



811080

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/29/2012	.	
	.	
	.	
	.	

The Committee on Budget (Richter) recommended the following:

1 **Senate Substitute for Amendment (344314) (with title**
2 **amendment)**

3
4 Delete lines 296 - 1482

5 and insert:

6 Notwithstanding this subsection, an entity shall be deemed a
7 clinic and must be licensed under this part in order to receive
8 reimbursement under the Florida Motor Vehicle No-Fault Law,
9 unless exempted under s. 627.736(5)(h), or under the Florida
10 Motor Vehicle No-Fault Medical Care Coverage Law, unless
11 exempted under s. 627.7485(1)(a)3.

12 Section 3. Subsection (6) is added to section 400.991,
13 Florida Statutes, to read:



811080

14 400.991 License requirements; background screenings;
15 prohibitions.-

16 (6) All agency forms for licensure application or exemption
17 from licensure under this part must contain the following
18 statement:

19
20 INSURANCE FRAUD NOTICE.-A person who knowingly submits
21 a false, misleading, or fraudulent application or
22 other document when applying for licensure as a health
23 care clinic, seeking an exemption from licensure as a
24 health care clinic, or demonstrating compliance with
25 part X of chapter 400, Florida Statutes, with the
26 intent to use the license, exemption from licensure,
27 or demonstration of compliance to provide services or
28 seek reimbursement under the Florida Motor Vehicle No-
29 Fault Law or the Florida Motor Vehicle No-Fault
30 Medical Care Coverage Law, commits a fraudulent
31 insurance act, as defined in s. 626.989, Florida
32 Statutes. A person who presents a claim for personal
33 injury protection or medical care coverage benefits
34 knowing that the payee knowingly submitted such health
35 care clinic application or document, commits insurance
36 fraud, as defined in s. 817.234, Florida Statutes.

37
38 Section 4. Subsection (1) of section 626.989, Florida
39 Statutes, is amended to read:

40 626.989 Investigation by department or Division of
41 Insurance Fraud; compliance; immunity; confidential information;
42 reports to division; division investigator's power of arrest.-



811080

43 (1) For the purposes of this section:7

44 (a) A person commits a "fraudulent insurance act" if the
45 person:

46 1. Knowingly and with intent to defraud presents, causes to
47 be presented, or prepares with knowledge or belief that it will
48 be presented, to or by an insurer, self-insurer, self-insurance
49 fund, servicing corporation, purported insurer, broker, or any
50 agent thereof, any written statement as part of, or in support
51 of, an application for the issuance of, or the rating of, any
52 insurance policy, or a claim for payment or other benefit
53 pursuant to any insurance policy, which the person knows to
54 contain materially false information concerning any fact
55 material thereto or if the person conceals, for the purpose of
56 misleading another, information concerning any fact material
57 thereto.

58 2. Knowingly submits:

59 a. A false, misleading, or fraudulent application or other
60 document when applying for licensure as a health care clinic,
61 seeking an exemption from licensure as a health care clinic, or
62 demonstrating compliance with part X of chapter 400 with an
63 intent to use the license, exemption from licensure, or
64 demonstration of compliance to provide services or seek
65 reimbursement under the Florida Motor Vehicle No-Fault Law or
66 the Florida Motor Vehicle No-Fault Medical Care Coverage Law.

67 b. A claim for payment or other benefit pursuant to an
68 insurance policy under the Florida Motor Vehicle No-Fault Law or
69 the Florida Motor Vehicle No-Fault Medical Care Coverage Law if
70 the person knows that the payee knowingly submitted a false,
71 misleading, or fraudulent application or other document when



811080

72 applying for licensure as a health care clinic, seeking an
73 exemption from licensure as a health care clinic, or
74 demonstrating compliance with part X of chapter 400. For the
75 purposes of this section,

76 (b) The term "insurer" also includes a ~~any~~ health
77 maintenance organization, and the term "insurance policy" also
78 includes a health maintenance organization subscriber contract.

79 Section 5. Section 626.9895, Florida Statutes, is created
80 to read:

81 626.9895 Motor vehicle insurance fraud direct-support
82 organization.—

83 (1) DEFINITIONS.—As used in this section, the term:

84 (a) "Division" means the Division of Insurance Fraud of the
85 Department of Financial Services.

86 (b) "Motor vehicle insurance fraud" means any act defined
87 as a "fraudulent insurance act" under s. 626.989, which relates
88 to the coverage of motor vehicle insurance as described in part
89 XI of chapter 627.

90 (c) "Organization" means the direct-support organization
91 established under this section.

92 (2) ORGANIZATION ESTABLISHED.—The division may establish a
93 direct-support organization, to be known as the "Automobile
94 Insurance Fraud Strike Force," whose sole purpose is to support
95 the prosecution, investigation, and prevention of motor vehicle
96 insurance fraud. The organization shall:

97 (a) Be a not-for-profit corporation incorporated under
98 chapter 617 and approved by the Department of State.

99 (b) Be organized and operated to conduct programs and
100 activities; raise funds; request and receive grants, gifts, and



811080

101 bequests of money; acquire, receive, hold, invest, and
102 administer, in its own name, securities, funds, objects of
103 value, or other property, real or personal; and make grants and
104 expenditures to or for the direct or indirect benefit of the
105 division, state attorneys' offices, the statewide prosecutor,
106 the Agency for Health Care Administration, and the Department of
107 Health to the extent that such grants and expenditures are used
108 exclusively to advance the prosecution, investigation, or
109 prevention of motor vehicle insurance fraud. Grants and
110 expenditures may include the cost of salaries or benefits of
111 motor vehicle insurance fraud investigators, prosecutors, or
112 support personnel if such grants and expenditures do not
113 interfere with prosecutorial independence or otherwise create
114 conflicts of interest which threaten the success of
115 prosecutions.

116 (c) Be determined by the division to operate in a manner
117 that promotes the goals of laws relating to motor vehicle
118 insurance fraud, that is in the best interest of the state, and
119 that is in accordance with the adopted goals and mission of the
120 division.

121 (d) Use all of its grants and expenditures solely for the
122 purpose of preventing and decreasing motor vehicle insurance
123 fraud, and not for the purpose of lobbying as defined in s.
124 11.045.

125 (e) Be subject to an annual financial audit in accordance
126 with s. 215.981.

127 (3) CONTRACT.—The organization shall operate under written
128 contract with the division. The contract must provide for:

129 (a) Approval of the articles of incorporation and bylaws of



811080

130 the organization by the division.

131 (b) Submission of an annual budget for approval of the
132 division. The budget must require the organization to minimize
133 costs to the division and its members at all times by using
134 existing personnel and property and allowing for telephonic
135 meetings, if appropriate.

136 (c) Certification by the division that the organization is
137 complying with the terms of the contract and in a manner
138 consistent with the goals and purposes of the department and in
139 the best interest of the state. Such certification must be made
140 annually and reported in the official minutes of a meeting of
141 the organization.

142 (d) Allocation of funds to address motor vehicle insurance
143 fraud.

144 (e) Reversion of moneys and property held in trust by the
145 organization for motor vehicle insurance fraud prosecution,
146 investigation, and prevention to the division if the
147 organization is no longer approved to operate for the department
148 or if the organization ceases to exist, or to the state if the
149 division ceases to exist.

150 (f) Specific criteria to be used by the organization's
151 board of directors to evaluate the effectiveness of funding used
152 to combat motor vehicle insurance fraud.

153 (g) The fiscal year of the organization, which begins July
154 1 of each year and ends June 30 of the following year.

155 (h) Disclosure of the material provisions of the contract,
156 and distinguishing between the department and the organization
157 to donors of gifts, contributions, or bequests, including
158 providing such disclosure on all promotional and fundraising



811080

159 publications.

160 (4) BOARD OF DIRECTORS.—

161 (a) The board of directors of the organization shall
162 consist of the following eleven members:

163 1. The Chief Financial Officer, or designee, who shall
164 serve as chair.

165 2. Two state attorneys, one of whom shall be appointed by
166 the Chief Financial Officer and one of whom shall be appointed
167 by the Attorney General.

168 3. Two representatives of motor vehicle insurers appointed
169 by the Chief Financial Officer.

170 4. Two representatives of local law enforcement agencies,
171 one of whom shall be appointed by the Chief Financial Officer
172 and one of whom shall be appointed by the Attorney General.

173 5. Two representatives of the types of health care
174 providers who regularly make claims for benefits under the
175 Florida Motor Vehicle No-Fault Law or the Florida Motor Vehicle
176 No-Fault Medical Care Coverage Law, one of whom shall be
177 appointed by the President of the Senate and one of whom shall
178 be appointed by the Speaker of the House of Representatives. The
179 appointees may not represent the same type of health care
180 provider.

181 6. A private attorney who has experience in representing
182 claimants in actions for benefits under the Florida Motor
183 Vehicle No-Fault Law, who shall be appointed by the President of
184 the Senate.

185 7. A private attorney who has experience in representing
186 insurers in actions for benefits under the Florida Motor Vehicle
187 No-Fault Law, who shall be appointed by the Speaker of the House



811080

188 of Representatives.

189 (b) The officer who appointed a member of the board may
190 remove that member for cause. The term of office of an appointed
191 member expires at the same time as the term of the officer who
192 appointed him or her or at such earlier time as the person
193 ceases to be qualified.

194 (5) USE OF PROPERTY.—The department may authorize, without
195 charge, appropriate use of fixed property and facilities of the
196 division by the organization, subject to this subsection.

197 (a) The department may prescribe any condition with which
198 the organization must comply in order to use the division's
199 property or facilities.

200 (b) The department may not authorize the use of the
201 division's property or facilities if the organization does not
202 provide equal membership and employment opportunities to all
203 persons regardless of race, religion, sex, age, or national
204 origin.

205 (c) The department shall adopt rules prescribing the
206 procedures by which the organization is governed and any
207 conditions with which the organization must comply to use the
208 division's property or facilities.

209 (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an
210 insurer to the organization shall be allowed as an appropriate
211 business expense of the insurer for all regulatory purposes.

212 (7) DEPOSITORY ACCOUNT.—Any moneys received by the
213 organization may be held in a separate depository account in the
214 name of the organization and subject to the contract with the
215 division.

216 (8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by



811080

217 the division from the organization shall be deposited into the
218 Insurance Regulatory Trust Fund.

219 Section 6. Section 627.732, Florida Statutes, is reordered
220 and amended to read:

221 627.732 Definitions.—As used in ss. 627.730–627.7405, the
222 term:

223 (1) “Broker” means any person not possessing a license
224 under chapter 395, chapter 400, chapter 429, chapter 458,
225 chapter 459, chapter 460, chapter 461, or chapter 641 who
226 charges or receives compensation for any use of medical
227 equipment and is not the 100-percent owner or the 100-percent
228 lessee of such equipment. For purposes of this section, such
229 owner or lessee may be an individual, a corporation, a
230 partnership, or any other entity and any of its 100-percent-
231 owned affiliates and subsidiaries. For purposes of this
232 subsection, the term “lessee” means a long-term lessee under a
233 capital or operating lease, but does not include a part-time
234 lessee. The term “broker” does not include a hospital or
235 physician management company whose medical equipment is
236 ancillary to the practices managed, a debt collection agency, or
237 an entity that has contracted with the insurer to obtain a
238 discounted rate for such services; nor does the term include a
239 management company that has contracted to provide general
240 management services for a licensed physician or health care
241 facility and whose compensation is not materially affected by
242 the usage or frequency of usage of medical equipment or an
243 entity that is 100-percent owned by one or more hospitals or
244 physicians. The term “broker” does not include a person or
245 entity that certifies, upon request of an insurer, that:



811080

246 (a) It is a clinic licensed under ss. 400.990-400.995;
247 (b) It is a 100-percent owner of medical equipment; and
248 (c) The owner's only part-time lease of medical equipment
249 for personal injury protection patients is on a temporary basis
250 not to exceed 30 days in a 12-month period, and such lease is
251 solely for the purposes of necessary repair or maintenance of
252 the 100-percent-owned medical equipment or pending the arrival
253 and installation of the newly purchased or a replacement for the
254 100-percent-owned medical equipment, or for patients for whom,
255 because of physical size or claustrophobia, it is determined by
256 the medical director or clinical director to be medically
257 necessary that the test be performed in medical equipment that
258 is open-style. The leased medical equipment cannot be used by
259 patients who are not patients of the registered clinic for
260 medical treatment of services. Any person or entity making a
261 false certification under this subsection commits insurance
262 fraud as defined in s. 817.234. However, the 30-day period
263 provided in this paragraph may be extended for an additional 60
264 days as applicable to magnetic resonance imaging equipment if
265 the owner certifies that the extension otherwise complies with
266 this paragraph.

267 (9)~~(2)~~ "Medically necessary" refers to a medical service or
268 supply that a prudent physician would provide for the purpose of
269 preventing, diagnosing, or treating an illness, injury, disease,
270 or symptom in a manner that is:

271 (a) In accordance with generally accepted standards of
272 medical practice;

273 (b) Clinically appropriate in terms of type, frequency,
274 extent, site, and duration; and



811080

275 (c) Not primarily for the convenience of the patient,
276 physician, or other health care provider.

277 ~~(10)(3)~~ "Motor vehicle" means any self-propelled vehicle
278 with four or more wheels which is of a type both designed and
279 required to be licensed for use on the highways of this state
280 and any trailer or semitrailer designed for use with such
281 vehicle and includes:

282 (a) A "private passenger motor vehicle," which is any motor
283 vehicle which is a sedan, station wagon, or jeep-type vehicle
284 and, if not used primarily for occupational, professional, or
285 business purposes, a motor vehicle of the pickup, panel, van,
286 camper, or motor home type.

287 (b) A "commercial motor vehicle," which is any motor
288 vehicle which is not a private passenger motor vehicle.

289
290 The term "motor vehicle" does not include a mobile home or any
291 motor vehicle which is used in mass transit, other than public
292 school transportation, and designed to transport more than five
293 passengers exclusive of the operator of the motor vehicle and
294 which is owned by a municipality, a transit authority, or a
295 political subdivision of the state.

296 ~~(11)(4)~~ "Named insured" means a person, usually the owner
297 of a vehicle, identified in a policy by name as the insured
298 under the policy.

299 ~~(12)(5)~~ "Owner" means a person who holds the legal title to
300 a motor vehicle; or, in the event a motor vehicle is the subject
301 of a security agreement or lease with an option to purchase with
302 the debtor or lessee having the right to possession, then the
303 debtor or lessee shall be deemed the owner for the purposes of



811080

304 ss. 627.730-627.7405.

305 ~~(14)(6)~~ "Relative residing in the same household" means a
306 relative of any degree by blood or by marriage who usually makes
307 her or his home in the same family unit, whether or not
308 temporarily living elsewhere.

309 ~~(2)(7)~~ "Certify" means to swear or attest to being true or
310 represented in writing.

311 (3) "Entity wholly owned" means a proprietorship, group
312 practice, partnership, or corporation that provides health care
313 services rendered by licensed health care practitioners and in
314 which licensed health care practitioners are the business owners
315 of all aspects of the business entity, including, but not
316 limited to, being reflected as the business owners on the title
317 or lease of the physical facility, filing taxes as the business
318 owners, being account holders on the entity's bank account,
319 being listed as the principals on all incorporation documents
320 required by this state, and having ultimate authority over all
321 personnel and compensation decisions relating to the entity.
322 However, this definition does not apply to an entity that is
323 wholly owned, directly or indirectly, by a hospital licensed
324 under chapter 395.

325 ~~(5)(8)~~ "Immediate personal supervision," as it relates to
326 the performance of medical services by nonphysicians not in a
327 hospital, means that an individual licensed to perform the
328 medical service or provide the medical supplies must be present
329 within the confines of the physical structure where the medical
330 services are performed or where the medical supplies are
331 provided such that the licensed individual can respond
332 immediately to any emergencies if needed.



811080

333 ~~(6)-(9)~~ "Incident," with respect to services considered as
334 incident to a physician's professional service, for a physician
335 licensed under chapter 458, chapter 459, chapter 460, or chapter
336 461, if not furnished in a hospital, means such services must be
337 an integral, even if incidental, part of a covered physician's
338 service.

339 ~~(7)-(10)~~ "Knowingly" means that a person, with respect to
340 information, has actual knowledge of the information; acts in
341 deliberate ignorance of the truth or falsity of the information;
342 or acts in reckless disregard of the information, and proof of
343 specific intent to defraud is not required.

344 ~~(8)-(11)~~ "Lawful" or "lawfully" means in substantial
345 compliance with all relevant applicable criminal, civil, and
346 administrative requirements of state and federal law related to
347 the provision of medical services or treatment.

348 ~~(4)-(12)~~ "Hospital" means a facility that, at the time
349 services or treatment were rendered, was licensed under chapter
350 395.

351 (13) "Properly completed" means providing truthful,
352 substantially complete, and substantially accurate responses as
353 to all material elements to each applicable request for
354 information or statement by a means that may lawfully be
355 provided and that complies with this section, or as agreed by
356 the parties.

357 ~~(16)-(14)~~ "Upcoding" means an action that submits a billing
358 code that would result in payment greater in amount than would
359 be paid using a billing code that accurately describes the
360 services performed. The term does not include an otherwise
361 lawful bill by a magnetic resonance imaging facility, which



811080

362 globally combines both technical and professional components, if
363 the amount of the global bill is not more than the components if
364 billed separately; however, payment of such a bill constitutes
365 payment in full for all components of such service.

366 (15) "Unbundling" means an action that submits a billing
367 code that is properly billed under one billing code, but that
368 has been separated into two or more billing codes, and would
369 result in payment greater in amount than would be paid using one
370 billing code.

371 Section 7. Subsection (6) is added to section 627.733,
372 Florida Statutes, to read:

373 627.733 Required security.—

374 (6) The owner or registrant of a motor vehicle otherwise
375 subject to this section is not required to maintain the security
376 described herein if the owner or registrant maintains the
377 security required under s. 627.7483.

378 Section 8. Subsections (1), (4), (5), (8), (9), (10), (11),
379 and (16) of section 627.736, Florida Statutes, are amended to
380 read:

381 627.736 Required personal injury protection benefits;
382 exclusions; priority; claims.—

383 (1) REQUIRED BENEFITS.—An Every insurance policy providing
384 personal injury protection must ~~complying with the security~~
385 ~~requirements of s. 627.733 shall~~ provide personal injury
386 protection benefits to the named insured, relatives residing in
387 the same household, persons operating the insured motor vehicle,
388 passengers in the ~~such~~ motor vehicle, and other persons struck
389 by the ~~such~~ motor vehicle and suffering bodily injury while not
390 an occupant of a self-propelled vehicle, subject to ~~the~~



811080

391 ~~provisions of~~ subsection (2) and paragraph (4)(e), up to a limit
392 of \$10,000 in medical and disability benefits and \$5,000 in
393 death benefits resulting from ~~for loss sustained by any such~~
394 ~~person as a result of~~ bodily injury, sickness, disease, or death
395 to such persons arising out of the ownership, maintenance, or
396 use of a motor vehicle as follows:

397 (a) *Medical benefits.*—Eighty percent of all reasonable
398 expenses for medically necessary medical, surgical, X-ray,
399 dental, and rehabilitative services, including prosthetic
400 devices, and medically necessary ambulance, hospital, and
401 nursing services. Medical benefits do not include massage as
402 defined in s. 480.033 or acupuncture as defined in s. 457.102,
403 regardless of the person, entity, or licensee providing massage
404 or acupuncture, and a licensed massage therapist or licensed
405 acupuncturist may not be reimbursed for medical benefits under
406 this section. ~~However,~~ The medical benefits ~~shall~~ provide
407 reimbursement only for ~~such~~ services and care that are lawfully
408 provided, supervised, ordered, or prescribed by a physician
409 licensed under chapter 458 or chapter 459, a dentist licensed
410 under chapter 466, or a chiropractic physician licensed under
411 chapter 460 or that are provided by any of the following ~~persons~~
412 ~~or entities~~:

413 1. A hospital or ambulatory surgical center licensed under
414 chapter 395.

415 2. A person or entity licensed under part III of chapter
416 401 which ss. 401.2101-401.45 ~~that~~ provides emergency
417 transportation and treatment.

418 3. An entity wholly owned by one or more physicians
419 licensed under chapter 458 or chapter 459, chiropractic



811080

420 physicians licensed under chapter 460, or dentists licensed
421 under chapter 466 or by such ~~practitioner or~~ practitioners and
422 the spouse, parent, child, or sibling of such ~~that practitioner~~
423 ~~or those~~ practitioners.

424 4. An entity wholly owned, directly or indirectly, by a
425 hospital or hospitals.

426 5. A health care clinic licensed under part X of chapter
427 400 which ~~ss. 400.990-400.995 that~~ is:

428 a. A health care clinic accredited by the Joint Commission
429 on Accreditation of Healthcare Organizations, the American
430 Osteopathic Association, the Commission on Accreditation of
431 Rehabilitation Facilities, or the Accreditation Association for
432 Ambulatory Health Care, Inc.; or

433 b. A health care clinic that:

434 (I) Has a medical director licensed under chapter 458,
435 chapter 459, or chapter 460;

436 (II) Has been continuously licensed for more than 3 years
437 or is a publicly traded corporation that issues securities
438 traded on an exchange registered with the United States
439 Securities and Exchange Commission as a national securities
440 exchange; and

441 (III) Provides at least four of the following medical
442 specialties:

443 (A) General medicine.

444 (B) Radiography.

445 (C) Orthopedic medicine.

446 (D) Physical medicine.

447 (E) Physical therapy.

448 (F) Physical rehabilitation.



811080

449 (G) Prescribing or dispensing outpatient prescription
450 medication.

451 (H) Laboratory services.
452

453 The Financial Services Commission shall adopt by rule the form
454 that must be used by an insurer and a health care provider
455 specified in subparagraph 3., subparagraph 4., or subparagraph
456 5. to document that the health care provider meets the criteria
457 of this paragraph, which rule must include a requirement for a
458 sworn statement or affidavit.

459 (b) *Disability benefits.*—Sixty percent of any loss of gross
460 income and loss of earning capacity per individual from
461 inability to work proximately caused by the injury sustained by
462 the injured person, plus all expenses reasonably incurred in
463 obtaining from others ordinary and necessary services in lieu of
464 those that, but for the injury, the injured person would have
465 performed without income for the benefit of his or her
466 household. All disability benefits payable under this provision
467 must shall be paid at least not less than every 2 weeks.

468 (c) *Death benefits.*—~~Death benefits equal to the lesser of~~
469 ~~\$5,000 or the remainder of unused personal injury protection~~
470 ~~benefits~~ per individual. Death benefits are in addition to the
471 medical and disability benefits provided under the insurance
472 policy. The insurer may pay death such benefits to the executor
473 or administrator of the deceased, to any of the deceased's
474 relatives by blood, ~~or~~ legal adoption, ~~or connection by~~
475 marriage, or to any person appearing to the insurer to be
476 equitably entitled to such benefits thereto.
477



811080

478 ~~Only insurers writing motor vehicle liability insurance in this~~
479 ~~state may provide the required benefits of this section, and no~~
480 ~~such insurer shall require the purchase of any other motor~~
481 ~~vehicle coverage other than the purchase of property damage~~
482 ~~liability coverage as required by s. 627.7275 as a condition for~~
483 ~~providing such required benefits. Insurers may not require that~~
484 ~~property damage liability insurance in an amount greater than~~
485 ~~\$10,000 be purchased in conjunction with personal injury~~
486 ~~protection. Such insurers shall make benefits and required~~
487 ~~property damage liability insurance coverage available through~~
488 ~~normal marketing channels. Any insurer writing motor vehicle~~
489 ~~liability insurance in this state who fails to comply with such~~
490 ~~availability requirement as a general business practice shall be~~
491 ~~deemed to have violated part IX of chapter 626, and such~~
492 ~~violation shall constitute an unfair method of competition or an~~
493 ~~unfair or deceptive act or practice involving the business of~~
494 ~~insurance; and any such insurer committing such violation shall~~
495 ~~be subject to the penalties afforded in such part, as well as~~
496 ~~those which may be afforded elsewhere in the insurance code.~~

497 (4) PAYMENT OF BENEFITS; WHEN DUE. ~~Except for medical care~~
498 ~~coverage under ss. 627.748-627.7491, personal injury protection~~
499 ~~benefits due from an insurer under ss. 627.730-627.7405 are~~
500 ~~shall be primary, except that benefits received under any~~
501 ~~workers' compensation law must shall be credited against the~~
502 ~~benefits provided by subsection (1) and are shall be due and~~
503 ~~payable as loss accrues, upon receipt of reasonable proof of~~
504 ~~such loss and the amount of expenses and loss incurred which are~~
505 ~~covered by the policy issued under ss. 627.730-627.7405. If ~~When~~~~
506 ~~the Agency for Health Care Administration provides, pays, or~~



811080

507 becomes liable for medical assistance under the Medicaid program
508 related to injury, sickness, disease, or death arising out of
509 the ownership, maintenance, or use of a motor vehicle, the
510 benefits under ss. 627.730-627.7405 are ~~shall be~~ subject to the
511 provisions of the Medicaid program. However, within 30 days
512 after receiving notice that the Medicaid program paid such
513 benefits, the insurer shall repay the full amount of the
514 benefits to the Medicaid program.

515 (a) An insurer may require written notice to be given as
516 soon as practicable after an accident involving a motor vehicle
517 with respect to which the policy affords the security required
518 by ss. 627.730-627.7405.

519 (b) ~~Personal injury protection insurance~~ Benefits paid
520 pursuant to this section are ~~shall be~~ overdue if not paid within
521 30 days after the insurer is furnished written notice of the
522 fact of a covered loss and of the amount of same. However:

523 1. If ~~such~~ written notice of the entire claim is not
524 furnished to the insurer ~~as to the entire claim~~, any partial
525 amount supported by written notice is overdue if not paid within
526 30 days after ~~such~~ written notice is furnished to the insurer.
527 Any part or all of the remainder of the claim that is
528 subsequently supported by written notice is overdue if not paid
529 within 30 days after ~~such~~ written notice is furnished to the
530 insurer.

531 2. If ~~When~~ an insurer pays only a portion of a claim or
532 rejects a claim, the insurer shall provide at the time of the
533 partial payment or rejection an itemized specification of each
534 item that the insurer had reduced, omitted, or declined to pay
535 and any information that the insurer desires the claimant to



811080

536 consider related to the medical necessity of the denied
537 treatment or to explain the reasonableness of the reduced charge
538 ~~if, provided that~~ this does ~~shall~~ not limit the introduction of
539 evidence at trial. ~~and~~ The insurer must also ~~shall~~ include the
540 name and address of the person to whom the claimant should
541 respond and a claim number to be referenced in future
542 correspondence.

543 3. If an insurer pays only a portion of a claim or rejects
544 a claim due to an alleged error in the claim, the insurer shall
545 provide at the time of the partial payment or rejection an
546 itemized specification or explanation of benefits of the
547 specified error. Upon receiving the specification or
548 explanation, the person making the claim has, at the person's
549 option and without waiving any other legal remedy for payment,
550 15 days to submit a revised claim. The revised claim shall be
551 considered a timely submission of written notice of a claim.

552 4. However, Notwithstanding ~~the fact~~ that written notice
553 has been furnished to the insurer, ~~any~~ payment is ~~shall~~ not ~~be~~
554 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~
555 ~~establish~~ that the insurer is not responsible for the payment.

556 5. For the purpose of calculating the extent to which any
557 benefits are overdue, payment shall be treated as being made on
558 the date a draft or other valid instrument that ~~which~~ is
559 equivalent to payment was placed in the United States mail in a
560 properly addressed, postpaid envelope or, if not so posted, on
561 the date of delivery.

562 6. This paragraph does not preclude or limit the ability of
563 the insurer to assert that the claim was unrelated, was not
564 medically necessary, or was unreasonable or that the amount of



811080

565 the charge was in excess of that permitted under, or in
566 violation of, subsection (5). Such assertion ~~by the insurer~~ may
567 be made at any time, including after payment of the claim or
568 after the 30-day ~~time~~ period for payment set forth in this
569 paragraph.

570 (c) Upon receiving notice of an accident that is
571 potentially covered by personal injury protection benefits, the
572 insurer must reserve \$5,000 of coverage ~~of personal injury~~
573 ~~protection benefits~~ for payment to physicians licensed under
574 chapter 458 or chapter 459 or dentists licensed under chapter
575 466 who provide emergency services and care, as defined in s.
576 395.002(9), or who provide hospital inpatient care.

577
578 The amount required to be held in reserve may be used only to
579 pay claims from such physicians or dentists until 30 days after
580 the date the insurer receives notice of the accident. After the
581 30-day period, any amount of the reserve for which the insurer
582 has not received notice of such claims ~~a claim from a physician~~
583 ~~or dentist who provided emergency services and care or who~~
584 ~~provided hospital inpatient care~~ may then be used by the insurer
585 to pay other claims. The time periods specified in paragraph (b)
586 for ~~required~~ payment of ~~personal injury protection~~ benefits are
587 ~~shall be~~ tolled for the period of time that an insurer is
588 required ~~by this paragraph~~ to hold payment of a claim that is
589 not from a physician or dentist ~~who provided emergency services~~
590 ~~and care or who provided hospital inpatient care~~ to the extent
591 that the amount ~~personal injury protection~~ benefits not held in
592 reserve is ~~are~~ insufficient to pay the claim. This paragraph
593 does not require an insurer to establish a claim reserve for



811080

594 insurance accounting purposes.

595 (d) All overdue payments ~~shall~~ bear simple interest at the
596 rate established under s. 55.03 or the rate established in the
597 insurance contract, whichever is greater, for the quarter ~~year~~
598 in which the payment became overdue, calculated from the date
599 the insurer was furnished with written notice of the amount of
600 covered loss. Interest is ~~shall be~~ due at the time payment of
601 the overdue claim is made.

602 (e) The insurer of the owner of a motor vehicle shall pay
603 personal injury protection benefits for:

604 1. Accidental bodily injury sustained in this state by the
605 owner while occupying a motor vehicle, or while not an occupant
606 of a self-propelled vehicle if the injury is caused by physical
607 contact with a motor vehicle.

608 2. Accidental bodily injury sustained outside this state,
609 but within the United States of America or its territories or
610 possessions or Canada, by the owner while occupying the owner's
611 motor vehicle.

612 3. Accidental bodily injury sustained by a relative of the
613 owner residing in the same household, under the circumstances
614 described in subparagraph 1. or subparagraph 2., if ~~provided~~ the
615 relative at the time of the accident is domiciled in the owner's
616 household and is not ~~himself or herself~~ the owner of a motor
617 vehicle with respect to which security is required under ss.
618 627.730-627.7405.

619 4. Accidental bodily injury sustained in this state by any
620 other person while occupying the owner's motor vehicle or, if a
621 resident of this state, while not an occupant of a self-
622 propelled vehicle, if the injury is caused by physical contact



811080

623 with such motor vehicle, if provided the injured person is not
624 ~~himself or herself~~:

625 a. The owner of a motor vehicle for ~~with respect to~~ which
626 personal injury protection benefits have been obtained pursuant
627 to security is required under ss. 627.730-627.7405; or

628 b. Entitled to personal injury benefits from the insurer of
629 the owner ~~or owners~~ of such a motor vehicle.

630 (f) If two or more insurers are liable for paying ~~to pay~~
631 personal injury protection benefits for the same injury to any
632 one person, the maximum payable is ~~shall be~~ as specified in
633 subsection (1), and the ~~any~~ insurer paying the benefits is ~~shall~~
634 ~~be~~ entitled to recover from each of the other insurers an
635 equitable pro rata share of the benefits paid and expenses
636 incurred in processing the claim.

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

641 (h) Benefits are ~~shall~~ not be due or payable to or on the
642 behalf of an insured person if that person has committed, by a
643 material act or omission, ~~any~~ insurance fraud relating to
644 personal injury protection coverage under his or her policy, if
645 the fraud is admitted to in a sworn statement by the insured or
646 ~~if it is~~ established in a court of competent jurisdiction. Any
647 insurance fraud voids ~~shall void~~ all coverage arising from the
648 claim related to such fraud under the personal injury protection
649 coverage of the insured person who committed the fraud,
650 irrespective of whether a portion of the insured person's claim
651 may be legitimate, and any benefits paid before ~~prior to~~ the



811080

652 discovery of the ~~insured person's insurance~~ fraud is shall be
653 recoverable by the insurer in its entirety from the person who
654 committed insurance fraud ~~in their entirety~~. The prevailing
655 party is entitled to its costs and attorney ~~attorney's~~ fees in
656 any action in which it prevails in an insurer's action to
657 enforce its right of recovery under this paragraph.

658 (i) An insurer shall create and maintain for each insured a
659 log of personal injury protection benefits paid by the insurer
660 on behalf of the insured. The insurer shall provide to the
661 insured a copy of the log within 30 days after receiving a
662 request for the log from the insured.

663 (j) In a dispute between the insured and the insurer, or
664 between an assignee of the insured's rights and the insurer, the
665 insurer must notify the insured or the assignee that the policy
666 limits under this section have been reached within 15 days after
667 the limits have been reached.

668 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

669 (a) ~~1. A~~ Any physician, hospital, clinic, or other person or
670 institution lawfully rendering treatment to an injured person
671 for a bodily injury covered by personal injury protection
672 insurance may charge the insurer and injured party only a
673 reasonable amount pursuant to this section for the services and
674 supplies rendered, and the insurer providing such coverage may
675 pay for such charges directly to such person or institution
676 lawfully rendering such treatment, ~~if the insured receiving such~~
677 ~~treatment or his or her guardian has countersigned the properly~~
678 ~~completed invoice, bill, or claim form approved by the office~~
679 ~~upon which such charges are to be paid for as having actually~~
680 ~~been rendered, to the best knowledge of the insured or his or~~



811080

681 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
682 exceed ~~be in excess of~~ the amount the person or institution
683 customarily charges for like services or supplies. In
684 determining ~~With respect to a determination of~~ whether a charge
685 for a particular service, treatment, or supply ~~otherwise~~ is
686 reasonable, consideration may be given to evidence of usual and
687 customary charges and payments accepted by the provider involved
688 in the dispute, ~~and~~ reimbursement levels in the community and
689 various federal and state medical fee schedules applicable to
690 motor vehicle ~~automobile~~ and other insurance coverages, and
691 other information relevant to the reasonableness of the
692 reimbursement for the service, treatment, or supply.

693 ~~1.2.~~ The insurer may limit reimbursement to 80 percent of
694 the following schedule of maximum charges:

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

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

700 c. For emergency services and care as defined by s.
701 395.002(9) provided in a facility licensed under chapter 395
702 rendered by a physician or dentist, and related hospital
703 inpatient services rendered by a physician or dentist, the usual
704 and customary charges in the community.

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

709 e. For hospital outpatient services, other than emergency



811080

710 services and care, 200 percent of the Medicare Part A Ambulatory
711 Payment Classification for the specific hospital providing the
712 outpatient services.

713 f. For all other medical services, supplies, and care, 200
714 percent of the allowable amount under:

715 (I) The participating physicians fee schedule of Medicare
716 Part B, except as provided in sub-sub-subparagraphs (II) and
717 (III).

718 (II) Medicare Part B, in the case of services, supplies,
719 and care provided by ambulatory surgical centers and clinical
720 laboratories.

721 (III) The Durable Medical Equipment Prosthetics/Orthotics
722 and Supplies fee schedule of Medicare Part B, in the case of
723 durable medical equipment.

724
725 However, if such services, supplies, or care is not reimbursable
726 under Medicare Part B, as provided in this sub-subparagraph, the
727 insurer may limit reimbursement to 80 percent of the maximum
728 reimbursable allowance under workers' compensation, as
729 determined under s. 440.13 and rules adopted thereunder which
730 are in effect at the time such services, supplies, or care is
731 provided. Services, supplies, or care that is not reimbursable
732 under Medicare or workers' compensation is not required to be
733 reimbursed by the insurer.

734 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable fee
735 schedule or payment limitation under Medicare is the fee
736 schedule or payment limitation in effect on March 1 of the year
737 in which ~~at the time~~ the services, supplies, or care is ~~was~~
738 rendered and for the area in which such services, supplies, or



811080

739 care is were rendered, and applies until March 1 of the
740 following year, notwithstanding any subsequent change made to
741 the fee schedule or payment limitation, except that it may not
742 be less than the allowable amount under the applicable
743 participating physicians schedule of Medicare Part B for 2007
744 for medical services, supplies, and care subject to Medicare
745 Part B.

746 3.4. Subparagraph 1. ~~2.~~ does not allow the insurer to apply
747 any limitation on the number of treatments or other utilization
748 limits that apply under Medicare or workers' compensation. An
749 insurer that applies the allowable payment limitations of
750 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully
751 provided care or treatment under the scope of his or her
752 license, regardless of whether such provider is ~~would be~~
753 entitled to reimbursement under Medicare due to restrictions or
754 limitations on the types or discipline of health care providers
755 who may be reimbursed for particular procedures or procedure
756 codes. However, subparagraph 1. does not prohibit an insurer
757 from using the Medicare coding policies and payment
758 methodologies of the federal Centers for Medicare and Medicaid
759 Services, including applicable modifiers, to determine the
760 appropriate amount of reimbursement for medical services,
761 supplies, or care if the coding policy or payment methodology
762 does not constitute a utilization limit.

763 4.5. If an insurer limits payment as authorized by
764 subparagraph 1. ~~2.~~, the person providing such services,
765 supplies, or care may not bill or attempt to collect from the
766 insured any amount in excess of such limits, except for amounts
767 that are not covered by the insured's personal injury protection



811080

768 coverage due to the coinsurance amount or maximum policy limits.

769 5. Effective January 1, 2013, an insurer may limit payment
770 as authorized by this paragraph only if the insurance policy
771 includes a notice at the time of issuance or renewal that the
772 insurer may limit payment pursuant to the schedule of charges
773 specified in this paragraph. A policy form approved by the
774 office satisfies this requirement. If a provider submits a
775 charge for an amount less than the amount allowed under
776 subparagraph 1., the insurer may pay the amount of the charge
777 submitted.

778 (b)1. An insurer or insured is not required to pay a claim
779 or charges:

780 a. Made by a broker or by a person making a claim on behalf
781 of a broker;

782 b. For any service or treatment that was not lawful at the
783 time rendered;

784 c. To any person who knowingly submits a false or
785 misleading statement relating to the claim or charges;

786 d. With respect to a bill or statement that does not
787 substantially meet the applicable requirements of paragraph (d);

788 e. For any treatment or service that is upcoded, or that is
789 unbundled when such treatment or services should be bundled, in
790 accordance with paragraph (d). To facilitate prompt payment of
791 lawful services, an insurer may change codes that it determines
792 ~~to~~ have been improperly or incorrectly upcoded or unbundled, and
793 may make payment based on the changed codes, without affecting
794 the right of the provider to dispute the change by the insurer,
795 if, provided that before doing so, the insurer contacts ~~must~~
796 ~~contact~~ the health care provider and discusses ~~discuss~~ the



811080

797 reasons for the insurer's change and the health care provider's
798 reason for the coding, or makes ~~make~~ a reasonable good faith
799 effort to do so, as documented in the insurer's file; and

800 f. For medical services or treatment billed by a physician
801 and not provided in a hospital unless such services are rendered
802 by the physician or are incident to his or her professional
803 services and are included on the physician's bill, including
804 documentation verifying that the physician is responsible for
805 the medical services that were rendered and billed.

806 2. The Department of Health, in consultation with the
807 appropriate professional licensing boards, shall adopt, by rule,
808 a list of diagnostic tests deemed not to be medically necessary
809 for use in the treatment of persons sustaining bodily injury
810 covered by personal injury protection benefits under this
811 section. The ~~initial list shall be adopted by January 1, 2004,~~
812 ~~and~~ shall be revised from time to time as determined by the
813 Department of Health, in consultation with the respective
814 professional licensing boards. Inclusion of a test on the list
815 ~~of invalid diagnostic tests~~ shall be based on lack of
816 demonstrated medical value and a level of general acceptance by
817 the relevant provider community and may ~~shall~~ not be dependent
818 for results entirely upon subjective patient response.
819 Notwithstanding its inclusion on a fee schedule in this
820 subsection, an insurer or insured is not required to pay any
821 charges or reimburse claims for an ~~any~~ invalid diagnostic test
822 as determined by the Department of Health.

823 (c)~~1~~. With respect to any treatment or service, other than
824 medical services billed by a hospital or other provider for
825 emergency services and care as defined in s. 395.002 or



811080

826 inpatient services rendered at a hospital-owned facility, the
827 statement of charges must be furnished to the insurer by the
828 provider and may not include, and the insurer is not required to
829 pay, charges for treatment or services rendered more than 35
830 days before the postmark date or electronic transmission date of
831 the statement, except for past due amounts previously billed on
832 a timely basis under this paragraph, and except that, if the
833 provider submits to the insurer a notice of initiation of
834 treatment within 21 days after its first examination or
835 treatment of the claimant, the statement may include charges for
836 treatment or services rendered up to, but not more than, 75 days
837 before the postmark date of the statement. The injured party is
838 not liable for, and the provider may ~~shall~~ not bill the injured
839 party for, charges that are unpaid because of the provider's
840 failure to comply with this paragraph. Any agreement requiring
841 the injured person or insured to pay for such charges is
842 unenforceable.

843 1.2. ~~If, however,~~ the insured fails to furnish the provider
844 with the correct name and address of the insured's personal
845 injury protection insurer, the provider has 35 days from the
846 date the provider obtains the correct information to furnish the
847 insurer with a statement of the charges. The insurer is not
848 required to pay for such charges unless the provider includes
849 with the statement documentary evidence that was provided by the
850 insured during the 35-day period demonstrating that the provider
851 reasonably relied on erroneous information from the insured and
852 either:

- 853 a. A denial letter from the incorrect insurer; or
- 854 b. Proof of mailing, which may include an affidavit under



811080

855 penalty of perjury, reflecting timely mailing to the incorrect
856 address or insurer.

857 ~~2.3.~~ For emergency services and care ~~as defined in s.~~
858 ~~395.002~~ rendered in a hospital emergency department or for
859 transport and treatment rendered by an ambulance provider
860 licensed pursuant to part III of chapter 401, the provider is
861 not required to furnish the statement of charges within the time
862 periods established by this paragraph,~~7~~ and the insurer is ~~shall~~
863 not ~~be~~ considered to have been furnished with notice of the
864 amount of covered loss for purposes of paragraph (4) (b) until it
865 receives a statement complying with paragraph (d), or copy
866 thereof, which specifically identifies the place of service to
867 be a hospital emergency department or an ambulance in accordance
868 with billing standards recognized by the federal Centers for
869 Medicare and Medicaid Services Health Care Finance
870 Administration.

871 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401
872 must include the following statement in at least 12-point type
873 ~~in type no smaller than 12 points~~:

874
875 BILLING REQUIREMENTS.—Florida law provides ~~Statutes~~
876 ~~provide~~ that with respect to any treatment or
877 services, other than certain hospital and emergency
878 services, the statement of charges furnished to the
879 insurer by the provider may not include, and the
880 insurer and the injured party are not required to pay,
881 charges for treatment or services rendered more than
882 35 days before the postmark date of the statement,
883 except for past due amounts previously billed on a



811080

884 timely basis, and except that, if the provider submits
885 to the insurer a notice of initiation of treatment
886 within 21 days after its first examination or
887 treatment of the claimant, the statement may include
888 charges for treatment or services rendered up to, but
889 not more than, 75 days before the postmark date of the
890 statement.

891
892 (d) All statements and bills for medical services rendered
893 by a ~~any~~ physician, hospital, clinic, or other person or
894 institution shall be submitted to the insurer on a properly
895 completed Centers for Medicare and Medicaid Services (CMS) 1500
896 form, UB 92 forms, or any other standard form approved by the
897 office or adopted by the commission for purposes of this
898 paragraph. All billings for such services rendered by providers
899 must ~~shall~~, to the extent applicable, follow the Physicians'
900 Current Procedural Terminology (CPT) or Healthcare Correct
901 Procedural Coding System (HCPCS), or ICD-9 in effect for the
902 year in which services are rendered and comply with the ~~Centers~~
903 ~~for Medicare and Medicaid Services (CMS) 1500 form instructions,~~
904 and the American Medical Association ~~Current Procedural~~
905 ~~Terminology (CPT) Editorial Panel,~~ and the ~~Healthcare Correct~~
906 ~~Procedural Coding System (HCPCS).~~ All providers, other than
907 hospitals, must ~~shall~~ include on the applicable claim form the
908 professional license number of the provider in the line or space
909 provided for "Signature of Physician or Supplier, Including
910 Degrees or Credentials." In determining compliance with
911 applicable CPT and HCPCS coding, guidance shall be provided by
912 the Physicians' Current Procedural Terminology (CPT) or the



811080

913 Healthcare Correct Procedural Coding System (HCPCS) in effect
914 for the year in which services were rendered, the Office of the
915 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
916 other authoritative treatises designated by rule by the Agency
917 for Health Care Administration. A ~~Ne~~ statement of medical
918 services may not include charges for medical services of a
919 person or entity that performed such services without possessing
920 the valid licenses required to perform such services. For
921 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~
922 considered to have been furnished with notice of the amount of
923 covered loss or medical bills due unless the statements or bills
924 comply with this paragraph, ~~and unless the statements or bills~~
925 are properly completed in their entirety as to all material
926 provisions, with all relevant information being provided
927 therein.

928 (e)1. At the initial treatment or service provided, each
929 physician, other licensed professional, clinic, or other medical
930 institution providing medical services upon which a claim for
931 personal injury protection benefits is based shall require an
932 insured person, or his or her guardian, to execute a disclosure
933 and acknowledgment form, which reflects at a minimum that:

934 a. The insured, or his or her guardian, must countersign
935 the form attesting to the fact that the services set forth
936 therein were actually rendered;

937 b. The insured, or his or her guardian, has both the right
938 and affirmative duty to confirm that the services were actually
939 rendered;

940 c. The insured, or his or her guardian, was not solicited
941 by any person to seek any services from the medical provider;



811080

942 d. The physician, other licensed professional, clinic, or
943 other medical institution rendering services for which payment
944 is being claimed explained the services to the insured or his or
945 her guardian; and

946 e. If the insured notifies the insurer in writing of a
947 billing error, the insured may be entitled to a certain
948 percentage of a reduction in the amounts paid by the insured's
949 motor vehicle insurer.

950 2. The physician, other licensed professional, clinic, or
951 other medical institution rendering services for which payment
952 is being claimed has the affirmative duty to explain the
953 services rendered to the insured, or his or her guardian, so
954 that the insured, or his or her guardian, countersigns the form
955 with informed consent.

956 3. Countersignature by the insured, or his or her guardian,
957 is not required for the reading of diagnostic tests or other
958 services that are of such a nature that they are not required to
959 be performed in the presence of the insured.

960 4. The licensed medical professional rendering treatment
961 for which payment is being claimed must sign, by his or her own
962 hand, the form complying with this paragraph.

963 5. The original completed disclosure and acknowledgment
964 form shall be furnished to the insurer pursuant to paragraph
965 (4) (b) and may not be electronically furnished.

966 6. The ~~This~~ disclosure and acknowledgment form is not
967 required for services billed by a provider ~~for emergency~~
968 ~~services as defined in s. 395.002,~~ for emergency services and
969 care as defined in s. 395.002 rendered in a hospital emergency
970 department, or for transport and treatment rendered by an



811080

971 ambulance provider licensed pursuant to part III of chapter 401.

972 7. The Financial Services Commission shall adopt, by rule,
973 a standard disclosure and acknowledgment form to ~~that shall~~ be
974 used to fulfill the requirements of this paragraph, ~~effective 90~~
975 ~~days after such form is adopted and becomes final.~~ The
976 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
977 ~~the rule is final, the provider may use a form of its own which~~
978 ~~otherwise complies with the requirements of this paragraph.~~

979 8. As used in this paragraph, the term "countersign" or
980 "countersignature" ~~"countersigned"~~ means a second or verifying
981 signature, as on a previously signed document, and is not
982 satisfied by the statement "signature on file" or any similar
983 statement.

984 9. The requirements of this paragraph apply only with
985 respect to the initial treatment or service of the insured by a
986 provider. For subsequent treatments or service, the provider
987 must maintain a patient log signed by the patient, in
988 chronological order by date of service, which ~~that~~ is consistent
989 with the services being rendered to the patient as claimed. The
990 requirement to maintain ~~requirements of this subparagraph for~~
991 ~~maintaining~~ a patient log signed by the patient may be met by a
992 hospital that maintains medical records as required by s.
993 395.3025 and applicable rules and makes such records available
994 to the insurer upon request.

995 (f) Upon written notification by any person, an insurer
996 shall investigate any claim of improper billing by a physician
997 or other medical provider. The insurer shall determine if the
998 insured was properly billed for only those services and
999 treatments that the insured actually received. If the insurer



811080

1000 determines that the insured has been improperly billed, the
1001 insurer shall notify the insured, the person making the written
1002 notification, and the provider of its findings and ~~shall~~ reduce
1003 the amount of payment to the provider by the amount determined
1004 to be improperly billed. If a reduction is made due to a ~~such~~
1005 written notification by any person, the insurer shall pay to the
1006 person 20 percent of the amount of the reduction, up to \$500. If
1007 the provider is arrested due to the improper billing, ~~then~~ the
1008 insurer shall pay to the person 40 percent of the amount of the
1009 reduction, up to \$500.

1010 (g) An insurer may not systematically downcode with the
1011 intent to deny reimbursement otherwise due. Such action
1012 constitutes a material misrepresentation under s.
1013 626.9541(1)(i)2.

1014 (h) As provided in s. 400.9905, an entity excluded from the
1015 definition of a clinic shall be deemed a clinic and must be
1016 licensed under part X of chapter 400 in order to receive
1017 reimbursement under ss. 627.730-627.7405. However, this
1018 licensing requirement does not apply to:

1019 1. An entity wholly owned by a physician licensed under
1020 chapter 458 or chapter 459, or by the physician and the spouse,
1021 parent, child, or sibling of the physician;

1022 2. An entity wholly owned by a dentist licensed under
1023 chapter 466, or by the dentist and the spouse, parent, child, or
1024 sibling of the dentist;

1025 3. An entity wholly owned by a chiropractic physician
1026 licensed under chapter 460, or by the chiropractic physician and
1027 the spouse, parent, child, or sibling of the chiropractic
1028 physician if such entity has filed for a licensing exemption



811080

1029 with the Agency for Health Care Administration;

1030 4. A hospital or ambulatory surgical center licensed under
1031 chapter 395; or

1032 5. An entity wholly owned, directly or indirectly, by a
1033 hospital or hospitals licensed under chapter 395.

1034 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY

1035 ~~ATTORNEY'S FEES.~~—With respect to any dispute under the
1036 provisions of ss. 627.730–627.7405 between the insured and the
1037 insurer, or between an assignee of an insured's rights and the
1038 insurer, the provisions of ss. ~~627.428~~ and ~~768.79~~ shall
1039 apply, except as provided in subsections (10) and (15).

1040 (9) PREFERRED PROVIDERS.—An insurer may negotiate and
1041 ~~contract enter into contracts~~ with preferred licensed health
1042 ~~care~~ providers for the benefits described in this section,
1043 ~~including referred to in this section as "preferred providers,"~~
1044 ~~which shall include~~ health care providers licensed under chapter
1045 ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter
1046 ~~and~~ 463. The insurer may provide an option to an insured to use
1047 a preferred provider at the time of purchasing ~~purchase~~ of the
1048 policy ~~for personal injury protection benefits~~, if the
1049 requirements of this subsection are met. If the insured elects
1050 to use a provider who is not a preferred provider, whether the
1051 insured purchased a preferred provider policy or a nonpreferred
1052 provider policy, the medical benefits provided by the insurer
1053 shall be as required by this section. If the insured elects to
1054 use a provider who is a preferred provider, the insurer may pay
1055 medical benefits in excess of the benefits required by this
1056 section and may waive or lower the amount of any deductible that
1057 applies to such medical benefits. If the insurer offers a



811080

1058 preferred provider policy to a policyholder or applicant, it
1059 must also offer a nonpreferred provider policy. The insurer
1060 shall provide each insured ~~policyholder~~ with a current roster of
1061 preferred providers in the county in which the insured resides
1062 at the time of purchase of such policy, and shall make such list
1063 available for public inspection during regular business hours at
1064 the insurer's principal office ~~of the insurer~~ within the state.

1065 (10) DEMAND LETTER.—

1066 (a) As a condition precedent to filing any action for
1067 benefits under this section, ~~the insurer must be provided with~~
1068 written notice of an intent to initiate litigation must be
1069 provided to the insurer. Such notice may not be sent until the
1070 claim is overdue, including any additional time the insurer has
1071 to pay the claim pursuant to paragraph (4) (b).

1072 (b) The notice must ~~required shall~~ state that it is a
1073 "demand letter under s. 627.736(10)" and ~~shall~~ state with
1074 specificity:

1075 1. The name of the insured upon which such benefits are
1076 being sought, including a copy of the assignment giving rights
1077 to the claimant if the claimant is not the insured.

1078 2. The claim number or policy number upon which such claim
1079 was originally submitted to the insurer.

1080 3. To the extent applicable, the name of any medical
1081 provider who rendered to an insured the treatment, services,
1082 accommodations, or supplies that form the basis of such claim;
1083 and an itemized statement specifying each exact amount, the date
1084 of treatment, service, or accommodation, and the type of benefit
1085 claimed to be due. A completed form satisfying the requirements
1086 of paragraph (5) (d) or the lost-wage statement previously



811080

1087 submitted may be used as the itemized statement. To the extent
1088 that the demand involves an insurer's withdrawal of payment
1089 under paragraph (7) (a) for future treatment not yet rendered,
1090 the claimant shall attach a copy of the insurer's notice
1091 withdrawing such payment and an itemized statement of the type,
1092 frequency, and duration of future treatment claimed to be
1093 reasonable and medically necessary.

1094 (c) Each notice required by this subsection must be
1095 delivered to the insurer by United States certified or
1096 registered mail, return receipt requested. Such postal costs
1097 shall be reimbursed by the insurer if ~~so~~ requested by the
1098 claimant in the notice, when the insurer pays the claim. Such
1099 notice must be sent to the person and address specified by the
1100 insurer for the purposes of receiving notices under this
1101 subsection. Each licensed insurer, whether domestic, foreign, or
1102 alien, shall file with the office designation of the name and
1103 address of the person to whom notices must ~~pursuant to this~~
1104 ~~subsection shall~~ be sent which the office shall make available
1105 on its Internet website. The name and address on file with the
1106 office pursuant to s. 624.422 are ~~shall be~~ deemed the authorized
1107 representative to accept notice pursuant to this subsection if
1108 ~~in the event~~ no other designation has been made.

1109 (d) If, within 30 days after receipt of notice by the
1110 insurer, the overdue claim specified in the notice is paid by
1111 the insurer together with applicable interest and a penalty of
1112 10 percent of the overdue amount paid by the insurer, subject to
1113 a maximum penalty of \$250, no action may be brought against the
1114 insurer. If the demand involves an insurer's withdrawal of
1115 payment under paragraph (7) (a) for future treatment not yet



811080

1116 rendered, no action may be brought against the insurer if,
1117 within 30 days after its receipt of the notice, the insurer
1118 mails to the person filing the notice a written statement of the
1119 insurer's agreement to pay for such treatment in accordance with
1120 the notice and to pay a penalty of 10 percent, subject to a
1121 maximum penalty of \$250, when it pays for such future treatment
1122 in accordance with the requirements of this section. To the
1123 extent the insurer determines not to pay any amount demanded,
1124 the penalty is ~~shall~~ not be payable in any subsequent action.
1125 For purposes of this subsection, payment or the insurer's
1126 agreement shall be treated as being made on the date a draft or
1127 other valid instrument that is equivalent to payment, or the
1128 insurer's written statement of agreement, is placed in the
1129 United States mail in a properly addressed, postpaid envelope,
1130 or if not so posted, on the date of delivery. The insurer is not
1131 obligated to pay any attorney ~~attorney's~~ fees if the insurer
1132 pays the claim or mails its agreement to pay for future
1133 treatment within the time prescribed by this subsection.

1134 (e) The applicable statute of limitation for an action
1135 under this section shall be tolled for ~~a period of~~ 30 business
1136 days by the mailing of the notice required by this subsection.

1137 (f) Any insurer making a general business practice of not
1138 paying valid claims until receipt of the notice required by this
1139 subsection is engaging in an unfair trade practice under the
1140 insurance code.

1141 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
1142 PRACTICE.—

1143 (a) If an insurer fails to pay valid claims for personal
1144 injury protection with such frequency so as to indicate a



811080

1145 general business practice, the insurer is engaging in a
1146 prohibited unfair or deceptive practice ~~that is~~ subject to the
1147 penalties provided in s. 626.9521 and the office has the powers
1148 and duties specified under in ss. 626.9561-626.9601 ~~with respect~~
1149 ~~thereto.~~

1150 (b) Notwithstanding s. 501.212, the Department of Legal
1151 Affairs may investigate and initiate actions for a violation of
1152 this subsection, including, but not limited to, the powers and
1153 duties specified in part II of chapter 501.

1154 (16) SECURE ELECTRONIC DATA TRANSFER. ~~If all parties~~
1155 ~~mutually and expressly agree,~~ A notice, documentation,
1156 transmission, or communication of any kind required or
1157 authorized under ss. 627.730-627.7405 may be transmitted
1158 electronically if it is transmitted by secure electronic data
1159 transfer that is consistent with state and federal privacy and
1160 security laws.

1161 Section 9. Section 627.748, Florida Statutes, is created to
1162 read:

1163 627.748 Short title.—Sections 627.748-627.7491 may be cited
1164 as the “Florida Motor Vehicle No-Fault Medical Care Coverage
1165 Law.”

1166 Section 10. Section 627.7481, Florida Statutes, is created
1167 to read:

1168 627.7481 Legislative findings; purpose.—

1169 (1) LEGISLATIVE FINDINGS.—

1170 (a) The Florida Motor Vehicle No-Fault Law, ss. 627.730-
1171 627.7405, was intended to deliver medically necessary and
1172 appropriate medical care promptly, without regard to fault, and
1173 without undue litigation or other associated costs. This intent



811080

1174 has been frustrated at significant cost and harm to consumers by
1175 fraud, inappropriate medical treatments, overutilization of
1176 medical services, inflated charges, and other abusive practices.

1177 (b) Personal injury protection fraud has become pervasive.
1178 Widespread fraud has been documented by a Statewide Grand Jury,
1179 "Report on Insurance Fraud Related to Personal Injury
1180 Protection" by the Fifteenth Statewide Grand Jury," 2000; the
1181 Insurance Consumer Advocate, "Report on Florida Motor Vehicle
1182 No-Fault Insurance," dated December 2011; and the Office of
1183 Insurance Regulation, "Report on Review of the 2011 Personal
1184 Injury Protection Data Call," dated April 11, 2011.

1185 (c) Personal injury protection premiums have risen to
1186 unacceptable levels as a result of fraud and abuse,
1187 significantly impairing the ability of insureds to maintain
1188 coverage mandated by law. The rise in such premiums is directly
1189 related to large increases in carrier losses. From 2008 to 2010,
1190 personal injury protection benefits paid by insurers increased
1191 from \$1.43 billion to \$2.37 billion.

1192 (d) Significant reforms must be enacted to curtail the
1193 level of fraudulent activity, inappropriate medical treatments,
1194 overutilization of medical services, inflated charges, and other
1195 abusive practices within no-fault motor vehicle insurance to
1196 preserve the affordability and availability of coverage within
1197 this state.

1198 (e) Ensuring the availability and affordability of no-fault
1199 motor vehicle insurance by requiring medical care coverage is an
1200 overwhelming public necessity and provides a commensurate
1201 benefit. Moreover, deterrence and prevention of fraud and abuse
1202 is a matter of great public interest and importance to the



811080

1203 public's health, safety, and welfare.

1204 (2) PURPOSE.—The purpose of the Florida Motor Vehicle No-
1205 Fault Medical Care Coverage Law is to provide for emergency
1206 services and care, medical services and care provided in a
1207 hospital, prescribed followup care, funeral costs, and
1208 disability insurance benefits without regard to fault; to
1209 require motor vehicle insurance that secures such benefits for
1210 motor vehicles required to be registered in this state; and,
1211 with respect to motor vehicle accidents, to provide a limitation
1212 on the right to claim damages for pain, suffering, mental
1213 anguish, and inconvenience.

1214 Section 11. Section 627.74811, Florida Statutes, is created
1215 to read:

1216 627.74811 Effect of law on medical care coverage policies.—
1217 The provisions, schedules, and procedures authorized in ss.
1218 627.748-627.7491 must be implemented by insurers offering
1219 policies pursuant to the Florida Motor Vehicle No-Fault Medical
1220 Care Coverage Law. The Legislature intends that these
1221 provisions, schedules, and procedures have full force and effect
1222 regardless of their express inclusion in an insurance policy
1223 form and govern over any general provisions in the insurance
1224 policy form. An insurer is not required to amend its policy form
1225 or to expressly notify providers, claimants, or insureds of the
1226 applicable fee schedules in order to implement and apply such
1227 provisions, schedules, or procedures.

1228 Section 12. Section 627.7482, Florida Statutes, is created
1229 to read:

1230 627.7482 Definitions.—As used in ss. 627.748-627.7491, the
1231 term:



811080

1232 (1) "Broker" means any person not licensed under chapter
1233 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter
1234 460, chapter 461, or chapter 641 who charges or receives
1235 compensation for the use of medical equipment and is not the 100
1236 percent owner or the 100 percent lessee of such equipment. For
1237 purposes of this subsection, such owner or lessee may be an
1238 individual, a corporation, a partnership, or any other entity
1239 and any of its 100 percent owned affiliates and subsidiaries.

1240 (a) The term "broker" does not include:

1241 1. A hospital or physician management company whose medical
1242 equipment is ancillary to the practices managed; a debt
1243 collection agency; an entity that has contracted with the
1244 insurer to obtain a discounted rate; a management company that
1245 has contracted to provide general management services for a
1246 licensed physician or health care facility and whose
1247 compensation is not materially affected by the usage or
1248 frequency of usage of medical equipment; or an entity that is
1249 100 percent owned by one or more hospitals or physicians.

1250 2. A person or entity that certifies, upon the request of
1251 an insurer, that:

- 1252 a. It is a clinic licensed under part X of chapter 400;
1253 b. It is a 100 percent owner of medical equipment; and
1254 c. The owner's only part-time lease of medical equipment
1255 for medical care coverage patients is on a temporary basis not
1256 to exceed 30 days in a 12-month period and is necessitated by:

1257 (I) The repair or maintenance of existing 100 percent-owned
1258 medical equipment;

1259 (II) The pending arrival and installation of newly
1260 purchased medical equipment or the replacement 100-percent-owned



811080

1261 medical equipment; or
1262 (III) A determination by the medical director or clinical
1263 director that open-style medical equipment is medically
1264 necessary for the performance of tests or procedures for
1265 patients due to the patients' physical sizes or claustrophobia.
1266 The leased medical equipment may not be used, for medical
1267 treatment or services, for a patient who is not a patient of the
1268 registered clinic for medical treatment of services.

1269
1270 However, the 30-day lease period provided in this sub-
1271 paragraph may be extended for an additional 60 days as
1272 applicable to magnetic resonance imaging equipment if the owner
1273 certifies that the extension otherwise complies with this
1274 paragraph.

1275 (b) As used in this subsection, the term "lessee" means a
1276 long-term lessee under a capital or operating lease but does not
1277 include a part-time lessee.

1278 (c) Any person or entity making a false certification under
1279 this subsection commits insurance fraud as defined in s.
1280 817.234.

1281 (2) "Certify" means to swear or attest to a fact being true
1282 or accurately represented in a writing.

1283 (3) "Emergency medical condition" means:

1284 (a) A medical condition manifesting itself by acute
1285 symptoms of sufficient severity, which may include severe pain,
1286 such that the absence of immediate medical attention could
1287 reasonably be expected to result in any of the following:

1288 1. Serious jeopardy to the health of a patient, including a
1289 pregnant woman or fetus.



811080

1290 2. Serious impairment to bodily functions.

1291 3. Serious dysfunction of any bodily organ or part.

1292 (b) With respect to a pregnant woman:

1293 1. That there is inadequate time for a safe transfer to
1294 another hospital before delivery;

1295 2. That a transfer may pose a threat to the health and
1296 safety of the woman or fetus; or

1297 3. That there is evidence of the onset and persistence of
1298 uterine contractions or rupture of the membranes.

1299 (4) "Emergency services and care" means medical screening,
1300 examination and evaluation by a physician or, to the extent
1301 permitted by applicable law, by other appropriate personnel
1302 under the supervision of a physician, to determine if an
1303 emergency medical condition exists and, if it does, the care,
1304 treatment, or surgery by a physician necessary to relieve or
1305 eliminate the emergency medical condition, within the service
1306 capability of the facility.

1307 (5) "Entity wholly owned" means a proprietorship, group
1308 practice, partnership, or corporation that provides health care
1309 services rendered by licensed health care practitioners and in
1310 which licensed health care practitioners are the business owners
1311 of all aspects of the business entity, including, but not
1312 limited to, being reflected as the business owners on the title
1313 or lease of the physical facility, filing taxes as the business
1314 owners, being account holders on the entity's bank account,
1315 being listed as the principals on all incorporation documents
1316 required by this state, and having ultimate authority over all
1317 personnel and compensation decisions relating to the entity.
1318 However, this definition does not apply to an entity that is



811080

1319 wholly owned, directly or indirectly, by a hospital licensed
1320 under chapter 395.

1321 (6) "Hospital" means a facility that, at the time services
1322 or treatment was rendered, was licensed under chapter 395.

1323 (7) "Knowingly" means having actual knowledge of
1324 information and acting in deliberate ignorance of the truth or
1325 falsity of the information or in reckless disregard of the
1326 information. Proof of specific intent to defraud is not
1327 required.

1328 (8) "Lawful" or "lawfully" means in substantial compliance
1329 with all relevant applicable criminal, civil, and administrative
1330 requirements of state and federal law related to the provision
1331 of medical services or treatment.

1332 (9) "Medically necessary" refers to a medical service or
1333 supply that a prudent physician would provide for the purpose of
1334 preventing, diagnosing, or treating an illness, injury, disease,
1335 or symptom in a manner that is:

1336 (a) In accordance with generally accepted standards of
1337 medical practice;

1338 (b) Clinically appropriate in terms of type, frequency,
1339 extent, site, and duration; and

1340 (c) Not primarily for the convenience of the patient,
1341 physician, or other health care provider.

1342 (10) "Motor vehicle" means any self-propelled vehicle that
1343 has four or more wheels and is of a type both designed and
1344 required to be licensed for use on the highways of this state
1345 and any trailer or semitrailer designed for use with such
1346 vehicle. The term includes:

1347 (a) A "private passenger motor vehicle," which is any motor



811080

1348 vehicle that is a sedan, station wagon, or jeep-type vehicle
1349 and, if not used primarily for occupational, professional, or
1350 business purposes, a motor vehicle of the pickup truck, panel
1351 truck, van, camper, or motor home type.

1352 (b) A "commercial motor vehicle," which is a motor vehicle
1353 that is not a private passenger motor vehicle.

1354

1355 The term does not include a mobile home or a motor vehicle that
1356 is used in mass transit, other than public school
1357 transportation; is designed to transport more than five
1358 passengers exclusive of the operator of the motor vehicle; and
1359 is owned by a municipality, a transit authority, or a political
1360 subdivision of the state.

1361 (11) "Named insured" means a person, usually the owner of a
1362 motor vehicle, identified in a policy by name as the insured
1363 under the policy.

1364 (12) "Owner," with respect to a motor vehicle, means a
1365 person who holds legal title to the motor vehicle or, if the
1366 motor vehicle is the subject of a security agreement or lease
1367 with an option to purchase and the debtor or lessee has the
1368 right to possession, the debtor or lessee of the motor vehicle.

1369 (13) "Physician" means an allopathic physician licensed
1370 under chapter 458 or an osteopathic physician licensed under
1371 chapter 459.

1372 (14) "Properly completed" means providing truthful,
1373 substantially complete, and substantially accurate responses as
1374 to all material elements to each applicable request for
1375 information or statement by a means that may lawfully be
1376 provided and that complies with this section, or as otherwise



811080

1377 agreed to by the parties.

1378 (15) "Relative residing in the insured's household" means a
1379 relative of any degree by blood, marriage, or adoption who
1380 usually makes her or his home in the same family unit regardless
1381 of whether she or he is temporarily living elsewhere.

1382 (16) "Unbundling" means separating treatment or services
1383 that would be properly billed under one billing code into two or
1384 more billing codes, resulting in a payment amount greater than
1385 would be paid using one billing code.

1386 (17) "Upcoding" means using a billing code to describe
1387 treatment or services in a manner that would result in a payment
1388 amount greater than would be paid using a billing code that
1389 accurately describes such treatment or services. The term does
1390 not include an otherwise lawful bill by a magnetic resonance
1391 imaging facility, which globally combines both technical and
1392 professional components, if the amount of the global bill is not
1393 more than the components if billed separately; however, payment
1394 of such a bill constitutes payment in full for all components of
1395 such service.

1396 Section 13. Section 627.7483, Florida Statutes, is created
1397 to read:

1398 627.7483 Required security.-

1399 (1) An owner or registrant of a motor vehicle, other than a
1400 motor vehicle used as a school bus as defined in s. 1006.25, a
1401 limousine, or a taxicab, which must be registered and licensed
1402 in this state shall continuously maintain security as described
1403 in subsection (3) throughout the licensing or registration
1404 period. An owner or registrant of a motor vehicle used as a
1405 taxicab shall maintain security as required under s. 324.032(1)



811080

1406 and is exempt from s. 627.7486.

1407 (2) A nonresident owner or registrant of a motor vehicle,
1408 whether operated or not operated, which has been physically
1409 present within this state for more than 90 days during the
1410 preceding 365 days must thereafter continuously maintain
1411 security as described in subsection (3) while such motor vehicle
1412 is physically present within this state.

1413 (3) Security required by this section shall be provided:

1414 (a) By an insurance policy delivered or issued for delivery
1415 in this state by an authorized or eligible motor vehicle
1416 liability insurer which provides the benefits and exemptions
1417 contained in ss. 627.748-627.7491. Any policy of insurance
1418 represented or sold as providing the security required under
1419 this section shall be deemed to provide insurance for the
1420 payment of the required benefits; or

1421 (b) By any other method authorized by s. 324.031(2), (3),
1422 or (4) and approved by the Department of Highway Safety and
1423 Motor Vehicles as affording security equivalent to that afforded
1424 by a policy of insurance or by self-insuring as authorized by s.
1425 768.28(16). The person filing such security has all of the
1426 obligations and rights of an insurer under ss. 627.748-627.7491.

1427 (4) An owner of a motor vehicle for which security is
1428 required by this section who fails to have such security in
1429 effect at the time of an accident is not immune from tort
1430 liability and is personally liable for the payment of benefits
1431 under s. 627.7485. With respect to such benefits, the owner has
1432 all of the rights and obligations of an insurer under ss.
1433 627.748-627.7491.

1434 (5) In addition to persons who are not required to provide



811080

1435 security under this section or s. 324.022, the owner or
1436 registrant of a motor vehicle who is a member of the United
1437 States Armed Forces and who is called to or on active duty
1438 outside the United States in an emergency situation is exempt
1439 from such requirements. The exemption applies only while the
1440 owner or registrant is on such active duty and while the motor
1441 vehicle otherwise required to be covered by the security under
1442 this section or s. 324.022 is not operated by any person. Upon
1443 receipt of a written request from the insured to whom this
1444 exemption applies, the insurer shall cancel the coverages and
1445 return any unearned premium or suspend the security required by
1446 this section and s. 324.022. Notwithstanding s. 324.0221(2), the
1447 Department of Highway Safety and Motor Vehicles may not suspend
1448 the registration or operator's license of the owner or
1449 registrant of a motor vehicle during the time she or he
1450 qualifies for this exemption. The owner or registrant of the
1451 motor vehicle qualifying for the exemption must immediately
1452 notify the department before and at the end of the expiration of
1453 the exemption.

1454 Section 14. Section 627.7484, Florida Statutes, is created
1455 to read:

1456 627.7484 Proof of security; security requirements;
1457 penalties.—

1458 (1) The provisions of chapter 324 which pertain to the
1459 method of giving and maintaining proof of financial
1460 responsibility and which govern and define a motor vehicle
1461 liability policy apply to filing and maintaining proof of
1462 security required by ss. 627.748-627.7491.

1463 (2) Any person who:



811080

1464 (a) Gives information required in a report or otherwise as
1465 provided in ss. 627.748-627.7491, knowing or having reason to
1466 believe that such information is false;

1467 (b) Forges or, without authority, signs any evidence of
1468 proof of security; or

1469 (c) Files, or offers for filing, any such evidence of
1470 proof, knowing or having reason to believe that it is forged or
1471 signed without authority

1472
1473 commits a misdemeanor of the first degree, punishable as
1474 provided in s. 775.082 or s. 775.083.

1475 Section 15. Section 627.7485, Florida Statutes, is created
1476 to read:

1477 627.7485 Required medical care coverage benefits.-

1478 (1) REQUIRED BENEFITS.-An insurance policy complying with
1479 the security requirements of s. 627.7483 must provide medical
1480 care coverage to the named insured, relatives residing in the
1481 insured's household, persons operating the insured motor
1482 vehicle, passengers in the motor vehicle, and other persons
1483 struck by such motor vehicle and suffering bodily injury while
1484 not an occupant of a self-propelled vehicle, subject to
1485 subsection (2) and paragraph (4) (d), up to a limit of \$10,000 in
1486 medical and disability benefits and \$5,000 in death benefits
1487 resulting from bodily injury, sickness, disease, or death to
1488 such persons arising out of the ownership, maintenance, or use
1489 of the motor vehicle as follows:

1490 (a) Medical benefits.-

1491 1. Up to a limit of \$10,000, 80 percent of all reasonable
1492 expenses for:



811080

1493 a. Emergency transport and treatment rendered by an
1494 ambulance provider licensed under part III of chapter 401 within
1495 24 hours after the motor vehicle accident.

1496 b. Emergency services and care provided within 7 days after
1497 the motor vehicle accident if such services and care are
1498 provided:

1499 (I) In a hospital or in a facility wholly owned by a
1500 hospital;

1501 (II) In a facility wholly owned by a physician licensed
1502 under chapter 458 or chapter 459, or by the physician and the
1503 spouse, parents, children, or siblings of such physician.

1504 c. Services and care rendered when an insured is admitted
1505 to a hospital within 7 days after the motor vehicle accident,
1506 for a condition related to the motor vehicle accident.

1507 d. If the insured receives emergency transport and
1508 treatment or emergency services and care pursuant to sub-sub-
1509 subparagraph a. or sub-subparagraph b., or services and care
1510 pursuant to sub-subparagraph c., prescribed followup services
1511 and care directly related to the medical diagnosis arising from
1512 the motor vehicle accident if:

1513 (I) The medical diagnosis and determination of the
1514 emergency medical condition was rendered in a hospital by a
1515 physician licensed under chapter 458, an osteopathic physician
1516 licensed under chapter 459, a dentist licensed under chapter
1517 466, or, to the extent permitted by applicable law and under the
1518 supervision of such physician, osteopathic physician, or
1519 dentist, by a physician assistant licensed under chapter 458 or
1520 chapter 459 or an advanced registered nurse practitioner
1521 licensed under chapter 464, or the insured received services and



811080

1522 care while admitted to a hospital; and

1523 (II) The prescribed followup services and care are rendered
1524 by a physician licensed under chapter 458, an osteopathic
1525 physician licensed under chapter 459, a chiropractic physician
1526 licensed under chapter 460, a dentist licensed under chapter
1527 466, a physician assistant licensed under chapter 458 or chapter
1528 459, or an advanced registered nurse practitioner licensed under
1529 chapter 464.

1530 e. If the insured receives services and care pursuant to
1531 sub-subparagraph a., sub-subparagraph b., sub-subparagraph c. or
1532 sub-subparagraph d., all medically necessary medical, surgical,
1533 dental, nursing, or diagnostic ancillary services, hospital or
1534 ambulatory surgical center services, durable medical equipment,
1535 prosthetics, or orthotics and supplies.

1536 2. Up to a limit of \$2,000, 80 percent of all reasonable
1537 expenses as follows:

1538 a. Services and care rendered within 7 days after the motor
1539 vehicle accident by a physician licensed under chapter 458, an
1540 osteopathic physician licensed under chapter 459, a dentist
1541 licensed under chapter 466, a physician assistant licensed under
1542 chapter 458 or 459, or an advanced registered nurse practitioner
1543 licensed under chapter 464.

1544 b. If the insured receives services and care pursuant to
1545 sub-subparagraph a., prescribed followup services and care
1546 directly related to the medical diagnosis arising from the motor
1547 vehicle accident. The medical benefits provide reimbursement
1548 only for followup services and care provided, supervised,
1549 ordered, or prescribed by a physician licensed under chapter
1550 458, an osteopathic physician licensed under chapter 459, a



811080

1551 dentist licensed under chapter 466 or, to the extent permitted
1552 by applicable law and under the supervision of such physician,
1553 osteopathic physician, or dentist, by a physician assistant
1554 licensed under chapter 458 or chapter 459 or an advanced
1555 registered nurse practitioner licensed under chapter 46. Such
1556 followup services and care may be rendered by a physician
1557 licensed under chapter 458, an osteopathic physician licensed
1558 under chapter 459, a chiropractic physician licensed under
1559 chapter 460, a dentist licensed under chapter 466, or, to the
1560 extent permitted by applicable law and under the supervision of
1561 such physician, osteopathic physician, or dentist, by a
1562 physician assistant licensed under chapter 458 or chapter 459 or
1563 an advanced registered nurse practitioner licensed under chapter
1564 464.

1565 c. All medically necessary medical, surgical, dental,
1566 nursing, or diagnostic ancillary services, hospital or
1567 ambulatory surgical center services, durable medical equipment,
1568 prosthetics, orthotics and supplies.

1569 d. Payment of benefits under sub-subparagraph a., sub-
1570 subparagraph b., or sub-subparagraph c. occur only if an insured
1571 has been determined in a hospital to not have an emergency
1572 medical condition or did not present at a hospital but received
1573 treatment from a provider identified in sub-subparagraph a.
1574 within 7 days after the motor vehicle accident.

1575 3. Prescribed followup services and care under sub-
1576 subparagraph 1.d., and reimbursable medical benefits under
1577 subparagraph 2. must be provided in a clinic licensed under part
1578 X of chapter 400 or an entity excluded from the definition of a
1579 clinic. However, as provided in s. 400.9905, an entity excluded



811080

1580 from the definition of a clinic shall be deemed a clinic and
1581 must be licensed under part X of chapter 400 in order to receive
1582 reimbursement for prescribed followup services and care under
1583 sub-subparagraph 1.d. unless the entity is:

1584 a. An entity wholly owned by a physician licensed under
1585 chapter 458 or chapter 459, or by the physician and the spouse,
1586 parent, child, or sibling of the physician;

1587 b. An entity wholly owned by a dentist licensed under
1588 chapter 466, or by the dentist and the spouse, parent, child, or
1589 sibling of the dentist;

1590 c. An entity wholly owned by a chiropractic physician
1591 licensed under chapter 460, or by the chiropractic physician and
1592 the spouse, parent, child, or sibling of the chiropractic
1593 physician if such entity has filed for a licensing exemption
1594 with the Agency for Health Care Administration;

1595 d. A hospital or ambulatory surgical center licensed under
1596 chapter 395; or

1597 e. An entity wholly owned, directly or indirectly, by a
1598 hospital licensed under chapter 395.

1599 4. Reimbursement for services provided by a chiropractic
1600 physician is limited to the lesser of 24 treatments or to
1601 services rendered within 12 weeks after the date of the initial
1602 chiropractic treatment, whichever comes first, unless the
1603 insurer authorizes additional chiropractic services.

1604 5. Medical benefits do not include massage as defined in s.
1605 480.033 or acupuncture as defined in s. 457.102, regardless of
1606 the person, entity, or licensee providing massage or
1607 acupuncture.

1608 6. For purposes of ss. 627.748-627.7491, a medical



811080

1609 diagnosis that an emergency medical condition exists is presumed
1610 to be correct unless rebutted by clear and convincing evidence
1611 to the contrary.

1612 (b) Disability benefits.—Sixty percent of any loss of gross
1613 income and loss of earning capacity per individual from
1614 inability to work proximately caused by the injury sustained by
1615 the injured person, plus all expenses reasonably incurred in
1616 obtaining from others ordinary and necessary services in lieu of
1617 those that, but for the injury, the injured person would have
1618 performed without income for the benefit of her or his
1619 household. All disability benefits payable under this paragraph
1620 must be paid at least every 2 weeks.

1621 (c) Death benefits.—Up to a limit of \$5,000. Death benefits
1622 are in addition to medical benefits and disability benefits
1623 provided under the insurance policy. The insurer may pay death
1624 benefits to the executor or administrator of the deceased, to
1625 any of the deceased's relatives by blood, legal adoption, or
1626 marriage, or to any person who appears to the insurer to be
1627 equitably entitled to such benefits.

1628
1629 Only insurers writing motor vehicle liability insurance in this
1630 state may provide the benefits required by this section, and
1631 such insurer may not require the purchase of any other motor
1632 vehicle coverage other than the purchase of property damage
1633 liability coverage as required by s. 627.7275 as a condition for
1634 providing such benefits. Insurers may not require that property
1635 damage liability insurance in an amount greater than \$10,000 be
1636 purchased in conjunction with medical care coverage insurance.
1637 Such insurers shall make benefits and required property damage



811080

1638 liability insurance coverage available through normal marketing
1639 channels. An insurer writing motor vehicle liability insurance
1640 in this state who fails to comply with such availability
1641 requirement as a general business practice, as determined by the
1642 office, violates part IX of chapter 626, and such violation
1643 constitutes an unfair method of competition or an unfair or
1644 deceptive act or practice involving the business of insurance.
1645 An insurer committing such violation is subject to the penalties
1646 provided under that part, as well as those provided elsewhere in
1647 the insurance code.

1648 (2) AUTHORIZED EXCLUSIONS.—An insurer may exclude benefits:

1649 (a) For injury sustained by the named insured and relatives
1650 residing in the insured's household while occupying another
1651 motor vehicle owned by the named insured and not insured under
1652 the policy or for injury sustained by any person operating the
1653 insured motor vehicle without the express or implied consent of
1654 the insured.

1655 (b) To any injured person if such person's conduct
1656 contributed to her or his injury under the following
1657 circumstance:

- 1658 1. Causing injury to herself or himself intentionally; or
1659 2. Being injured while committing a felony.

1660
1661 If an insured is charged with conduct as set forth in
1662 subparagraph 2., the 30-day payment provision of paragraph
1663 (4) (b) shall be held in abeyance, and the insurer shall withhold
1664 payment of any benefits pending the outcome of the case at the
1665 trial level. If the charge is nolle prossed or dismissed or the
1666 insured is acquitted, the 30-day payment provision shall run



811080

1667 from the date the insurer is notified of such action.

1668 (3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT
1669 CLAIMS.—An insurer may not have a lien on any recovery in tort
1670 by judgment, settlement, or otherwise for medical care coverage
1671 benefits, whether suit has been filed or settlement has been
1672 reached without suit. An injured party who is entitled to bring
1673 suit under ss. 627.748-627.7491, or her or his legal
1674 representative, may not recover any damages for which benefits
1675 are paid or payable. The plaintiff may prove all of her or his
1676 special damages notwithstanding this limitation, but if special
1677 damages are introduced in evidence, the trier of facts, whether
1678 judge or jury, may not award damages for medical care coverage
1679 benefits paid or payable. In all cases in which a jury is
1680 required to fix damages, the court shall instruct the jury that
1681 the plaintiff may not recover such special damages for medical
1682 care coverage benefits paid or payable.

1683 (4) PAYMENT OF BENEFITS.—Benefits due from an insurer under
1684 ss. 627.748-627.7491 are primary, except that benefits received
1685 under any workers' compensation law must be credited against the
1686 benefits provided under subsection (1) and are due and payable
1687 as loss accrues upon receipt of reasonable proof of such loss
1688 and the amount of expenses and loss incurred that are covered by
1689 the policy issued under ss. 627.748-627.7491. If the Agency for
1690 Health Care Administration provides, pays, or becomes liable for
1691 medical assistance under the Medicaid program related to injury,
1692 sickness, disease, or death arising out of the ownership,
1693 maintenance, or use of a motor vehicle, the benefits under ss.
1694 627.748-627.7491 are subject to the provisions of the Medicaid
1695 program. However, within 30 days after receiving notice that the



1696 Medicaid program paid such benefits, the insurer must repay the
1697 full amount of the benefits to the Medicaid program.

1698 (a) An insurer may require written notice to be given as
1699 soon as practicable after an accident involving a motor vehicle
1700 for which the policy provides the security required by ss.
1701 627.748-627.7491.

1702 (b) Medical care coverage insurance benefits paid pursuant
1703 to this section are overdue if not paid within 30 days after
1704 written notice of the fact and amount of a covered loss is
1705 furnished to the insurer.

1706 1. If written notice of the entire claim is not furnished
1707 to the insurer, any partial amount supported by the written
1708 notice is overdue if not paid within 30 days after the written
1709 notice is furnished. Any part or all of the remainder of the
1710 claim that is subsequently supported by written notice is
1711 overdue if not paid within 30 days after subsequent written
1712 notice is furnished to the insurer.

1713 2. This paragraph does not preclude or limit the ability of
1714 the insurer to assert that the claim or a portion of the claim
1715 was unrelated, was not medically necessary, or was unreasonable,
1716 or that the amount of the charge was in excess of that permitted
1717 under, or in violation of, subsection (5). Such assertion may be
1718 made at any time, including after payment of the claim or after
1719 the 30-day period for payment set forth in this paragraph.

1720 3. If an insurer pays only a portion of a claim or rejects
1721 a claim, the insurer shall provide at the time of the partial
1722 payment or rejection an itemized specification of each item that
1723 the insurer has reduced, omitted, or declined to pay and any
1724 information that the insurer desires the claimant to consider



811080

1725 related to the medical necessity of the denied treatment or to
1726 explain the reasonableness of the reduced charge if this
1727 information does not limit the introduction of evidence at
1728 trial. The insurer must also include the name and address of the
1729 person to whom the claimant should respond and a claim number to
1730 be referenced in future correspondence.

1731 4. If an insurer pays only a portion of a claim or rejects
1732 a claim due to an alleged error in the claim, the insurer shall
1733 provide at the time of the partial payment or rejection an
1734 itemized specification or explanation of benefits of the
1735 specified error. Upon receiving the specification or
1736 explanation, the person making the claim has, at the person's
1737 option and without waiving any other legal remedy for payment,
1738 15 days to submit a revised claim. The revised claim shall be
1739 considered a timely submission of written notice of a claim.

1740 5. Notwithstanding that written notice has been furnished
1741 to the insurer, payment is not overdue if the insurer has
1742 reasonable proof that the insurer is not responsible for the
1743 payment.

1744 6. For the purpose of calculating the extent to which
1745 benefits are overdue, payment is considered made on the date a
1746 draft or other valid instrument that is equivalent to payment
1747 was placed in the United States mail in a properly addressed,
1748 postpaid envelope or, if not so posted, on the date of delivery.

1749 7. All overdue payments bear simple interest at the rate
1750 established under s. 55.03 or the rate established in the
1751 insurance contract, whichever is greater, for the quarter in
1752 which the payment became overdue, calculated from the date the
1753 insurer was furnished with written notice of the amount of the



811080

1754 covered loss. Interest is due at the time payment of the overdue
1755 claim is made.

1756 (c) Upon receiving notice of an accident that is
1757 potentially covered by benefits under this section, the insurer
1758 must reserve \$5,000 of such coverage for payment to physicians
1759 licensed under chapter 458 or chapter 459 or dentists licensed
1760 under chapter 466 who provide medical care coverage pursuant to
1761 sub-subparagraph (1)(a)1.b., sub-subparagraph (1)(a)1.c., or
1762 (1)(a)1.d. The reserved amount may be used only to pay claims
1763 for such providers until 30 days after the date the insurer
1764 receives notice of the accident. After the 30-day period, any
1765 amount of the reserve for which the insurer has not received
1766 notice of a claim for medical care coverage benefits may be used
1767 to pay other claims. The time periods specified in paragraph (b)
1768 for the payment of benefits shall be tolled for the period of
1769 time that the insurer is required by this paragraph to hold
1770 payment of such other claims to the extent that the amount not
1771 held in reserve is insufficient to pay such other claims. This
1772 paragraph does not require an insurer to establish a claim
1773 reserve for insurance accounting purposes.

1774 (d) The insurer of the owner of a motor vehicle shall pay
1775 medical care coverage benefits for accidental bodily injury
1776 requiring medical treatment:

1777 1. Sustained in this state by the owner while occupying a
1778 motor vehicle, or while not an occupant of a self-propelled
1779 vehicle if the injury is caused by physical contact with a motor
1780 vehicle.

1781 2. Sustained outside this state, but within the United
1782 States or its territories or possessions or Canada, by the owner



811080

1783 while occupying the owner's motor vehicle.

1784 3. Sustained by a relative of the owner residing in the
1785 owner's household, under the circumstances described in
1786 subparagraph 1. or subparagraph 2. if the relative at the time
1787 of the accident is domiciled in the owner's household and is not
1788 the owner of a motor vehicle with respect to which security is
1789 required under ss. 627.748-627.7491.

1790 4. Sustained in this state by any other person while
1791 occupying the owner's motor vehicle or, if a resident of this
1792 state, while not an occupant of a self-propelled vehicle, if the
1793 injury is caused by physical contact with such motor vehicle if
1794 the injured person is not:

1795 a. The owner of a motor vehicle for which security is
1796 required under ss. 627.748-627.7491; or

1797 b. Entitled to benefits from the insurer of the owner of
1798 such motor vehicle.

1799 (e) If two or more insurers are liable for paying medical
1800 care coverage benefits for the same injury to any one person,
1801 the maximum amount payable shall be as specified in subsection
1802 (1), and an insurer paying the benefits is entitled to recover
1803 from each of the other insurers an equitable pro rata share of
1804 the benefits paid and expenses incurred in processing the claim.

1805 (f) In a dispute between the insured and the insurer, or
1806 between an assignee of the insured's rights and the insurer, the
1807 insurer must notify the insured or the assignee that the policy
1808 limits under this section have been reached within 15 days after
1809 the limits have been reached.

1810 (g) An insurer shall create and maintain for each insured a
1811 log of medical care coverage benefits paid by the insurer on



811080

1812 behalf of the insured. The insurer shall provide to the insured
1813 a copy of the log within 30 days after receiving a request for
1814 the log from the insured.

1815 (h) Benefits are not due or payable to or on behalf of an
1816 insured, claimant, medical provider, or attorney if the insured,
1817 claimant, medical provider, or attorney has:

1818 1. Knowingly submitted a false material statement,
1819 document, record, or bill;

1820 2. Knowingly submitted false material information; or

1821 3. Otherwise committed or attempted to commit a fraudulent
1822 insurance act as defined in s. 626.989.

1823

1824 A claimant who violates this paragraph is not entitled to any
1825 medical care coverage benefits or payment for any bills and
1826 services, regardless of whether a portion of the claim may be
1827 legitimate. However, a medical provider who does not violate
1828 this paragraph may not be denied benefits solely due to
1829 violation by another claimant.

1830 (i) If an insurer has a reasonable belief that a fraudulent
1831 insurance act, as defined in s. 626.989 or s. 817.134, has been
1832 committed, the insurer shall notify the claimant in writing
1833 within 30 days of submission of the claim that the claim is
1834 being investigated for suspected fraud. The insurer then has an
1835 additional 60 days, beginning at the end of the initial 30-day
1836 period, to conduct its fraud investigation. Notwithstanding
1837 subsection (8), no later than the 90th day after the submission
1838 of the claim, the insurer must deny the claim or pay the claim
1839 with simple interest as provided in subparagraph (b)7. All
1840 claims denied for suspected fraudulent insurance acts shall be



811080

1841 reported to the Division of Insurance Fraud.

1842
1843 Subject to s. 626.989(4), persons or entities that in good faith
1844 report suspected fraud to the Division of Insurance Fraud or
1845 share information in the furtherance of a fraud investigation
1846 are not subject to any civil or criminal liability relating to
1847 the reporting or release of such information.

1848 (j) It is a violation of the insurance code for an insurer
1849 to fail to timely provide benefits as required by this section
1850 with such frequency as to constitute a general business
1851 practice, as determined by the office.

1852 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

1853 (a) A physician, hospital, clinic, or other person or
1854 institution lawfully rendering treatment to an injured person
1855 for a bodily injury covered by medical care coverage insurance
1856 may charge the insurer and injured party only a reasonable
1857 amount pursuant to this section for the services, treatment,
1858 supplies, and care rendered, and the insurer providing such
1859 coverage may pay such charges directly to such person or
1860 institution lawfully rendering such treatment if the insured
1861 receiving such treatment, or her or his guardian, has
1862 countersigned the properly completed invoice, bill, or claim
1863 form approved by the office attesting that such treatment has
1864 actually been rendered to the best knowledge of the insured or
1865 her or his guardian. However, such charge may not exceed the
1866 amount that the person or institution customarily charges for
1867 like services, treatment, supplies, or care. When determining
1868 whether a charge for a particular service, treatment, supply, or
1869 care is reasonable, consideration may be given to evidence of



811080

1870 usual and customary charges and payments accepted by the
1871 provider involved in the dispute, reimbursement levels in the
1872 community and various federal and state medical fee schedules
1873 applicable to motor vehicle and other insurance coverages, and
1874 other information relevant to the reasonableness of the charges
1875 for the service, treatment, supply, or care.

1876 1. If a health care provider or entity bills an insurer an
1877 amount less than that indicated in the following schedule of
1878 maximum charges and the insurer pays the amount billed, the
1879 payment shall be considered reasonable. A payment made by an
1880 insurer that limits reimbursement to 80 percent of the following
1881 schedule of maximum charges is considered reasonable:

1882 a. For emergency transport and treatment by providers
1883 licensed under chapter 401, 200 percent of Medicare charges.

1884 b. For emergency services and care provided by a hospital,
1885 75 percent of the hospital's usual and customary charges.

1886 c. For emergency services and care provided in a hospital
1887 and rendered by a physician or dentist, and related hospital
1888 inpatient services rendered by a physician or dentist, the usual
1889 and customary charges in the community.

1890 d. For hospital inpatient services, other than emergency
1891 services and care, 200 percent of the Medicare Part A
1892 prospective payment applicable to the specific hospital
1893 providing the inpatient services.

1894 e. For hospital outpatient services, other than emergency
1895 services and care, 200 percent of the Medicare Part A Ambulatory
1896 Payment Classification for the specific hospital providing the
1897 outpatient services.

1898 f. For all other medical services, treatment, supplies, and



811080

1899 care, 200 percent of the allowable amount under:
1900 (I) The participating physicians fee schedule of Medicare
1901 Part B.
1902 (II) For medical services, treatment, supplies, and care
1903 provided by clinical laboratories, Medicare Part B.
1904 (III) For durable medical equipment, the Durable Medical
1905 Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee
1906 schedule of Medicare Part B.
1907
1908 However, if such services, treatment, supplies, or care is not
1909 reimbursable under Medicare Part B as provided in this sub-
1910 subparagraph, the insurer may limit reimbursement to 80 percent
1911 of the maximum reimbursable allowance under workers'
1912 compensation, as determined under s. 440.13 and rules adopted
1913 thereunder which are in effect at the time such services,
1914 treatment, supplies, or care is provided. Services, treatment,
1915 supplies, or care that is not reimbursable under Medicare or
1916 workers' compensation is not required to be reimbursed by the
1917 insurer.
1918 2. For purposes of subparagraph 1., the applicable fee
1919 schedule or payment limitation under Medicare is the fee
1920 schedule or payment limitation that was in effect on March 1 of
1921 the year and for the area in which the services, treatment,
1922 supplies, or care was rendered, and applies until March 1 of the
1923 following year, notwithstanding subsequent changes made to such
1924 fee schedule or payment limitation, except that it may not be
1925 less than the allowable amount under the participating
1926 physicians schedule of Medicare Part B for 2007 for medical
1927 services, treatment, supplies, and care subject to Medicare Part



811080

1928 B.

1929 3. Subparagraph 1. does not allow the insurer to apply any
1930 limitation on the number of treatments or other utilization
1931 limits that apply under Medicare or workers' compensation. An
1932 insurer that applies the allowable payment limitations of
1933 subparagraph 1. must reimburse a provider who lawfully provided
1934 care or treatment under the scope of her or his license
1935 regardless of whether such provider is entitled to reimbursement
1936 under Medicare due to restrictions or limitations on the types
1937 or discipline of health care providers who may be reimbursed for
1938 particular procedures or procedure codes. However, subparagraph
1939 1. does not prohibit an insurer from using the Medicare coding
1940 policies and payment methodologies of the Centers for Medicare
1941 and Medicaid Services, including applicable modifiers, to
1942 determine the appropriate amount of reimbursement.

1943 4. If an insurer limits payment as authorized by
1944 subparagraph 1., the person providing such services, treatment,
1945 supplies, or care may not bill or attempt to collect from the
1946 insured any amount in excess of such limits, except for amounts
1947 that are not covered by the insured's medical care coverage
1948 insurance due to the coinsurance amount or maximum policy
1949 limits.

1950 (b) An insurer or insured is not required to pay a claim or
1951 charges:

1952 1. Made by a broker or by a person making a claim on behalf
1953 of a broker;

1954 2. For any service or treatment that was not lawful at the
1955 time rendered;

1956 3. To any person who knowingly submits a false material



811080

1957 statement relating to the claim or charges;

1958 4. With respect to a bill or statement that does not
1959 substantially meet the applicable requirements of paragraph (d);

1960 5. For any treatment or service that is upcoded, or that is
1961 unbundled when such treatment or services should be bundled, in
1962 accordance with paragraph (e). To facilitate prompt payment of
1963 lawful services, an insurer may change billing codes that it
1964 determines have been improperly or incorrectly upcoded or
1965 unbundled and may make payment based on the changed billing
1966 codes without affecting the right of the provider to dispute the
1967 change by the insurer. However, before doing that, the insurer
1968 must contact the health care provider and discuss the reasons
1969 for the insurer's change and the health care provider's reason
1970 for the coding or make a reasonable good faith effort to do so
1971 as documented in the insurer's file; or

1972 6. For medical services or treatment billed by a physician
1973 and not provided in a hospital unless such services are rendered
1974 by the physician or are incident to her or his professional
1975 services and included on the physician's bill, including
1976 documentation verifying that the physician is responsible for
1977 the medical services that were rendered and billed.

1978 (c) The Department of Health, in consultation with the
1979 appropriate professional licensing boards, shall adopt by rule a
1980 list of diagnostic tests deemed not to be medically necessary
1981 for use in the treatment of persons sustaining bodily injury
1982 covered by medical care coverage benefits under this section.
1983 The list shall be revised from time to time as determined by the
1984 Department of Health in consultation with the respective
1985 professional licensing boards. Inclusion of a test on the list



811080

1986 shall be based on lack of demonstrated medical value and a level
1987 of general acceptance by the relevant provider community and may
1988 not be dependent entirely upon subjective patient response.
1989 Notwithstanding its inclusion on a fee schedule in this
1990 subsection, an insurer or insured is not required to pay any
1991 charges or reimburse claims for any diagnostic test deemed not
1992 medically necessary by the Department of Health.

1993 (d) With respect to any treatment or service, other than
1994 medical services billed by a hospital or other provider for
1995 emergency services and care or inpatient services rendered at a
1996 hospital-owned facility, the statement of charges must be
1997 furnished to the insurer by the provider and may not include,
1998 and the insurer is not required to pay, charges for treatment or
1999 services rendered more than 35 days before the postmark date or
2000 electronic transmission date of the statement, except for past
2001 due amounts previously billed on a timely basis under this
2002 paragraph. However, if the provider submits to the insurer a
2003 notice of initiation of treatment within 21 days after its first
2004 examination or treatment of the claimant, the statement may
2005 include charges for treatment or services rendered up to, but
2006 not more than, 75 days before the postmark date of the
2007 statement. The injured party is not liable for, and the provider
2008 may not bill the injured party for, charges that are unpaid
2009 because of the provider's failure to comply with this paragraph.
2010 Any agreement requiring the injured person or insured to pay for
2011 such charges is unenforceable.

2012 1. If the insured fails to furnish the provider with the
2013 correct name and address of the insured's medical care coverage
2014 insurer, the provider has 35 days after the date the provider



2015 obtains the correct information to furnish the insurer with a
2016 statement of the charges. The insurer is not required to pay for
2017 such charges unless the provider includes with the statement
2018 documentary evidence that was provided by the insured during the
2019 35-day period which demonstrates that the provider reasonably
2020 relied on erroneous information from the insured and:

- 2021 a. A denial letter from the incorrect insurer; or
2022 b. Proof of mailing, which may include an affidavit under
2023 penalty of perjury reflecting timely mailing to the incorrect
2024 address or insurer.

2025 2. For emergency services and care rendered in a hospital
2026 emergency department or for transport and treatment rendered by
2027 an ambulance provider licensed pursuant to part III of chapter
2028 401, the provider is not required to furnish the statement of
2029 charges within the time period established by this paragraph,
2030 and the insurer is not considered to have been furnished with
2031 notice of the amount of the covered loss for purposes of
2032 paragraph (4) (b) until it receives a statement complying with
2033 paragraph (e), or a copy thereof, which specifically identifies
2034 the place of service as a hospital emergency department or an
2035 ambulance in accordance with billing standards recognized by the
2036 federal Centers for Medicare and Medicaid Services.

2037 3. Each notice of the insured's rights under s. 627.7488
2038 must include the following statement in at least 12-point type:

2039
2040 BILLING REQUIREMENTS.—Florida law provides that with
2041 respect to any treatment or services, other than
2042 certain hospital and emergency services, the statement
2043 of charges furnished to the insurer by the provider



811080

2044 may not include, and the insurer and the injured party
2045 are not required to pay, charges for treatment or
2046 services rendered more than 35 days before the
2047 postmark date of the statement, except for past due
2048 amounts previously billed on a timely basis, and
2049 except that, if the provider submits to the insurer a
2050 notice of initiation of treatment within 21 days after
2051 its first examination or treatment of the claimant,
2052 the statement may include charges for treatment or
2053 services rendered up to, but not more than, 75 days
2054 before the postmark date of the statement.

2056 (e) All statements and bills for medical services rendered
2057 by a physician, hospital, clinic, or other person or institution
2058 shall be submitted to the insurer on a properly completed
2059 Centers for Medicare and Medicaid Services (CMS) 1500 form, UB
2060 92 form, or any other standard form approved by the office or
2061 adopted by the commission for purposes of this paragraph. All
2062 billings for such services rendered by providers must, to the
2063 extent applicable, follow the Physicians' Current Procedural
2064 Terminology (CPT) or Healthcare Correct Procedural Coding System
2065 (HCPCS), or ICD-9 in effect for the year in which services are
2066 rendered and comply with the CMS 1500 form instructions, the
2067 American Medical Association CPT Editorial Panel and the HCPCS.
2068 All providers, other than hospitals, must include on the
2069 applicable claim form the professional license number of the
2070 provider in the line or space provided for "Signature of
2071 Physician or Supplier, Including Degrees or Credentials." In
2072 determining compliance with applicable CPT and HCPCS coding,



811080

2073 guidance shall be provided by the CPT or HCPCS in effect for the
2074 year in which services were rendered, the Office of the
2075 Inspector General, Physicians Compliance Guidelines, and other
2076 authoritative treatises designated by rule by the Agency for
2077 Health Care Administration. A statement of medical services may
2078 not include charges for the medical services of a person or
2079 entity that performed such services without possessing the valid
2080 licenses required to perform such services. For purposes of
2081 paragraph (4) (b), an insurer is not considered to have been
2082 furnished with notice of the amount of the covered loss or
2083 medical bills due unless the statements or bills comply with
2084 this paragraph and are properly completed in their entirety as
2085 to all material provisions, with all relevant information being
2086 provided therein.

2087 (f)1. At the time the initial treatment or service is
2088 provided, each physician, licensed professional, clinic, or
2089 medical institution providing medical services upon which a
2090 claim for benefits is based shall require an insured person or
2091 her or his guardian to execute a disclosure and acknowledgment
2092 form that reflects at a minimum that:

2093 a. The insured or her or his guardian must countersign the
2094 form attesting to the fact that the services set forth in the
2095 form were actually rendered.

2096 b. The insured or her or his guardian has both the right
2097 and the affirmative duty to confirm that the services were
2098 actually rendered.

2099 c. The insured or her or his guardian was not solicited by
2100 any person to seek any services from the medical provider.

2101 d. The physician, other licensed professional, clinic, or



811080

2102 other medical institution rendering services for which payment
2103 is being claimed explained the services to the insured or her or
2104 his guardian.

2105 e. If the insured notifies the insurer in writing of a
2106 billing error, the insured may be entitled to a certain
2107 percentage of any reduction in the amounts paid by the insured's
2108 motor vehicle insurer.

2109 2. The physician, other licensed professional, clinic, or
2110 other medical institution rendering services for which payment
2111 is being claimed has the affirmative duty to explain the
2112 services rendered to the insured or her or his guardian so that
2113 the insured or her or his guardian countersigns the form with
2114 informed consent.

2115 3. Countersignature by the insured or her or his guardian
2116 is not required for the reading of diagnostic tests or other
2117 services that are not required to be performed in the presence
2118 of the insured.

2119 4. The licensed medical professional rendering treatment
2120 for which payment is being claimed must, by her or his own hand,
2121 sign the form complying with this paragraph.

2122 5. The completed original disclosure and acknowledgment
2123 form shall be furnished to the insurer pursuant to paragraph
2124 (4) (b) and may not be electronically furnished.

2125 6. The disclosure and acknowledgment form is not required
2126 for services billed by a provider for emergency services and
2127 care rendered in a hospital emergency department or for
2128 transport and treatment rendered by an ambulance provider
2129 licensed pursuant to part III of chapter 401.

2130 7. The Financial Services Commission shall adopt a standard



811080

2131 disclosure and acknowledgment form by rule to fulfill the
2132 requirements of this paragraph.

2133 8. As used in this paragraph, the term "countersign" or
2134 "countersignature" means bearing a second or verifying
2135 signature, as on a previously signed document, and is not
2136 satisfied by the statement "signature on file" or similar
2137 statement.

2138 9. This paragraph applies only with respect to the initial
2139 treatment or service of the insured by a provider. For
2140 subsequent treatments or service, the provider must maintain a
2141 patient log signed by the patient, in chronological order by
2142 date of service, which is consistent with the services being
2143 rendered to the patient as claimed. The requirement to maintain
2144 a patient log signed by the patient may be met by a hospital
2145 that maintains medical records as required by s. 395.3025 and
2146 applicable rules and makes such records available to the insurer
2147 upon request.

2148 (g) Upon written notification by any person, an insurer
2149 shall investigate any claim of improper billing by a physician
2150 or other medical provider. The insurer shall determine whether
2151 the insured was properly billed for only those services and
2152 treatments that the insured actually received. If the insurer
2153 determines that the insured has been improperly billed, the
2154 insurer shall notify the insured, the person making the written
2155 notification, and the provider of its findings and reduce the
2156 amount of payment to the provider by the amount determined to be
2157 improperly billed. If a reduction is made due to a written
2158 notification by any person, the insurer shall pay to that person
2159 20 percent of the amount of the reduction, up to \$500. If the



811080

2160 provider is arrested due to the improper billing, the insurer
2161 shall pay to that person 40 percent of the amount of the
2162 reduction, up to \$500.

2163 (h) An insurer may not systematically downcode with the
2164 intent to deny reimbursement otherwise due. Such action
2165 constitutes a material misrepresentation under s.
2166 626.9541(1)(i)2.

2167 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.-

2168 (a) In all circumstances, an insured seeking benefits under
2169 ss. 627.748-627.7491, including omnibus insureds, must comply
2170 with the terms of the policy, which includes, but is not limited
2171 to, submitting to an examination under oath. The scope of
2172 questioning during the examination under oath is limited to
2173 relevant information or information that could reasonably be
2174 expected to lead to relevant information. Compliance with this
2175 paragraph is a condition precedent to the insured's recovering
2176 benefits. An insurer that, as a general business practice, as
2177 determined by the office, requests examinations under oath
2178 without a reasonable basis is subject to s. 626.9541.

2179 (b) If a request is made by an insurer against whom a claim
2180 for medical benefits has been made, an employer must furnish a
2181 sworn statement, in a form approved by the office, of the
2182 earnings of the person upon whose injury the claim is based
2183 since the time of the bodily injury and for a reasonable period
2184 before the injury.

2185 (c) If an insured seeking to recover benefits pursuant to
2186 ss. 627.748-627.7491 assigns the contractual right to such
2187 benefits or payment of such benefits to any person or entity,
2188 the assignee must comply with the terms of the policy. In all



811080

2189 circumstances, the assignee is obligated to cooperate under the
2190 policy, except that an assignee may not be required to submit to
2191 an examination under oath.

2192 (d) All claimants must produce and allow for the inspection
2193 of all documents requested by the insurer which are relevant to
2194 the services rendered and reasonably obtainable by the claimant.

2195 (e) Each physician, hospital, clinic, or other medical
2196 institution providing, before or after bodily injury upon which
2197 a claim for medical care coverage is based, any products,
2198 services, or accommodations relating to that or any other
2199 injury, or to a condition claimed to be connected with that or
2200 any other injury, shall, if requested by the insurer against
2201 whom the claim has been made, permit the insurer or the
2202 insurer's representative to conduct, within 10 days after the
2203 insurer's request, an onsite physical review and examination of
2204 the treatment location, treatment apparatuses, diagnostic
2205 devices, and any other medical equipment used for the services
2206 rendered, and shall furnish a written report of the history,
2207 condition, treatment, dates, and costs of such treatment of the
2208 injured person and why the items identified by the insurer were
2209 reasonable in amount and medically necessary.

2210 1. The report shall be furnished with a sworn statement
2211 that the treatment or services rendered were reasonable and
2212 necessary with respect to the bodily injury sustained and must
2213 identify which portion of the expenses for the treatment or
2214 services was incurred as a result of the bodily injury. The
2215 sworn statement must read as follows: "Under penalty of perjury,
2216 I declare that I have read the foregoing, and the facts alleged
2217 are true to the best of my knowledge and belief."



811080

2218 2. The physician, hospital, clinic, or other medical
2219 institution shall also permit the inspection and copying of any
2220 records regarding such history, condition, treatment, dates, and
2221 costs of treatment; however, this does not limit the
2222 introduction of evidence at trial.

2223 3. The person requesting such records and sworn statement
2224 shall pay all reasonable costs connected therewith.

2225 4. If an insurer makes a written request for documentation
2226 or information within 30 days after having received notice of
2227 the amount of a covered loss under paragraph (4) (b), the amount
2228 or the partial amount that is the subject of the insurer's
2229 inquiry is overdue if the insurer does not pay in accordance
2230 with paragraph (4) (b) or within 10 days after the insurer's
2231 receipt of the requested documentation or information, whichever
2232 occurs later. As used in this subparagraph, the term "receipt"
2233 includes, but is not limited to, inspection and copying pursuant
2234 to this paragraph.

2235 5. An insurer that requests documentation or information
2236 pertaining to the reasonableness of charges or medical necessity
2237 without a reasonable basis for such requests as a general
2238 business practice, as determined by the office, is engaging in
2239 an unfair trade practice under the insurance code.

2240 6. Section 626.989(4) (d) applies to the sharing of
2241 information related to reviews and examinations conducted
2242 pursuant to this section.

2243 7. A cause of action for violation of the physician-patient
2244 privilege or invasion of the right of privacy is prohibited
2245 against any person or entity complying with this paragraph.

2246 (f) If there is a dispute regarding an insurer's right to



811080

2247 discovery of facts under this section, the insurer may petition
2248 the court to enter an order permitting such discovery. The order
2249 may be made only on motion for good cause shown and upon notice
2250 to all persons having an interest, and must specify the time,
2251 place, manner, conditions, and scope of the discovery. The court
2252 may, in order to protect against annoyance, embarrassment, or
2253 oppression, as justice requires, enter an order refusing
2254 discovery or specifying conditions of discovery and may order
2255 payments of costs and expenses of the proceeding, including
2256 reasonable fees for the appearance of attorneys at the
2257 proceedings, as justice requires.

2258 (g) Upon request, the injured person shall be furnished a
2259 copy of all information obtained by the insurer under this
2260 section and shall pay a reasonable charge if required by the
2261 insurer.

2262 (h) Notice to an insurer of the existence of a claim may
2263 not be unreasonably withheld by an insured.

2264 (7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON;
2265 REPORTS.—If the mental or physical condition of an injured
2266 person covered by medical care coverage is material to a claim
2267 that has been or may be made for past or future benefits under
2268 such coverage, upon the request of an insurer, such person must
2269 submit to mental or physical examination by a physician. The
2270 costs of such examination shall be borne entirely by the
2271 insurer. The insurer may include reasonable provisions in
2272 medical care coverage insurance policies for the mental and
2273 physical examination of those claiming benefits under the
2274 policy.

2275 (a) The examination must be conducted within the



811080

2276 municipality where the insured is receiving treatment, or in a
2277 location reasonably accessible to the insured, which means any
2278 location within the municipality in which the insured resides,
2279 or within 10 miles by road of the insured's residence if such
2280 location is within the county in which the insured resides. If
2281 the examination is to be conducted in a location reasonably
2282 accessible to the insured but there is no qualified physician to
2283 conduct the examination in such location, the examination shall
2284 be conducted in an area that is in the closest proximity to the
2285 insured's residence.

2286 (b) An insurer may not withdraw payment from a treating
2287 physician without the consent of the injured person covered by
2288 the policy unless the insurer first obtains a valid report by a
2289 Florida physician licensed under the same chapter as the
2290 treating physician stating that treatment was not reasonable,
2291 related, or necessary. A valid report is one that is prepared
2292 and signed by the physician examining the injured person or who
2293 reviewed the treatment records of the injured person, is
2294 factually supported by the examination or treatment records
2295 reviewed, and that has not been modified by anyone other than
2296 the reviewing physician. The physician preparing the report must
2297 be in active practice, unless he or she is physically disabled.
2298 "Active practice" means that during the 3 years immediately
2299 preceding the date of the physical examination or review of
2300 treatment records, the physician devoted professional time to
2301 the active clinical practice of evaluation, diagnosis, or
2302 treatment of medical conditions or to the instruction of
2303 students in an accredited health professional school, accredited
2304 residency program, or a clinical research program that is



811080

2305 affiliated with an accredited health professional school,
2306 teaching hospital, or accredited residency program. The insurer
2307 and any person acting at the direction of or on behalf of the
2308 insurer may not materially change an opinion in a report
2309 prepared under this paragraph or direct the physician preparing
2310 the report to change such opinion. The denial of a payment
2311 resulting from a changed opinion constitutes a material
2312 misrepresentation under s. 626.9541(1)(i)2. This provision does
2313 not preclude the insurer from calling to the physician's
2314 attention any errors of fact in the report based upon
2315 information in the claim file.

2316 (c) If requested by the person examined, a party causing an
2317 examination to be made must deliver a copy of every written
2318 report concerning a examination rendered by an examining
2319 physician to the person examined, at least one of which must set
2320 out the examining physician's findings and conclusions in
2321 detail. After such request and delivery, the party causing the
2322 examination to be made is entitled, upon request, to receive
2323 from the person examined every written report available to him
2324 or her or his or her representative concerning any examination,
2325 previously or thereafter made, of the same mental or physical
2326 condition. By requesting and obtaining a report of the
2327 examination so ordered, or by taking the deposition of the
2328 examiner, the person examined waives any privilege he or she may
2329 have, relating to the claim for benefits, regarding the
2330 testimony of every other person who has examined, or may
2331 thereafter examine, him or her with respect to the same mental
2332 or physical condition.

2333 (d) The physician preparing a report at the request of an



811080

2334 insurer and physicians rendering expert opinions on behalf of
2335 persons claiming medical benefits for medical care coverage, or
2336 on behalf of an insured through an attorney or another entity,
2337 must maintain copies of all examination reports as medical
2338 records and all payments for the examinations and reports for at
2339 least 3 years.

2340 (e) If a person unreasonably refuses to submit to an
2341 examination or fails to appear for an examination, the insurer
2342 is no longer liable for subsequent medical care benefits.
2343 Refusal or failure to appear for two examinations raises a
2344 rebuttable presumption that such refusal or failure was
2345 unreasonable.

2346 (8) DEMAND LETTER.—

2347 (a) As a condition precedent to filing an action for
2348 benefits under this section, the insurer must be provided with
2349 written notice of an intent to initiate litigation. Such notice
2350 may not be sent until the claim is overdue, including any
2351 additional time the insurer has to pay the claim pursuant to
2352 subsection (4).

2353 (b) The notice required must state that it is a "demand
2354 letter under s. 627.7485(8), F.S.," and state with specificity:

2355 1. The name of the insured upon whom such benefits are
2356 being sought, including a copy of the assignment giving rights
2357 to the claimant if the claimant is not the insured.

2358 2. The claim number or policy number upon which such claim
2359 was originally submitted to the insurer.

2360 3. To the extent applicable, the name of any medical
2361 provider who rendered the treatment, services, accommodations,
2362 or supplies to an insured which form the basis of such claim and



811080

2363 an itemized statement specifying each exact amount, the date of
2364 treatment, service, or accommodation, and the type of benefit
2365 claimed to be due. A completed form satisfying the requirements
2366 of paragraph (5) (e) or the lost-wage statement previously
2367 submitted may be used as the itemized statement. If the demand
2368 involves an insurer's withdrawal of payment under paragraph
2369 (7) (b) for future treatment not yet rendered, the claimant shall
2370 attach a copy of the insurer's notice withdrawing such payment
2371 and an itemized statement of the type, frequency, and duration
2372 of future treatment claimed to be reasonable and medically
2373 necessary.

2374 (c) Each notice required by this subsection must be
2375 delivered to the insurer by United States certified or
2376 registered mail, return receipt requested. If requested by the
2377 claimant in the notice, such postal costs shall be reimbursed by
2378 the insurer when the insurer pays the claim. The notice must be
2379 sent to the person and address specified by the insurer for the
2380 purposes of receiving notices under this subsection. Each
2381 licensed insurer, whether domestic, foreign, or alien, shall
2382 file with the office the name and address of the person to whom
2383 notices pursuant to this subsection are sent, which the office
2384 shall make available on its website. The name and address on
2385 file with the office pursuant to s. 624.422 shall be deemed the
2386 authorized representative to accept notice pursuant to this
2387 subsection if no other designation has been made.

2388 (d) If the overdue claim specified in the notice is paid by
2389 the insurer within 30 days after receipt of notice by the
2390 insurer, plus applicable interest and a penalty of 10 percent of
2391 the overdue amount, subject to a maximum penalty of \$250, no



811080

2392 action may be brought against the insurer. If the demand
2393 involves an insurer's withdrawal of payment under paragraph
2394 (7) (b) for future treatment not yet rendered, no action may be
2395 brought against the insurer if, within 30 days after receipt of
2396 the notice, the insurer mails to the person filing the notice a
2397 written statement of the insurer's agreement to pay for such
2398 treatment in accordance with the notice and to pay a penalty of
2399 10 percent, subject to a maximum penalty of \$250, when it pays
2400 for such future treatment in accordance with the requirements of
2401 this section. To the extent the insurer determines not to pay
2402 any amount demanded, the penalty is not payable in any
2403 subsequent action. For purposes of this paragraph, payment or
2404 the insurer's agreement are considered made on the date a draft
2405 or other valid instrument that is equivalent to payment, or the
2406 insurer's written statement of agreement, is placed in the
2407 United States mail in a properly addressed, postpaid envelope,
2408 or if not so posted, on the date of delivery. The insurer is not
2409 obligated to pay any attorney fees if the insurer pays the claim
2410 or mails its agreement to pay for future treatment within the
2411 time prescribed by this paragraph.

2412 (e) The applicable statute of limitation for an action
2413 under this section shall be tolled for 30 business days by the
2414 mailing of the notice required by this subsection.

2415 (f) Any insurer making a general business practice of not
2416 paying valid claims until receipt of the notice required by this
2417 subsection, as determined by the office, is engaging in an
2418 unfair trade practice under the insurance code.

2419 (9) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
2420 PRACTICE.—



811080

2421 (a) If an insurer fails to pay valid claims for medical
2422 care coverage with such frequency as to indicate a general
2423 business practice, as determined by the office, the insurer is
2424 engaging in a prohibited unfair or deceptive practice subject to
2425 the penalties provided in s. 626.9521, and the office has the
2426 powers and duties specified in ss. 626.9561-626.9601 with
2427 respect thereto.

2428 (b) Notwithstanding s. 501.212, the Department of Legal
2429 Affairs may investigate and initiate actions for a violation of
2430 this subsection, including, but not limited to, the powers and
2431 duties specified in part II of chapter 501.

2432 (10) CIVIL ACTION FOR INSURANCE FRAUD.—An insurer shall
2433 have a cause of action against any person convicted of, or who,
2434 regardless of adjudication of guilt, pleads guilty or nolo
2435 contendere to, insurance fraud under s. 817.234, patient
2436 brokering under s. 817.505, or kickbacks under s. 456.054,
2437 associated with a claim for medical care coverage in accordance
2438 with this section. An insurer prevailing in an action brought
2439 under this subsection may recover compensatory, consequential,
2440 and punitive damages subject to the requirements and limitations
2441 of part II of chapter 768 and attorney fees and costs incurred
2442 in litigating the cause of action.

2443 (11) FRAUD ADVISORY NOTICE.—Upon receiving notice of a
2444 claim under this section, an insurer shall provide a notice to
2445 the insured or to a person for whom a claim for reimbursement
2446 for diagnosis or treatment of injuries has been filed advising
2447 that:

2448 (a) Pursuant to s. 626.9892, the Department of Financial
2449 Services may pay rewards of up to \$25,000 to persons providing



811080

2450 information leading to the arrest and conviction of persons
2451 committing crimes investigated by the Division of Insurance
2452 Fraud arising from violations of s. 440.105, s. 624.15, s.
2453 626.9541, s. 626.989, or s. 817.234.

2454 (b) Solicitation of a person injured in a motor vehicle
2455 crash for purposes of filing medical care coverage or tort
2456 claims could be a violation of s. 817.234 or s. 817.505 or the
2457 rules regulating The Florida Bar and, if such conduct has taken
2458 place, should be immediately reported to the Division of
2459 Insurance Fraud.

2460 (12) ALL CLAIMS BROUGHT IN A SINGLE ACTION.-In any civil
2461 action to recover medical care coverage benefits brought by a
2462 claimant pursuant to this section against an insurer, all claims
2463 related to the same health care provider for the same injured
2464 person shall be brought in one action unless good cause is shown
2465 why such claims should be brought separately. If the court
2466 determines that a civil action is filed for a claim that should
2467 have been brought in a prior civil action, the court may not
2468 award attorney fees to the claimant.

2469 (13) SECURE ELECTRONIC DATA TRANSFER.-A notice,
2470 documentation, transmission, or communication of any kind
2471 required or authorized under ss. 627.748-627.7491 may be
2472 transmitted electronically if it is transmitted by secure
2473 electronic data transfer that is consistent with state and
2474 federal privacy and security laws.

2475 Section 16. Section 627.7486, Florida Statutes, is created
2476 to read:

2477 627.7486 Tort exemption; limitation on right to damages;
2478 punitive damages.-



811080

2479 (1) Every owner, registrant, operator, or occupant of a
2480 motor vehicle for which security has been provided as required
2481 by ss. 627.748-627.7491, and every person or organization
2482 legally responsible for her or his acts or omissions, is exempt
2483 from tort liability for damages because of bodily injury,
2484 sickness, or disease arising out of the ownership, operation,
2485 maintenance, or use of such motor vehicle in this state to the
2486 extent that the benefits described in s. 627.7485(1) are payable
2487 for such injury, or would be payable but for any exclusion
2488 authorized by ss. 627.748-627.7491, under any insurance policy
2489 or other method of security complying with s. 627.7483, or by an
2490 owner personally liable under s. 627.7483 for the payment of
2491 such benefits, unless the person is entitled to maintain an
2492 action for pain, suffering, mental anguish, and inconvenience
2493 for such injury under subsection (2).

2494 (2) In any action of tort brought against the owner,
2495 registrant, operator, or occupant of a motor vehicle for which
2496 security has been provided as required by ss. 627.748-627.7491,
2497 or against any person or organization legally responsible for
2498 her or his acts or omissions, a plaintiff may recover damages in
2499 tort for pain, suffering, mental anguish, and inconvenience
2500 because of bodily injury, sickness, or disease arising out of
2501 the ownership, maintenance, operation, or use of such motor
2502 vehicle only if the injury or disease consists in whole or in
2503 part of:

2504 (a) Significant and permanent loss of an important bodily
2505 function;

2506 (b) Permanent injury within a reasonable degree of medical
2507 probability, other than scarring or disfigurement;



811080

2508 (c) Significant and permanent scarring or disfigurement; or
2509 (d) Death.

2510 (3) If a defendant in a proceeding brought pursuant to ss.
2511 627.748-627.7491 questions whether the plaintiff has met the
2512 requirements of subsection (2), the defendant may file an
2513 appropriate motion with the court, and the court, 30 days before
2514 the date set for the trial or the pretrial hearing, whichever is
2515 first, shall, on a one-time basis only, ascertain by examining
2516 the pleadings and the evidence before it whether the plaintiff
2517 will be able to submit some evidence that the plaintiff will
2518 meet the requirements of subsection (2). If the court finds that
2519 the plaintiff will not be able to submit such evidence, the
2520 court shall dismiss the plaintiff's claim without prejudice.

2521 (4) A claim for punitive damages is not allowed in any
2522 action brought against a motor vehicle liability insurer for
2523 damages in excess of its policy limits.

2524 Section 17. Section 627.7487, Florida Statutes, is created
2525 to read:

2526 627.7487 Medical care coverage; optional limitations;
2527 deductibles.-

2528 (1) The named insured may elect a deductible or modified
2529 coverage or combination thereof to apply to the named insured
2530 alone or to the named insured and dependent relatives residing
2531 in the insured's household but may not elect a deductible or
2532 modified coverage to apply to any other person covered under the
2533 policy.

2534 (2) Upon the renewal of an existing policy, an insurer
2535 shall offer deductibles of \$250, \$500, and \$1,000 to each
2536 applicant and to each policyholder. The deductible amount must



811080

2537 be applied to 100 percent of the expenses and losses described
2538 in s. 627.7485. After the deductible is met, each insured may
2539 receive up to \$10,000 in total benefits as described in s.
2540 627.7485(1). However, this subsection may not be applied to
2541 reduce the amount of any benefits received in accordance with s.
2542 627.7485(1)(c).

2543 (3) An insurer shall offer coverage where, at the election
2544 of the named insured, the benefits for loss of gross income and
2545 loss of earning capacity described in s. 627.7485(1)(b) are
2546 excluded.

2547 (4) The named insured may not be prevented from electing a
2548 deductible under subsection (2) and modified coverage under
2549 subsection (3). Each election made by the named insured under
2550 this section must result in an appropriate reduction of premium
2551 associated with that election.

2552 (5) All such offers must be made in clear and unambiguous
2553 language at the time the initial application is taken and before
2554 each annual renewal and indicate that a premium reduction will
2555 result from each election. At the option of the insurer, such
2556 requirement may be met by using forms of notice approved by the
2557 office or by providing the following notice in 10-point type in
2558 the insurer's application for initial issuance of a policy of
2559 motor vehicle insurance and the insurer's annual notice of
2560 renewal premium:

2561
2562 For medical care coverage insurance, the named insured may elect
2563 a deductible and may choose to exclude coverage for loss of
2564 gross income and loss of earning capacity ("lost wages"). This
2565 selection and choice apply to the named insured alone, or to the



811080

2566 named insured and all dependent resident relatives. A premium
2567 reduction will result from these elections. The named insured is
2568 hereby advised not to elect the lost wage exclusion if the named
2569 insured or dependent resident relatives are employed, since lost
2570 wages will not be payable in the event of an accident.

2571 Section 18. Section 627.7488, Florida Statutes, is created
2572 to read:

2573 627.7488 Notice of insured's rights.-

2574 (1) The commission shall adopt by rule a form for notifying
2575 insureds of their right to receive coverage under the Florida
2576 Motor Vehicle No-Fault Medical Care Coverage Law. Such notice
2577 must include:

2578 (a) A description of the benefits provided, including, but
2579 not limited to, the specific types of services for which medical
2580 benefits are paid, disability benefits, death benefits,
2581 significant exclusions from and limitations on coverage, how
2582 benefits are coordinated with other insurance benefits that the
2583 insured may have, when payments are due, penalties and interest
2584 that may be imposed on insurers for failure to make timely
2585 payments of benefits, and rights of parties regarding disputes
2586 as to benefits.

2587 (b) An advisory informing insureds that:

2588 1. Pursuant to s. 626.9892, the Department of Financial
2589 Services may pay rewards of up to \$25,000 to persons providing
2590 information leading to the arrest and conviction of persons
2591 committing crimes investigated by the Division of Insurance
2592 Fraud arising from violations of s. 440.105, s. 624.15, s.
2593 626.9541, s. 626.989, or s. 817.234.

2594 2. Pursuant to s. 627.7485(5)(f)1.e., if the insured



811080

2595 notifies the insurer in writing of a billing error, the insured
2596 may be entitled to a certain percentage of a reduction in the
2597 amounts paid by the insured's motor vehicle insurer.

2598 (c) A notice that solicitation of a person injured in a
2599 motor vehicle crash for purposes of filing medical care coverage
2600 or tort claims could be a violation of s. 817.234 or s. 817.505
2601 or the rules regulating The Florida Bar and, if such conduct has
2602 taken place, it should be immediately reported to the Division
2603 of Insurance Fraud.

2604 (2) Each insurer issuing a policy in this state providing
2605 medical care coverage must mail or deliver the notice as
2606 specified in subsection (1) to an insured within 21 days after
2607 receiving from the insured notice of a motor vehicle accident or
2608 claim involving personal injury to an insured who is covered
2609 under the policy. The office may allow an insurer additional
2610 time, not to exceed 30 days, to provide the notice specified in
2611 subsection (1) upon a showing by the insurer that an emergency
2612 justifies an extension of time.

2613 (3) The notice required by this section does not alter or
2614 modify the terms of the insurance contract or other requirements
2615 of ss. 627.748-627.7491.

2616 Section 19. Section 627.7489, Florida Statutes, is created
2617 to read:

2618 627.7489 Mandatory joinder of derivative claim.—In any
2619 action brought pursuant to s. 627.7486 claiming personal
2620 injuries, all claims arising out of the plaintiff's injuries,
2621 including all derivative claims, shall be brought together,
2622 unless good cause is shown why such claims should be brought
2623 separately.



811080

2624 Section 20. Section 627.749, Florida Statutes, is created
2625 to read:

2626 627.749 Insurers' right of reimbursement.—Notwithstanding
2627 any other provisions of ss. 627.748-627.7491, an insurer
2628 providing medical care coverage on a private passenger motor
2629 vehicle shall, to the extent of any medical care coverage paid
2630 to any person as a benefit arising out of such private passenger
2631 motor vehicle insurance, have a right of reimbursement against
2632 the owner or the insurer of the owner of a commercial motor
2633 vehicle if the benefits paid result from such person having been
2634 an occupant of the commercial motor vehicle or having been
2635 struck by the commercial motor vehicle while not an occupant of
2636 any self-propelled vehicle.

2637 Section 21. Effective December 1, 2012, section 627.7491,
2638 Florida Statutes, is created to read:

2639 627.7491 Application of the Florida Motor Vehicle No-Fault
2640 Medical Care Coverage Law.—

2641 (1) All forms and rates for policies issued or renewed on
2642 or after January 1, 2013, must reflect ss. 627.748-627.7491 and
2643 must be approved by the office before use.

2644 (2) After January 1, 2013, insurers must provide notice of
2645 the Florida Motor Vehicle No-Fault Medical Care Coverage Law to
2646 existing policyholders at least 30 days before the policy
2647 expiration date and to applicants for no-fault coverage upon
2648 receipt of the application. The notice is not subject to
2649 approval by the office and must clearly inform the policyholder
2650 or applicant of the following:

2651 (a) That, effective January 1, 2013, no-fault motor vehicle
2652 insurance requirements are governed by the Florida Motor Vehicle



811080

2653 No-Fault Medical Care Coverage Law and must provide an
2654 explanation of medical care coverage. With respect to the
2655 initial renewal after January 1, 2013, current policyholders
2656 must also be provided with an explanation of differences between
2657 their current policies and the coverage provided under medical
2658 care coverage policies.

2659 (b) That failure to maintain required medical care coverage
2660 and \$10,000 in property damage liability coverage may result in
2661 state suspension of the policyholder's driver license and
2662 vehicle registration.

2663 (c) The name and telephone number of a person to contact
2664 with any questions she or he may have.

2665 Section 22. Subsection (1), paragraph (c) of subsection
2666 (7), paragraphs (a), (b), and (c) of subsection (8), and
2667 subsections (9), (10), and (13) of section 817.234, Florida
2668 Statutes, are amended to read:

2669 817.234 False and fraudulent insurance claims.—

2670 (1) (a) A person commits insurance fraud punishable as
2671 provided in subsection (11) if that person, with the intent to
2672 injure, defraud, or deceive any insurer:

2673 1. Presents or causes to be presented any written or oral
2674 statement as part of, or in support of, a claim for payment or
2675 other benefit pursuant to an insurance policy or a health
2676 maintenance organization subscriber or provider contract,
2677 knowing that such statement contains any false, incomplete, or
2678 misleading information concerning any fact or thing material to
2679 such claim;

2680 2. Prepares or makes any written or oral statement that is
2681 intended to be presented to any insurer in connection with, or



811080

2682 in support of, any claim for payment or other benefit pursuant
2683 to an insurance policy or a health maintenance organization
2684 subscriber or provider contract, knowing that such statement
2685 contains any false, incomplete, or misleading information
2686 concerning any fact or thing material to such claim; ~~or~~

2687 3.a. Knowingly presents, causes to be presented, or
2688 prepares or makes with knowledge or belief that it will be
2689 presented to any insurer, purported insurer, servicing
2690 corporation, insurance broker, or insurance agent, or any
2691 employee or agent thereof, any false, incomplete, or misleading
2692 information or written or oral statement as part of, or in
2693 support of, an application for the issuance of, or the rating
2694 of, any insurance policy, or a health maintenance organization
2695 subscriber or provider contract; or

2696 b. ~~Who~~ Knowingly conceals information concerning any fact
2697 material to such application; ~~or-~~

2698 4. Knowingly presents, causes to be presented, or, with
2699 knowledge or belief that it will be presented to an insurer,
2700 prepares or makes a claim for payment or other benefit under a
2701 personal injury protection insurance policy or an emergency care
2702 coverage insurance policy and the person knows that the payee
2703 knowingly submitted a false, misleading, or fraudulent
2704 application or other document when applying for licensure as a
2705 health care clinic, seeking an exemption from licensure as a
2706 health care clinic, or demonstrating compliance with part X of
2707 chapter 400.

2708 (b) All claims and application forms must ~~shall~~ contain a
2709 statement that is approved by the Office of Insurance Regulation
2710 of the Financial Services Commission which clearly states in



811080

2711 substance the following: "Any person who knowingly and with
2712 intent to injure, defraud, or deceive any insurer files a
2713 statement of claim or an application containing any false,
2714 incomplete, or misleading information is guilty of a felony of
2715 the third degree." This paragraph does ~~shall~~ not apply to
2716 reinsurance contracts, reinsurance agreements, or reinsurance
2717 claims transactions.

2718 (7)

2719 (c) An insurer, or any person acting at the direction of or
2720 on behalf of an insurer, may not change an opinion in a mental
2721 or physical report prepared under s. 627.736(7) or s.
2722 627.7485(7), as applicable, s. ~~627.736(8)~~ or direct the
2723 physician preparing the report to change such opinion; however,
2724 this provision does not preclude the insurer from calling to the
2725 attention of the physician errors of fact in the report based
2726 upon information in the claim file. Any person who violates this
2727 paragraph commits a felony of the third degree, punishable as
2728 provided in s. 775.082, s. 775.083, or s. 775.084.

2729 (8) (a) It is unlawful for any person intending to defraud
2730 any other person to solicit or cause to be solicited any
2731 business from a person involved in a motor vehicle accident for
2732 the purpose of making, adjusting, or settling motor vehicle tort
2733 claims or claims for personal injury protection or medical care
2734 coverage benefits required by s. 627.736 or 627.7485, as
2735 applicable. Any person who violates ~~the provisions of~~ this
2736 paragraph commits a felony of the second degree, punishable as
2737 provided in s. 775.082, s. 775.083, or s. 775.084. A person who
2738 is convicted of a violation of this subsection shall be
2739 sentenced to a minimum term of imprisonment of 2 years.



811080

2740 (b) A person may not solicit or cause to be solicited any
2741 business from a person involved in a motor vehicle accident by
2742 any means of communication other than advertising directed to
2743 the public for the purpose of making motor vehicle tort claims
2744 or claims for personal injury protection or medical care
2745 coverage benefits required by s. 627.736 or 627.7485, as
2746 applicable, within 60 days after the occurrence of the motor
2747 vehicle accident. Any person who violates this paragraph commits
2748 a felony of the third degree, punishable as provided in s.
2749 775.082, s. 775.083, or s. 775.084.

2750 (c) A lawyer, health care practitioner as defined in s.
2751 456.001, or owner or medical director of a clinic required to be
2752 licensed pursuant to s. 400.9905 may not, at any time after 60
2753 days have elapsed from the occurrence of a motor vehicle
2754 accident, solicit or cause to be solicited any business from a
2755 person involved in a motor vehicle accident by means of in
2756 person or telephone contact at the person's residence, for the
2757 purpose of making motor vehicle tort claims or claims for
2758 personal injury protection or medical care coverage benefits
2759 required by s. 627.736 or 627.7485, as applicable. Any person
2760 who violates this paragraph commits a felony of the third
2761 degree, punishable as provided in s. 775.082, s. 775.083, or s.
2762 775.084.

2763 (9) A person may not organize, plan, or knowingly
2764 participate in an intentional motor vehicle crash or a scheme to
2765 create documentation of a motor vehicle crash that did not occur
2766 for the purpose of making motor vehicle tort claims or claims
2767 for personal injury protection or medical care coverage benefits
2768 as required by s. 627.736 or s. 627.7485, as applicable. Any



811080

2769 person who violates this subsection commits a felony of the
2770 second degree, punishable as provided in s. 775.082, s. 775.083,
2771 or s. 775.084. A person who is convicted of a violation of this
2772 subsection shall be sentenced to a minimum term of imprisonment
2773 of 2 years.

2774 (10) A licensed health care practitioner who is found
2775 guilty of insurance fraud under this section for an act relating
2776 to a personal injury protection or medical care coverage
2777 insurance policy may not be licensed or continue to be licensed
2778 for 5 years and may not receive reimbursement for benefits under
2779 such policies for 10 years. ~~As used in this section, the term~~
2780 ~~"insurer" means any insurer, health maintenance organization,~~
2781 ~~self-insurer, self-insurance fund, or other similar entity or~~
2782 ~~person regulated under chapter 440 or chapter 641 or by the~~
2783 ~~Office of Insurance Regulation under the Florida Insurance Code.~~

2784 (13) As used in this section, the term:

2785 (a) "Insurer" means any insurer, health maintenance
2786 organization, self-insurer, self-insurance fund, or similar
2787 entity or person regulated under chapter 440 or chapter 641 or
2788 by the Office of Insurance Regulation under the Florida
2789 Insurance Code.

2790 (b) ~~(a)~~ "Property" means property as defined in s. 812.012.

2791 (c) ~~(b)~~ "Value" means value as defined in s. 812.012.

2792 Section 23. Subsection (4) of section 316.065, Florida
2793 Statutes, is amended to read:

2794 316.065 Crashes; reports; penalties.—

2795 (4) Any person who knowingly repairs a motor vehicle
2796 without having made a report as required by subsection (3) is
2797 guilty of a misdemeanor of the first degree, punishable as



811080

2798 provided in s. 775.082 or s. 775.083. The owner and driver of a
2799 vehicle involved in a crash who makes a report thereof in
2800 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable
2801 under this section.

2802 Section 24. Subsection (1) of section 316.646, Florida
2803 Statutes, is amended to read:

2804 316.646 Security required; proof of security and display
2805 thereof; dismissal of cases.—

2806 (1) Any person required by s. 324.022 to maintain property
2807 damage liability security, required by s. 324.023 to maintain
2808 liability security for bodily injury or death, ~~or~~ required by s.
2809 627.733 to maintain personal injury protection security, or
2810 required by s. 627.7483 to maintain medical care coverage
2811 security, as applicable, on a motor vehicle must ~~shall~~ have in
2812 his or her immediate possession at all times while operating
2813 such motor vehicle proper proof of maintenance of the required
2814 security. Such proof must ~~shall~~ be a uniform proof-of-insurance
2815 card in a form prescribed by the department, a valid insurance
2816 policy, an insurance policy binder, a certificate of insurance,
2817 or such other proof as may be prescribed by the department.

2818 Section 25. Paragraph (b) of subsection (2) of section
2819 318.18, Florida Statutes, is amended to read:

2820 318.18 Amount of penalties.—The penalties required for a
2821 noncriminal disposition pursuant to s. 318.14 or a criminal
2822 offense listed in s. 318.17 are as follows:

2823 (2) Thirty dollars for all nonmoving traffic violations
2824 and:

2825 (b) For all violations of ss. 320.0605, 320.07(1), 322.065,
2826 and 322.15(1). Any person who is cited for a violation of s.



811080

2827 320.07(1) shall be charged a delinquent fee pursuant to s.
2828 320.07(4).

2829 1. If a person who is cited for a violation of s. 320.0605
2830 or s. 320.07 can show proof of having a valid registration at
2831 the time of arrest, the clerk of the court may dismiss the case
2832 and may assess a dismissal fee of up to \$10. A person who finds
2833 it impossible or impractical to obtain a valid registration
2834 certificate must submit an affidavit detailing the reasons for
2835 the impossibility or impracticality. The reasons may include,
2836 but are not limited to, the fact that the vehicle was sold,
2837 stolen, or destroyed; that the state in which the vehicle is
2838 registered does not issue a certificate of registration; or that
2839 the vehicle is owned by another person.

2840 2. If a person who is cited for a violation of s. 322.03,
2841 s. 322.065, or s. 322.15 can show a driver ~~driver's~~ license
2842 issued to him or her and valid at the time of arrest, the clerk
2843 of the court may dismiss the case and may assess a dismissal fee
2844 of up to \$10.

2845 3. If a person who is cited for a violation of s. 316.646
2846 can show proof of security as required by s. 627.733 or s.
2847 627.7483, as applicable, issued to the person and valid at the
2848 time of arrest, the clerk of the court may dismiss the case and
2849 may assess a dismissal fee of up to \$10. A person who finds it
2850 impossible or impractical to obtain proof of security must
2851 submit an affidavit detailing the reasons for the
2852 impracticality. The reasons may include, but are not limited to,
2853 the fact that the vehicle has since been sold, stolen, or
2854 destroyed; that the owner or registrant of the vehicle is not
2855 required by s. 627.733 or s. 627.7483 to maintain personal



811080

2856 injury protection insurance or medical care coverage insurance,
2857 as applicable; or that the vehicle is owned by another person.

2858 Section 26. Paragraphs (a) and (d) of subsection (5) of
2859 section 320.02, Florida Statutes, are amended to read:

2860 320.02 Registration required; application for registration;
2861 forms.—

2862 (5) (a) Proof that personal injury protection benefits or
2863 medical care coverage benefits, as applicable, have been
2864 purchased if when required under s. 627.733 or s. 627.7483, as
2865 applicable, that property damage liability coverage has been
2866 purchased as required under s. 324.022, that bodily injury or
2867 death coverage has been purchased if required under s. 324.023,
2868 and that combined bodily liability insurance and property damage
2869 liability insurance have been purchased if when required under
2870 s. 627.7415 shall be provided in the manner prescribed by law by
2871 the applicant at the time of application for registration of any
2872 motor vehicle that is subject to such requirements. The issuing
2873 agent shall refuse to issue registration if such proof of
2874 purchase is not provided. Insurers shall furnish uniform proof-
2875 of-purchase cards in a form prescribed by the department and
2876 ~~shall~~ include the name of the insured's insurance company, the
2877 coverage identification number, and the make, year, and vehicle
2878 identification number of the vehicle insured. The card must
2879 ~~shall~~ contain a statement notifying the applicant of the penalty
2880 specified in s. 316.646(4). The card or insurance policy,
2881 insurance policy binder, or certificate of insurance or a
2882 photocopy of any of these; an affidavit containing the name of
2883 the insured's insurance company, the insured's policy number,
2884 and the make and year of the vehicle insured; or such other



811080

2885 proof as may be prescribed by the department ~~shall~~ constitute
2886 sufficient proof of purchase. If an affidavit is provided as
2887 proof, it must ~~shall~~ be in substantially the following form:
2888

2889 Under penalty of perjury, I ...(Name of insured)... do
2890 hereby certify that I have ...(Personal Injury Protection or
2891 Medical Care Coverage, as applicable, Property Damage Liability,
2892 and, if when required, Bodily Injury Liability)... Insurance
2893 currently in effect with ...(Name of insurance company)... under
2894 ...(policy number)... covering ...(make, year, and vehicle
2895 identification number of vehicle).... ...(Signature of
2896 Insured)...

2897
2898 The ~~Such~~ affidavit must ~~shall~~ include the following
2899 warning:
2900

2901 WARNING: GIVING FALSE INFORMATION IN ORDER TO OBTAIN A
2902 VEHICLE REGISTRATION CERTIFICATE IS A CRIMINAL OFFENSE UNDER
2903 FLORIDA LAW. ANYONE GIVING FALSE INFORMATION ON THIS AFFIDAVIT
2904 IS SUBJECT TO PROSECUTION.
2905

2906 If ~~When~~ an application is made through a licensed motor
2907 vehicle dealer as required in s. 319.23, the original or a
2908 photostatic copy of such card, insurance policy, insurance
2909 policy binder, or certificate of insurance or the original
2910 affidavit from the insured shall be forwarded by the dealer to
2911 the tax collector of the county or the Department of Highway
2912 Safety and Motor Vehicles for processing. By executing the
2913 aforesaid affidavit, the ~~ne~~ licensed motor vehicle dealer will



811080

2914 not be liable in damages for any inadequacy, insufficiency, or
2915 falsification of any statement contained therein. A card must
2916 ~~shall~~ also indicate the existence of any bodily injury liability
2917 insurance voluntarily purchased.

2918 (d) The verifying of proof of personal injury protection
2919 insurance or medical care coverage insurance, as applicable,
2920 proof of property damage liability insurance, proof of combined
2921 bodily liability insurance and property damage liability
2922 insurance, or proof of financial responsibility insurance and
2923 the issuance or failure to issue the motor vehicle registration
2924 under ~~the provisions of~~ this chapter may not be construed in any
2925 court as a warranty of the reliability or accuracy of the
2926 evidence of such proof. Neither the department nor any tax
2927 collector is liable in damages for any inadequacy,
2928 insufficiency, falsification, or unauthorized modification of
2929 any item of the proof of personal injury protection insurance or
2930 medical care coverage insurance, as applicable, proof of
2931 property damage liability insurance, proof of combined bodily
2932 liability insurance and property damage liability insurance, or
2933 proof of financial responsibility insurance before ~~prior to,~~
2934 during, or subsequent to the verification of the proof. The
2935 issuance of a motor vehicle registration does not constitute
2936 prima facie evidence or a presumption of insurance coverage.

2937 Section 27. Paragraph (b) of subsection (1) of section
2938 320.0609, Florida Statutes, is amended to read:

2939 320.0609 Transfer and exchange of registration license
2940 plates; transfer fee.—

2941 (1)

2942 (b) The transfer of a license plate from a vehicle disposed



811080

2943 of to a newly acquired vehicle does not constitute a new
2944 registration. The application for transfer shall be accepted
2945 without requiring proof of personal injury protection insurance
2946 or medical care coverage insurance, as applicable, or liability
2947 insurance.

2948 Section 28. Subsection (3) of section 320.27, Florida
2949 Statutes, is amended to read:

2950 320.27 Motor vehicle dealers.—

2951 (3) APPLICATION AND FEE.—The application for the license
2952 must ~~shall~~ be in such form as may be prescribed by the
2953 department and ~~shall be~~ subject to such rules with respect
2954 thereto as may be so prescribed by it. Such application must
2955 ~~shall~~ be verified by oath or affirmation and ~~shall~~ contain a
2956 full statement of the name and birth date of the applicant
2957 ~~person or persons applying therefor~~; the name of the firm or
2958 copartnership, with the names and places of residence of all
2959 members thereof, if such applicant is a firm or copartnership;
2960 the names and places of residence of the principal officers, if
2961 the applicant is a body corporate or other artificial body; the
2962 name of the state under whose laws the corporation is organized;
2963 the present and former place or places of residence of the
2964 applicant; and prior business in which the applicant has been
2965 engaged and the location thereof. The ~~Such~~ application must
2966 ~~shall~~ describe the exact location of the place of business and
2967 ~~shall~~ state whether the place of business is owned by the
2968 applicant and if ~~when~~ acquired, or, if leased, a true copy of
2969 the lease must ~~shall~~ be attached to the application. The
2970 applicant shall certify that the location provides an adequately
2971 equipped office and is not a residence; that the location



811080

2972 affords sufficient unoccupied space upon and within which to
2973 adequately ~~to~~ store all motor vehicles offered and displayed for
2974 sale; and that the location is a suitable place where the
2975 applicant can in good faith carry on such business and keep and
2976 maintain books, records, and files necessary to conduct such
2977 business, which will be available at all reasonable hours for ~~to~~
2978 inspection by the department or ~~any~~ of its inspectors or other
2979 employees. The applicant shall certify that the business of a
2980 motor vehicle dealer is the principal business that will ~~which~~
2981 ~~shall~~ be conducted at that location. The ~~Such~~ application must
2982 ~~shall~~ contain a statement that the applicant is ~~either~~
2983 franchised by a manufacturer of motor vehicles, in which case
2984 the name of each motor vehicle that the applicant is franchised
2985 to sell shall be included, or an independent, ~~(nonfranchised,)~~
2986 motor vehicle dealer. The ~~Such~~ application must ~~shall~~ contain
2987 such other relevant information as may be required by the
2988 department, including evidence that the applicant is insured
2989 under a garage liability insurance policy or a general liability
2990 insurance policy coupled with a business automobile policy,
2991 which includes ~~shall include~~, at a minimum, \$25,000 combined
2992 single-limit liability coverage including bodily injury and
2993 property damage protection and \$10,000 personal injury
2994 protection or medical care coverage, as applicable. Franchise
2995 dealers must submit a garage liability insurance policy, and all
2996 other dealers must submit a garage liability insurance policy or
2997 a general liability insurance policy coupled with a business
2998 automobile policy. The ~~Such~~ policy shall be for the license
2999 period, and evidence of a new or continued policy must ~~shall~~ be
3000 delivered to the department at the beginning of each license



811080

3001 period. Upon making initial application, the applicant shall pay
3002 to the department a fee of \$300 in addition to any other fees
3003 ~~now~~ required by law; upon making a subsequent renewal
3004 application, the applicant shall pay to the department a fee of
3005 \$75 in addition to any other fees ~~now~~ required by law. Upon
3006 making an application for a change of location, the person shall
3007 pay a fee of \$50 in addition to any other fees ~~now~~ required by
3008 law. The department shall, in the case of every application for
3009 initial licensure, verify whether certain facts set forth in the
3010 application are true. Each applicant, general partner in the
3011 case of a partnership, or corporate officer and director in the
3012 case of a corporate applicant, must file a set of fingerprints
3013 with the department for the purpose of determining any prior
3014 criminal record or any outstanding warrants. The department
3015 shall submit the fingerprints to the Department of Law
3016 Enforcement for state processing and forwarding to the Federal
3017 Bureau of Investigation for federal processing. The actual cost
3018 of state and federal processing shall be borne by the applicant
3019 and is in addition to the fee for licensure. The department may
3020 issue a license to an applicant pending the results of the
3021 fingerprint investigation, which ~~license~~ is fully revocable if
3022 the department subsequently determines that any facts set forth
3023 in the application are not true or correctly represented.

3024 Section 29. Paragraph (j) of subsection (3) of section
3025 320.771, Florida Statutes, is amended to read:

3026 320.771 License required of recreational vehicle dealers.—

3027 (3) APPLICATION.—The application for such license shall be
3028 in the form prescribed by the department and subject to such
3029 rules as may be prescribed by it. The application shall be



3030 verified by oath or affirmation and shall contain:
3031 (j) A statement that the applicant is insured under a
3032 garage liability insurance policy, which ~~shall include~~, at a
3033 minimum, includes \$25,000 combined single-limit liability
3034 coverage, including bodily injury and property damage
3035 protection, and \$10,000 personal injury protection or medical
3036 care coverage, as applicable, if the applicant is to be licensed
3037 as a dealer in, or intends to sell, recreational vehicles.

3038
3039 The department shall, if it deems necessary, cause an
3040 investigation to be made to ascertain if the facts set forth in
3041 the application are true and may ~~shall~~ not issue a license to
3042 the applicant until it is satisfied that the facts set forth in
3043 the application are true.

3044 Section 30. Subsection (1) of section 322.251, Florida
3045 Statutes, is amended to read:

3046 322.251 Notice of cancellation, suspension, revocation, or
3047 disqualification of license.—

3048 (1) All orders of cancellation, suspension, revocation, or
3049 disqualification issued under ~~the provisions of~~ this chapter,
3050 chapter 318, chapter 324, ~~or~~ ss. 627.732-627.734, or ss.
3051 627.748-627.7491 must be made ~~shall be given either~~ by personal
3052 delivery ~~thereof~~ to the licensee whose license is being
3053 canceled, suspended, revoked, or disqualified or by deposit in
3054 the United States mail in an envelope, first class, postage
3055 prepaid, addressed to the licensee at his or her last known
3056 mailing address furnished to the department. Such mailing by the
3057 department constitutes notification, and any failure by the
3058 person to receive the mailed order does ~~will~~ not affect or stay



811080

3059 the effective date or term of the cancellation, suspension,
3060 revocation, or disqualification of the licensee's driving
3061 privilege.

3062 Section 31. Paragraph (a) of subsection (8) of section
3063 322.34, Florida Statutes, is amended to read:

3064 322.34 Driving while license suspended, revoked, canceled,
3065 or disqualified.—

3066 (8) (a) Upon the arrest of a person for the offense of
3067 driving while the person's driver ~~driver's~~ license or driving
3068 privilege is suspended or revoked, the arresting officer must
3069 ~~shall~~ determine:

3070 1. Whether the person's driver ~~driver's~~ license is
3071 suspended or revoked.

3072 2. Whether the person's driver ~~driver's~~ license has
3073 remained suspended or revoked since a conviction for the offense
3074 of driving with a suspended or revoked license.

3075 3. Whether the suspension or revocation was made under s.
3076 316.646, ~~or~~ s. 627.733, or s. 627.7483, relating to failure to
3077 maintain required security, or under s. 322.264, relating to
3078 habitual traffic offenders.

3079 4. Whether the driver is the registered owner or coowner of
3080 the vehicle.

3081 Section 32. Subsection (1) and paragraph (c) of subsection
3082 (9) of section 324.021, Florida Statutes, are amended to read:

3083 324.021 Definitions; minimum insurance required.—The
3084 following words and phrases when used in this chapter shall, for
3085 the purpose of this chapter, have the meanings respectively
3086 ascribed to them in this section, except in those instances
3087 where the context clearly indicates a different meaning:



811080

3088 (1) MOTOR VEHICLE.—Every self-propelled vehicle that ~~which~~
3089 is designed and required to be licensed for use upon a highway,
3090 including trailers and semitrailers designed for use with such
3091 vehicles, except traction engines, road rollers, farm tractors,
3092 power shovels, and well drillers, and every vehicle that ~~which~~
3093 is propelled by electric power obtained from overhead wires but
3094 not operated upon rails, but not including any bicycle or moped.
3095 However, the term "motor vehicle" does ~~shall~~ not include a ~~any~~
3096 motor vehicle as defined in s. 627.732~~(3)~~ or s. 627.7482, as
3097 applicable, if ~~when~~ the owner of such vehicle has complied with
3098 ~~the requirements of~~ ss. 627.730-627.7405 or ss. 627.748-
3099 627.7491, as applicable, inclusive, unless ~~the provisions of~~ s.
3100 324.051 applies ~~apply~~; and, in such case, the applicable proof
3101 of insurance provisions of s. 320.02 apply.

3102 (9) OWNER; OWNER/LESSOR.—

3103 (c) *Application*.—

3104 1. The limits on liability in subparagraphs (b)2. and 3. do
3105 not apply to an owner of motor vehicles that are used for
3106 commercial activity in the owner's ordinary course of business,
3107 other than a rental company that rents or leases motor vehicles.
3108 For purposes of this paragraph, the term "rental company"
3109 includes only an entity that is engaged in the business of
3110 renting or leasing motor vehicles to the general public and that
3111 rents or leases a majority of its motor vehicles to persons who
3112 have ~~with~~ no direct or indirect affiliation with the rental
3113 company. The term also includes a motor vehicle dealer that
3114 provides temporary replacement vehicles to its customers for up
3115 to 10 days. The term "rental company" also includes:

3116 a. A related rental or leasing company that is a subsidiary



811080

3117 of the same parent company as that of the renting or leasing
3118 company that rented or leased the vehicle.

3119 b. The holder of a motor vehicle title or an equity
3120 interest in a motor vehicle title if the title or equity
3121 interest is held pursuant to or to facilitate an asset-backed
3122 securitization of a fleet of motor vehicles used solely in the
3123 business of renting or leasing motor vehicles to the general
3124 public and under the dominion and control of a rental company,
3125 as described in this subparagraph, in the operation of such
3126 rental company's business.

3127 2. ~~Furthermore,~~ With respect to commercial motor vehicles
3128 as defined in s. 627.732 or s. 627.7482, as applicable, the
3129 limits on liability in subparagraphs (b)2. and 3. do not apply
3130 if, at the time of the incident, the commercial motor vehicle is
3131 being used in the transportation of materials found to be
3132 hazardous for the purposes of the Hazardous Materials
3133 Transportation Authorization Act of 1994, as amended, 49 U.S.C.
3134 ss. 5101 et seq., and that is required pursuant to such act to
3135 carry placards warning others of the hazardous cargo, unless at
3136 the time of lease or rental ~~either~~:

3137 a. The lessee indicates in writing that the vehicle will
3138 not be used to transport materials found to be hazardous for the
3139 purposes of the Hazardous Materials Transportation Authorization
3140 Act of 1994, as amended, 49 U.S.C. ss. 5101 et seq.; or

3141 b. The lessee or other operator of the commercial motor
3142 vehicle has in effect insurance with limits of at least
3143 \$5,000,000 combined property damage and bodily injury liability.

3144 Section 33. Section 324.0221, Florida Statutes, is amended
3145 to read:



811080

3146 324.0221 Reports by insurers to the department; suspension
3147 of driver ~~driver's~~ license and vehicle registrations;
3148 reinstatement.—

3149 (1) (a) Each insurer that has issued a policy providing
3150 personal injury protection or medical care coverage or property
3151 damage liability coverage shall report the renewal,
3152 cancellation, or nonrenewal of the policy ~~thereof~~ to the
3153 department within 45 days after the effective date of each
3154 renewal, cancellation, or nonrenewal. Upon the issuance of a
3155 policy providing personal injury protection or medical care
3156 coverage or property damage liability coverage to a named
3157 insured not previously insured by the insurer during that
3158 calendar year, the insurer shall report the issuance of the new
3159 policy to the department within 30 days. The report shall be in
3160 the form and format and contain any information required by the
3161 department and must be provided in a format that is compatible
3162 with the data processing capabilities of the department. The
3163 department may adopt rules regarding the form and documentation
3164 required. Failure by an insurer to file proper reports with the
3165 department as required by this subsection or rules adopted with
3166 respect to the requirements of this subsection constitutes a
3167 violation of the Florida Insurance Code. These records shall be
3168 used by the department only for enforcement and regulatory
3169 purposes, including the generation by the department of data
3170 regarding compliance by owners of motor vehicles with the
3171 requirements for financial responsibility coverage.

3172 (b) With respect to an insurance policy providing personal
3173 injury protection or medical care coverage or property damage
3174 liability coverage, each insurer shall notify the named insured,



811080

3175 or the first-named insured in the case of a commercial fleet
3176 policy, in writing that any cancellation or nonrenewal of the
3177 policy will be reported by the insurer to the department. The
3178 notice must also inform the named insured that failure to
3179 maintain personal injury protection or medical care coverage and
3180 property damage liability coverage on a motor vehicle as when
3181 required by law may result in the loss of registration and
3182 driving privileges in this state and inform the named insured of
3183 the amount of the reinstatement fees required by this section.
3184 This notice is for informational purposes only, and an insurer
3185 is not civilly liable for failing to provide this notice.

3186 (2) The department shall suspend, after due notice and an
3187 opportunity to be heard, the registration and driver ~~driver's~~
3188 license of any owner or registrant of a motor vehicle with
3189 respect to which security is required under s. ss. 324.022 and
3190 either s. 627.733 or s. 627.7483, as applicable, upon:

3191 (a) The department's records showing that the owner or
3192 registrant of such motor vehicle did not have in full force and
3193 effect when required security that complies with the
3194 requirements of s. ss. 324.022 and either s. 627.733 or s.
3195 627.7483, as applicable; or

3196 (b) Notification by the insurer to the department, in a
3197 form approved by the department, of cancellation or termination
3198 of the required security.

3199 (3) An operator or owner whose driver ~~driver's~~ license or
3200 registration has been suspended under this section or s. 316.646
3201 may effect its reinstatement upon compliance with the
3202 requirements of this section and upon payment to the department
3203 of a nonrefundable reinstatement fee of \$150 for the first



3204 reinstatement. The reinstatement fee is \$250 for the second
3205 reinstatement and \$500 for each subsequent reinstatement during
3206 the 3 years following the first reinstatement. A person
3207 reinstating her or his insurance under this subsection must also
3208 secure noncancelable coverage as described in ss. 324.021(8),
3209 324.023, and 627.7275(2) and present proof to the appropriate
3210 person ~~proof~~ that the coverage is in force on a form adopted by
3211 the department, and such proof shall be maintained for 2 years.
3212 If the person does not have a second reinstatement within 3
3213 years after her or his initial reinstatement, the reinstatement
3214 fee is \$150 for the first reinstatement after that 3-year
3215 period. If a person's license and registration are suspended
3216 under this section or s. 316.646, only one reinstatement fee
3217 must be paid to reinstate the license and the registration. All
3218 fees shall be collected by the department at the time of
3219 reinstatement. The department shall issue proper receipts for
3220 such fees and ~~shall~~ promptly deposit those fees in the Highway
3221 Safety Operating Trust Fund. One-third of the fees collected
3222 ~~under this subsection~~ shall be distributed from the Highway
3223 Safety Operating Trust Fund to the local governmental entity or
3224 state agency that employed the law enforcement officer seizing
3225 the license plate pursuant to s. 324.201. The funds may be used
3226 by the local governmental entity or state agency for any
3227 authorized purpose.

3228 Section 34. Paragraph (a) of subsection (1) of section
3229 324.032, Florida Statutes, is amended to read:

3230 324.032 Manner of proving financial responsibility; for-
3231 hire passenger transportation vehicles.—Notwithstanding the
3232 provisions of s. 324.031:



811080

3233 (1) (a) A person who is ~~either~~ the owner or a lessee
3234 required to maintain insurance under s. 627.733(1) (b) or s.
3235 627.7483(1), as applicable, and who operates one or more
3236 taxicabs, limousines, jitneys, or any other for-hire passenger
3237 transportation vehicles may prove financial responsibility by
3238 furnishing satisfactory evidence of holding a motor vehicle
3239 liability policy that has, ~~but with~~ minimum limits of
3240 \$125,000/250,000/50,000.

3241
3242 Upon request by the department, the applicant must provide the
3243 department at the applicant's principal place of business in
3244 this state access to the applicant's underlying financial
3245 information and financial statements that provide the basis of
3246 the certified public accountant's certification. The applicant
3247 shall reimburse the requesting department for all reasonable
3248 costs incurred by it in reviewing the supporting information.
3249 The maximum amount of self-insurance permissible under this
3250 subsection is \$300,000 and must be stated on a per-occurrence
3251 basis, and the applicant shall maintain adequate excess
3252 insurance issued by an authorized or eligible insurer licensed
3253 or approved by the Office of Insurance Regulation. All risks
3254 self-insured shall remain with the owner or lessee providing it,
3255 and the risks are not transferable to any other person, unless a
3256 policy complying with subsection (1) is obtained.

3257 Section 35. Subsection (2) of section 324.171, Florida
3258 Statutes, is amended to read:

3259 324.171 Self-insurer.—

3260 (2) The self-insurance certificate must ~~shall~~ provide
3261 limits of liability insurance in the amounts specified under s.



811080

3262 324.021(7) or s. 627.7415 and ~~shall~~ provide personal injury
3263 protection or medical care coverage under s. 627.733(3)(b) or s.
3264 627.7483(3)(b), as applicable.

3265 Section 36. Paragraph (g) of subsection (1) of section
3266 400.9935, Florida Statutes, is amended to read:

3267 400.9935 Clinic responsibilities.—

3268 (1) Each clinic shall appoint a medical director or clinic
3269 director who shall agree in writing to accept legal
3270 responsibility for the following activities on behalf of the
3271 clinic. The medical director or the clinic director shall:

3272 (g) Conduct systematic reviews of clinic billings to ensure
3273 that the billings are not fraudulent or unlawful. Upon discovery
3274 of an unlawful charge, the medical director or clinic director
3275 must ~~shall~~ take immediate corrective action. If the clinic
3276 performs only the technical component of magnetic resonance
3277 imaging, static radiographs, computed tomography, or positron
3278 emission tomography, and provides the professional
3279 interpretation of such services, in a fixed facility that is
3280 accredited by the Joint Commission on Accreditation of
3281 Healthcare Organizations or the Accreditation Association for
3282 Ambulatory Health Care, and the American College of Radiology;
3283 and if, in the preceding quarter, the percentage of scans
3284 performed by that clinic which was billed to all personal injury
3285 protection insurance or medical care coverage insurance carriers
3286 was less than 15 percent, the chief financial officer of the
3287 clinic may, in a written acknowledgment provided to the agency,
3288 assume ~~the~~ responsibility for the conduct of the systematic
3289 reviews of clinic billings to ensure that the billings are not
3290 fraudulent or unlawful.



811080

3291 Section 37. Subsection (28) of section 409.901, Florida
3292 Statutes, is amended to read:

3293 409.901 Definitions; ss. 409.901-409.920.—As used in ss.
3294 409.901-409.920, except as otherwise specifically provided, the
3295 term:

3296 (28) "Third-party benefit" means any benefit that is or may
3297 be available at any time through contract, court award,
3298 judgment, settlement, agreement, or any arrangement between a
3299 third party and any person or entity, including, without
3300 limitation, a Medicaid recipient, a provider, another third
3301 party, an insurer, or the agency, for any Medicaid-covered
3302 injury, illness, goods, or services, including costs of related
3303 medical services ~~related thereto~~, for personal injury or for
3304 death of the recipient, but specifically excluding policies of
3305 life insurance on the recipient, unless available under terms of
3306 the policy to pay medical expenses before ~~prior to~~ death. The
3307 term includes, without limitation, collateral, ~~as defined in~~
3308 ~~this section~~, health insurance, any benefit under a health
3309 maintenance organization, a preferred provider arrangement, a
3310 prepaid health clinic, liability insurance, uninsured motorist
3311 insurance or personal injury protection or medical care
3312 coverage, medical benefits under workers' compensation, and any
3313 obligation under law or equity to provide medical support.

3314 Section 38. Paragraph (f) of subsection (11) of section
3315 409.910, Florida Statutes, is amended to read:

3316 409.910 Responsibility for payments on behalf of Medicaid-
3317 eligible persons when other parties are liable.—

3318 (11) The agency may, as a matter of right, in order to
3319 enforce its rights under this section, institute, intervene in,



811080

3320 or join any legal or administrative proceeding in its own name
3321 in one or more of the following capacities: individually, as
3322 subrogee of the recipient, as assignee of the recipient, or as
3323 lienholder of the collateral.

3324 (f) Notwithstanding any other provision in this section ~~to~~
3325 ~~the contrary~~, in the event of an action in tort against a third
3326 party in which the recipient or his or her legal representative
3327 is a party which results in a judgment, award, or settlement
3328 from a third party, the amount recovered shall be distributed as
3329 follows:

3330 1. After attorney ~~attorney's~~ fees and taxable costs as
3331 defined by the Florida Rules of Civil Procedure, one-half of the
3332 remaining recovery shall be paid to the agency up to the total
3333 amount of medical assistance provided by Medicaid.

3334 2. The remaining amount of the recovery shall be paid to
3335 the recipient.

3336 3. For purposes of calculating the agency's recovery of
3337 medical assistance benefits paid, the fee for services of an
3338 attorney retained by the recipient or his or her legal
3339 representative shall be calculated at 25 percent of the
3340 judgment, award, or settlement.

3341 4. Notwithstanding any other provision of this section ~~to~~
3342 ~~the contrary~~, the agency is ~~shall be~~ entitled to all medical
3343 coverage benefits up to the total amount of medical assistance
3344 provided by Medicaid. For purposes of this paragraph, "medical
3345 coverage" means any benefits under health insurance, a health
3346 maintenance organization, a preferred provider arrangement, or a
3347 prepaid health clinic, and the portion of benefits designated
3348 for medical payments under coverage for workers' compensation,



811080

3349 medical care coverage, personal injury protection, and casualty.

3350 Section 39. Paragraph (k) of subsection (2) of section
3351 456.057, Florida Statutes, is amended to read:

3352 456.057 Ownership and control of patient records; report or
3353 copies of records to be furnished.—

3354 (2) As used in this section, the terms "records owner,"
3355 "health care practitioner," and "health care practitioner's
3356 employer" do not include any of the following persons or
3357 entities; furthermore, the following persons or entities may ~~are~~
3358 not ~~authorized to~~ acquire or own medical records, but, are
3359 ~~authorized~~ under the confidentiality and disclosure requirements
3360 of this section, may ~~to~~ maintain those documents that are
3361 required by the part or chapter under which they are licensed or
3362 regulated:

3363 (k) Persons or entities practicing under s. 627.736(7) or
3364 s. 627.7485(7), as applicable.

3365 Section 40. Paragraphs (ee) and (ff) of subsection (1) of
3366 section 456.072, Florida Statutes, are amended to read:

3367 456.072 Grounds for discipline; penalties; enforcement.—

3368 (1) The following acts shall constitute grounds for which
3369 the disciplinary actions specified in subsection (2) may be
3370 taken:

3371 (ee) With respect to making a personal injury protection or
3372 an medical care coverage claim as required by s. 627.736 or s.
3373 627.7485, respectively, intentionally submitting a claim,
3374 statement, or bill that has been "upcoded" as defined in s.
3375 627.732 or s. 627.7482, as applicable.

3376 (ff) With respect to making a personal injury protection or
3377 an medical care coverage claim as required by s. 627.736 or s.



811080

3378 627.7485, respectively, intentionally submitting a claim,
3379 statement, or bill for payment of services that were not
3380 rendered.

3381 Section 41. Paragraph (o) of subsection (1) of section
3382 626.9541, Florida Statutes, is amended to read:

3383 626.9541 Unfair methods of competition and unfair or
3384 deceptive acts or practices defined.—

3385 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
3386 ACTS.—The following are defined as unfair methods of competition
3387 and unfair or deceptive acts or practices:

3388 (o) *Illegal dealings in premiums; excess or reduced charges*
3389 *for insurance.—*

3390 1. Knowingly collecting any sum as a premium or charge for
3391 insurance, which is not then provided, or is not in due course
3392 to be provided, subject to acceptance of the risk by the
3393 insurer, by an insurance policy issued by an insurer as
3394 permitted by this code.

3395 2. Knowingly collecting as a premium or charge for
3396 insurance any sum in excess of or less than the premium or
3397 charge applicable to such insurance, in accordance with the
3398 applicable classifications and rates as filed with and approved
3399 by the office, and as specified in the policy; or, if in cases
3400 ~~when~~ classifications, premiums, or rates are not required by
3401 this code to be so filed and approved, premiums and charges
3402 collected from a Florida resident in excess of or less than
3403 those specified in the policy and as fixed by the insurer. This
3404 provision may shall not be deemed to prohibit the charging and
3405 collection, by surplus lines agents licensed under part VIII of
3406 this chapter, of the amount of applicable state and federal



811080

3407 taxes, or fees as authorized by s. 626.916(4), in addition to
3408 the premium required by the insurer or the charging and
3409 collection, by licensed agents, of the exact amount of any
3410 discount or other such fee charged by a credit card facility in
3411 connection with the use of a credit card, as authorized by
3412 subparagraph (q)3., in addition to the premium required by the
3413 insurer. This subparagraph does ~~shall~~ not be construed to
3414 prohibit collection of a premium for a universal life or a
3415 variable or indeterminate value insurance policy made in
3416 accordance with the terms of the contract.

3417 ~~3.a.~~ Imposing or requesting an additional premium for a
3418 policy of motor vehicle liability, medical care coverage,
3419 personal injury protection, medical payment, or collision
3420 insurance or any combination thereof or refusing to renew the
3421 policy solely because the insured was involved in a motor
3422 vehicle accident unless the insurer's file contains information
3423 from which the insurer in good faith determines that the insured
3424 was substantially at fault in the accident.

3425 ~~a.b.~~ An insurer which imposes and collects such a surcharge
3426 or which refuses to renew such policy shall, in conjunction with
3427 the notice of premium due or notice of nonrenewal, notify the
3428 named insured that he or she is entitled to reimbursement of
3429 such amount or renewal of the policy under the conditions listed
3430 below and will subsequently reimburse him or her or renew the
3431 policy~~7~~ if the named insured demonstrates that the operator
3432 involved in the accident was:

3433 (I) Lawfully parked;

3434 (II) Reimbursed by, or on behalf of, a person responsible
3435 for the accident or has a judgment against such person;



811080

3436 (III) Struck in the rear by another vehicle headed in the
3437 same direction and was not convicted of a moving traffic
3438 violation in connection with the accident;

3439 (IV) Hit by a "hit-and-run" driver, if the accident was
3440 reported to the proper authorities within 24 hours after
3441 discovering the accident;

3442 (V) Not convicted of a moving traffic violation in
3443 connection with the accident, but the operator of the other
3444 automobile involved in such accident was convicted of a moving
3445 traffic violation;

3446 (VI) Finally adjudicated not to be liable by a court of
3447 competent jurisdiction;

3448 (VII) In receipt of a traffic citation that ~~which~~ was
3449 dismissed or nolle prossed; or

3450 (VIII) Not at fault as evidenced by a written statement
3451 from the insured establishing facts demonstrating lack of fault
3452 which are not rebutted by information in the insurer's file from
3453 which the insurer in good faith determines that the insured was
3454 substantially at fault.

3455 ~~b.e.~~ In addition to the other provisions of this
3456 subparagraph, an insurer may not fail to renew a policy if the
3457 insured has had only one accident in which he or she was at
3458 fault within the current 3-year period. However, an insurer may
3459 nonrenew a policy for reasons other than accidents in accordance
3460 with s. 627.728. This subparagraph does not prohibit nonrenewal
3461 of a policy under which the insured has had three or more
3462 accidents, regardless of fault, during the most recent 3-year
3463 period.

3464 4. Imposing or requesting an additional premium for, or



811080

3465 refusing to renew, a policy for motor vehicle insurance solely
3466 because the insured committed a noncriminal traffic infraction
3467 as described in s. 318.14 unless the infraction is:

3468 a. A second infraction committed within an 18-month period,
3469 or a third or subsequent infraction committed within a 36-month
3470 period.

3471 b. A violation of s. 316.183, if ~~when~~ such violation is a
3472 result of exceeding the lawful speed limit by more than 15 miles
3473 per hour.

3474 5. Upon the request of the insured, the insurer and
3475 licensed agent shall supply to the insured the complete proof of
3476 fault or other criteria which justifies the additional charge or
3477 cancellation.

3478 6. Imposing or requesting ~~No insurer shall impose or~~
3479 ~~request~~ an additional premium for motor vehicle insurance,
3480 cancelling or refusing ~~cancel or refuse~~ to issue a policy, or
3481 refusing ~~refuse~~ to renew a policy because the insured or the
3482 applicant is a handicapped or physically disabled person if, ~~so~~
3483 ~~long as~~ such handicap or physical disability does not
3484 substantially impair such person's mechanically assisted driving
3485 ability.

3486 7. Cancelling ~~No insurer may cancel~~ or otherwise
3487 terminating an ~~terminate any~~ insurance contract or coverage, or
3488 requiring ~~require~~ execution of a consent to rate endorsement,
3489 during the stated policy term for the purpose of offering to
3490 issue, or issuing, a similar or identical contract or coverage
3491 to the same insured with the same exposure at a higher premium
3492 rate or continuing an existing contract or coverage with the
3493 same exposure at an increased premium.



811080

3494 8. Issuing ~~No insurer may issue~~ a nonrenewal notice on any
3495 insurance contract or coverage, or requiring ~~require~~ execution
3496 of a consent to rate endorsement, for the purpose of offering to
3497 issue, or issuing, a similar or identical contract or coverage
3498 to the same insured at a higher premium rate or continuing an
3499 existing contract or coverage at an increased premium without
3500 meeting any applicable notice requirements.

3501 9. ~~No insurer shall,~~ With respect to premiums charged for
3502 motor vehicle insurance, unfairly discriminating ~~discriminate~~
3503 solely on the basis of age, sex, marital status, or scholastic
3504 achievement.

3505 10. Imposing or requesting an additional premium for motor
3506 vehicle comprehensive or uninsured motorist coverage solely
3507 because the insured was involved in a motor vehicle accident or
3508 was convicted of a moving traffic violation.

3509 11. Cancelling or issuing ~~No insurer shall cancel or issue~~
3510 a nonrenewal notice on any insurance policy or contract without
3511 complying with any applicable cancellation or nonrenewal
3512 provision required under the Florida Insurance Code.

3513 12. Imposing or requesting ~~No insurer shall impose or~~
3514 ~~request~~ an additional premium, cancelling ~~cancel~~ a policy, or
3515 issuing ~~issue~~ a nonrenewal notice on any insurance policy or
3516 contract because of any traffic infraction when adjudication has
3517 been withheld and no points have been assessed pursuant to s.
3518 318.14(9) and (10). However, this subparagraph does not apply to
3519 traffic infractions involving accidents in which the insurer has
3520 incurred a loss due to the fault of the insured.

3521 Section 42. Subsection (5) of section 626.9894, Florida
3522 Statutes, is amended to read:



811080

3523 626.9894 Gifts and grants.-
3524 (5) Notwithstanding ~~the provisions of~~ s. 216.301 and
3525 pursuant to s. 216.351, any balance of moneys deposited into the
3526 Insurance Regulatory Trust Fund pursuant to this section or s.
3527 626.9895 remaining at the end of any fiscal year is shall be
3528 available for carrying out the duties and responsibilities of
3529 the division. The department may request annual appropriations
3530 from the grants and donations received pursuant to this section
3531 or s. 626.9895 and cash balances in the Insurance Regulatory
3532 Trust Fund for the purpose of carrying out its duties and
3533 responsibilities related to the division's anti-fraud efforts,
3534 including the funding of dedicated prosecutors and related
3535 personnel.

3536 Section 43. Subsection (1) of section 627.06501, Florida
3537 Statutes, is amended to read:

3538 627.06501 Insurance discounts for certain persons
3539 completing driver improvement course.-

3540 (1) Any rate, rating schedule, or rating manual for the
3541 liability, medical care coverage, personal injury protection,
3542 and collision coverages of a motor vehicle insurance policy
3543 filed with the office may provide for an appropriate reduction
3544 in premium charges as to such coverages if when the principal
3545 operator on the covered vehicle has successfully completed a
3546 driver improvement course approved and certified by the
3547 Department of Highway Safety and Motor Vehicles which is
3548 effective in reducing crash or violation rates, or both, as
3549 determined pursuant to s. 318.1451(5). Any discount, not to
3550 exceed 10 percent, used by an insurer is presumed to be
3551 appropriate unless credible data demonstrates otherwise.



811080

3552 Section 44. Subsection (1) of section 627.0652, Florida
3553 Statutes, is amended to read:

3554 627.0652 Insurance discounts for certain persons completing
3555 safety course.—

3556 (1) Any rates, rating schedules, or rating manuals for the
3557 liability, medical care coverage, personal injury protection,
3558 and collision coverages of a motor vehicle insurance policy
3559 filed with the office must ~~shall~~ provide for an appropriate
3560 reduction in premium charges as to such coverages if ~~when~~ the
3561 principal operator on the covered vehicle is an insured 55 years
3562 of age or older who has successfully completed a motor vehicle
3563 accident prevention course approved by the Department of Highway
3564 Safety and Motor Vehicles. Any discount used by an insurer is
3565 presumed to be appropriate unless credible data demonstrates
3566 otherwise.

3567 Section 45. Subsections (1) and (3) of section 627.0653,
3568 Florida Statutes, are amended to read:

3569 627.0653 Insurance discounts for specified motor vehicle
3570 equipment.—

3571 (1) Any rates, rating schedules, or rating manuals for the
3572 liability, medical care coverage, personal injury protection,
3573 and collision coverages of a motor vehicle insurance policy
3574 filed with the office must ~~shall~~ provide a premium discount if
3575 the insured vehicle is equipped with factory-installed, four-
3576 wheel antilock brakes.

3577 (3) Any rates, rating schedules, or rating manuals for
3578 medical care coverage, personal injury protection coverage, and
3579 medical payments coverage, if offered, of a motor vehicle
3580 insurance policy filed with the office shall provide a premium



811080

3581 discount if the insured vehicle is equipped with one or more air
3582 bags that ~~which~~ are factory installed.

3583 Section 46. Section 627.4132, Florida Statutes, is amended
3584 to read:

3585 627.4132 Stacking of coverages prohibited.—If an insured or
3586 named insured is protected by any type of motor vehicle
3587 insurance policy for liability, medical care coverage, personal
3588 injury protection, or other coverage, the policy must ~~shall~~
3589 provide that the insured or named insured is protected only to
3590 the extent of the coverage she or he has on the vehicle involved
3591 in the accident. However, if none of the insured's or named
3592 insured's vehicles is involved in the accident, coverage is
3593 available only to the extent of coverage on any one of the
3594 vehicles with applicable coverage. Coverage on any other
3595 vehicles may ~~shall~~ not be added to or stacked upon that
3596 coverage. This section does not apply:

3597 (1) To uninsured motorist coverage that ~~which~~ is separately
3598 governed by s. 627.727.

3599 (2) To reduce the coverage available by reason of insurance
3600 policies insuring different named insureds.

3601 Section 47. Subsection (6) of section 627.6482, Florida
3602 Statutes, is amended to read:

3603 627.6482 Definitions.—As used in ss. 627.648-627.6498, the
3604 term:

3605 (6) "Health insurance" means any hospital and medical
3606 expense incurred policy, minimum premium plan, stop-loss
3607 coverage, health maintenance organization contract, prepaid
3608 health clinic contract, multiple-employer welfare arrangement
3609 contract, or fraternal benefit society health benefits contract,



3610 whether sold as an individual or group policy or contract. The
3611 term does not include a any policy covering medical payment
3612 coverage or medical care coverage or personal injury protection
3613 coverage in a motor vehicle policy, coverage issued as a
3614 supplement to liability insurance, or workers' compensation.

3615 Section 48. Section 627.7263, Florida Statutes, is amended
3616 to read:

3617 627.7263 Rental and leasing driver ~~driver's~~ insurance to be
3618 primary; exception.—

3619 (1) The valid and collectible liability insurance, medical
3620 care coverage insurance, or personal injury protection insurance
3621 providing coverage for the lessor of a motor vehicle for rent or
3622 lease is primary unless otherwise stated in at least 10-point
3623 type on the face of the rental or lease agreement. Such
3624 insurance is primary for the limits of liability and personal
3625 injury protection or medical care coverage as required by s. ~~ss.~~
3626 324.021(7) and either s. 627.736 or s. 627.7485, as applicable.

3627 (2) If the lessee's coverage is to be primary, the rental
3628 or lease agreement must contain the following language, in at
3629 least 10-point type:

3630
3631 "The valid and collectible liability insurance and
3632 personal injury protection insurance or medical care
3633 coverage insurance, as applicable, of an any
3634 authorized rental or leasing driver is primary for the
3635 limits of liability and personal injury protection or
3636 medical care coverage required by s. ~~ss.~~ 324.021(7)
3637 and either s. 627.736 or s. 627.7485, Florida
3638 Statutes, as applicable."



811080

3639
3640
3641
3642
3643
3644
3645
3646
3647
3648
3649
3650
3651
3652
3653
3654
3655
3656
3657
3658
3659
3660
3661
3662
3663
3664
3665
3666
3667

Section 49. Subsections (1) and (7) of section 627.727, Florida Statutes, are amended to read:

627.727 Motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.—

(1) A ~~Ne~~ motor vehicle liability insurance policy which provides bodily injury liability coverage may not shall be delivered or issued for delivery in this state with respect to any specifically insured or identified motor vehicle registered or principally garaged in this state unless uninsured motor vehicle coverage is provided therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom. However, the coverage required under this section is not applicable if when, or to the extent that, an insured named in the policy makes a written rejection of the coverage on behalf of all insureds under the policy. If When a motor vehicle is leased for ~~a period of~~ 1 year or longer and the lessor ~~of such vehicle~~, by the terms of the lease contract, provides liability coverage on the leased vehicle, the lessee ~~of such vehicle~~ shall have the sole privilege to reject uninsured motorist coverage or to select lower limits than the bodily injury liability limits, regardless of whether the lessor is qualified as a self-insurer pursuant to s. 324.171. Unless an insured, or lessee having the privilege of rejecting uninsured motorist coverage, requests such coverage or requests higher uninsured motorist limits in writing, the coverage or such higher uninsured motorist limits need not be



811080

3668 provided in or supplemental to any other policy that ~~which~~
3669 renews, extends, changes, supersedes, or replaces an existing
3670 policy with the same bodily injury liability limits if ~~when~~ an
3671 insured or lessee had rejected the coverage. If ~~When~~ an insured
3672 or lessee has initially selected limits of uninsured motorist
3673 coverage lower than her or his bodily injury liability limits,
3674 higher limits of uninsured motorist coverage need not be
3675 provided in or supplemental to any other policy that ~~which~~
3676 renews, extends, changes, supersedes, or replaces an existing
3677 policy with the same bodily injury liability limits unless an
3678 insured requests higher uninsured motorist coverage in writing.
3679 The rejection or selection of lower limits shall be made on a
3680 form approved by the office. The form must ~~shall~~ fully advise
3681 the applicant of the nature of the coverage and ~~shall~~ state that
3682 the coverage is equal to bodily injury liability limits unless
3683 lower limits are requested or the coverage is rejected. The
3684 heading of the form must ~~shall~~ be in 12-point bold type and
3685 ~~shall~~ state: "You are electing not to purchase certain valuable
3686 coverage that ~~which~~ protects you and your family or you are
3687 purchasing uninsured motorist limits less than your bodily
3688 injury liability limits when you sign this form. Please read
3689 carefully." If this form is signed by a named insured, it will
3690 be conclusively presumed that there was an informed, knowing
3691 rejection of coverage or election of lower limits on behalf of
3692 all insureds. The insurer shall notify the named insured at
3693 least annually of her or his options as to the coverage required
3694 by this section. Such notice must ~~shall~~ be part of, and attached
3695 to, the notice of premium, ~~shall~~ provide for a means to allow
3696 the insured to request such coverage, and ~~shall~~ be given in a



811080

3697 manner approved by the office. Receipt of this notice does not
3698 constitute an affirmative waiver of the insured's right to
3699 uninsured motorist coverage if ~~where~~ the insured has not signed
3700 a selection or rejection form. The coverage described under this
3701 section shall be over and above, but may ~~shall~~ not duplicate,
3702 the benefits available to an insured under any workers'
3703 compensation law, medical care coverage or personal injury
3704 protection benefits, disability benefits law, or similar law;
3705 under any automobile medical expense coverage; under any motor
3706 vehicle liability insurance coverage; or from the owner or
3707 operator of the uninsured motor vehicle or any other person or
3708 organization jointly or severally liable together with such
3709 owner or operator for the accident; and such coverage must ~~shall~~
3710 cover the difference, if any, between the sum of such benefits
3711 and the damages sustained, up to the maximum amount of ~~such~~
3712 coverage provided under this section. The amount of coverage
3713 available under this section may ~~shall~~ not be reduced by a
3714 setoff against any coverage, including liability insurance. Such
3715 coverage may ~~shall~~ not inure directly or indirectly to the
3716 benefit of any workers' compensation or disability benefits
3717 carrier or any person or organization qualifying as a self-
3718 insurer under any workers' compensation or disability benefits
3719 law or similar law.

3720 (7) The legal liability of an uninsured motorist coverage
3721 insurer does not include damages in tort for pain, suffering,
3722 mental anguish, and inconvenience unless the injury or disease
3723 is described in one or more of paragraphs (a)-(d) of s.
3724 627.737(2) or paragraphs (a)-(d) of s. 627.7486(2).

3725 Section 50. Subsection (1) of section 627.7275, Florida



811080

3726 Statutes, is amended to read:

3727 627.7275 Motor vehicle liability.—

3728 (1) A motor vehicle insurance policy providing personal
3729 injury protection as set forth in s. 627.736 or medical care
3730 coverage as set forth in s. 627.7485 may not be delivered or
3731 issued for delivery in this state with respect to any
3732 specifically insured or identified motor vehicle registered or
3733 principally garaged in this state unless the policy also
3734 provides coverage for property damage liability as required by
3735 s. 324.022.

3736 Section 51. Paragraph (a) of subsection (1) of section
3737 627.728, Florida Statutes, is amended to read:

3738 627.728 Cancellations; nonrenewals.—

3739 (1) As used in this section, the term:

3740 (a) "Policy" means the bodily injury and property damage
3741 liability, medical care coverage or personal injury protection,
3742 medical payments, comprehensive, collision, and uninsured
3743 motorist coverage portions of a policy of motor vehicle
3744 insurance delivered or issued for delivery in this state:

3745 1. Insuring a natural person as named insured or one or
3746 more related individuals resident of the same household; and

3747 2. Insuring only a motor vehicle of the private passenger
3748 type or station wagon type which is not used as a public or
3749 livery conveyance for passengers or rented to others; or
3750 insuring any other four-wheel motor vehicle having a load
3751 capacity of 1,500 pounds or less which is not used in the
3752 occupation, profession, or business of the insured other than
3753 farming; other than any policy issued under an automobile
3754 insurance assigned risk plan; insuring more than four



811080

3755 automobiles; or covering garage, automobile sales agency, repair
3756 shop, service station, or public parking place operation
3757 hazards.

3758
3759 The term "policy" does not include a binder as defined in s.
3760 627.420 unless the duration of the binder period exceeds 60
3761 days.

3762 Section 52. Subsection (1), paragraph (a) of subsection
3763 (5), and subsections (6) and (7) of section 627.7295, Florida
3764 Statutes, are amended to read:

3765 627.7295 Motor vehicle insurance contracts.-

3766 (1) As used in this section, the term:

3767 (a) "Policy" means a motor vehicle insurance policy that
3768 provides personal injury protection or medical care coverage, or
3769 property damage liability coverage, or both.

3770 (b) "Binder" means a binder that provides motor vehicle
3771 personal injury protection or medical care coverage and property
3772 damage liability coverage.

3773 (5) (a) A licensed general lines agent may charge a per-
3774 policy fee of up to ~~not to exceed~~ \$10 to cover the
3775 administrative costs of the agent associated with selling the
3776 motor vehicle insurance policy if the policy covers only
3777 personal injury protection or medical care coverage as provided
3778 by s. 627.736 or s. 627.7485, as applicable, and property damage
3779 liability coverage as provided by s. 627.7275 and if no other
3780 insurance is sold or issued in conjunction with or collateral to
3781 the policy. The fee is not considered part of the premium.

3782 (6) If a motor vehicle owner's driver license, license
3783 plate, and registration have previously been suspended pursuant



811080

3784 to s. 316.646, ~~or~~ s. 627.733, or s. 627.7483, an insurer may
3785 cancel a new policy only as provided in s. 627.7275.

3786 (7) A policy of private passenger motor vehicle insurance
3787 or a binder for such a policy may be initially issued in this
3788 state only if, before the effective date of such binder or
3789 policy, the insurer or agent ~~has~~ collected from the insured an
3790 amount equal to 2 months' premium. An insurer, agent, or premium
3791 finance company may not, directly or indirectly, take any action
3792 resulting in the insured paying ~~having paid~~ from the insured's
3793 own funds an amount less than the 2 months' premium required by
3794 this subsection. This subsection applies without regard to
3795 whether the premium is financed by a premium finance company or
3796 is paid pursuant to a periodic payment plan of an insurer or an
3797 insurance agent.

3798 (a) This subsection does not apply:

3799 1. If an insured or member of the insured's family is
3800 renewing or replacing a policy or a binder for such policy
3801 written by the same insurer or a member of the same insurer
3802 group. ~~This subsection does not apply~~

3803 2. To an insurer that issues private passenger motor
3804 vehicle coverage primarily to active duty or former military
3805 personnel or their dependents. ~~This subsection does not apply~~

3806 3. If all policy payments are paid pursuant to a payroll
3807 deduction plan or an automatic electronic funds transfer payment
3808 plan from the policyholder.

3809 (b) This subsection and subsection (4) do not apply

3810 1. If all policy payments to an insurer are paid pursuant
3811 to an automatic electronic funds transfer payment plan from an
3812 agent, a managing general agent, or a premium finance company



811080

3813 and if the policy includes, at a minimum, personal injury
3814 protection or medical care coverage pursuant to ss. 627.730-
3815 627.7405 or ss. 627.748-627.7491, as applicable; motor vehicle
3816 property damage liability pursuant to s. 627.7275; and bodily
3817 injury liability in at least the amount of \$10,000 because of
3818 bodily injury to, or death of, one person in any one accident
3819 and in the amount of \$20,000 because of bodily injury to, or
3820 death of, two or more persons in any one accident. ~~This~~
3821 ~~subsection and subsection (4) do not apply~~

3822 2. If an insured has had a policy in effect for at least 6
3823 months, the insured's agent is terminated by the insurer that
3824 issued the policy, and the insured obtains coverage on the
3825 policy's renewal date with a new company through the terminated
3826 agent.

3827 Section 53. Subsections (1), (2), and (3) of section
3828 627.737, Florida Statutes, are amended to read:

3829 627.737 Tort exemption; limitation on right to damages;
3830 punitive damages.-

3831 (1) Every owner, registrant, operator, or occupant of a
3832 motor vehicle with respect to which security has been provided
3833 as required by ss. 627.730-627.7405 or ss. 627.748-627.7491, as
3834 applicable, and every person or organization legally responsible
3835 for her or his acts or omissions, is ~~hereby~~ exempted from tort
3836 liability for damages because of bodily injury, sickness, or
3837 disease arising out of the ownership, operation, maintenance, or
3838 use of such motor vehicle in this state to the extent that the
3839 benefits described in s. 627.736(1) or s. 627.7485(1), as
3840 applicable, are payable for such injury, or would be payable but
3841 for any exclusion authorized by ss. 627.730-627.7405 or ss.



811080

3842 627.748-627.7491, as applicable, under any insurance policy or
3843 other method of security complying with the requirements of s.
3844 627.733, or by an owner personally liable under s. 627.733 for
3845 the payment of such benefits, unless a person is entitled to
3846 maintain an action for pain, suffering, mental anguish, and
3847 inconvenience for such injury under the provisions of subsection
3848 (2).

3849 (2) In any action of tort brought against the owner,
3850 registrant, operator, or occupant of a motor vehicle with
3851 respect to which security has been provided as required by ss.
3852 627.730-627.7405 or ss. 627.748-627.7491, as applicable, or
3853 against any person or organization legally responsible for her
3854 or his acts or omissions, a plaintiff may recover damages in
3855 tort for pain, suffering, mental anguish, and inconvenience
3856 because of bodily injury, sickness, or disease arising out of
3857 the ownership, maintenance, operation, or use of such motor
3858 vehicle only if ~~in the event that~~ the injury or disease consists
3859 in whole or in part of:

3860 (a) Significant and permanent loss of an important bodily
3861 function.

3862 (b) Permanent injury within a reasonable degree of medical
3863 probability, other than scarring or disfigurement.

3864 (c) Significant and permanent scarring or disfigurement.

3865 (d) Death.

3866 (3) ~~If~~ When a defendant, in a proceeding brought pursuant
3867 to ss. 627.730-627.7405 or ss. 627.748-627.7491, as applicable,
3868 questions whether the plaintiff has met the requirements of
3869 subsection (2), ~~then~~ the defendant may file an appropriate
3870 motion with the court, and the court shall, on a one-time basis



811080

3871 only, 30 days before the date set for the trial or the pretrial
3872 hearing, whichever is first, by examining the pleadings and the
3873 evidence before it, ascertain whether the plaintiff will be able
3874 to submit some evidence that the plaintiff will meet the
3875 requirements of subsection (2). If the court finds that the
3876 plaintiff will not be able to submit such evidence, ~~then~~ the
3877 court shall dismiss the plaintiff's claim without prejudice.

3878 Section 54. Section 627.8405, Florida Statutes, is amended
3879 to read:

3880 627.8405 Prohibited acts; financing companies.—~~A No~~ premium
3881 finance company ~~shall~~, in a premium finance agreement or other
3882 agreement, may not finance the cost of or otherwise provide for
3883 the collection or remittance of dues, assessments, fees, or
3884 other periodic payments of money for the cost of:

3885 (1) A membership in an automobile club. The term
3886 "automobile club" means a legal entity that ~~which~~, in
3887 consideration of dues, assessments, or periodic payments of
3888 money, promises its members or subscribers to assist them in
3889 matters relating to the ownership, operation, use, or
3890 maintenance of a motor vehicle; however, this definition of
3891 "automobile club" does not include persons, associations, or
3892 corporations that ~~which~~ are organized and operated solely for
3893 the purpose of conducting, sponsoring, or sanctioning motor
3894 vehicle races, exhibitions, or contests upon racetracks, or upon
3895 racecourses established and marked as such for the duration of
3896 such particular events. The term ~~words~~ "motor vehicle" has used
3897 ~~herein have~~ the same meaning as provided ~~defined~~ in s. 320.01
3898 ~~chapter 320~~.

3899 (2) An accidental death and dismemberment policy sold in



811080

3900 combination with a personal injury protection and property
3901 damage only policy or an emergency care and property damage only
3902 policy, as applicable.

3903 (3) Any product not regulated under the ~~provisions of this~~
3904 insurance code.

3905
3906 This section also applies to premium financing by any insurance
3907 agent or insurance company under part XVI. The commission shall
3908 adopt rules to assure disclosure, at the time of sale, of
3909 coverages financed with personal injury protection or medical
3910 care coverage and ~~shall~~ prescribe the form of such disclosure.

3911 Section 55. Subsection (1) of section 627.915, Florida
3912 Statutes, is amended to read:

3913 627.915 Insurer experience reporting.-

3914 (1) Each insurer transacting private passenger automobile
3915 insurance in this state shall report certain information
3916 annually to the office. The information is ~~will be~~ due on or
3917 before July 1 of each year. The information shall be divided
3918 into the following categories: bodily injury liability; property
3919 damage liability; uninsured motorist; medical care coverage or
3920 personal injury protection benefits; medical payments;
3921 comprehensive and collision. The information given must ~~shall~~ be
3922 on direct insurance writings in the state alone and ~~shall~~
3923 represent total limits data. The information set forth in
3924 paragraphs (a)-(f) is applicable to voluntary private passenger
3925 and Joint Underwriting Association private passenger writings
3926 and must ~~shall~~ be reported for each of the latest 3 calendar-
3927 accident years, with an evaluation date of March 31 of the
3928 current year. The information set forth in paragraphs (g)-(j) is



811080

3929 applicable to voluntary private passenger writings and must
3930 ~~shall~~ be reported on a calendar-accident year basis ultimately
3931 seven times at seven different stages of development.

3932 (a) Premiums earned for the latest 3 calendar-accident
3933 years.

3934 (b) Loss development factors and the historic development
3935 of those factors.

3936 (c) Policyholder dividends incurred.

3937 (d) Expenses for other acquisition and general expense.

3938 (e) Expenses for agents' commissions and taxes, licenses,
3939 and fees.

3940 (f) Profit and contingency factors as used ~~utilized~~ in the
3941 insurer's automobile rate filings for the applicable years.

3942 (g) Losses paid.

3943 (h) Losses unpaid.

3944 (i) Loss adjustment expenses paid.

3945 (j) Loss adjustment expenses unpaid.

3946 Section 56. Paragraph (d) of subsection (2) and paragraph
3947 (d) of subsection (3) of section 628.909, Florida Statutes, are
3948 amended to read:

3949 628.909 Applicability of other laws.—

3950 (2) The following provisions of the Florida Insurance Code
3951 shall apply to captive insurers who are not industrial insured
3952 captive insurers to the extent that such provisions are not
3953 inconsistent with this part:

3954 (d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as
3955 applicable, if ~~when~~ no-fault coverage is provided.

3956 (3) The following provisions of the Florida Insurance Code
3957 ~~shall~~ apply to industrial insured captive insurers to the extent



811080

3958 that such provisions are not inconsistent with this part:
3959 (d) Sections 627.730-627.7405 or ss. 627.748-627.7491, as
3960 applicable, if ~~when~~ no-fault coverage is provided.
3961 Section 57. Subsections (2) and (6) and paragraphs (a),
3962 (c), and (d) of subsection (7) of section 705.184, Florida
3963 Statutes, are amended to read:
3964 705.184 Derelict or abandoned motor vehicles on the
3965 premises of public-use airports.—
3966 (2) The airport director or the director's designee shall
3967 contact the Department of Highway Safety and Motor Vehicles to
3968 notify that department that the airport has possession of the
3969 abandoned or derelict motor vehicle and to determine the name
3970 and address of the owner of the motor vehicle, the insurance
3971 company insuring the motor vehicle, notwithstanding ~~the~~
3972 ~~provisions of~~ s. 627.736 or s. 627.7485, as applicable, and any
3973 person who has filed a lien on the motor vehicle. Within 7
3974 business days after receipt of the information, the director or
3975 the director's designee shall send notice by certified mail,
3976 return receipt requested, to the owner of the motor vehicle, the
3977 insurance company insuring the motor vehicle, notwithstanding
3978 ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and
3979 all persons of record claiming a lien against the motor vehicle.
3980 The notice must ~~shall~~ state the fact of possession of the motor
3981 vehicle, that charges for reasonable towing, storage, and
3982 parking fees, if any, have accrued and the amount thereof, that
3983 a lien as provided in subsection (6) will be claimed, that the
3984 lien is subject to enforcement pursuant to law, that the owner
3985 or lienholder, if any, has the right to a hearing as set forth
3986 in subsection (4), and that any motor vehicle that ~~which~~, at the



811080

3987 end of 30 calendar days after receipt of the notice, has not
3988 been removed from the airport upon payment in full of all
3989 accrued charges for reasonable towing, storage, and parking
3990 fees, if any, may be disposed of as provided in s.
3991 705.182(2)(a), (b), (d), or (e), including, but not limited to,
3992 ~~the motor vehicle~~ being sold free of all prior liens after 35
3993 calendar days after the time the motor vehicle is stored if any
3994 prior liens on the motor vehicle are more than 5 years of age or
3995 after 50 calendar days after the time the motor vehicle is
3996 stored if any prior liens on the motor vehicle are 5 years of
3997 age or less.

3998 (6) The airport pursuant to this section or, if used, a
3999 licensed independent wrecker company pursuant to s. 713.78 shall
4000 have a lien on an abandoned or derelict motor vehicle for all
4001 reasonable towing, storage, and accrued parking fees, if any,
4002 except that a no storage fee may not shall be charged if the
4003 motor vehicle is stored less than 6 hours. As a prerequisite to
4004 perfecting a lien under this section, the airport director or
4005 the director's designee must serve a notice in accordance with
4006 subsection (2) on the owner of the motor vehicle, the insurance
4007 company insuring the motor vehicle, notwithstanding ~~the~~
4008 ~~provisions of s. 627.736 or s. 627.7485, as applicable,~~ and all
4009 persons of record claiming a lien against the motor vehicle. If
4010 attempts to notify the owner, the insurance company insuring the
4011 motor vehicle, ~~notwithstanding the provisions of s. 627.736,~~ or
4012 lienholders are not successful, the requirement of notice by
4013 mail shall be considered met. Serving of the notice does not
4014 dispense with recording the claim of lien.

4015 (7) (a) For the purpose of perfecting its lien under this



811080

4016 section, the airport shall record a claim of lien which shall
4017 state:

4018 1. The name and address of the airport.

4019 2. The name of the owner of the motor vehicle, the
4020 insurance company insuring the motor vehicle, notwithstanding
4021 ~~the provisions of~~ s. 627.736 or s. 627.7485, as applicable, and
4022 all persons of record claiming a lien against the motor vehicle.

4023 3. The costs incurred from reasonable towing, storage, and
4024 parking fees, if any.

4025 4. A description of the motor vehicle sufficient for
4026 identification.

4027 (c) The claim of lien shall be sufficient if it is in
4028 substantially the following form:

4029 CLAIM OF LIEN

4030 State of

4031 County of

4032 Before me, the undersigned notary public, personally
4033 appeared, who was duly sworn and says that he/she is the
4034 of, whose address is.....; and that the following
4035 described motor vehicle:

4036 ...(Description of motor vehicle)...

4037 owned by, whose address is, has accrued \$.... in
4038 fees for a reasonable tow, for storage, and for parking, if
4039 applicable; that the lienor served its notice to the owner, the
4040 insurance company insuring the motor vehicle notwithstanding ~~the~~
4041 ~~provisions of~~ s. 627.736 or s. 627.7485, Florida Statutes, as
4042 applicable, and all persons of record claiming a lien against
4043 the motor vehicle on, ...(year)..., by.....

4044 ...(Signature)...



811080

4045 Sworn to (or affirmed) and subscribed before me this
4046 day of, ...(year)..., by ...(name of person making
4047 statement)....

4048 ...(Signature of Notary Public).....(Print, Type, or Stamp
4049 Commissioned name of Notary Public)...

4050 Personally Known....OR Produced....as identification.

4051
4052 However, the negligent inclusion or omission of any information
4053 in this claim of lien which does not prejudice the owner does
4054 not constitute a default that operates to defeat an otherwise
4055 valid lien.

4056 (d) The claim of lien shall be served on the owner of the
4057 motor vehicle, the insurance company insuring the motor vehicle,
4058 notwithstanding ~~the provisions of s. 627.736 or s. 627.7485, as~~
4059 applicable, if no-fault coverage is provided, and all persons of
4060 record claiming a lien against the motor vehicle. If attempts to
4061 notify the owner, the insurance company insuring the motor
4062 vehicle ~~notwithstanding the provisions of s. 627.736, or~~
4063 lienholders are not successful, the requirement of notice by
4064 mail shall be considered met. The claim of lien shall be so
4065 served before recordation.

4066 Section 58. Paragraphs (a), (b), and (c) of subsection (4)
4067 of section 713.78, Florida Statutes, are amended to read:

4068 713.78 Liens for recovering, towing, or storing vehicles
4069 and vessels.-

4070 (4) (a) Any person regularly engaged in the business of
4071 recovering, towing, or storing vehicles or vessels who comes
4072 into possession of a vehicle or vessel pursuant to subsection
4073 (2), and who claims a lien for recovery, towing, or storage



811080

4074 services, must ~~shall~~ give notice to the registered owner, the
4075 insurance company insuring the vehicle notwithstanding ~~the~~
4076 ~~provisions of s. 627.736 or s. 627.7485, as applicable,~~ and to
4077 all persons claiming a lien thereon, as disclosed by the records
4078 in the Department of Highway Safety and Motor Vehicles or of a
4079 corresponding agency in any other state.

4080 (b) If a ~~Whenever any~~ law enforcement agency authorizes the
4081 removal of a vehicle or vessel or if ~~whenever~~ any towing
4082 service, garage, repair shop, or automotive service, storage, or
4083 parking place notifies the law enforcement agency of possession
4084 of a vehicle or vessel pursuant to s. 715.07(2)(a)2., the law
4085 enforcement agency of the jurisdiction where the vehicle or
4086 vessel is stored shall contact the Department of Highway Safety
4087 and Motor Vehicles, or the appropriate agency of the state of
4088 registration, if known, within 24 hours through the medium of
4089 electronic communications, giving the full description of the
4090 vehicle or vessel. Upon receipt of the full description of the
4091 vehicle or vessel, the department shall search its files to
4092 determine the owner's name, the insurance company insuring the
4093 vehicle or vessel, and whether any person has filed a lien upon
4094 the vehicle or vessel as provided in s. 319.27(2) and (3) and
4095 notify the applicable law enforcement agency within 72 hours.
4096 The person in charge of the towing service, garage, repair shop,
4097 or automotive service, storage, or parking place shall obtain
4098 such information from the applicable law enforcement agency
4099 within 5 days after the date of storage and ~~shall~~ give notice
4100 pursuant to paragraph (a). The department may release the
4101 insurance company information to the requestor notwithstanding
4102 ~~the provisions of s. 627.736 or s. 627.7485, as applicable.~~



811080

4103 (c) Notice by certified mail, return receipt requested,
4104 shall be sent within 7 business days after the date of storage
4105 of the vehicle or vessel to the registered owner, the insurance
4106 company insuring the vehicle notwithstanding ~~the provisions of~~
4107 s. 627.736 or s. 627.7485, as applicable, and all persons of
4108 record claiming a lien against the vehicle or vessel. The notice
4109 must ~~It shall~~ state the fact of possession of the vehicle or
4110 vessel, that a lien as provided in subsection (2) is claimed,
4111 that charges have accrued and the amount thereof, that the lien
4112 is subject to enforcement pursuant to law, and that the owner or
4113 lienholder, if any, has the right to a hearing as set forth in
4114 subsection (5), and that any vehicle or vessel that ~~which~~
4115 remains unclaimed, or for which the charges for recovery,
4116 towing, or storage services remain unpaid, may be sold free of
4117 all prior liens after 35 days if the vehicle or vessel is more
4118 than 3 years of age or after 50 days if the vehicle or vessel is
4119 3 years of age or less.

4120 Section 59. The Office of Insurance Regulation shall
4121 perform a data call relating to coverage under the Florida Motor
4122 Vehicle No-Fault Medical Care Coverage Law and publish the
4123 results by January 1, 2015. It is the intent of the Legislature
4124 that the office design the data call with the expectation that
4125 the Legislature will use the data to help evaluate market
4126 conditions relating to motor vehicle insurance and the impact on
4127 the market of reforms made by this act. The elements of the data
4128 call must address, but need not be limited to, the following
4129 components of the new law:

- 4130 (1) Quantity of claims.
4131 (2) Type or nature of claimants.



811080

4132 (3) Amount and type of benefits paid and expenses incurred.

4133 (4) Type and quantity of, and charges for, medical
4134 benefits.

4135 (5) Attorney fees related to bringing and defending actions
4136 for benefits.

4137 (6) Direct earned premiums for medical care coverage, pure
4138 loss ratios, pure premiums, and other information related to
4139 premiums and losses.

4140 (7) Licensed drivers and accidents.

4141 (8) Fraud and enforcement.

4142 Section 60. Any motor vehicle policy issued or renewed on
4143 or after January 1, 2013, is subject to and deemed to
4144 incorporate the Florida Motor Vehicle No-Fault Medical Care
4145 Coverage Law as created by this act and is not subject to ss.
4146 627.730-627.7405, Florida Statutes, the Florida Motor Vehicle
4147 No-Fault Act. The coverage provided under ss. 627.748-627.7491,
4148 Florida Statutes, supersedes and replaces the coverage provided
4149 by the Florida Motor Vehicle No-Fault Law for any motor vehicle
4150 insurance policy issued on or after the effective date of the
4151 Florida Motor Vehicle No-Fault Medical Care Coverage Law.

4152 Section 61. Sections 627.730, 627.731, 627.732, 627.733,
4153 627.734, 627.736, 627.737, 627.739, 627.7401, 627.7403,
4154 627.7405, and 627.7407, Florida Statutes, do not apply to
4155 persons subject to the s. 627.7483, Florida Statutes, and are
4156 repealed effective January 1, 2014.

4157 Section 62. If any provision of this act or its application
4158 to any person or circumstance is held invalid, the invalidity
4159 does not affect other provisions or applications of the act
4160 which can be given effect without the invalid provision or



811080

4161 application, and to this end the provisions of this act are
4162 severable.

4163 Section 63. Except as otherwise expressly provided in this
4164 act and except for this section, which shall take effect
4165 December 1, 2012, this act shall take effect January 1, 2013.

4166
4167 ===== T I T L E A M E N D M E N T =====

4168 And the title is amended as follows:

4169 Delete lines 14 - 94

4170 and insert:

4171 injury protection and medical care coverage benefits;
4172 amending s. 400.991, F.S.; requiring that an
4173 application for licensure, or exemption from
4174 licensure, as a health care clinic include a statement
4175 regarding insurance fraud; amending s. 626.989, F.S.;
4176 providing that knowingly submitting false, misleading,
4177 or fraudulent documents relating to licensure as a
4178 health care clinic, or submitting a claim for personal
4179 injury protection or medical care coverage relating to
4180 clinic licensure documents, is a fraudulent insurance
4181 act under certain conditions; creating s. 626.9895,
4182 F.S.; providing definitions; authorizing the Division
4183 of Insurance Fraud of the Department of Financial
4184 Services to establish a direct-support organization
4185 for the purpose of prosecuting, investigating, and
4186 preventing motor vehicle insurance fraud; providing
4187 requirements for, and duties of, the organization;
4188 requiring that the organization operate pursuant to a
4189 contract with the division; providing for the



811080

4190 requirements of the contract; providing for a board of
4191 directors; authorizing the organization to use the
4192 division's property and facilities subject to certain
4193 requirements; requiring that the department adopt
4194 rules relating to procedures for the organization's
4195 governance and relating to conditions for the use of
4196 the division's property or facilities; authorizing
4197 contributions from insurers; authorizing any moneys
4198 received by the organization to be held in a separate
4199 depository account in the name of the organization;
4200 requiring that the division deposit certain proceeds
4201 into the Insurance Regulatory Trust Fund; reordering
4202 and amending s. 627.732, F.S.; defining the term
4203 "entity wholly owned"; amending s. 627.733, F.S.;
4204 providing that an owner or registrant of a motor
4205 vehicle does not have to comply with this section if
4206 required security is obtained under the Florida Motor
4207 Vehicle No-Fault Medical Care Coverage Law; amending
4208 s. 627.736, F.S.; revising the cap on benefits to
4209 provide that death benefits are in addition to medical
4210 and disability benefits; excluding massage and
4211 acupuncture from medical benefits that may be
4212 reimbursed under the motor vehicle no-fault law;
4213 deleting provisions prohibiting the purchase of other
4214 motor vehicle coverage; requiring that an insurer
4215 repay any benefits covered by the Medicaid program
4216 within a specified time; requiring that an insurer
4217 provide a claimant an opportunity to revise claims
4218 that contain errors; requiring that an insurer create



4219 and maintain a log of benefits paid and provide a copy
4220 of the log to the insured upon request; requiring that
4221 an insurer notify parties in disputes over claims when
4222 policy limits are reached; revising the Medicare fee
4223 schedules that an insurer may use as a basis for
4224 limiting reimbursement of benefits; providing that the
4225 Medicare fee schedule in effect on a specific date
4226 applies for purposes of limiting such reimbursement;
4227 authorizing insurers to apply certain Medicare coding
4228 policies and payment methodologies; requiring that an
4229 insurer that limits payments based on the statutory
4230 fee schedule include a notice in insurance policies at
4231 the time of issuance or renewal; deleting obsolete
4232 provisions; providing that certain entities exempt
4233 from licensure as a clinic must nonetheless be
4234 licensed to receive reimbursement for the provision of
4235 personal injury protection benefits; providing
4236 exceptions; eliminating a requirement that all parties
4237 mutually and expressly agree for the use of electronic
4238 transmission of data; creating s. 627.748, F.S.;

4239 designating specified provisions as the Florida Motor
4240 Vehicle No-Fault Medical Care Coverage Law; providing
4241 a short title; creating s. 627.7481, F.S.; providing
4242 legislative findings and purposes; creating s.
4243 627.74811, F.S.; providing legislative intent that
4244 provisions, schedules, or procedures are to be given
4245 full force and effect regardless of their express
4246 inclusion in insurer forms; creating s. 627.7482,
4247 F.S.; providing definitions; creating s. 627.7483,



4248 F.S.; requiring every owner or registrant of a motor
4249 vehicle required to be registered and licensed in this
4250 state to maintain specified security; providing
4251 exceptions; requiring every nonresident owner or
4252 registrant of a motor vehicle that has been physically
4253 present within this state for a specified period to
4254 maintain security; specifying means by which such
4255 security is provided; providing that an owner of a
4256 motor vehicle who fails to have such security is not
4257 immune to certain liabilities; providing an exemption;
4258 creating s. 627.7484, F.S.; providing requirements for
4259 filing and maintaining proof of security; providing
4260 penalties; creating s. 627.7485, F.S.; requiring that
4261 insurance policies provide medical care coverage to
4262 specified persons; providing limits of coverage;
4263 specifying limits for medical, disability, and death
4264 benefits; providing restrictions on insurers with
4265 respect to provision of required benefits; prohibiting
4266 an insurer from requiring the purchase of other motor
4267 vehicle coverage as a condition for providing such
4268 benefits; prohibiting an insurer from requiring the
4269 purchase of property damage liability insurance
4270 exceeding a specified amount in conjunction with
4271 medical care coverage insurance; providing that
4272 failure to comply with specified availability
4273 requirements constitutes an unfair method of
4274 competition or an unfair or deceptive act or practice;
4275 providing penalties; authorizing an insurer to exclude
4276 certain benefits; providing procedure with respect to



811080

4277 such exclusions; specifying when benefits are due from
4278 an insurer; prohibiting insurers from obtaining liens
4279 on recovery of special damages in tort claims for
4280 medical care coverage benefits; prohibiting an insured
4281 party from recovering any damages for which medical
4282 care coverage benefits are paid or payable; requiring
4283 that benefits received under any workers' compensation
4284 law be credited against the benefits provided under
4285 the medical care coverage; providing that benefits
4286 under the Florida Motor Vehicle No-Fault Medical Care
4287 Coverage Law are subject to the Medicaid program in
4288 specified circumstances; providing for notice to
4289 insurers; specifying when benefits are overdue;
4290 providing for interest on overdue payments; requiring
4291 insurers to hold a specified amount of benefits in
4292 reserve for a certain time for the payment of
4293 providers; specifying injuries for which an insurer
4294 must pay benefits; providing for a pro rata
4295 distribution of benefits paid and expenses if there
4296 are two or more insurers; requiring that an insurer
4297 notify parties in disputes over claims when policy
4298 limits are reached; requiring that an insurer create
4299 and maintain a log of benefits paid and provide the
4300 log to the insured upon request; providing for tolling
4301 the time period in which benefits are required to be
4302 paid when the insurer has reasonable belief that fraud
4303 has been committed; requiring that the insurer notify
4304 the claimant if the claim is being investigated for
4305 fraud; providing immunity to persons or entities that



811080

4306 report suspected fraud in good faith; providing that
4307 an insurer who fails to timely provide benefits
4308 violates the insurance code; providing that a person
4309 or entity lawfully rendering treatment to an injured
4310 person for a bodily injury covered by medical care
4311 coverage may charge only a reasonable amount for
4312 services and care; providing that the insurer may pay
4313 such charges directly to the person or entity lawfully
4314 rendering such treatment; providing limits on such
4315 charges; providing for determination of reasonableness
4316 of charges; providing that payments made by an insurer
4317 pursuant to the schedule of maximum charges, or for
4318 lesser amounts billed by providers, are considered
4319 reasonable; establishing a schedule of maximum
4320 charges; specifying that reimbursement under a
4321 schedule of maximum charges which is based on Medicare
4322 is to be calculated under the applicable Medicare
4323 schedule in effect on a specified date each year;
4324 authorizing insurers to use all Medicare coding
4325 policies and CMS payment methodologies in determining
4326 reimbursement under a schedule of maximum charges
4327 which is Medicare based; establishing limits on
4328 specified emergency services and care; providing
4329 conditions under which an insurer or insured is not
4330 required to pay a claim or charges; requiring the
4331 Department of Health to adopt by rule a list of
4332 diagnostic tests deemed not to be medically necessary
4333 and to periodically revise the list; providing
4334 procedures and requirements with respect to statements



4335 of and bills for charges for emergency services and
4336 care; requiring that a notice of the insured's rights
4337 include a specified statement; requiring that a
4338 physician, licensed professional, clinic, or medical
4339 institution providing medical services require an
4340 insured person to execute and countersign a disclosure
4341 and acknowledgement form; directing the Financial
4342 Services Commission to adopt by rule a disclosure and
4343 acknowledgment form to be countersigned by claimants
4344 upon receipt of medical services; providing procedures
4345 and requirements with respect to investigation of
4346 claims of improper billing by a physician or other
4347 medical provider; prohibiting insurers from
4348 systematically downcoding with intent to deny
4349 reimbursement; requiring insureds and persons to whom
4350 the right to payment for benefits has been assigned to
4351 comply with all terms of the policy; providing that
4352 compliance with policy terms is a condition precedent
4353 to the receipt of benefits; requiring that an employer
4354 furnish a sworn statement of an employee's earnings
4355 under certain circumstances; requiring that an
4356 insured's assignee comply with the terms of the
4357 insurance policy; providing for insurers to inspect
4358 the physical premises of providers seeking payment;
4359 requiring that a provider seeking payment furnish to
4360 the insurer a written report; requiring the insurer to
4361 furnish to the injured person a copy of all
4362 information; authorizing the insurer to petition the
4363 court to enter an order permitting discovery of facts



4364 under certain circumstances; providing for the
4365 examination of the injured person and reports
4366 regarding the examination; prohibiting an insurer from
4367 withdrawing payment from a treating physician under
4368 certain circumstances; providing requirements with
4369 respect to a demand letter; providing procedures and
4370 requirements with respect to payment of an overdue
4371 claim; providing for the tolling of the time period
4372 for an action against an insurer; providing that
4373 failure to pay valid claims with specified frequency
4374 constitutes an unfair or deceptive trade practice;
4375 providing penalties; providing circumstances under
4376 which an insurer has a cause of action; providing for
4377 fraud advisory notice; requiring that all claims
4378 related to the same health care provider for the same
4379 injured person be brought in one action unless good
4380 cause is shown; authorizing the electronic
4381 transmission of notices and communications under
4382 certain conditions; creating s. 627.7486, F.S.;;
4383 providing an exemption from tort liability for certain
4384 damages in legal actions under the Florida Motor
4385 Vehicle No-Fault Medical Care Coverage Law in certain
4386 circumstances; providing for recovery of tort damages
4387 in certain circumstances; providing for motions to
4388 dismiss action on specified grounds; prohibiting a
4389 claim for punitive damages in excess of the coverage
4390 policy limits; creating s. 627.7487, F.S.;; providing
4391 for optional deductibles and limitations of coverage
4392 for medical care coverage policies; requiring a



811080

4393 specified notice to policyholders; creating s.
4394 627.7488, F.S.; requiring the commission to adopt by
4395 rule a form for the notification of insureds of their
4396 right to receive medical care coverage benefits;
4397 specifying contents of such notice; providing
4398 requirements for the mailing or delivery of such
4399 notice; creating s. 627.7489, F.S.; providing for
4400 mandatory joinder of specified claims; creating s.
4401 627.749, F.S.; providing for an insurer's right of
4402 reimbursement for emergency medical care benefits paid
4403 to a person injured by a commercial motor vehicle
4404 under specified circumstances; creating s. 627.7491,
4405 F.S.; providing for application of the Florida Motor
4406 Vehicle No-Fault Medical Care Coverage Law; providing
4407 for requirements for forms and rates for policies
4408 issued or renewed on or after a specified date;
4409 requiring a specified notice to existing
4410 policyholders; amending s. 817.234, F.S.; providing
4411 that it is insurance fraud to present a claim for
4412 personal injury protection or medical care coverage
4413 benefits payable to a person or entity that knowingly
4414 submitted false, misleading, or fraudulent documents
4415 relating to licensure as a health care clinic;
4416 providing that a licensed health care practitioner who
4417 is found guilty of certain insurance fraud loses his
4418 or her license and may not receive reimbursement for
4419 personal injury protection or medical care coverage
4420 benefits for a specified period; defining the term
4421 "insurer"; conforming provisions; amending ss.



811080

4422 316.065, 316.646, 318.18, 320.02, 320.0609, 320.27,
4423 320.771, 322.251, 322.34, 324.021, 324.0221, 324.032,
4424 324.171, 400.9935, 409.901, 409.910, 456.057, 456.072,
4425 626.9541, 626.9894, 627.06501, 627.0652, 627.0653,
4426 627.4132, 627.6482, 627.7263, 627.727, 627.7275,
4427 627.728, 627.7295, 627.737, 627.8405, 627.915,
4428 628.909, 705.184, 713.78, and 817.234, F.S.;
4429 conforming provisions; requiring that the Office of
4430 Insurance Regulation perform a data call relating to
4431 medical care coverage and publish the results;
4432 providing applicability; repealing ss. 627.730,
4433 627.731, 627.732, 627.733, 627.734, 627.736, 627.737,
4434 627.739, 627.7401, 627.7403, 627.7405, and 627.7407.
4435 Sections 627.730, 627.731, 627.732, 627.733, 627.734,
4436 627.736, 627.737, 627.739, 627.7401, 627.7403,
4437 627.7405, and 627.7407, relating to the Florida Motor
4438 Vehicle No-Fault Law; providing for severability;