawful services, an insurer may change codes that it
1107 determines ~~to~~ have been improperly or incorrectly upcoded or
1108 unbundled~~,~~ and may make payment based on the changed codes,
1109 without affecting the right of the provider to dispute the
1110 change by the insurer, if, ~~provided that~~ before doing so, the
1111 insurer contacts ~~must contact~~ the health care provider and
1112 discusses ~~discuss~~ the reasons for the insurer's change and the
1113 health care provider's reason for the coding, or makes ~~make~~ a
1114 reasonable good faith effort to do so, as documented in the
1115 insurer's file; and
1116 f. For medical services or treatment billed by a physician
1117 and not provided in a hospital unless such services are rendered
1118 by the physician or are incident to his or her professional
1119 services and are included on the physician's bill, including
1120 documentation verifying that the physician is responsible for
1121 the medical services that were rendered and billed.
1122 2. The Department of Health, in consultation with the
1123 appropriate professional licensing boards, shall adopt, by rule,
1124 a list of diagnostic tests deemed not to be medically necessary
1125 for use in the treatment of persons sustaining bodily injury
1126 covered by personal injury protection benefits under this
1127 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
1128 ~~and~~ shall be revised from time to time as determined by the
1129 Department of Health, in consultation with the respective
1130 professional licensing boards. Inclusion of a test on the list

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1131 ~~of invalid diagnostic tests~~ shall be based on lack of
1132 demonstrated medical value and a level of general acceptance by
1133 the relevant provider community and may ~~shall~~ not be dependent
1134 for results entirely upon subjective patient response.
1135 Notwithstanding its inclusion on a fee schedule in this
1136 subsection, an insurer or insured is not required to pay any
1137 charges or reimburse claims for an ~~any~~ invalid diagnostic test
1138 as determined by the Department of Health.
1139 (c)~~1.~~ With respect to any treatment or service, other than
1140 medical services billed by a hospital or other provider for
1141 emergency services and care as defined in s. 395.002 or
1142 inpatient services rendered at a hospital-owned facility, the
1143 statement of charges must be furnished to the insurer by the
1144 provider and may not include, and the insurer is not required to
1145 pay, charges for treatment or services rendered more than 35
1146 days before the postmark date or electronic transmission date of
1147 the statement, except for past due amounts previously billed on
1148 a timely basis under this paragraph, and except that, if the
1149 provider submits to the insurer a notice of initiation of
1150 treatment within 21 days after its first examination or
1151 treatment of the claimant, the statement may include charges for
1152 treatment or services rendered up to, but not more than, 75 days
1153 before the postmark date of the statement. The injured party is
1154 not liable for, and the provider may ~~shall~~ not bill the injured
1155 party for, charges that are unpaid because of the provider's
1156 failure to comply with this paragraph. Any agreement requiring
1157 the injured person or insured to pay for such charges is
1158 unenforceable.

1159 1.~~2.~~ If~~, however,~~ the insured fails to furnish the
1160 provider with the correct name and address of the insured's
1161 personal injury protection insurer, the provider has 35 days
1162 from the date the provider obtains the correct information to
1163 furnish the insurer with a statement of the charges. The insurer
1164 is not required to pay for such charges unless the provider
1165 includes with the statement documentary evidence that was
1166 provided by the insured during the 35-day period demonstrating
1167 that the provider reasonably relied on erroneous information
1168 from the insured and either:
1169 a. A denial letter from the incorrect insurer; or
1170 b. Proof of mailing, which may include an affidavit under
1171 penalty of perjury, reflecting timely mailing to the incorrect
1172 address or insurer.
1173 2.~~3.~~ For emergency services and care ~~as defined in s.~~
1174 ~~395.002~~ rendered in a hospital emergency department or for
1175 transport and treatment rendered by an ambulance provider
1176 licensed pursuant to part III of chapter 401, the provider is
1177 not required to furnish the statement of charges within the time
1178 periods established by this paragraph,~~;~~ and the insurer is ~~shall~~
1179 not ~~be~~ considered to have been furnished with notice of the
1180 amount of covered loss for purposes of paragraph (4)(b) until it
1181 receives a statement complying with paragraph (d), or copy
1182 thereof, which specifically identifies the place of service to
1183 be a hospital emergency department or an ambulance in accordance
1184 with billing standards recognized by the federal Centers for
1185 Medicare and Medicaid Services ~~Health Care Finance~~
1186 ~~Administration~~.

1187 3.~~4.~~ Each notice of the insured's rights under s. 627.7401
1188 must include the following statement in at least 12-point type
1189 ~~in type no smaller than 12 points~~:
1190
1191 BILLING REQUIREMENTS.—Florida law provides ~~Statutes~~
1192 ~~provide~~ that with respect to any treatment or
1193 services, other than certain hospital and emergency
1194 services, the statement of charges furnished to the
1195 insurer by the provider may not include, and the
1196 insurer and the injured party are not required to pay,
1197 charges for treatment or services rendered more than
1198 35 days before the postmark date of the statement,
1199 except for past due amounts previously billed on a
1200 timely basis, and except that, if the provider submits
1201 to the insurer a notice of initiation of treatment
1202 within 21 days after its first examination or
1203 treatment of the claimant, the statement may include
1204 charges for treatment or services rendered up to, but
1205 not more than, 75 days before the postmark date of the
1206 statement.
1207
1208 (d) All statements and bills for medical services rendered
1209 by a ~~any~~ physician, hospital, clinic, or other person or
1210 institution shall be submitted to the insurer on a properly
1211 completed Centers for Medicare and Medicaid Services (CMS) 1500
1212 form, UB 92 forms, or any other standard form approved by the
1213 office or adopted by the commission for purposes of this
1214 paragraph. All billings for such services rendered by providers

1215 <u>must</u> ~~shall~~, to the extent applicable, follow the Physicians'
1216 Current Procedural Terminology (CPT) or Healthcare Correct
1217 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1218 year in which services are rendered and comply with the ~~Centers~~
1219 ~~for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions<u>,</u>
1220 ~~and~~ the American Medical Association ~~Current Procedural~~
1221 ~~Terminology (~~CPT~~)~~ Editorial Panel<u>,</u> and <u>the</u> ~~Healthcare Correct~~
1222 ~~Procedural Coding System (~~HCPCS~~)~~. All providers<u>,</u> other than
1223 hospitals<u>, must</u> ~~shall~~ include on the applicable claim form the
1224 professional license number of the provider in the line or space
1225 provided for "Signature of Physician or Supplier, Including
1226 Degrees or Credentials." In determining compliance with
1227 applicable CPT and HCPCS coding, guidance shall be provided by
1228 the Physicians' Current Procedural Terminology (CPT) or the
1229 Healthcare Correct Procedural Coding System (HCPCS) in effect
1230 for the year in which services were rendered, the Office of the
1231 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1232 other authoritative treatises designated by rule by the Agency
1233 for Health Care Administration. <u>A</u> ~~No~~ statement of medical
1234 services may <u>not</u> include charges for medical services of a
1235 person or entity that performed such services without possessing
1236 the valid licenses required to perform such services. For
1237 purposes of paragraph (4)(b), an insurer <u>is</u> ~~shall~~ not ~~be~~
1238 considered to have been furnished with notice of the amount of
1239 covered loss or medical bills due unless the statements or bills
1240 comply with this paragraph~~,~~ and ~~unless the statements or bills~~
1241 are properly completed in their entirety as to all material

1242 provisions, with all relevant information being provided
1243 therein.
1244 (e)1. At the initial treatment or service provided, each
1245 physician, other licensed professional, clinic, or other medical
1246 institution providing medical services upon which a claim for
1247 personal injury protection benefits is based shall require an
1248 insured person, or his or her guardian, to execute a disclosure
1249 and acknowledgment form, which reflects at a minimum that:
1250 a. The insured, or his or her guardian, must countersign
1251 the form attesting to the fact that the services set forth
1252 therein were actually rendered;
1253 b. The insured, or his or her guardian, has both the right
1254 and affirmative duty to confirm that the services were actually
1255 rendered;
1256 c. The insured, or his or her guardian, was not solicited
1257 by any person to seek any services from the medical provider;
1258 d. The physician, other licensed professional, clinic, or
1259 other medical institution rendering services for which payment
1260 is being claimed explained the services to the insured or his or
1261 her guardian; and
1262 e. If the insured notifies the insurer in writing of a
1263 billing error, the insured may be entitled to a certain
1264 percentage of a reduction in the amounts paid by the insured's
1265 motor vehicle insurer.
1266 2. The physician, other licensed professional, clinic, or
1267 other medical institution rendering services for which payment
1268 is being claimed has the affirmative duty to explain the
1269 services rendered to the insured, or his or her guardian, so

1270 that the insured, or his or her guardian, countersigns the form
1271 with informed consent.
1272 3. Countersignature by the insured, or his or her
1273 guardian, is not required for the reading of diagnostic tests or
1274 other services that are of such a nature that they are not
1275 required to be performed in the presence of the insured.
1276 4. The licensed medical professional rendering treatment
1277 for which payment is being claimed must sign, by his or her own
1278 hand, the form complying with this paragraph.
1279 5. The original completed disclosure and acknowledgment
1280 form shall be furnished to the insurer pursuant to paragraph
1281 (4)(b) and may not be electronically furnished.
1282 6. The ~~This~~ disclosure and acknowledgment form is not
1283 required for services billed by a provider ~~for emergency~~
1284 ~~services as defined in s. 395.002,~~ for emergency services and
1285 care as defined in s. 395.002 rendered in a hospital emergency
1286 department, or for transport and treatment rendered by an
1287 ambulance provider licensed pursuant to part III of chapter 401.
1288 7. The Financial Services Commission shall adopt, by rule,
1289 a standard disclosure and acknowledgment form to ~~that shall~~ be
1290 used to fulfill the requirements of this paragraph~~, effective 90~~
1291 ~~days after such form is adopted and becomes final~~. ~~The~~
1292 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1293 ~~the rule is final, the provider may use a form of its own which~~
1294 ~~otherwise complies with the requirements of this paragraph.~~
1295 8. As used in this paragraph, the term "countersign" or
1296 "countersignature" ~~"countersigned"~~ means a second or verifying
1297 signature, as on a previously signed document, and is not

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1298 satisfied by the statement "signature on file" or any similar
1299 statement.
1300 9. The requirements of this paragraph apply only with
1301 respect to the initial treatment or service of the insured by a
1302 provider. For subsequent treatments or service, the provider
1303 must maintain a patient log signed by the patient, in
1304 chronological order by date of service, which ~~that~~ is consistent
1305 with the services being rendered to the patient as claimed. The
1306 requirement to maintain ~~requirements of this subparagraph for~~
1307 ~~maintaining~~ a patient log signed by the patient may be met by a
1308 hospital that maintains medical records as required by s.
1309 395.3025 and applicable rules and makes such records available
1310 to the insurer upon request.
1311 (f) Upon written notification by any person, an insurer
1312 shall investigate any claim of improper billing by a physician
1313 or other medical provider. The insurer shall determine if the
1314 insured was properly billed for only those services and
1315 treatments that the insured actually received. If the insurer
1316 determines that the insured has been improperly billed, the
1317 insurer shall notify the insured, the person making the written
1318 notification, and the provider of its findings and ~~shall~~ reduce
1319 the amount of payment to the provider by the amount determined
1320 to be improperly billed. If a reduction is made due to a ~~such~~
1321 written notification by any person, the insurer shall pay to the
1322 person 20 percent of the amount of the reduction, up to $500. If
1323 the provider is arrested due to the improper billing, ~~then~~ the
1324 insurer shall pay to the person 40 percent of the amount of the
1325 reduction, up to $500.

1326 (g) An insurer may not systematically downcode with the
1327 intent to deny reimbursement otherwise due. Such action
1328 constitutes a material misrepresentation under s.
1329 626.9541(1)(i)2.
1330 (h) As provided in s. 400.9905, an entity excluded from
1331 the definition of a clinic shall be deemed a clinic and must be
1332 licensed under part X of chapter 400 in order to receive
1333 reimbursement under ss. 627.730-627.7405. However, this
1334 licensing requirement does not apply to:
1335 1. An entity wholly owned by a physician licensed under
1336 chapter 458 or chapter 459, or by the physician and the spouse,
1337 parent, child, or sibling of the physician;
1338 2. An entity wholly owned by a dentist licensed under
1339 chapter 466, or by the dentist and the spouse, parent, child, or
1340 sibling of the dentist;
1341 3. An entity wholly owned by a chiropractic physician
1342 licensed under chapter 460, or by the chiropractic physician and
1343 the spouse, parent, child, or sibling of the chiropractic
1344 physician;
1345 4. A hospital or ambulatory surgical center licensed under
1346 chapter 395;
1347 5. An entity that wholly owns or is wholly owned, directly
1348 or indirectly, by a hospital or hospitals licensed under chapter
1349 395; or
1350 6. An entity that is a clinical facility affiliated with
1351 an accredited medical school at which training is provided for
1352 medical students, residents, or fellows.
1353 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

1354 (a) ~~Every employer shall,~~ If a request is made by an
1355 insurer providing personal injury protection benefits under ss.
1356 627.730-627.7405 against whom a claim has been made, an employer
1357 must furnish ~~forthwith~~, in a form approved by the office, a
1358 sworn statement of the earnings, since the time of the bodily
1359 injury and for a reasonable period before the injury, of the
1360 person upon whose injury the claim is based.
1361 (b) Every physician, hospital, clinic, or other medical
1362 institution providing, before or after bodily injury upon which
1363 a claim for personal injury protection insurance benefits is
1364 based, any products, services, or accommodations in relation to
1365 that or any other injury, or in relation to a condition claimed
1366 to be connected with that or any other injury, shall, if
1367 requested ~~to do so~~ by the insurer against whom the claim has
1368 been made, furnish ~~forthwith~~ a written report of the history,
1369 condition, treatment, dates, and costs of such treatment of the
1370 injured person and why the items identified by the insurer were
1371 reasonable in amount and medically necessary, together with a
1372 sworn statement that the treatment or services rendered were
1373 reasonable and necessary with respect to the bodily injury
1374 sustained and identifying which portion of the expenses for such
1375 treatment or services was incurred as a result of such bodily
1376 injury, and produce ~~forthwith~~, and allow ~~permit~~ the inspection
1377 and copying of, his or her or its records regarding such
1378 history, condition, treatment, dates, and costs of treatment if~~;~~
1379 ~~provided that~~ this does ~~shall~~ not limit the introduction of
1380 evidence at trial. Such sworn statement must ~~shall~~ read as
1381 follows: "Under penalty of perjury, I declare that I have read

1382 the foregoing, and the facts alleged are true, to the best of my
1383 knowledge and belief." A ~~No~~ cause of action for violation of the
1384 physician-patient privilege or invasion of the right of privacy
1385 may not be brought ~~shall be permitted~~ against any physician,
1386 hospital, clinic, or other medical institution complying with
1387 ~~the provisions of~~ this section. The person requesting such
1388 records and such sworn statement shall pay all reasonable costs
1389 connected therewith. If an insurer makes a written request for
1390 documentation or information under this paragraph within 30 days
1391 after having received notice of the amount of a covered loss
1392 under paragraph (4)(a), the amount or the partial amount that
1393 ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~
1394 overdue if the insurer does not pay in accordance with paragraph
1395 (4)(b) or within 10 days after the insurer's receipt of the
1396 requested documentation or information, whichever occurs later.
1397 As used in ~~For purposes of~~ this paragraph, the term "receipt"
1398 includes, but is not limited to, inspection and copying pursuant
1399 to this paragraph. An ~~Any~~ insurer that requests documentation or
1400 information pertaining to reasonableness of charges or medical
1401 necessity under this paragraph without a reasonable basis for
1402 such requests as a general business practice is engaging in an
1403 unfair trade practice under the insurance code.
1404 (c) In the event of a ~~any~~ dispute regarding an insurer's
1405 right to discovery of facts under this section, the insurer may
1406 petition a court of competent jurisdiction to enter an order
1407 permitting such discovery. The order may be made only on motion
1408 for good cause shown and upon notice to all persons having an
1409 interest, and must ~~it shall~~ specify the time, place, manner,

1410 conditions, and scope of the discovery. ~~Such court may,~~ In order
1411 to protect against annoyance, embarrassment, or oppression, as
1412 justice requires, the court may enter an order refusing
1413 discovery or specifying conditions of discovery and may order
1414 payments of costs and expenses of the proceeding, including
1415 reasonable fees for the appearance of attorneys at the
1416 proceedings, as justice requires.
1417 (d) The injured person shall be furnished, upon request, a
1418 copy of all information obtained by the insurer under ~~the~~
1419 ~~provisions of~~ this section, and ~~shall~~ pay a reasonable charge,
1420 if required by the insurer.
1421 (e) Notice to an insurer of the existence of a claim may
1422 ~~shall~~ not be unreasonably withheld by an insured.
1423 (f) In a dispute between the insured and the insurer, or
1424 between an assignee of the insured's rights and the insurer,
1425 upon request, the insurer must notify the insured or the
1426 assignee that the policy limits under this section have been
1427 reached within 15 days after the limits have been reached.
1428 (g) An insured seeking benefits under ss. 627.730-
1429 627.7405, including an omnibus insured, must comply with the
1430 terms of the policy, which include, but are not limited to,
1431 submitting to an examination under oath. The scope of
1432 questioning during the examination under oath is limited to
1433 relevant information or information that could reasonably be
1434 expected to lead to relevant information. Compliance with this
1435 paragraph is a condition precedent to receiving benefits. An
1436 insurer that, as a general business practice as determined by
1437 the office, requests an examination under oath of an insured or

1438 an omnibus insured without a reasonable basis is subject to s.
1439 626.9541.
1440 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
1441 REPORTS.—
1442 (a) Whenever the mental or physical condition of an
1443 injured person covered by personal injury protection is material
1444 to any claim that has been or may be made for past or future
1445 personal injury protection insurance benefits, such person
1446 shall, upon the request of an insurer, submit to mental or
1447 physical examination by a physician or physicians. The costs of
1448 any examinations requested by an insurer shall be borne entirely
1449 by the insurer. Such examination shall be conducted within the
1450 municipality where the insured is receiving treatment, or in a
1451 location reasonably accessible to the insured, which, for
1452 purposes of this paragraph, means any location within the
1453 municipality in which the insured resides, or any location
1454 within 10 miles by road of the insured's residence, provided
1455 such location is within the county in which the insured resides.
1456 If the examination is to be conducted in a location reasonably
1457 accessible to the insured, and if there is no qualified
1458 physician to conduct the examination in a location reasonably
1459 accessible to the insured, ~~then~~ such examination shall be
1460 conducted in an area of the closest proximity to the insured's
1461 residence. Personal protection insurers are authorized to
1462 include reasonable provisions in personal injury protection
1463 insurance policies for mental and physical examination of those
1464 claiming personal injury protection insurance benefits. An
1465 insurer may not withdraw payment of a treating physician without

1466 the consent of the injured person covered by the personal injury
1467 protection, unless the insurer first obtains a valid report by a
1468 Florida physician licensed under the same chapter as the
1469 treating physician whose treatment authorization is sought to be
1470 withdrawn, stating that treatment was not reasonable, related,
1471 or necessary. A valid report is one that is prepared and signed
1472 by the physician examining the injured person or reviewing the
1473 treatment records of the injured person and is factually
1474 supported by the examination and treatment records if reviewed
1475 and that has not been modified by anyone other than the
1476 physician. The physician preparing the report must be in active
1477 practice, unless the physician is physically disabled. Active
1478 practice means that during the 3 years immediately preceding the
1479 date of the physical examination or review of the treatment
1480 records the physician must have devoted professional time to the
1481 active clinical practice of evaluation, diagnosis, or treatment
1482 of medical conditions or to the instruction of students in an
1483 accredited health professional school or accredited residency
1484 program or a clinical research program that is affiliated with
1485 an accredited health professional school or teaching hospital or
1486 accredited residency program. The physician preparing a report
1487 at the request of an insurer and physicians rendering expert
1488 opinions on behalf of persons claiming medical benefits for
1489 personal injury protection, or on behalf of an insured through
1490 an attorney or another entity, shall maintain, for at least 3
1491 years, copies of all examination reports as medical records and
1492 shall maintain, for at least 3 years, records of all payments
1493 for the examinations and reports. Neither an insurer nor any

1494 person acting at the direction of or on behalf of an insurer may
1495 materially change an opinion in a report prepared under this
1496 paragraph or direct the physician preparing the report to change
1497 such opinion. The denial of a payment as the result of such a
1498 changed opinion constitutes a material misrepresentation under
1499 s. 626.9541(1)(i)2.; however, this provision does not preclude
1500 the insurer from calling to the attention of the physician
1501 errors of fact in the report based upon information in the claim
1502 file.
1503 (b) If requested by the person examined, a party causing
1504 an examination to be made shall deliver to him or her a copy of
1505 every written report concerning the examination rendered by an
1506 examining physician, at least one of which reports must set out
1507 the examining physician's findings and conclusions in detail.
1508 After such request and delivery, the party causing the
1509 examination to be made is entitled, upon request, to receive
1510 from the person examined every written report available to him
1511 or her or his or her representative concerning any examination,
1512 previously or thereafter made, of the same mental or physical
1513 condition. By requesting and obtaining a report of the
1514 examination so ordered, or by taking the deposition of the
1515 examiner, the person examined waives any privilege he or she may
1516 have, in relation to the claim for benefits, regarding the
1517 testimony of every other person who has examined, or may
1518 thereafter examine, him or her in respect to the same mental or
1519 physical condition. If a person unreasonably refuses to submit
1520 to or fails to appear at an examination, the personal injury
1521 protection carrier is no longer liable for subsequent personal

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1522 injury protection benefits. An insured's refusal to submit to or
1523 failure to appear at two examinations raises a rebuttable
1524 presumption that the insured's refusal or failure was
1525 unreasonable.
1526 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY
1527 ATTORNEY'S FEES.—With respect to any dispute under the
1528 provisions of ss. 627.730-627.7405 between the insured and the
1529 insurer, or between an assignee of an insured's rights and the
1530 insurer, the provisions of ss. s. 627.428 and 768.79 shall
1531 apply, except as provided in subsections (10) and (15), and
1532 except that any attorney fees recovered must:
1533 (a) Comply with prevailing professional standards;
1534 (b) Not overstate or inflate the number of hours
1535 reasonably necessary for a case of comparable skill or
1536 complexity; and
1537 (c) Represent legal services that are reasonable and
1538 necessary to achieve the result obtained.
1539
1540 Upon request by either party, a judge must make written
1541 findings, substantiated by evidence presented at trial or any
1542 hearings associated therewith, that any award of attorney fees
1543 complies with this subsection. Notwithstanding s. 627.428,
1544 attorney fees recovered under ss. 627.730-627.7405 must be
1545 calculated without regard to a contingency risk multiplier.
1546 (9) PREFERRED PROVIDERS.—An insurer may negotiate and
1547 contract enter into contracts with preferred licensed health
1548 care providers for the benefits described in this section,
1549 referred to in this section as "preferred providers," which

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1550 ~~shall~~ include health care providers licensed under chapter
1551 ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter
1552 ~~and~~ 463. The insurer may provide an option to an insured to use
1553 a preferred provider at the time of purchasing ~~purchase of~~ the
1554 policy for personal injury protection benefits, if the
1555 requirements of this subsection are met. If the insured elects
1556 to use a provider who is not a preferred provider, whether the
1557 insured purchased a preferred provider policy or a nonpreferred
1558 provider policy, the medical benefits provided by the insurer
1559 shall be as required by this section. If the insured elects to
1560 use a provider who is a preferred provider, the insurer may pay
1561 medical benefits in excess of the benefits required by this
1562 section and may waive or lower the amount of any deductible that
1563 applies to such medical benefits. If the insurer offers a
1564 preferred provider policy to a policyholder or applicant, it
1565 must also offer a nonpreferred provider policy. The insurer
1566 shall provide each insured ~~policyholder~~ with a current roster of
1567 preferred providers in the county in which the insured resides
1568 at the time of purchase of such policy, and shall make such list
1569 available for public inspection during regular business hours at
1570 the insurer's principal office ~~of the insurer~~ within the state.
1571 (10) DEMAND LETTER.—
1572 (a) As a condition precedent to filing any action for
1573 benefits under this section, ~~the insurer must be provided with~~
1574 written notice of an intent to initiate litigation must be
1575 provided to the insurer. Such notice may not be sent until the
1576 claim is overdue, including any additional time the insurer has
1577 to pay the claim pursuant to paragraph (4)(b).

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1578 (b) The notice must ~~required shall~~ state that it is a
1579 "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with
1580 specificity:
1581 1. The name of the insured upon which such benefits are
1582 being sought, including a copy of the assignment giving rights
1583 to the claimant if the claimant is not the insured.
1584 2. The claim number or policy number upon which such claim
1585 was originally submitted to the insurer.
1586 3. To the extent applicable, the name of any medical
1587 provider who rendered to an insured the treatment, services,
1588 accommodations, or supplies that form the basis of such claim;
1589 and an itemized statement specifying each exact amount, the date
1590 of treatment, service, or accommodation, and the type of benefit
1591 claimed to be due. A completed form satisfying the requirements
1592 of paragraph (5)(d) or the lost-wage statement previously
1593 submitted may be used as the itemized statement. To the extent
1594 that the demand involves an insurer's withdrawal of payment
1595 under paragraph (7)(a) for future treatment not yet rendered,
1596 the claimant shall attach a copy of the insurer's notice
1597 withdrawing such payment and an itemized statement of the type,
1598 frequency, and duration of future treatment claimed to be
1599 reasonable and medically necessary.
1600 (c) Each notice required by this subsection must be
1601 delivered to the insurer by United States certified or
1602 registered mail, return receipt requested. Such postal costs
1603 shall be reimbursed by the insurer if ~~so~~ requested by the
1604 claimant in the notice, when the insurer pays the claim. Such
1605 notice must be sent to the person and address specified by the

1606 insurer for the purposes of receiving notices under this
1607 subsection. Each licensed insurer, whether domestic, foreign, or
1608 alien, shall file with the office ~~designation of~~ the name and
1609 address of the designated person to whom notices must ~~pursuant~~
1610 ~~to this subsection shall~~ be sent which the office shall make
1611 available on its Internet website. The name and address on file
1612 with the office pursuant to s. 624.422 are ~~shall be~~ deemed the
1613 authorized representative to accept notice pursuant to this
1614 subsection if ~~in the event~~ no other designation has been made.
1615 (d) If, within 30 days after receipt of notice by the
1616 insurer, the overdue claim specified in the notice is paid by
1617 the insurer together with applicable interest and a penalty of
1618 10 percent of the overdue amount paid by the insurer, subject to
1619 a maximum penalty of $250, no action may be brought against the
1620 insurer. If the demand involves an insurer's withdrawal of
1621 payment under paragraph (7)(a) for future treatment not yet
1622 rendered, no action may be brought against the insurer if,
1623 within 30 days after its receipt of the notice, the insurer
1624 mails to the person filing the notice a written statement of the
1625 insurer's agreement to pay for such treatment in accordance with
1626 the notice and to pay a penalty of 10 percent, subject to a
1627 maximum penalty of $250, when it pays for such future treatment
1628 in accordance with the requirements of this section. To the
1629 extent the insurer determines not to pay any amount demanded,
1630 the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action.
1631 For purposes of this subsection, payment or the insurer's
1632 agreement shall be treated as being made on the date a draft or
1633 other valid instrument that is equivalent to payment, or the

1634 insurer's written statement of agreement, is placed in the
1635 United States mail in a properly addressed, postpaid envelope,
1636 or if not so posted, on the date of delivery. The insurer is not
1637 obligated to pay any attorney ~~attorney's~~ fees if the insurer
1638 pays the claim or mails its agreement to pay for future
1639 treatment within the time prescribed by this subsection.
1640 (e) The applicable statute of limitation for an action
1641 under this section shall be tolled for ~~a period of~~ 30 business
1642 days by the mailing of the notice required by this subsection.
1643 ~~(f) Any insurer making a general business practice of not~~
1644 ~~paying valid claims until receipt of the notice required by this~~
1645 ~~subsection is engaging in an unfair trade practice under the~~
1646 ~~insurance code.~~
1647 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
1648 PRACTICE.—
1649 (a) ~~If~~ An insurer ~~fails to pay valid claims for personal~~
1650 ~~injury protection with such frequency so as to indicate a~~
1651 ~~general business practice, the insurer~~ is engaging in a
1652 prohibited unfair or deceptive practice that is subject to the
1653 penalties provided in s. 626.9521 and the office has the powers
1654 and duties specified in ss. 626.9561-626.9601 if the insurer,
1655 with such frequency so as to indicate a general business
1656 practice: ~~with respect thereto~~
1657 1. Fails to pay valid claims for personal injury
1658 protection; or
1659 2. Fails to pay valid claims until receipt of the notice
1660 required by subsection (10).

1661 (b) Notwithstanding s. 501.212, the Department of Legal
1662 Affairs may investigate and initiate actions for a violation of
1663 this subsection, including, but not limited to, the powers and
1664 duties specified in part II of chapter 501.
1665 (17) NONREIMBURSIBLE CLAIMS.-Claims generated as a result
1666 of activities that are unlawful pursuant to s. 817.505 are not
1667 reimbursable under the Florida Motor Vehicle No-Fault Law.
1668 Section 11. Effective December 1, 2012, subsection (16) of
1669 section 627.736, Florida Statutes, is amended to read:
1670 627.736 Required personal injury protection benefits;
1671 exclusions; priority; claims.—
1672 (16) SECURE ELECTRONIC DATA TRANSFER.—If all parties
1673 mutually and expressly agree, A notice, documentation,
1674 transmission, or communication of any kind required or
1675 authorized under ss. 627.730-627.7405 may be transmitted
1676 electronically if it is transmitted by secure electronic data
1677 transfer that is consistent with state and federal privacy and
1678 security laws.
1679 Section 12. Section 627.7405, Florida Statutes, is amended
1680 to read:
1681 627.7405 Insurers' right of reimbursement.—
1682 (1) Notwithstanding any other provisions of ss. 627.730-
1683 627.7405, an any insurer providing personal injury protection
1684 benefits on a private passenger motor vehicle shall have, to the
1685 extent of any personal injury protection benefits paid to any
1686 person as a benefit arising out of such private passenger motor
1687 vehicle insurance, a right of reimbursement against the owner or
1688 the insurer of the owner of a commercial motor vehicle, if the

1689 benefits paid result from such person having been an occupant of
1690 the commercial motor vehicle or having been struck by the
1691 commercial motor vehicle while not an occupant of any self-
1692 propelled vehicle.
1693 (2) The insurer's right of reimbursement under this
1694 section does not apply to an owner or registrant as identified
1695 in s. 627.733(1)(b).
1696 Section 13. Subsections (1), (10), and (13) of section
1697 817.234, Florida Statutes, are amended to read:
1698 817.234 False and fraudulent insurance claims.—
1699 (1)(a) A person commits insurance fraud punishable as
1700 provided in subsection (11) if that person, with the intent to
1701 injure, defraud, or deceive any insurer:
1702 1. Presents or causes to be presented any written or oral
1703 statement as part of, or in support of, a claim for payment or
1704 other benefit pursuant to an insurance policy or a health
1705 maintenance organization subscriber or provider contract,
1706 knowing that such statement contains any false, incomplete, or
1707 misleading information concerning any fact or thing material to
1708 such claim;
1709 2. Prepares or makes any written or oral statement that is
1710 intended to be presented to any insurer in connection with, or
1711 in support of, any claim for payment or other benefit pursuant
1712 to an insurance policy or a health maintenance organization
1713 subscriber or provider contract, knowing that such statement
1714 contains any false, incomplete, or misleading information
1715 concerning any fact or thing material to such claim; ~~or~~

1716 3.a. Knowingly presents, causes to be presented, or
1717 prepares or makes with knowledge or belief that it will be
1718 presented to any insurer, purported insurer, servicing
1719 corporation, insurance broker, or insurance agent, or any
1720 employee or agent thereof, any false, incomplete, or misleading
1721 information or written or oral statement as part of, or in
1722 support of, an application for the issuance of, or the rating
1723 of, any insurance policy, or a health maintenance organization
1724 subscriber or provider contract; or
1725 b. ~~Who~~ Knowingly conceals information concerning any fact
1726 material to such application; or~~.~~
1727 4. Knowingly presents, causes to be presented, or prepares
1728 or makes with knowledge or belief that it will be presented to
1729 any insurer a claim for payment or other benefit under a
1730 personal injury protection insurance policy if the person knows
1731 that the payee knowingly submitted a false, misleading, or
1732 fraudulent application or other document when applying for
1733 licensure as a health care clinic, seeking an exemption from
1734 licensure as a health care clinic, or demonstrating compliance
1735 with part X of chapter 400.
1736 (b) All claims and application forms must ~~shall~~ contain a
1737 statement that is approved by the Office of Insurance Regulation
1738 of the Financial Services Commission which clearly states in
1739 substance the following: "Any person who knowingly and with
1740 intent to injure, defraud, or deceive any insurer files a
1741 statement of claim or an application containing any false,
1742 incomplete, or misleading information is guilty of a felony of
1743 the third degree." This paragraph does ~~shall~~ not apply to

1744 reinsurance contracts, reinsurance agreements, or reinsurance
1745 claims transactions.
1746 (10) A licensed health care practitioner who is found
1747 guilty of insurance fraud under this section for an act relating
1748 to a personal injury protection insurance policy loses his or
1749 her license to practice for 5 years and may not receive
1750 reimbursement for personal injury protection benefits for 10
1751 years. ~~As used in this section, the term "insurer" means any~~
1752 ~~insurer, health maintenance organization, self-insurer, self-~~
1753 ~~insurance fund, or other similar entity or person regulated~~
1754 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~
1755 ~~Regulation under the Florida Insurance Code.~~
1756 (13) As used in this section, the term:
1757 (a) "Insurer" means any insurer, health maintenance
1758 organization, self-insurer, self-insurance fund, or similar
1759 entity or person regulated under chapter 440 or chapter 641 or
1760 by the Office of Insurance Regulation under the Florida
1761 Insurance Code.
1762 (b) ~~(a)~~ "Property" means property as defined in s. 812.012.
1763 (c) ~~(b)~~ "Value" means value as defined in s. 812.012.
1764 Section 14. Subsection (4) of section 316.065, Florida
1765 Statutes, is amended to read:
1766 316.065 Crashes; reports; penalties.—
1767 (4) Any person who knowingly repairs a motor vehicle
1768 without having made a report as required by subsection (3) is
1769 guilty of a misdemeanor of the first degree, punishable as
1770 provided in s. 775.082 or s. 775.083. The owner and driver of a
1771 vehicle involved in a crash who makes a report thereof in

1772 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable
1773 under this section.
1774 Section 15. <u>(1) Within 60 days after the effective date</u>
1775 <u>of this section, the Office of Insurance Regulation shall enter</u>
1776 <u>into a contract with an independent consultant to calculate the</u>
1777 <u>savings expected as a result of this act. The contract shall</u>
1778 <u>require the use of generally accepted actuarial techniques and</u>
1779 <u>standards as provided in s. 627.0651, Florida Statutes, in</u>
1780 <u>determining the expected impact on losses and expenses. By</u>
1781 <u>September 15, 2012, the office shall submit to the Governor, the</u>
1782 <u>President of Senate, and the Speaker of the House of</u>
1783 <u>Representatives a report concerning the results of the</u>
1784 <u>independent consultant's calculations.</u>
1785 <u>(2) By October 1, 2012, an insurer writing private</u>
1786 <u>passenger automobile personal injury protection insurance in</u>
1787 <u>this state shall make a rate filing with the Office of Insurance</u>
1788 <u>Regulation. A rate certification is not sufficient to satisfy</u>
1789 <u>this requirement. If the insurer requests a rate in excess of a</u>
1790 <u>10-percent reduction as applied to the current rate in its</u>
1791 <u>overall base rate for personal injury protection insurance, the</u>
1792 <u>insurer must include in its rate filing a detailed explanation</u>
1793 <u>of the reasons for failure to achieve a 10-percent reduction.</u>
1794 <u>(3) By January 1, 2014, an insurer writing private</u>
1795 <u>passenger automobile personal injury protection insurance in</u>
1796 <u>this state shall make a rate filing with the Office of Insurance</u>
1797 <u>Regulation. A rate certification is not sufficient to satisfy</u>
1798 <u>this requirement. If the insurer requests a rate in excess of a</u>
1799 <u>25-percent reduction as applied to the rate in effect as of the</u>

1800 effective date of this act in its overall base rate for personal
1801 injury protection insurance since the effective date of this
1802 act, the insurer must include in its rate filing a detailed
1803 explanation of the reasons for failure to achieve a 25-percent
1804 reduction.
1805 (4) If an insurer fails to provide the detailed
1806 explanation required by subsection (2) or subsection (3), the
1807 Office of Insurance Regulation shall order the insurer to stop
1808 writing new personal injury protection policies in this state
1809 until it provides the required explanation.
1810 (5) The sum of $200,000 of nonrecurring revenue is
1811 appropriated from the Insurance Regulatory Trust Fund to the
1812 Office of Insurance Regulation for the purpose of implementing
1813 the requirements of subsection (1) during the 2011-2012 fiscal
1814 year. Any unexpended balance of the appropriation at the end of
1815 the fiscal year shall be carried forward and be available for
1816 expenditure during the 2012-2013 fiscal year. Notwithstanding s.
1817 287.057, Florida Statutes, the office may retain an independent
1818 consultant to implement the requirements of subsection (1)
1819 without a competitive solicitation.
1820 (6) This section shall take effect upon this act becoming
1821 a law.
1822 Section 16. The Office of Insurance Regulation shall
1823 perform a comprehensive personal injury protection data call and
1824 publish the results by January 1, 2015. It is the intent of the
1825 Legislature that the office design the data call with the
1826 expectation that the Legislature will use the data to help
1827 evaluate market conditions relating to the Florida Motor Vehicle

1828 No-Fault Law and the impact on the market of reforms to the law
1829 made by this act. The elements of the data call must address,
1830 but need not be limited to, the following components of the
1831 Florida Motor Vehicle No-Fault Law:
1832 (1) Quantity of personal injury protection claims.
1833 (2) Type or nature of claimants.
1834 (3) Amount and type of personal injury protection benefits
1835 paid and expenses incurred.
1836 (4) Type and quantity of, and charges for, medical
1837 benefits.
1838 (5) Attorney fees related to bringing and defending
1839 actions for benefits.
1840 (6) Direct earned premiums for personal injury protection
1841 coverage, pure loss ratios, pure premiums, and other information
1842 related to premiums and losses.
1843 (7) Licensed drivers and accidents.
1844 (8) Fraud and enforcement.
1845 Section 17. If any provision of this act or its
1846 application to any person or circumstance is held invalid, the
1847 invalidity does not affect other provisions or applications of
1848 the act which can be given effect without the invalid provision
1849 or application, and to this end the provisions of this act are
1850 severable.
1851 Section 18. Except as otherwise expressly provided in this
1852 act, this act shall take effect July 1, 2012.