

By Senator Negrón

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1                                   A bill to be entitled  
2           An act relating to motor vehicle personal injury  
3           protection insurance; amending s. 316.066, F.S.;  
4           revising the conditions for completing the long-form  
5           traffic crash report; revising the information  
6           contained in the long-form and the short-form reports;  
7           limiting the inclusion of telephone numbers in crash  
8           reports; authorizing an investigating officer to  
9           testify at trial or provide an affidavit regarding a  
10          crash; amending s. 400.9905, F.S.; providing that  
11          certain entities exempt from licensure as a health  
12          care clinic must nonetheless be licensed in order to  
13          receive reimbursement for the provision of personal  
14          injury protection benefits; amending s. 400.991, F.S.;  
15          requiring that an application for licensure, or  
16          exemption from licensure, as a health care clinic  
17          include a statement regarding insurance fraud;  
18          amending s. 626.989, F.S.; providing that knowingly  
19          submitting false, misleading, or fraudulent documents  
20          relating to licensure as a health care clinic, or  
21          submitting a claim for personal injury protection  
22          relating to clinic licensure documents, is a  
23          fraudulent insurance act under certain conditions;  
24          amending s. 626.9894, F.S.; conforming provisions to  
25          changes made by act; creating s. 626.9895, F.S.;  
26          providing definitions; authorizing the Division of  
27          Insurance Fraud of the Department of Financial  
28          Services to establish a direct-support organization  
29          for the purpose of prosecuting, investigating, and

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30 preventing motor vehicle insurance fraud; providing  
31 requirements for, and duties of, the organization;  
32 requiring that the organization operate pursuant to a  
33 contract with the division; providing for the  
34 requirements of the contract; providing for a board of  
35 directors; authorizing the organization to use the  
36 division's property and facilities subject to certain  
37 requirements; requiring that the department adopt  
38 rules relating to procedures for the organization's  
39 governance and relating to conditions for the use of  
40 the division's property or facilities; authorizing  
41 contributions from insurers; authorizing any moneys  
42 received by the organization to be held in a separate  
43 depository account in the name of the organization;  
44 requiring that the division deposit certain proceeds  
45 into the Insurance Regulatory Trust Fund; amending s.  
46 627.0651, F.S.; prohibiting attorney fees awarded to  
47 plaintiffs in claims for benefits under the motor  
48 vehicle no-fault law from being included in insurance  
49 rates; amending s. 627.736, F.S.; excluding massage  
50 and acupuncture from medical benefits that may be  
51 reimbursed under the motor vehicle no-fault law;  
52 requiring that an insurer give priority to the payment  
53 of death benefits under certain conditions; requiring  
54 that an insurer repay any benefits covered by the  
55 Medicaid program; requiring that an insurer provide a  
56 claimant an opportunity to revise claims that contain  
57 errors; including hospitals within a requirement for  
58 insurers to reserve a portion of personal injury

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59 protection benefits; requiring that an insurer create  
60 and maintain a log of personal injury protection  
61 benefits paid and that the insurer provide to the  
62 insured or an assignee of the insured, upon request, a  
63 copy of the log; revising the Medicare fee schedules  
64 that an insurer may use as a basis for limiting  
65 reimbursement of personal injury protection benefits;  
66 providing that the Medicare fee schedule in effect on  
67 a specific date applies for purposes of limiting such  
68 reimbursement; authorizing insurers to apply certain  
69 Medicare coding policies and payment methodologies;  
70 requiring that an insurer that limits payments based  
71 on the statutory fee schedule include a notice in  
72 insurance policies at the time of issuance or renewal;  
73 deleting obsolete provisions; providing that certain  
74 entities exempt from licensure as a clinic must  
75 nonetheless be licensed to receive reimbursement for  
76 the provision of personal injury protection benefits;  
77 providing exceptions; requiring that an insurer notify  
78 parties in disputes over personal injury protection  
79 claims when policy limits are reached; consolidating  
80 provisions relating to unfair or deceptive practices  
81 under certain conditions; eliminating a requirement  
82 that all parties mutually and expressly agree for the  
83 use of electronic transmission of data; amending s.  
84 817.234, F.S.; providing that it is insurance fraud to  
85 present a claim for personal injury protection  
86 benefits payable to a person or entity that knowingly  
87 submitted false, misleading, or fraudulent documents

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88 relating to licensure as a health care clinic;  
 89 providing that a licensed health care practitioner  
 90 guilty of certain insurance fraud loses his or her  
 91 license and may not receive personal injury protection  
 92 benefits for a specified period; defining the term  
 93 "insurer"; amending s. 316.065, F.S.; conforming a  
 94 cross-reference; requiring that the Office of  
 95 Insurance Regulation perform a data call relating to  
 96 personal injury protection; prescribing required  
 97 elements of the data call; providing for severability;  
 98 providing effective dates.

99

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

101

102 Section 1. Subsection (1) of section 316.066, Florida  
 103 Statutes, is amended to read:

104 316.066 Written reports of crashes.—

105 (1) (a) A Florida Traffic Crash Report, Long Form, must ~~is~~  
 106 ~~required to~~ be completed and submitted to the department within  
 107 10 days after ~~completing~~ an investigation is completed by the  
 108 ~~every~~ law enforcement officer who in the regular course of duty  
 109 investigates a motor vehicle crash that:

110 1. Resulted in death, ~~or~~ personal injury, or any complaint  
 111 of pain or discomfort by any of the parties or passengers  
 112 involved in the crash;-

113 2. Involved one or more passengers in any vehicle involved  
 114 in the crash, other than the driver of the vehicle; or

115 ~~3.2.~~ Involved a violation of s. 316.061(1) or s. 316.193.

116 (b) In any ~~every~~ crash for which a Florida Traffic Crash

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117 Report, Long Form, is not required ~~by this section~~, the law  
118 enforcement officer may complete a short-form crash report or  
119 provide a driver exchange-of-information form to be completed by  
120 each party involved in the crash. The agency that employs the  
121 law enforcement officer who prepares the short-form crash report  
122 shall maintain the report.

123 (c) The long-form and the short-form reports ~~report~~ must  
124 include:

125 1. The date, time, and location of the crash.

126 2. A description of the vehicles involved.

127 3. The names and addresses of the parties involved,  
128 including all drivers and passengers, with each party clearly  
129 identified as a driver or passenger and the vehicle that he or  
130 she occupied.

131 4. The names and addresses of witnesses.

132 5. The name, badge number, and law enforcement agency of  
133 the officer investigating the crash.

134 6. The names of the insurance companies for the respective  
135 parties involved in the crash.

136

137 Except for a crash in which a party is charged with a criminal  
138 traffic offense, a long-form or short-form crash report may not  
139 include the telephone number of a party involved in the crash.

140 (d) ~~(e)~~ Each party to the crash must provide the law  
141 enforcement officer with proof of insurance, which must be  
142 documented in the crash report. If a law enforcement officer  
143 submits a report on the crash, proof of insurance must be  
144 provided to the officer by each party involved in the crash. Any  
145 party who fails to provide the required information commits a

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146 noncriminal traffic infraction, punishable as a nonmoving  
147 violation as provided in chapter 318, unless the officer  
148 determines that due to injuries or other special circumstances  
149 such insurance information cannot be provided immediately. If,  
150 within 24 hours after the crash, the person provides the law  
151 enforcement agency with, ~~within 24 hours after the crash,~~ proof  
152 of insurance that was valid at the time of the crash, the law  
153 enforcement agency may void the citation.

154 (e) ~~(d)~~ The driver of a vehicle that was in any manner  
155 involved in a crash resulting in damage to any vehicle or other  
156 property in an amount of \$500 or more which was not investigated  
157 by a law enforcement agency, shall, within 10 days after the  
158 crash, submit a written report of the crash to the department.  
159 The entity receiving the report may require witnesses of the  
160 crash to render reports and may require the ~~any~~ driver of a  
161 vehicle involved in a crash of which a written report must be  
162 made to file supplemental written reports if the original report  
163 is deemed insufficient by the receiving entity.

164 (f) The law enforcement officer who investigates a crash  
165 may testify at trial, provide a deposition for use at trial, or  
166 provide a signed affidavit to confirm or supplement information  
167 included in the long-form or short-form crash report.

168 ~~(e) Short form crash reports prepared by law enforcement~~  
169 ~~shall be maintained by the law enforcement officer's agency.~~

170 Section 2. Subsection (4) of section 400.9905, Florida  
171 Statutes, is amended to read:

172 400.9905 Definitions.—

173 (4) "Clinic" means an entity where ~~at which~~ health care  
174 services are provided to individuals and which tenders charges

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175 for reimbursement for such services, including a mobile clinic  
176 and a portable equipment provider. As used in ~~For purposes of~~  
177 this part, the term does not include and the licensure  
178 requirements of this part do not apply to:

179 (a) Entities licensed or registered by the state under  
180 chapter 395; ~~or~~ entities licensed or registered by the state and  
181 providing only health care services within the scope of services  
182 authorized under their respective licenses ~~granted~~ under ss.  
183 383.30-383.335, chapter 390, chapter 394, chapter 397, this  
184 chapter except part X, chapter 429, chapter 463, chapter 465,  
185 chapter 466, chapter 478, part I of chapter 483, chapter 484, or  
186 chapter 651; end-stage renal disease providers authorized under  
187 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42  
188 C.F.R. part 485, subpart B or subpart H; or any entity that  
189 provides neonatal or pediatric hospital-based health care  
190 services or other health care services by licensed practitioners  
191 solely within a hospital licensed under chapter 395.

192 (b) Entities that own, directly or indirectly, entities  
193 licensed or registered by the state pursuant to chapter 395; ~~or~~  
194 entities that own, directly or indirectly, entities licensed or  
195 registered by the state and providing only health care services  
196 within the scope of services authorized pursuant to their  
197 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter  
198 390, chapter 394, chapter 397, this chapter except part X,  
199 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,  
200 part I of chapter 483, chapter 484, chapter 651; end-stage renal  
201 disease providers authorized under 42 C.F.R. part 405, subpart  
202 U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or  
203 subpart H; or any entity that provides neonatal or pediatric

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204 hospital-based health care services by licensed practitioners  
205 solely within a hospital licensed under chapter 395.

206 (c) Entities that are owned, directly or indirectly, by an  
207 entity licensed or registered by the state pursuant to chapter  
208 395; ~~or~~ entities that are owned, directly or indirectly, by an  
209 entity licensed or registered by the state and providing only  
210 health care services within the scope of services authorized  
211 pursuant to their respective licenses ~~granted~~ under ss. 383.30-  
212 383.335, chapter 390, chapter 394, chapter 397, this chapter  
213 except part X, chapter 429, chapter 463, chapter 465, chapter  
214 466, chapter 478, part I of chapter 483, chapter 484, or chapter  
215 651; end-stage renal disease providers authorized under 42  
216 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42  
217 C.F.R. part 485, subpart B or subpart H; or any entity that  
218 provides neonatal or pediatric hospital-based health care  
219 services by licensed practitioners solely within a hospital  
220 under chapter 395.

221 (d) Entities that are under common ownership, directly or  
222 indirectly, with an entity licensed or registered by the state  
223 pursuant to chapter 395; ~~or~~ entities that are under common  
224 ownership, directly or indirectly, with an entity licensed or  
225 registered by the state and providing only health care services  
226 within the scope of services authorized pursuant to their  
227 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter  
228 390, chapter 394, chapter 397, this chapter except part X,  
229 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,  
230 part I of chapter 483, chapter 484, or chapter 651; end-stage  
231 renal disease providers authorized under 42 C.F.R. part 405,  
232 subpart U; ~~or~~ providers certified under 42 C.F.R. part 485,

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233 subpart B or subpart H; or any entity that provides neonatal or  
234 pediatric hospital-based health care services by licensed  
235 practitioners solely within a hospital licensed under chapter  
236 395.

237 (e) An entity that is exempt from federal taxation under 26  
238 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan  
239 under 26 U.S.C. s. 409 that has a board of trustees at least ~~not~~  
240 ~~less than~~ two-thirds of which are Florida-licensed health care  
241 practitioners and provides only physical therapy services under  
242 physician orders, any community college or university clinic,  
243 and any entity owned or operated by the federal or state  
244 government, including agencies, subdivisions, or municipalities  
245 thereof.

246 (f) A sole proprietorship, group practice, partnership, or  
247 corporation that provides health care services by physicians  
248 covered by s. 627.419, that is directly supervised by one or  
249 more of such physicians, and that is wholly owned by one or more  
250 of those physicians or by a physician and the spouse, parent,  
251 child, or sibling of that physician.

252 (g) A sole proprietorship, group practice, partnership, or  
253 corporation that provides health care services by licensed  
254 health care practitioners under chapter 457, chapter 458,  
255 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,  
256 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,  
257 chapter 490, chapter 491, or part I, part III, part X, part  
258 XIII, or part XIV of chapter 468, or s. 464.012, and that is  
259 ~~which are~~ wholly owned by one or more licensed health care  
260 practitioners, or the licensed health care practitioners set  
261 forth in this paragraph and the spouse, parent, child, or

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262 sibling of a licensed health care practitioner ~~if, so long as~~  
263 one of the owners who is a licensed health care practitioner is  
264 supervising the business activities and is legally responsible  
265 for the entity's compliance with all federal and state laws.  
266 However, a health care practitioner may not supervise services  
267 beyond the scope of the practitioner's license, except that, for  
268 the purposes of this part, a clinic owned by a licensee in s.  
269 456.053(3) (b) which ~~that~~ provides only services authorized  
270 pursuant to s. 456.053(3) (b) may be supervised by a licensee  
271 specified in s. 456.053(3) (b).

272 (h) Clinical facilities affiliated with an accredited  
273 medical school at which training is provided for medical  
274 students, residents, or fellows.

275 (i) Entities that provide only oncology or radiation  
276 therapy services by physicians licensed under chapter 458 or  
277 chapter 459 or entities that provide oncology or radiation  
278 therapy services by physicians licensed under chapter 458 or  
279 chapter 459 which are owned by a corporation whose shares are  
280 publicly traded on a recognized stock exchange.

281 (j) Clinical facilities affiliated with a college of  
282 chiropractic accredited by the Council on Chiropractic Education  
283 at which training is provided for chiropractic students.

284 (k) Entities that provide licensed practitioners to staff  
285 emergency departments or to deliver anesthesia services in  
286 facilities licensed under chapter 395 and that derive at least  
287 90 percent of their gross annual revenues from the provision of  
288 such services. Entities claiming an exemption from licensure  
289 under this paragraph must provide documentation demonstrating  
290 compliance.

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291 (1) Orthotic or prosthetic clinical facilities that are a  
292 publicly traded corporation or that are wholly owned, directly  
293 or indirectly, by a publicly traded corporation. As used in this  
294 paragraph, a publicly traded corporation is a corporation that  
295 issues securities traded on an exchange registered with the  
296 United States Securities and Exchange Commission as a national  
297 securities exchange.

298  
299 Notwithstanding this subsection, an entity shall be deemed a  
300 clinic and must be licensed under this part in order to receive  
301 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.  
302 627.730-627.7405, unless exempted under s. 627.736(5)(h).

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

305 400.991 License requirements; background screenings;  
306 prohibitions.—

307 (6) All agency forms for licensure application or exemption  
308 from licensure under this part must contain the following  
309 statement:

310  
311 INSURANCE FRAUD NOTICE.—A person who knowingly submits  
312 a false, misleading, or fraudulent application or  
313 other document when applying for licensure as a health  
314 care clinic, seeking an exemption from licensure as a  
315 health care clinic, or demonstrating compliance with  
316 part X of chapter 400, Florida Statutes, with the  
317 intent to use the license, exemption from licensure,  
318 or demonstration of compliance to provide services or  
319 seek reimbursement under the Florida Motor Vehicle No-

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320 Fault Law, commits a fraudulent insurance act, as  
 321 defined in s. 626.989, Florida Statutes. A person who  
 322 presents a claim for personal injury protection  
 323 benefits knowing that the payee knowingly submitted  
 324 such health care clinic application or document,  
 325 commits insurance fraud, as defined in s. 817.234,  
 326 Florida Statutes.

327 Section 4. Subsection (1) of section 626.989, Florida  
 328 Statutes, is amended to read:

329 626.989 Investigation by department or Division of  
 330 Insurance Fraud; compliance; immunity; confidential information;  
 331 reports to division; division investigator's power of arrest.-

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

333 (a) A person commits a "fraudulent insurance act" if the  
 334 person:

335 1. Knowingly and with intent to defraud presents, causes to  
 336 be presented, or prepares with knowledge or belief that it will  
 337 be presented, to or by an insurer, self-insurer, self-insurance  
 338 fund, servicing corporation, purported insurer, broker, or any  
 339 agent thereof, any written statement as part of, or in support  
 340 of, an application for the issuance of, or the rating of, any  
 341 insurance policy, or a claim for payment or other benefit  
 342 pursuant to any insurance policy, which the person knows to  
 343 contain materially false information concerning any fact  
 344 material thereto or if the person conceals, for the purpose of  
 345 misleading another, information concerning any fact material  
 346 thereto.

347 2. Knowingly submits:

348 a. A false, misleading, or fraudulent application or other

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349 document when applying for licensure as a health care clinic,  
 350 seeking an exemption from licensure as a health care clinic, or  
 351 demonstrating compliance with part X of chapter 400 with an  
 352 intent to use the license, exemption from licensure, or  
 353 demonstration of compliance to provide services or seek  
 354 reimbursement under the Florida Motor Vehicle No-Fault Law.

355 b. A claim for payment or other benefit pursuant to a  
 356 personal injury protection insurance policy under the Florida  
 357 Motor Vehicle No-Fault Law if the person knows that the payee  
 358 knowingly submitted a false, misleading, or fraudulent  
 359 application or other document when applying for licensure as a  
 360 health care clinic, seeking an exemption from licensure as a  
 361 health care clinic, or demonstrating compliance with part X of  
 362 chapter 400. ~~For the purposes of this section,~~

363 (b) The term "insurer" also includes a ~~any~~ health  
 364 maintenance organization, and the term "insurance policy" also  
 365 includes a health maintenance organization subscriber contract.

366 Section 5. Subsection (5) of section 626.9894, Florida  
 367 Statutes, is amended to read:

368 626.9894 Gifts and grants.—

369 (5) Notwithstanding ~~the provisions of~~ s. 216.301 and  
 370 pursuant to s. 216.351, any balance of moneys deposited into the  
 371 Insurance Regulatory Trust Fund pursuant to this section or s.  
 372 626.9895 remaining at the end of any fiscal year ~~is~~ shall be  
 373 available for carrying out the duties and responsibilities of  
 374 the division. The department may request annual appropriations  
 375 from the grants and donations received pursuant to this section  
 376 or s. 626.9895 and cash balances in the Insurance Regulatory  
 377 Trust Fund for the purpose of carrying out its duties and

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378 responsibilities related to the division's anti-fraud efforts,  
379 including the funding of dedicated prosecutors and related  
380 personnel.

381 Section 6. Section 626.9895, Florida Statutes, is created  
382 to read:

383 626.9895 Motor vehicle insurance fraud direct-support  
384 organization.-

385 (1) DEFINITIONS.-As used in this section, the term:

386 (a) "Division" means the Division of Insurance Fraud of the  
387 Department of Financial Services.

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

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

394 (2) ORGANIZATION ESTABLISHED.-The division may establish a  
395 direct-support organization, to be known as the "Automobile  
396 Insurance Fraud Strike Force," whose sole purpose is to support  
397 the prosecution, investigation, and prevention of motor vehicle  
398 insurance fraud. The organization shall:

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

401 (b) Be organized and operated to conduct programs and  
402 activities; raise funds; request and receive grants, gifts, and  
403 bequests of money; acquire, receive, hold, invest, and  
404 administer, in its own name, securities, funds, objects of  
405 value, or other property, real or personal; and make grants and  
406 expenditures to or for the direct or indirect benefit of the

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407 division, state attorneys' offices, the statewide prosecutor,  
408 the Agency for Health Care Administration, and the Department of  
409 Health to the extent that such grants and expenditures are used  
410 exclusively to advance the prosecution, investigation, or  
411 prevention of motor vehicle insurance fraud. Grants and  
412 expenditures may include the cost of salaries or benefits of  
413 motor vehicle insurance fraud investigators, prosecutors, or  
414 support personnel if such grants and expenditures do not  
415 interfere with prosecutorial independence or otherwise create  
416 conflicts of interest which threaten the success of  
417 prosecutions.

418 (c) Be determined by the division to operate in a manner  
419 that promotes the goals of laws relating to motor vehicle  
420 insurance fraud, that is in the best interest of the state, and  
421 that is in accordance with the adopted goals and mission of the  
422 division.

423 (d) Use all of its grants and expenditures solely for the  
424 purpose of preventing and decreasing motor vehicle insurance  
425 fraud, and not for the purpose of lobbying as defined in s.  
426 11.045.

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

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

431 (a) Approval of the articles of incorporation and bylaws of  
432 the organization by the division.

433 (b) Submission of an annual budget for approval of the  
434 division. The budget must require the organization to minimize  
435 costs to the division and its members at all times by using

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436 existing personnel and property and allowing for telephonic  
437 meetings if appropriate.

438 (c) Certification by the division that the organization is  
439 complying with the terms of the contract and in a manner  
440 consistent with the goals and purposes of the department and in  
441 the best interest of the state. Such certification must be made  
442 annually and reported in the official minutes of a meeting of  
443 the organization.

444 (d) Allocation of funds to address motor vehicle insurance  
445 fraud.

446 (e) Reversion of moneys and property held in trust by the  
447 organization for motor vehicle insurance fraud prosecution,  
448 investigation, and prevention to the division if the  
449 organization is no longer approved to operate for the department  
450 or if the organization ceases to exist, or to the state if the  
451 division ceases to exist.

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

455 (g) The fiscal year of the organization, which begins July  
456 1 of each year and ends June 30 of the following year.

457 (h) Disclosure of the material provisions of the contract,  
458 and distinguishing between the department and the organization  
459 to donors of gifts, contributions, or bequests, including  
460 providing such disclosure on all promotional and fundraising  
461 publications.

462 (4) BOARD OF DIRECTORS.—

463 (a) The board of directors of the organization shall  
464 consist of the following eleven members:

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465 1. The Chief Financial Officer, or designee, who shall  
466 serve as chair.

467 2. Two state attorneys, one of whom shall be appointed by  
468 the Chief Financial Officer and one of whom shall be appointed  
469 by the Attorney General.

470 3. Two representatives of motor vehicle insurers appointed  
471 by the Chief Financial Officer.

472 4. Two representatives of local law enforcement agencies,  
473 one of whom shall be appointed by the Chief Financial Officer  
474 and one of whom shall be appointed by the Attorney General.

475 5. Two representatives of the types of health care  
476 providers who regularly make claims for benefits under ss.  
477 627.730-627.7405, one of whom shall be appointed by the  
478 President of the Senate and one of whom shall be appointed by  
479 the Speaker of the House of Representatives. The appointees may  
480 not represent the same type of health care provider.

481 6. A private attorney that has experience in representing  
482 claimants in actions for benefits under ss. 627.730-627.7405,  
483 who shall be appointed by the President of the Senate.

484 7. A private attorney who has experience in representing  
485 insurers in actions for benefits under ss. 627.730-627.7405, who  
486 shall be appointed by the Speaker of the House of  
487 Representatives.

488 (b) The officer who appointed a member of the board may  
489 remove that member for cause. The term of office of an appointed  
490 member expires at the same time as the term of the officer who  
491 appointed him or her or at such earlier time as the person  
492 ceases to be qualified.

493 (5) USE OF PROPERTY.—The department may authorize, without

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494 charge, appropriate use of fixed property and facilities of the  
495 division by the organization, subject to this subsection.

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

499 (b) The department may not authorize the use of the  
500 division's property or facilities if the organization does not  
501 provide equal membership and employment opportunities to all  
502 persons regardless of race, religion, sex, age, or national  
503 origin.

504 (c) The department shall adopt rules prescribing the  
505 procedures by which the organization is governed and any  
506 conditions with which the organization must comply to use the  
507 division's property or facilities.

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

511 (7) DEPOSITORY ACCOUNT.—Any moneys received by the  
512 organization may be held in a separate depository account in the  
513 name of the organization and subject to the contract with the  
514 division.

515 (8) DIVISION'S RECEIPT OF PROCEEDS.—Proceeds received by  
516 the division from the organization shall be deposited into the  
517 Insurance Regulatory Trust Fund.

518 Section 7. Subsection (12) of section 627.0651, Florida  
519 Statutes, is amended to read:

520 627.0651 Making and use of rates for motor vehicle  
521 insurance.—

522 (12) (a) Any portion of a judgment entered as a result of a

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523 statutory or common-law bad faith action and any portion of a  
 524 judgment entered which awards punitive damages against an  
 525 insurer may ~~shall~~ not be included in the insurer's rate base,  
 526 and ~~shall not be~~ used to justify a rate or rate change. Any  
 527 portion of a settlement entered as a result of a statutory or  
 528 common-law bad faith action identified as such and any portion  
 529 of a settlement wherein an insurer agrees to pay specific  
 530 punitive damages may ~~shall~~ not be used to justify a rate or rate  
 531 change. The portion of the taxable costs and attorney ~~attorney's~~  
 532 fees which is identified as being related to the bad faith and  
 533 punitive damages in these judgments and settlements may ~~shall~~  
 534 not be included in the insurer's rate base and used ~~shall not be~~  
 535 ~~utilized~~ to justify a rate or rate change.

536 (b) Any portion of a judgment or settlement for taxable  
 537 costs and attorney fees in favor of a prevailing plaintiff  
 538 against an insurer in a claim for benefits under ss. 627.730-  
 539 627.7405, the Florida Motor Vehicle No-Fault Law, may not be  
 540 included in the insurer's rate base and used to justify a rate  
 541 or rate change.

542 Section 8. Subsections (1), (4), (5), (6), (8), (9), (10),  
 543 and (11) of section 627.736, Florida Statutes, are amended to  
 544 read:

545 627.736 Required personal injury protection benefits;  
 546 exclusions; priority; claims.—

547 (1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy complying  
 548 with the security requirements of s. 627.733 must ~~shall~~ provide  
 549 personal injury protection to the named insured, relatives  
 550 residing in the same household, persons operating the insured  
 551 motor vehicle, passengers in the ~~such~~ motor vehicle, and other

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552 persons struck by the ~~such~~ motor vehicle and suffering bodily  
553 injury while not an occupant of a self-propelled vehicle,  
554 subject to ~~the provisions of~~ subsection (2) and paragraph  
555 (4) (e), to a limit of \$10,000 for loss sustained by ~~any~~ such  
556 person as a result of bodily injury, sickness, disease, or death  
557 arising out of the ownership, maintenance, or use of a motor  
558 vehicle as follows:

559 (a) *Medical benefits.*—Eighty percent of all reasonable  
560 expenses for medically necessary medical, surgical, X-ray,  
561 dental, and rehabilitative services, including prosthetic  
562 devices, ~~and~~ medically necessary ambulance, hospital, and  
563 nursing services. Medical benefits do not includes massage as  
564 defined in s. 480.033 or acupuncture as defined in s. 457.102.  
565 ~~However,~~ The medical benefits ~~shall~~ provide reimbursement only  
566 for ~~such~~ services and care that are lawfully provided,  
567 supervised, ordered, or prescribed by a physician licensed under  
568 chapter 458 or chapter 459, a dentist licensed under chapter  
569 466, or a chiropractic physician licensed under chapter 460 or  
570 that are provided by any of the following ~~persons or entities~~:

571 1. A hospital or ambulatory surgical center licensed under  
572 chapter 395.

573 2. A person or entity licensed under part III of chapter  
574 401 which ~~ss. 401.2101-401.45~~ that provides emergency  
575 transportation and treatment.

576 3. An entity wholly owned by one or more physicians  
577 licensed under chapter 458 or chapter 459, chiropractic  
578 physicians licensed under chapter 460, or dentists licensed  
579 under chapter 466 or by such ~~practitioner or~~ practitioners and  
580 the spouse, parent, child, or sibling of such ~~that practitioner~~

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581 ~~or these~~ practitioners.

582 4. An entity wholly owned, directly or indirectly, by a  
583 hospital or hospitals.

584 5. A health care clinic licensed under part X of chapter  
585 400 which ss. ~~400.990-400.995~~ that is:

586 a. A health care clinic accredited by the Joint Commission  
587 on Accreditation of Healthcare Organizations, the American  
588 Osteopathic Association, the Commission on Accreditation of  
589 Rehabilitation Facilities, or the Accreditation Association for  
590 Ambulatory Health Care, Inc.; or

591 b. A health care clinic that:

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

594 (II) Has been continuously licensed for more than 3 years  
595 or is a publicly traded corporation that issues securities  
596 traded on an exchange registered with the United States  
597 Securities and Exchange Commission as a national securities  
598 exchange; and

599 (III) Provides at least four of the following medical  
600 specialties:

601 (A) General medicine.

602 (B) Radiography.

603 (C) Orthopedic medicine.

604 (D) Physical medicine.

605 (E) Physical therapy.

606 (F) Physical rehabilitation.

607 (G) Prescribing or dispensing outpatient prescription  
608 medication.

609 (H) Laboratory services.

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610  
611 The Financial Services Commission shall adopt by rule the form  
612 that must be used by an insurer and a health care provider  
613 specified in subparagraph 3., subparagraph 4., or subparagraph  
614 5. to document that the health care provider meets the criteria  
615 of this paragraph, which rule must include a requirement for a  
616 sworn statement or affidavit.

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

626 (c) *Death benefits.*—Death benefits equal to the lesser of  
627 \$5,000 or the remainder of unused personal injury protection  
628 benefits per individual. The insurer shall give priority to the  
629 payment of death benefits over the payment of other benefits of  
630 the deceased and, upon learning of the death of the individual,  
631 stop paying the other benefits until the death benefits are  
632 paid. The insurer may pay death ~~such~~ benefits to the executor or  
633 administrator of the deceased, to any of the deceased's  
634 relatives by blood, ~~or~~ legal adoption, or ~~connection by~~  
635 marriage, or to any person appearing to the insurer to be  
636 equitably entitled ~~thereto~~.

637  
638 Only insurers writing motor vehicle liability insurance in this

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639 state may provide the required benefits of this section, and ~~ne~~  
 640 such insurer may not ~~shall~~ require the purchase of any other  
 641 motor vehicle coverage other than the purchase of property  
 642 damage liability coverage as required by s. 627.7275 as a  
 643 condition for providing such ~~required~~ benefits. Insurers may not  
 644 require that property damage liability insurance in an amount  
 645 greater than \$10,000 be purchased in conjunction with personal  
 646 injury protection. Such insurers shall make benefits and  
 647 required property damage liability insurance coverage available  
 648 through normal marketing channels. An ~~Any~~ insurer writing motor  
 649 vehicle liability insurance in this state who fails to comply  
 650 with such availability requirement as a general business  
 651 practice violates ~~shall be deemed to have violated~~ part IX of  
 652 chapter 626, and such violation constitutes ~~shall constitute~~ an  
 653 unfair method of competition or an unfair or deceptive act or  
 654 practice involving the business of insurance. An; ~~and any such~~  
 655 insurer committing such violation is ~~shall be~~ subject to the  
 656 penalties provided under that ~~afforded in such~~ part, as well as  
 657 those provided ~~which may be afforded~~ elsewhere in the insurance  
 658 code.

659 (4) PAYMENT OF BENEFITS; ~~WHEN DUE.~~ Benefits due from an  
 660 insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except  
 661 that benefits received under any workers' compensation law must  
 662 ~~shall~~ be credited against the benefits provided by subsection  
 663 (1) and are ~~shall be~~ due and payable as loss accrues, upon  
 664 receipt of reasonable proof of such loss and the amount of  
 665 expenses and loss incurred which are covered by the policy  
 666 issued under ss. 627.730-627.7405. If ~~When~~ the Agency for Health  
 667 Care Administration provides, pays, or becomes liable for

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668 medical assistance under the Medicaid program related to injury,  
669 sickness, disease, or death arising out of the ownership,  
670 maintenance, or use of a motor vehicle, the benefits under ss.  
671 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of the~~  
672 Medicaid program. However, within 30 days after receiving notice  
673 that the Medicaid program paid such benefits, the insurer shall  
674 repay the full amount of the benefits to the Medicaid program.

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

679 (b) Personal injury protection insurance benefits paid  
680 pursuant to this section are ~~shall be~~ overdue if not paid within  
681 30 days after the insurer is furnished written notice of the  
682 fact of a covered loss and of the amount of same. However:

683 1. If ~~such~~ written notice of the entire claim is not  
684 furnished to the insurer ~~as to the entire claim~~, any partial  
685 amount supported by written notice is overdue if not paid within  
686 30 days after ~~such~~ written notice is furnished to the insurer.  
687 Any part or all of the remainder of the claim that is  
688 subsequently supported by written notice is overdue if not paid  
689 within 30 days after ~~such~~ written notice is furnished to the  
690 insurer.

691 2. If ~~When~~ an insurer pays only a portion of a claim or  
692 rejects a claim, the insurer shall provide at the time of the  
693 partial payment or rejection an itemized specification of each  
694 item that the insurer had reduced, omitted, or declined to pay  
695 and any information that the insurer desires the claimant to  
696 consider related to the medical necessity of the denied

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697 treatment or to explain the reasonableness of the reduced charge  
698 ~~if, provided that~~ this does ~~shall~~ not limit the introduction of  
699 evidence at trial. ~~;~~ ~~and~~ The insurer must also ~~shall~~ include the  
700 name and address of the person to whom the claimant should  
701 respond and a claim number to be referenced in future  
702 correspondence.

703 3. If an insurer pays only a portion of a claim or rejects  
704 a claim due to an alleged error in the claim, the insurer shall  
705 provide at the time of the partial payment or rejection an  
706 itemized specification or explanation of benefits of the  
707 specified error. Upon receiving the specification or  
708 explanation, the person making the claim has, at the person's  
709 option and without waiving any other legal remedy for payment,  
710 15 days to submit a revised claim, and the revised claim shall  
711 be considered a timely submission of written notice of a claim.

712 4. However, Notwithstanding the fact that written notice  
713 has been furnished to the insurer, ~~any~~ payment is ~~shall~~ not be  
714 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~  
715 ~~establish~~ that the insurer is not responsible for the payment.

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

722 6. This paragraph does not preclude or limit the ability of  
723 the insurer to assert that the claim was unrelated, was not  
724 medically necessary, or was unreasonable or that the amount of  
725 the charge was in excess of that permitted under, or in

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726 violation of, subsection (5). Such assertion ~~by the insurer~~ may  
 727 be made at any time, including after payment of the claim or  
 728 after the 30-day ~~time~~ period for payment set forth in this  
 729 paragraph.

730 (c) Upon receiving notice of an accident that is  
 731 potentially covered by personal injury protection benefits, the  
 732 insurer must reserve \$5,000 of personal injury protection  
 733 benefits for payment to:

734 1. Physicians licensed under chapter 458 or chapter 459 or  
 735 dentists licensed under chapter 466 who provide emergency  
 736 services and care, as defined in s. 395.002(9), or who provide  
 737 hospital inpatient care.

738 2. Hospitals licensed under chapter 395.

739  
 740 The amount required to be held in reserve may be used only to  
 741 pay claims from such physicians, ~~or dentists,~~ or hospitals until  
 742 30 days after the date the insurer receives notice of the  
 743 accident. After the 30-day period, any amount of the reserve for  
 744 which the insurer has not received notice of such claims ~~a claim~~  
 745 ~~from a physician or dentist who provided emergency services and~~  
 746 ~~care or who provided hospital inpatient care~~ may then be used by  
 747 the insurer to pay other claims. The time periods specified in  
 748 paragraph (b) for ~~required~~ payment of personal injury protection  
 749 benefits are ~~shall be~~ tolled for the period of time that an  
 750 insurer is required ~~by this paragraph~~ to hold payment of a claim  
 751 that is not from such a physician, or dentist, or hospital ~~who~~  
 752 ~~provided emergency services and care or who provided hospital~~  
 753 ~~inpatient care~~ to the extent that the personal injury protection  
 754 benefits not held in reserve are insufficient to pay the claim.

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755 This paragraph does not require an insurer to establish a claim  
756 reserve for insurance accounting purposes.

757 (d) All overdue payments ~~shall~~ bear simple interest at the  
758 rate established under s. 55.03 or the rate established in the  
759 insurance contract, whichever is greater, for the year in which  
760 the payment became overdue, calculated from the date the insurer  
761 was furnished with written notice of the amount of covered loss.  
762 Interest is ~~shall be~~ due at the time payment of the overdue  
763 claim is made.

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

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

770 2. Accidental bodily injury sustained outside this state,  
771 but within the United States of America or its territories or  
772 possessions or Canada, by the owner while occupying the owner's  
773 motor vehicle.

774 3. Accidental bodily injury sustained by a relative of the  
775 owner residing in the same household, under the circumstances  
776 described in subparagraph 1. or subparagraph 2., if provided the  
777 relative at the time of the accident is domiciled in the owner's  
778 household and is not ~~himself or herself~~ the owner of a motor  
779 vehicle with respect to which security is required under ss.  
780 627.730-627.7405.

781 4. Accidental bodily injury sustained in this state by any  
782 other person while occupying the owner's motor vehicle or, if a  
783 resident of this state, while not an occupant of a self-

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784 propelled vehicle, if the injury is caused by physical contact  
785 with such motor vehicle, if provided the injured person is not  
786 ~~himself or herself~~:

787 a. The owner of a motor vehicle with respect to which  
788 security is required under ss. 627.730-627.7405; or

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

791 (f) If two or more insurers are liable for paying ~~to pay~~  
792 personal injury protection benefits for the same injury to any  
793 one person, the maximum payable is ~~shall be~~ as specified in  
794 subsection (1), and the any insurer paying the benefits is ~~shall~~  
795 ~~be~~ entitled to recover from each of the other insurers an  
796 equitable pro rata share of the benefits paid and expenses  
797 incurred in processing the claim.

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

802 (h) Benefits are ~~shall~~ not be due or payable to or on the  
803 behalf of an insured person if that person has committed, by a  
804 material act or omission, ~~any~~ insurance fraud relating to  
805 personal injury protection coverage under his or her policy, if  
806 the fraud is admitted to in a sworn statement by the insured or  
807 ~~if it is~~ established in a court of competent jurisdiction. Any  
808 insurance fraud voids ~~shall void~~ all coverage arising from the  
809 claim related to such fraud under the personal injury protection  
810 coverage of the insured person who committed the fraud,  
811 irrespective of whether a portion of the insured person's claim  
812 may be legitimate, and any benefits paid before ~~prior to~~ the

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813 discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~  
814 recoverable by the insurer in its entirety from the person who  
815 committed insurance fraud ~~in their entirety~~. The prevailing  
816 party is entitled to its costs and attorney ~~attorney's~~ fees in  
817 any action in which it prevails in an insurer's action to  
818 enforce its right of recovery under this paragraph.

819 (i) An insurer shall create and maintain for each insured a  
820 log of personal injury protection benefits paid by the insurer  
821 on behalf of the insured. The insurer shall provide to the  
822 insured, or an assignee of the insured, a copy of the log within  
823 30 days after receiving a request for the log from the insured  
824 or the assignee.

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

826 (a) ~~1. A~~ Any physician, hospital, clinic, or other person or  
827 institution lawfully rendering treatment to an injured person  
828 for a bodily injury covered by personal injury protection  
829 insurance may charge the insurer and injured party only a  
830 reasonable amount pursuant to this section for the services and  
831 supplies rendered, and the insurer providing such coverage may  
832 pay for such charges directly to such person or institution  
833 lawfully rendering such treatment, ~~if the insured receiving such~~  
834 ~~treatment or his or her guardian has countersigned the properly~~  
835 ~~completed invoice, bill, or claim form approved by the office~~  
836 ~~upon which such charges are to be paid for as having actually~~  
837 ~~been rendered, to the best knowledge of the insured or his or~~  
838 ~~her guardian. In no event,~~ However, ~~may~~ such a charge may not  
839 exceed ~~be in excess of~~ the amount the person or institution  
840 customarily charges for like services or supplies. In  
841 determining ~~With respect to a determination of~~ whether a charge

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842 for a particular service, treatment, or otherwise is reasonable,  
843 consideration may be given to evidence of usual and customary  
844 charges and payments accepted by the provider involved in the  
845 dispute, ~~and~~ reimbursement levels in the community and various  
846 federal and state medical fee schedules applicable to motor  
847 vehicle ~~automobile~~ and other insurance coverages, and other  
848 information relevant to the reasonableness of the reimbursement  
849 for the service, treatment, or supply.

850 ~~1.2.~~ The insurer may limit reimbursement to 80 percent of  
851 the following schedule of maximum charges:

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

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

857 c. For emergency services and care as defined by s.  
858 395.002(9) provided in a facility licensed under chapter 395  
859 rendered by a physician or dentist, and related hospital  
860 inpatient services rendered by a physician or dentist, the usual  
861 and customary charges in the community.

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

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

870 f. For all other medical services, supplies, and care, 200

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871 percent of the allowable amount under:

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

875 (II) Medicare Part B, in the case of services, supplies,  
876 and care provided by ambulatory surgical centers and clinical  
877 laboratories.

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

881  
882 However, if such services, supplies, or care is not reimbursable  
883 under Medicare Part B, as provided in this sub-subparagraph, the  
884 insurer may limit reimbursement to 80 percent of the maximum  
885 reimbursable allowance under workers' compensation, as  
886 determined under s. 440.13 and rules adopted thereunder which  
887 are in effect at the time such services, supplies, or care is  
888 provided. Services, supplies, or care that is not reimbursable  
889 under Medicare or workers' compensation is not required to be  
890 reimbursed by the insurer.

891 ~~2.3.~~ For purposes of subparagraph 1. 2., the applicable fee  
892 schedule or payment limitation under Medicare is the fee  
893 schedule or payment limitation in effect on January 1 of the  
894 year in which ~~at the time~~ the services, supplies, or care is ~~was~~  
895 rendered and for the area in which such services, supplies, or  
896 care is ~~were~~ rendered, and the applicable fee schedule or  
897 payment limitation applies throughout the remainder of that  
898 year, notwithstanding any subsequent change made to the fee  
899 schedule or payment limitation, except that it may not be less

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900 than the allowable amount under the applicable ~~participating~~  
901 ~~physicians~~ schedule of Medicare Part B for 2007 for medical  
902 services, supplies, and care subject to Medicare Part B.

903 ~~3.4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply  
904 any limitation on the number of treatments or other utilization  
905 limits that apply under Medicare or workers' compensation. An  
906 insurer that applies the allowable payment limitations of  
907 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully  
908 provided care or treatment under the scope of his or her  
909 license, regardless of whether such provider is ~~would be~~  
910 entitled to reimbursement under Medicare due to restrictions or  
911 limitations on the types or discipline of health care providers  
912 who may be reimbursed for particular procedures or procedure  
913 codes. However, subparagraph 1. does not prohibit an insurer  
914 from using the Medicare coding policies and payment  
915 methodologies of the federal Centers for Medicare and Medicaid  
916 Services, including applicable modifiers, to determine the  
917 appropriate amount of reimbursement for medical services,  
918 supplies, or care if the coding policy or payment methodology  
919 does not constitute a utilization limit.

920 ~~4.5.~~ If an insurer limits payment as authorized by  
921 subparagraph 1. ~~2.~~, the person providing such services,  
922 supplies, or care may not bill or attempt to collect from the  
923 insured any amount in excess of such limits, except for amounts  
924 that are not covered by the insured's personal injury protection  
925 coverage due to the coinsurance amount or maximum policy limits.

926 5. Effective July 1, 2012, an insurer may limit payment as  
927 authorized by this paragraph only if the insurance policy  
928 includes a notice at the time of issuance or renewal that the

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929 insurer may limit payment pursuant to the schedule of charges  
930 specified in this paragraph. A policy form approved by the  
931 office satisfies this requirement. If a provider submits a  
932 charge for an amount less than the amount allowed under  
933 subparagraph 1., the insurer may pay the amount of the charge  
934 submitted.

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

937 a. Made by a broker or by a person making a claim on behalf  
938 of a broker;

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

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

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

945 e. For any treatment or service that is upcoded, or that is  
946 unbundled when such treatment or services should be bundled, in  
947 accordance with paragraph (d). To facilitate prompt payment of  
948 lawful services, an insurer may change codes that it determines  
949 ~~to~~ have been improperly or incorrectly upcoded or unbundled, and  
950 may make payment based on the changed codes, without affecting  
951 the right of the provider to dispute the change by the insurer,  
952 if, provided that before doing so, the insurer contacts ~~must~~  
953 ~~contact~~ the health care provider and discusses ~~discuss~~ the  
954 reasons for the insurer's change and the health care provider's  
955 reason for the coding, or makes ~~make~~ a reasonable good faith  
956 effort to do so, as documented in the insurer's file; and

957 f. For medical services or treatment billed by a physician

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958 and not provided in a hospital unless such services are rendered  
959 by the physician or are incident to his or her professional  
960 services and are included on the physician's bill, including  
961 documentation verifying that the physician is responsible for  
962 the medical services that were rendered and billed.

963 2. The Department of Health, in consultation with the  
964 appropriate professional licensing boards, shall adopt, by rule,  
965 a list of diagnostic tests deemed not to be medically necessary  
966 for use in the treatment of persons sustaining bodily injury  
967 covered by personal injury protection benefits under this  
968 section. The ~~initial list shall be adopted by January 1, 2004,~~  
969 ~~and~~ shall be revised from time to time as determined by the  
970 Department of Health, in consultation with the respective  
971 professional licensing boards. Inclusion of a test on the list  
972 ~~of invalid diagnostic tests~~ shall be based on lack of  
973 demonstrated medical value and a level of general acceptance by  
974 the relevant provider community and may ~~shall~~ not be dependent  
975 for results entirely upon subjective patient response.  
976 Notwithstanding its inclusion on a fee schedule in this  
977 subsection, an insurer or insured is not required to pay any  
978 charges or reimburse claims for an ~~any~~ invalid diagnostic test  
979 as determined by the Department of Health.

980 (c)~~1~~. With respect to any treatment or service, other than  
981 medical services billed by a hospital or other provider for  
982 emergency services and care as defined in s. 395.002 or  
983 inpatient services rendered at a hospital-owned facility, the  
984 statement of charges must be furnished to the insurer by the  
985 provider and may not include, and the insurer is not required to  
986 pay, charges for treatment or services rendered more than 35

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987 days before the postmark date or electronic transmission date of  
988 the statement, except for past due amounts previously billed on  
989 a timely basis under this paragraph, and except that, if the  
990 provider submits to the insurer a notice of initiation of  
991 treatment within 21 days after its first examination or  
992 treatment of the claimant, the statement may include charges for  
993 treatment or services rendered up to, but not more than, 75 days  
994 before the postmark date of the statement. The injured party is  
995 not liable for, and the provider may ~~shall~~ not bill the injured  
996 party for, charges that are unpaid because of the provider's  
997 failure to comply with this paragraph. Any agreement requiring  
998 the injured person or insured to pay for such charges is  
999 unenforceable.

1000 1.2. ~~If, however,~~ the insured fails to furnish the provider  
1001 with the correct name and address of the insured's personal  
1002 injury protection insurer, the provider has 35 days from the  
1003 date the provider obtains the correct information to furnish the  
1004 insurer with a statement of the charges. The insurer is not  
1005 required to pay for such charges unless the provider includes  
1006 with the statement documentary evidence that was provided by the  
1007 insured during the 35-day period demonstrating that the provider  
1008 reasonably relied on erroneous information from the insured and  
1009 either:

- 1010 a. A denial letter from the incorrect insurer; or
- 1011 b. Proof of mailing, which may include an affidavit under  
1012 penalty of perjury, reflecting timely mailing to the incorrect  
1013 address or insurer.

1014 2.3. For emergency services and care ~~as defined in s.~~  
1015 ~~395.002~~ rendered in a hospital emergency department or for

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1016 transport and treatment rendered by an ambulance provider  
 1017 licensed pursuant to part III of chapter 401, the provider is  
 1018 not required to furnish the statement of charges within the time  
 1019 periods established by this paragraph,~~+~~ and the insurer is ~~shall~~  
 1020 not ~~be~~ considered to have been furnished with notice of the  
 1021 amount of covered loss for purposes of paragraph (4)(b) until it  
 1022 receives a statement complying with paragraph (d), or copy  
 1023 thereof, which specifically identifies the place of service to  
 1024 be a hospital emergency department or an ambulance in accordance  
 1025 with billing standards recognized by the federal Centers for  
 1026 Medicare and Medicaid Services ~~Health Care Finance~~  
 1027 ~~Administration~~.

1028 ~~3.4.~~ Each notice of the insured's rights under s. 627.7401  
 1029 must include the following statement in at least 12-point type  
 1030 ~~in type no smaller than 12 points:~~

1031  
 1032 BILLING REQUIREMENTS.—Florida law provides ~~Statutes~~  
 1033 ~~provide~~ that with respect to any treatment or  
 1034 services, other than certain hospital and emergency  
 1035 services, the statement of charges furnished to the  
 1036 insurer by the provider may not include, and the  
 1037 insurer and the injured party are not required to pay,  
 1038 charges for treatment or services rendered more than  
 1039 35 days before the postmark date of the statement,  
 1040 except for past due amounts previously billed on a  
 1041 timely basis, and except that, if the provider submits  
 1042 to the insurer a notice of initiation of treatment  
 1043 within 21 days after its first examination or  
 1044 treatment of the claimant, the statement may include

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1045 charges for treatment or services rendered up to, but  
1046 not more than, 75 days before the postmark date of the  
1047 statement.

1048  
1049 (d) All statements and bills for medical services rendered  
1050 by a ~~any~~ physician, hospital, clinic, or other person or  
1051 institution shall be submitted to the insurer on a properly  
1052 completed Centers for Medicare and Medicaid Services (CMS) 1500  
1053 form, UB 92 forms, or any other standard form approved by the  
1054 office or adopted by the commission for purposes of this  
1055 paragraph. All billings for such services rendered by providers  
1056 must ~~shall~~, to the extent applicable, follow the Physicians'  
1057 Current Procedural Terminology (CPT) or Healthcare Correct  
1058 Procedural Coding System (HCPCS), or ICD-9 in effect for the  
1059 year in which services are rendered and comply with the ~~Centers~~  
1060 ~~for Medicare and Medicaid Services (CMS) 1500 form instructions,~~  
1061 ~~and the American Medical Association Current Procedural~~  
1062 ~~Terminology (CPT) Editorial Panel,~~ and the ~~Healthcare Correct~~  
1063 ~~Procedural Coding System (HCPCS).~~ All providers, other than  
1064 hospitals, must ~~shall~~ include on the applicable claim form the  
1065 professional license number of the provider in the line or space  
1066 provided for "Signature of Physician or Supplier, Including  
1067 Degrees or Credentials." In determining compliance with  
1068 applicable CPT and HCPCS coding, guidance shall be provided by  
1069 the Physicians' Current Procedural Terminology (CPT) or the  
1070 Healthcare Correct Procedural Coding System (HCPCS) in effect  
1071 for the year in which services were rendered, the Office of the  
1072 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and  
1073 other authoritative treatises designated by rule by the Agency

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1074 for Health Care Administration. A ~~Ne~~ statement of medical  
1075 services may not include charges for medical services of a  
1076 person or entity that performed such services without possessing  
1077 the valid licenses required to perform such services. For  
1078 purposes of paragraph (4) (b), an insurer is ~~shall~~ not ~~be~~  
1079 considered to have been furnished with notice of the amount of  
1080 covered loss or medical bills due unless the statements or bills  
1081 comply with this paragraph, ~~and unless the statements or bills~~  
1082 are properly completed in their entirety as to all material  
1083 provisions, with all relevant information being provided  
1084 therein.

1085 (e)1. At the initial treatment or service provided, each  
1086 physician, other licensed professional, clinic, or other medical  
1087 institution providing medical services upon which a claim for  
1088 personal injury protection benefits is based shall require an  
1089 insured person, or his or her guardian, to execute a disclosure  
1090 and acknowledgment form, which reflects at a minimum that:

1091 a. The insured, or his or her guardian, must countersign  
1092 the form attesting to the fact that the services set forth  
1093 therein were actually rendered;

1094 b. The insured, or his or her guardian, has both the right  
1095 and affirmative duty to confirm that the services were actually  
1096 rendered;

1097 c. The insured, or his or her guardian, was not solicited  
1098 by any person to seek any services from the medical provider;

1099 d. The physician, other licensed professional, clinic, or  
1100 other medical institution rendering services for which payment  
1101 is being claimed explained the services to the insured or his or  
1102 her guardian; and

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1103 e. If the insured notifies the insurer in writing of a  
1104 billing error, the insured may be entitled to a certain  
1105 percentage of a reduction in the amounts paid by the insured's  
1106 motor vehicle insurer.

1107 2. The physician, other licensed professional, clinic, or  
1108 other medical institution rendering services for which payment  
1109 is being claimed has the affirmative duty to explain the  
1110 services rendered to the insured, or his or her guardian, so  
1111 that the insured, or his or her guardian, countersigns the form  
1112 with informed consent.

1113 3. Countersignature by the insured, or his or her guardian,  
1114 is not required for the reading of diagnostic tests or other  
1115 services that are of such a nature that they are not required to  
1116 be performed in the presence of the insured.

1117 4. The licensed medical professional rendering treatment  
1118 for which payment is being claimed must sign, by his or her own  
1119 hand, the form complying with this paragraph.

1120 5. The original completed disclosure and acknowledgment  
1121 form shall be furnished to the insurer pursuant to paragraph  
1122 (4) (b) and may not be electronically furnished.

1123 6. The ~~This~~ disclosure and acknowledgment form is not  
1124 required for services billed by a provider ~~for emergency~~  
1125 ~~services as defined in s. 395.002,~~ for emergency services and  
1126 care as defined in s. 395.002 rendered in a hospital emergency  
1127 department, or for transport and treatment rendered by an  
1128 ambulance provider licensed pursuant to part III of chapter 401.

1129 7. The Financial Services Commission shall adopt, by rule,  
1130 a standard disclosure and acknowledgment form to ~~that shall~~ be  
1131 used to fulfill the requirements of this paragraph, ~~effective 90~~

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1132 ~~days after such form is adopted and becomes final. The~~  
1133 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~  
1134 ~~the rule is final, the provider may use a form of its own which~~  
1135 ~~otherwise complies with the requirements of this paragraph.~~

1136 8. As used in this paragraph, the term "countersign" or  
1137 "countersignature" ~~"countersigned"~~ means a second or verifying  
1138 signature, as on a previously signed document, and is not  
1139 satisfied by the statement "signature on file" or any similar  
1140 statement.

1141 9. The requirements of this paragraph apply only with  
1142 respect to the initial treatment or service of the insured by a  
1143 provider. For subsequent treatments or service, the provider  
1144 must maintain a patient log signed by the patient, in  
1145 chronological order by date of service, which ~~that~~ is consistent  
1146 with the services being rendered to the patient as claimed. The  
1147 requirement to maintain ~~requirements of this subparagraph for~~  
1148 ~~maintaining~~ a patient log signed by the patient may be met by a  
1149 hospital that maintains medical records as required by s.  
1150 395.3025 and applicable rules and makes such records available  
1151 to the insurer upon request.

1152 (f) Upon written notification by any person, an insurer  
1153 shall investigate any claim of improper billing by a physician  
1154 or other medical provider. The insurer shall determine if the  
1155 insured was properly billed for only those services and  
1156 treatments that the insured actually received. If the insurer  
1157 determines that the insured has been improperly billed, the  
1158 insurer shall notify the insured, the person making the written  
1159 notification, and the provider of its findings and ~~shall~~ reduce  
1160 the amount of payment to the provider by the amount determined

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1161 to be improperly billed. If a reduction is made due to a ~~such~~  
1162 written notification by any person, the insurer shall pay to the  
1163 person 20 percent of the amount of the reduction, up to \$500. If  
1164 the provider is arrested due to the improper billing, ~~then~~ the  
1165 insurer shall pay to the person 40 percent of the amount of the  
1166 reduction, up to \$500.

1167 (g) An insurer may not systematically downcode with the  
1168 intent to deny reimbursement otherwise due. Such action  
1169 constitutes a material misrepresentation under s.  
1170 626.9541(1)(i)2.

1171 (h) As provided in s. 400.9905, an entity excluded from the  
1172 definition of a clinic shall be deemed a clinic and must be  
1173 licensed under part X of chapter 400 in order to receive  
1174 reimbursement under ss. 627.730-627.7405. However, this  
1175 licensing requirement does not apply to:

1176 1. An entity wholly owned by a physician licensed under  
1177 chapter 458 or chapter 459, or by the physician and the spouse,  
1178 parent, child, or sibling of the physician;

1179 2. An entity wholly owned by a dentist licensed under  
1180 chapter 466, or by the dentist and the spouse, parent, child, or  
1181 sibling of the dentist;

1182 3. An entity wholly owned by a chiropractic physician  
1183 licensed under chapter 460, or by the chiropractic physician and  
1184 the spouse, parent, child, or sibling of the chiropractic  
1185 physician;

1186 4. A hospital or ambulatory surgical center licensed under  
1187 chapter 395; or

1188 5. An entity wholly owned, directly or indirectly, by a  
1189 hospital or hospitals licensed under chapter 395.

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1190 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.-

1191 (a) ~~Every employer shall,~~ If a request is made by an  
1192 insurer providing personal injury protection benefits under ss.  
1193 627.730-627.7405 against whom a claim has been made, an employer  
1194 must furnish ~~forthwith,~~ in a form approved by the office, a  
1195 sworn statement of the earnings, since the time of the bodily  
1196 injury and for a reasonable period before the injury, of the  
1197 person upon whose injury the claim is based.

1198 (b) Every physician, hospital, clinic, or other medical  
1199 institution providing, before or after bodily injury upon which  
1200 a claim for personal injury protection insurance benefits is  
1201 based, any products, services, or accommodations in relation to  
1202 that or any other injury, or in relation to a condition claimed  
1203 to be connected with that or any other injury, shall, if  
1204 requested ~~to do so~~ by the insurer against whom the claim has  
1205 been made, furnish ~~forthwith~~ a written report of the history,  
1206 condition, treatment, dates, and costs of such treatment of the  
1207 injured person and why the items identified by the insurer were  
1208 reasonable in amount and medically necessary, together with a  
1209 sworn statement that the treatment or services rendered were  
1210 reasonable and necessary with respect to the bodily injury  
1211 sustained and identifying which portion of the expenses for such  
1212 treatment or services was incurred as a result of such bodily  
1213 injury, and produce ~~forthwith,~~ and allow ~~permit~~ the inspection  
1214 and copying of, his or her or its records regarding such  
1215 history, condition, treatment, dates, and costs of treatment if  
1216 ~~provided that this does shall~~ not limit the introduction of  
1217 evidence at trial. Such sworn statement must ~~shall~~ read as  
1218 follows: "Under penalty of perjury, I declare that I have read

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1219 the foregoing, and the facts alleged are true, to the best of my  
 1220 knowledge and belief." A ~~No~~ cause of action for violation of the  
 1221 physician-patient privilege or invasion of the right of privacy  
 1222 may not be brought ~~shall be permitted~~ against any physician,  
 1223 hospital, clinic, or other medical institution complying with  
 1224 ~~the provisions of~~ this section. The person requesting such  
 1225 records and such sworn statement shall pay all reasonable costs  
 1226 connected therewith. If an insurer makes a written request for  
 1227 documentation or information under this paragraph within 30 days  
 1228 after having received notice of the amount of a covered loss  
 1229 under paragraph (4) (a), the amount or the partial amount that  
 1230 ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~  
 1231 overdue if the insurer does not pay in accordance with paragraph  
 1232 (4) (b) or within 10 days after the insurer's receipt of the  
 1233 requested documentation or information, whichever occurs later.  
 1234 As used in ~~For purposes of~~ this paragraph, the term "receipt"  
 1235 includes, but is not limited to, inspection and copying pursuant  
 1236 to this paragraph. An ~~Any~~ insurer that requests documentation or  
 1237 information pertaining to reasonableness of charges or medical  
 1238 necessity under this paragraph without a reasonable basis for  
 1239 such requests as a general business practice is engaging in an  
 1240 unfair trade practice under the insurance code.

1241 (c) In the event of a ~~any~~ dispute regarding an insurer's  
 1242 right to discovery of facts under this section, the insurer may  
 1243 petition a court of competent jurisdiction to enter an order  
 1244 permitting such discovery. The order may be made only on motion  
 1245 for good cause shown and upon notice to all persons having an  
 1246 interest, and must ~~it shall~~ specify the time, place, manner,  
 1247 conditions, and scope of the discovery. ~~Such court may,~~ In order

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1248 to protect against annoyance, embarrassment, or oppression, as  
1249 justice requires, the court may enter an order refusing  
1250 discovery or specifying conditions of discovery and may order  
1251 payments of costs and expenses of the proceeding, including  
1252 reasonable fees for the appearance of attorneys at the  
1253 proceedings, as justice requires.

1254 (d) The injured person shall be furnished, upon request, a  
1255 copy of all information obtained by the insurer under ~~the~~  
1256 ~~provisions of~~ this section, and ~~shall~~ pay a reasonable charge,  
1257 if required by the insurer.

1258 (e) Notice to an insurer of the existence of a claim may  
1259 ~~shall~~ not be unreasonably withheld by an insured.

1260 (f) In a dispute between the insured and the insurer, or  
1261 between an assignee of the insured's rights and the insurer, the  
1262 insurer must notify the insured or the assignee that the policy  
1263 limits under this section have been reached within 15 days after  
1264 the limits have been reached.

1265 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY  
1266 ATTORNEY'S FEES.—With respect to any dispute under the  
1267 provisions of ss. 627.730-627.7405 between the insured and the  
1268 insurer, or between an assignee of an insured's rights and the  
1269 insurer, the provisions of ss. 627.428 and 768.79 ~~shall~~  
1270 apply, except as provided in subsections (10) and (15).

1271 (9) PREFERRED PROVIDERS.—An insurer may negotiate and  
1272 contract enter into contracts with preferred licensed health  
1273 care providers for the benefits described in this section,  
1274 ~~referred to in this section as "preferred providers,"~~ which  
1275 ~~shall~~ include health care providers licensed under chapter  
1276 chapters 458, chapter 459, chapter 460, chapter 461, or chapter

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1277 ~~and~~ 463. The insurer may provide an option to an insured to use  
1278 a preferred provider at the time of purchasing ~~purchase~~ of the  
1279 policy for personal injury protection benefits, if the  
1280 requirements of this subsection are met. If the insured elects  
1281 to use a provider who is not a preferred provider, whether the  
1282 insured purchased a preferred provider policy or a nonpreferred  
1283 provider policy, the medical benefits provided by the insurer  
1284 shall be as required by this section. If the insured elects to  
1285 use a provider who is a preferred provider, the insurer may pay  
1286 medical benefits in excess of the benefits required by this  
1287 section and may waive or lower the amount of any deductible that  
1288 applies to such medical benefits. If the insurer offers a  
1289 preferred provider policy to a policyholder or applicant, it  
1290 must also offer a nonpreferred provider policy. The insurer  
1291 shall provide each insured ~~policyholder~~ with a current roster of  
1292 preferred providers in the county in which the insured resides  
1293 at the time of purchase of such policy, and shall make such list  
1294 available for public inspection during regular business hours at  
1295 the insurer's principal office ~~of the insurer~~ within the state.

1296 (10) DEMAND LETTER.—

1297 (a) As a condition precedent to filing any action for  
1298 benefits under this section, ~~the insurer must be provided with~~  
1299 written notice of an intent to initiate litigation must be  
1300 provided to the insurer. Such notice may not be sent until the  
1301 claim is overdue, including any additional time the insurer has  
1302 to pay the claim pursuant to paragraph (4) (b).

1303 (b) The notice must ~~required shall~~ state that it is a  
1304 "demand letter under s. 627.736(10)" and ~~shall~~ state with  
1305 specificity:

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1306 1. The name of the insured upon which such benefits are  
1307 being sought, including a copy of the assignment giving rights  
1308 to the claimant if the claimant is not the insured.

1309 2. The claim number or policy number upon which such claim  
1310 was originally submitted to the insurer.

1311 3. To the extent applicable, the name of any medical  
1312 provider who rendered to an insured the treatment, services,  
1313 accommodations, or supplies that form the basis of such claim;  
1314 and an itemized statement specifying each exact amount, the date  
1315 of treatment, service, or accommodation, and the type of benefit  
1316 claimed to be due. A completed form satisfying the requirements  
1317 of paragraph (5) (d) or the lost-wage statement previously  
1318 submitted may be used as the itemized statement. To the extent  
1319 that the demand involves an insurer's withdrawal of payment  
1320 under paragraph (7) (a) for future treatment not yet rendered,  
1321 the claimant shall attach a copy of the insurer's notice  
1322 withdrawing such payment and an itemized statement of the type,  
1323 frequency, and duration of future treatment claimed to be  
1324 reasonable and medically necessary.

1325 (c) Each notice required by this subsection must be  
1326 delivered to the insurer by United States certified or  
1327 registered mail, return receipt requested. Such postal costs  
1328 shall be reimbursed by the insurer if ~~so~~ requested by the  
1329 claimant in the notice, when the insurer pays the claim. Such  
1330 notice must be sent to the person and address specified by the  
1331 insurer for the purposes of receiving notices under this  
1332 subsection. Each licensed insurer, whether domestic, foreign, or  
1333 alien, shall file with the office designation of the name and  
1334 address of the person to whom notices must ~~pursuant to this~~

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1335 ~~subsection shall~~ be sent which the office shall make available  
1336 on its Internet website. The name and address on file with the  
1337 office pursuant to s. 624.422 are ~~shall be~~ deemed the authorized  
1338 representative to accept notice pursuant to this subsection if  
1339 ~~in the event~~ no other designation has been made.

1340 (d) If, within 30 days after receipt of notice by the  
1341 insurer, the overdue claim specified in the notice is paid by  
1342 the insurer together with applicable interest and a penalty of  
1343 10 percent of the overdue amount paid by the insurer, subject to  
1344 a maximum penalty of \$250, no action may be brought against the  
1345 insurer. If the demand involves an insurer's withdrawal of  
1346 payment under paragraph (7) (a) for future treatment not yet  
1347 rendered, no action may be brought against the insurer if,  
1348 within 30 days after its receipt of the notice, the insurer  
1349 mails to the person filing the notice a written statement of the  
1350 insurer's agreement to pay for such treatment in accordance with  
1351 the notice and to pay a penalty of 10 percent, subject to a  
1352 maximum penalty of \$250, when it pays for such future treatment  
1353 in accordance with the requirements of this section. To the  
1354 extent the insurer determines not to pay any amount demanded,  
1355 the penalty is ~~shall~~ not be payable in any subsequent action.  
1356 For purposes of this subsection, payment or the insurer's  
1357 agreement shall be treated as being made on the date a draft or  
1358 other valid instrument that is equivalent to payment, or the  
1359 insurer's written statement of agreement, is placed in the  
1360 United States mail in a properly addressed, postpaid envelope,  
1361 or if not so posted, on the date of delivery. The insurer is not  
1362 obligated to pay any attorney ~~attorney's~~ fees if the insurer  
1363 pays the claim or mails its agreement to pay for future

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1364 treatment within the time prescribed by this subsection.

1365 (e) The applicable statute of limitation for an action  
1366 under this section shall be tolled for ~~a period of~~ 30 business  
1367 days by the mailing of the notice required by this subsection.

1368 ~~(f) Any insurer making a general business practice of not~~  
1369 ~~paying valid claims until receipt of the notice required by this~~  
1370 ~~subsection is engaging in an unfair trade practice under the~~  
1371 ~~insurance code.~~

1372 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE  
1373 PRACTICE.—

1374 (a) ~~If An insurer fails to pay valid claims for personal~~  
1375 ~~injury protection with such frequency so as to indicate a~~  
1376 ~~general business practice, the insurer is engaging in a~~  
1377 prohibited unfair or deceptive practice that is subject to the  
1378 penalties provided in s. 626.9521 and the office has the powers  
1379 and duties specified in ss. 626.9561-626.9601 if the insurer,  
1380 with such frequency so as to indicate a general business  
1381 practice: with respect thereto

1382 1. Fails to pay valid claims for personal injury  
1383 protection; or

1384 2. Fails to pay valid claims until receipt of the notice  
1385 required by subsection (10).

1386 (b) Notwithstanding s. 501.212, the Department of Legal  
1387 Affairs may investigate and initiate actions for a violation of  
1388 this subsection, including, but not limited to, the powers and  
1389 duties specified in part II of chapter 501.

1390 Section 9. Effective December 1, 2012, subsection (16) of  
1391 section 627.736, Florida Statutes, is amended to read:

1392 627.736 Required personal injury protection benefits;

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1393 exclusions; priority; claims.-

1394 (16) SECURE ELECTRONIC DATA TRANSFER.-~~If all parties~~  
1395 ~~mutually and expressly agree,~~ A notice, documentation,  
1396 transmission, or communication of any kind required or  
1397 authorized under ss. 627.730-627.7405 may be transmitted  
1398 electronically if it is transmitted by secure electronic data  
1399 transfer that is consistent with state and federal privacy and  
1400 security laws.

1401 Section 10. Subsections (1), (10), and (13) of section  
1402 817.234, Florida Statutes, are amended to read:

1403 817.234 False and fraudulent insurance claims.-

1404 (1)(a) A person commits insurance fraud punishable as  
1405 provided in subsection (11) if that person, with the intent to  
1406 injure, defraud, or deceive any insurer:

1407 1. Presents or causes to be presented any written or oral  
1408 statement as part of, or in support of, a claim for payment or  
1409 other benefit pursuant to an insurance policy or a health  
1410 maintenance organization subscriber or provider contract,  
1411 knowing that such statement contains any false, incomplete, or  
1412 misleading information concerning any fact or thing material to  
1413 such claim;

1414 2. Prepares or makes any written or oral statement that is  
1415 intended to be presented to any insurer in connection with, or  
1416 in support of, any claim for payment or other benefit pursuant  
1417 to an insurance policy or a health maintenance organization  
1418 subscriber or provider contract, knowing that such statement  
1419 contains any false, incomplete, or misleading information  
1420 concerning any fact or thing material to such claim; ~~or~~

1421 3.a. Knowingly presents, causes to be presented, or

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1422 prepares or makes with knowledge or belief that it will be  
1423 presented to any insurer, purported insurer, servicing  
1424 corporation, insurance broker, or insurance agent, or any  
1425 employee or agent thereof, any false, incomplete, or misleading  
1426 information or written or oral statement as part of, or in  
1427 support of, an application for the issuance of, or the rating  
1428 of, any insurance policy, or a health maintenance organization  
1429 subscriber or provider contract; or

1430 b. ~~Who~~ Knowingly conceals information concerning any fact  
1431 material to such application; or-

1432 4. Knowingly presents, causes to be presented, or prepares  
1433 or makes with knowledge or belief that it will be presented to  
1434 any insurer a claim for payment or other benefit under a  
1435 personal injury protection insurance policy if the person knows  
1436 that the payee knowingly submitted a false, misleading, or  
1437 fraudulent application or other document when applying for  
1438 licensure as a health care clinic, seeking an exemption from  
1439 licensure as a health care clinic, or demonstrating compliance  
1440 with part X of chapter 400.

1441 (b) All claims and application forms must ~~shall~~ contain a  
1442 statement that is approved by the Office of Insurance Regulation  
1443 of the Financial Services Commission which clearly states in  
1444 substance the following: "Any person who knowingly and with  
1445 intent to injure, defraud, or deceive any insurer files a  
1446 statement of claim or an application containing any false,  
1447 incomplete, or misleading information is guilty of a felony of  
1448 the third degree." This paragraph does ~~shall~~ not apply to  
1449 reinsurance contracts, reinsurance agreements, or reinsurance  
1450 claims transactions.

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1451           (10) A licensed health care practitioner who is found  
1452 guilty of insurance fraud under this section for an act relating  
1453 to a personal injury protection insurance policy loses his or  
1454 her license to practice for 5 years and may not receive  
1455 reimbursement for personal injury protection benefits for 10  
1456 years. ~~As used in this section, the term "insurer" means any~~  
1457 ~~insurer, health maintenance organization, self-insurer, self-~~  
1458 ~~insurance fund, or other similar entity or person regulated~~  
1459 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~  
1460 ~~Regulation under the Florida Insurance Code.~~

1461           (13) As used in this section, the term:

1462           (a) "Insurer" means any insurer, health maintenance  
1463 organization, self-insurer, self-insurance fund, or similar  
1464 entity or person regulated under chapter 440 or chapter 641 or  
1465 by the Office of Insurance Regulation under the Florida  
1466 Insurance Code.

1467           (b) ~~(a)~~ "Property" means property as defined in s. 812.012.

1468           (c) ~~(b)~~ "Value" means value as defined in s. 812.012.

1469           Section 11. Subsection (4) of section 316.065, Florida  
1470 Statutes, is amended to read:

1471           316.065 Crashes; reports; penalties.—

1472           (4) Any person who knowingly repairs a motor vehicle  
1473 without having made a report as required by subsection (3) is  
1474 guilty of a misdemeanor of the first degree, punishable as  
1475 provided in s. 775.082 or s. 775.083. The owner and driver of a  
1476 vehicle involved in a crash who makes a report thereof in  
1477 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable  
1478 under this section.

1479           Section 12. The Office of Insurance Regulation shall

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1480 perform a comprehensive personal injury protection data call and  
1481 publish the results by January 1, 2015. It is the intent of the  
1482 Legislature that the office design the data call with the  
1483 expectation that the Legislature will use the data to help  
1484 evaluate market conditions relating to the Florida Motor Vehicle  
1485 No-Fault Law and the impact on the market of reforms to the law  
1486 made by this act. The elements of the data call must address,  
1487 but need not be limited to, the following components of the  
1488 Florida Motor Vehicle No-Fault Law:

- 1489 (1) Quantity of personal injury protection claims.  
1490 (2) Type or nature of claimants.  
1491 (3) Amount and type of personal injury protection benefits  
1492 paid and expenses incurred.  
1493 (4) Type and quantity of, and charges for, medical  
1494 benefits.  
1495 (5) Attorney fees related to bringing and defending actions  
1496 for benefits.  
1497 (6) Direct earned premiums for personal injury protection  
1498 coverage, pure loss ratios, pure premiums, and other information  
1499 related to premiums and losses.  
1500 (7) Licensed drivers and accidents.  
1501 (8) Fraud and enforcement.

1502 Section 13. If any provision of this act or its application  
1503 to any person or circumstance is held invalid, the invalidity  
1504 does not affect other provisions or applications of the act  
1505 which can be given effect without the invalid provision or  
1506 application, and to this end the provisions of this act are  
1507 severable.

1508 Section 14. Except as otherwise expressly provided in this

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act, this act shall take effect July 1, 2012.