By the Committees on Budget; and Banking and Insurance; and Senator Negron

576-04369-12 20121860c2

1 A bill to be entitled
2 An act relating to motor vehicle personal injury
3 protection insurance; amending s. 316.066, F.S.;
4 revising the conditions for completing the long-form
5 traffic crash report; revising the information
6 contained in the short-form report; revising the
7 requirements relating to the driver’s responsibility
8 for submitting a report for crashes not requiring a
9 law enforcement report; amending s. 400.9905, F.S.;
10 providing that certain entities exempt from licensure
11 as a health care clinic must nonetheless be licensed
12 in order to receive reimbursement for the provision of
13 personal injury protection benefits; amending s.
14 400.991, F.S.; requiring that an application for
15 licensure, or exemption from licensure, as a health
16 care clinic include a statement regarding insurance
17 fraud; amending s. 626.989, F.S.; providing that
18 knowingly submitting false, misleading, or fraudulent
19 documents relating to licensure as a health care
20 clinic, or submitting a claim for personal injury
21 protection relating to clinic licensure documents, is
22 a fraudulent insurance act under certain conditions;
23 amending s. 626.9894, F.S.; conforming provisions to
24 changes made by act; creating s. 626.9895, F.S.;
25 providing definitions; authorizing the Division of
26 Insurance Fraud of the Department of Financial
27 Services to establish a direct-support organization
28 for the purpose of prosecuting, investigating, and
29 preventing motor vehicle insurance fraud; providing

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

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

88 insurance fraud loses his or her license and may not
89 receive reimbursement for personal injury protection
90 benefits for a specified period; defining the term
91 "insurer"; amending s. 316.065, F.S.; conforming a
92 cross-reference; requiring that the Office of
93 Insurance Regulation perform a data call relating to
94 personal injury protection; prescribing required
95 elements of the data call; providing for severability;
96 providing effective dates.
97
98 Be It Enacted by the Legislature of the State of Florida:
99
100 Section 1. Subsection (1) of section 316.066, Florida
101 Statutes, is amended to read:
102 316.066 Written reports of crashes.—
103 (1)(a) A Florida Traffic Crash Report, Long Form must ~~is~~
104 ~~required to~~ be completed and submitted to the department within
105 10 days after ~~completing~~ an investigation is completed by the
106 ~~every~~ law enforcement officer who in the regular course of duty
107 investigates a motor vehicle crash that:
108 1. Resulted in death or personal injury;~~.~~
109 2. Involved a violation of s. 316.061(1) or s. 316.193;~~.~~
110 3. Rendered a vehicle inoperable to a degree that required
111 a wrecker to remove it from the scene of the crash; or
112 4. Involved a commercial motor vehicle.
113 (b) In any ~~every~~ crash for which a Florida Traffic Crash
114 Report, Long Form is not required by this section and which
115 occurs on the public roadways of this state, the law enforcement
116 officer shall ~~may~~ complete a short-form crash report or provide

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117 a driver exchange-of-information form, to be completed by all
118 drivers and passengers ~~each party~~ involved in the crash, which
119 requires the identification of each vehicle that the drivers and
120 passengers were in. The short-form report must include:
121 1. The date, time, and location of the crash.
122 2. A description of the vehicles involved.
123 3. The names and addresses of the parties involved,
124 including all drivers and passengers, and the identification of
125 the vehicle in which each was a passenger.
126 4. The names and addresses of witnesses.
127 5. The name, badge number, and law enforcement agency of
128 the officer investigating the crash.
129 6. The names of the insurance companies for the respective
130 parties involved in the crash.
131 (c) Each party to the crash must provide the law
132 enforcement officer with proof of insurance, which must be
133 documented in the crash report. If a law enforcement officer
134 submits a report on the crash, proof of insurance must be
135 provided to the officer by each party involved in the crash. Any
136 party who fails to provide the required information commits a
137 noncriminal traffic infraction, punishable as a nonmoving
138 violation as provided in chapter 318, unless the officer
139 determines that due to injuries or other special circumstances
140 such insurance information cannot be provided immediately. If
141 the person provides the law enforcement agency, within 24 hours
142 after the crash, proof of insurance that was valid at the time
143 of the crash, the law enforcement agency may void the citation.
144 (d) The driver of a vehicle that was in any manner involved
145 in a crash resulting in damage to a ~~any~~ vehicle or other

146 property which does not require a law enforcement report ~~in an~~
147 ~~amount of $500 or more which was not investigated by a law~~
148 ~~enforcement agency,~~ shall, within 10 days after the crash,
149 submit a written report of the crash to the department. The
150 report shall be submitted on a form approved by the department.
151 ~~The entity receiving the report may require witnesses of the~~
152 ~~crash to render reports and may require any driver of a vehicle~~
153 ~~involved in a crash of which a written report must be made to~~
154 ~~file supplemental written reports if the original report is~~
155 ~~deemed insufficient by the receiving entity.~~
156 (e) Long-form and short-form crash reports prepared by law
157 enforcement must be submitted to the department and may ~~shall~~ be
158 maintained by the law enforcement officer's agency.
159 Section 2. Subsection (4) of section 400.9905, Florida
160 Statutes, is amended to read:
161 400.9905 Definitions.—
162 (4) "Clinic" means an entity where ~~at which~~ health care
163 services are provided to individuals and which tenders charges
164 for reimbursement for such services, including a mobile clinic
165 and a portable equipment provider. As used in ~~For purposes of~~
166 this part, the term does not include and the licensure
167 requirements of this part do not apply to:
168 (a) Entities licensed or registered by the state under
169 chapter 395; ~~or~~ entities licensed or registered by the state and
170 providing only health care services within the scope of services
171 authorized under their respective licenses ~~granted~~ under ss.
172 383.30-383.335, chapter 390, chapter 394, chapter 397, this
173 chapter except part X, chapter 429, chapter 463, chapter 465,
174 chapter 466, chapter 478, part I of chapter 483, chapter 484, or

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175 chapter 651; end-stage renal disease providers authorized under
176 42 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
177 C.F.R. part 485, subpart B or subpart H; or any entity that
178 provides neonatal or pediatric hospital-based health care
179 services or other health care services by licensed practitioners
180 solely within a hospital licensed under chapter 395.
181 (b) Entities that own, directly or indirectly, entities
182 licensed or registered by the state pursuant to chapter 395; ~~or~~
183 entities that own, directly or indirectly, entities licensed or
184 registered by the state and providing only health care services
185 within the scope of services authorized pursuant to their
186 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
187 390, chapter 394, chapter 397, this chapter except part X,
188 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
189 part I of chapter 483, chapter 484, chapter 651; end-stage renal
190 disease providers authorized under 42 C.F.R. part 405, subpart
191 U; ~~or~~ providers certified under 42 C.F.R. part 485, subpart B or
192 subpart H; or any entity that provides neonatal or pediatric
193 hospital-based health care services by licensed practitioners
194 solely within a hospital licensed under chapter 395.
195 (c) Entities that are owned, directly or indirectly, by an
196 entity licensed or registered by the state pursuant to chapter
197 395; ~~or~~ entities that are owned, directly or indirectly, by an
198 entity licensed or registered by the state and providing only
199 health care services within the scope of services authorized
200 pursuant to their respective licenses ~~granted~~ under ss. 383.30-
201 383.335, chapter 390, chapter 394, chapter 397, this chapter
202 except part X, chapter 429, chapter 463, chapter 465, chapter
203 466, chapter 478, part I of chapter 483, chapter 484, or chapter

204 651; end-stage renal disease providers authorized under 42
205 C.F.R. part 405, subpart U; ~~or~~ providers certified under 42
206 C.F.R. part 485, subpart B or subpart H; or any entity that
207 provides neonatal or pediatric hospital-based health care
208 services by licensed practitioners solely within a hospital
209 under chapter 395.
210 (d) Entities that are under common ownership, directly or
211 indirectly, with an entity licensed or registered by the state
212 pursuant to chapter 395; ~~or~~ entities that are under common
213 ownership, directly or indirectly, with an entity licensed or
214 registered by the state and providing only health care services
215 within the scope of services authorized pursuant to their
216 respective licenses ~~granted~~ under ss. 383.30-383.335, chapter
217 390, chapter 394, chapter 397, this chapter except part X,
218 chapter 429, chapter 463, chapter 465, chapter 466, chapter 478,
219 part I of chapter 483, chapter 484, or chapter 651; end-stage
220 renal disease providers authorized under 42 C.F.R. part 405,
221 subpart U; ~~or~~ providers certified under 42 C.F.R. part 485,
222 subpart B or subpart H; or any entity that provides neonatal or
223 pediatric hospital-based health care services by licensed
224 practitioners solely within a hospital licensed under chapter
225 395.
226 (e) An entity that is exempt from federal taxation under 26
227 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
228 under 26 U.S.C. s. 409 that has a board of trustees at least ~~not~~
229 ~~less than~~ two-thirds of which are Florida-licensed health care
230 practitioners and provides only physical therapy services under
231 physician orders, any community college or university clinic,
232 and any entity owned or operated by the federal or state

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233 government, including agencies, subdivisions, or municipalities
234 thereof.
235 (f) A sole proprietorship, group practice, partnership, or
236 corporation that provides health care services by physicians
237 covered by s. 627.419, that is directly supervised by one or
238 more of such physicians, and that is wholly owned by one or more
239 of those physicians or by a physician and the spouse, parent,
240 child, or sibling of that physician.
241 (g) A sole proprietorship, group practice, partnership, or
242 corporation that provides health care services by licensed
243 health care practitioners under chapter 457, chapter 458,
244 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
245 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
246 chapter 490, chapter 491, or part I, part III, part X, part
247 XIII, or part XIV of chapter 468, or s. 464.012, and that is
248 ~~which are~~ wholly owned by one or more licensed health care
249 practitioners, or the licensed health care practitioners set
250 forth in this paragraph and the spouse, parent, child, or
251 sibling of a licensed health care practitioner if~~, so long as~~
252 one of the owners who is a licensed health care practitioner is
253 supervising the business activities and is legally responsible
254 for the entity’s compliance with all federal and state laws.
255 However, a health care practitioner may not supervise services
256 beyond the scope of the practitioner’s license, except that, for
257 the purposes of this part, a clinic owned by a licensee in s.
258 456.053(3)(b) which ~~that~~ provides only services authorized
259 pursuant to s. 456.053(3)(b) may be supervised by a licensee
260 specified in s. 456.053(3)(b).
261 (h) Clinical facilities affiliated with an accredited

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262 medical school at which training is provided for medical
263 students, residents, or fellows.
264 (i) Entities that provide only oncology or radiation
265 therapy services by physicians licensed under chapter 458 or
266 chapter 459 or entities that provide oncology or radiation
267 therapy services by physicians licensed under chapter 458 or
268 chapter 459 which are owned by a corporation whose shares are
269 publicly traded on a recognized stock exchange.
270 (j) Clinical facilities affiliated with a college of
271 chiropractic accredited by the Council on Chiropractic Education
272 at which training is provided for chiropractic students.
273 (k) Entities that provide licensed practitioners to staff
274 emergency departments or to deliver anesthesia services in
275 facilities licensed under chapter 395 and that derive at least
276 90 percent of their gross annual revenues from the provision of
277 such services. Entities claiming an exemption from licensure
278 under this paragraph must provide documentation demonstrating
279 compliance.
280 (l) Orthotic or prosthetic clinical facilities that are a
281 publicly traded corporation or that are wholly owned, directly
282 or indirectly, by a publicly traded corporation. As used in this
283 paragraph, a publicly traded corporation is a corporation that
284 issues securities traded on an exchange registered with the
285 United States Securities and Exchange Commission as a national
286 securities exchange.
287
288 Notwithstanding this subsection, an entity shall be deemed a
289 clinic and must be licensed under this part in order to receive
290 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.

291 627.730-627.7405, unless exempted under s. 627.736(5)(h).
292 Section 3. Subsection (6) is added to section 400.991,
293 Florida Statutes, to read:
294 400.991 License requirements; background screenings;
295 prohibitions.—
296 (6) All agency forms for licensure application or exemption
297 from licensure under this part must contain the following
298 statement:
299
300 INSURANCE FRAUD NOTICE.—A person who knowingly submits
301 a false, misleading, or fraudulent application or
302 other document when applying for licensure as a health
303 care clinic, seeking an exemption from licensure as a
304 health care clinic, or demonstrating compliance with
305 part X of chapter 400, Florida Statutes, with the
306 intent to use the license, exemption from licensure,
307 or demonstration of compliance to provide services or
308 seek reimbursement under the Florida Motor Vehicle No-
309 Fault Law, commits a fraudulent insurance act, as
310 defined in s. 626.989, Florida Statutes. A person who
311 presents a claim for personal injury protection
312 benefits knowing that the payee knowingly submitted
313 such health care clinic application or document,
314 commits insurance fraud, as defined in s. 817.234,
315 Florida Statutes.
316 Section 4. Subsection (1) of section 626.989, Florida
317 Statutes, is amended to read:
318 626.989 Investigation by department or Division of
319 Insurance Fraud; compliance; immunity; confidential information;

320 reports to division; division investigator’s power of arrest.—
321 (1) For the purposes of this section: ~~,~~
322 (a) A person commits a “fraudulent insurance act” if the
323 person:
324 1. Knowingly and with intent to defraud presents, causes to
325 be presented, or prepares with knowledge or belief that it will
326 be presented, to or by an insurer, self-insurer, self-insurance
327 fund, servicing corporation, purported insurer, broker, or any
328 agent thereof, any written statement as part of, or in support
329 of, an application for the issuance of, or the rating of, any
330 insurance policy, or a claim for payment or other benefit
331 pursuant to any insurance policy, which the person knows to
332 contain materially false information concerning any fact
333 material thereto or if the person conceals, for the purpose of
334 misleading another, information concerning any fact material
335 thereto.
336 2. Knowingly submits:
337 a. A false, misleading, or fraudulent application or other
338 document when applying for licensure as a health care clinic,
339 seeking an exemption from licensure as a health care clinic, or
340 demonstrating compliance with part X of chapter 400 with an
341 intent to use the license, exemption from licensure, or
342 demonstration of compliance to provide services or seek
343 reimbursement under the Florida Motor Vehicle No-Fault Law.
344 b. A claim for payment or other benefit pursuant to a
345 personal injury protection insurance policy under the Florida
346 Motor Vehicle No-Fault Law if the person knows that the payee
347 knowingly submitted a false, misleading, or fraudulent
348 application or other document when applying for licensure as a

349 health care clinic, seeking an exemption from licensure as a
350 health care clinic, or demonstrating compliance with part X of
351 chapter 400. For the purposes of this section,
352 (b) The term "insurer" also includes a any health
353 maintenance organization, and the term "insurance policy" also
354 includes a health maintenance organization subscriber contract.
355 Section 5. Subsection (5) of section 626.9894, Florida
356 Statutes, is amended to read:
357 626.9894 Gifts and grants.—
358 (5) Notwithstanding the provisions of s. 216.301 and
359 pursuant to s. 216.351, any balance of moneys deposited into the
360 Insurance Regulatory Trust Fund pursuant to this section or s.
361 626.9895 remaining at the end of any fiscal year is shall be
362 available for carrying out the duties and responsibilities of
363 the division. The department may request annual appropriations
364 from the grants and donations received pursuant to this section
365 or s. 626.9895 and cash balances in the Insurance Regulatory
366 Trust Fund for the purpose of carrying out its duties and
367 responsibilities related to the division's anti-fraud efforts,
368 including the funding of dedicated prosecutors and related
369 personnel.
370 Section 6. Section 626.9895, Florida Statutes, is created
371 to read:
372 626.9895 Motor vehicle insurance fraud direct-support
373 organization.—
374 (1) DEFINITIONS.—As used in this section, the term:
375 (a) "Division" means the Division of Insurance Fraud of the
376 Department of Financial Services.
377 (b) "Motor vehicle insurance fraud" means any act defined

378 as a “fraudulent insurance act” under s. 626.989, which relates
379 to the coverage of motor vehicle insurance as described in part
380 XI of chapter 627.
381 (c) “Organization” means the direct-support organization
382 established under this section.
383 (2) ORGANIZATION ESTABLISHED.—The division may establish a
384 direct-support organization, to be known as the “Automobile
385 Insurance Fraud Strike Force,” whose sole purpose is to support
386 the prosecution, investigation, and prevention of motor vehicle
387 insurance fraud. The organization shall:
388 (a) Be a not-for-profit corporation incorporated under
389 chapter 617 and approved by the Department of State.
390 (b) Be organized and operated to conduct programs and
391 activities; raise funds; request and receive grants, gifts, and
392 bequests of money; acquire, receive, hold, invest, and
393 administer, in its own name, securities, funds, objects of
394 value, or other property, real or personal; and make grants and
395 expenditures to or for the direct or indirect benefit of the
396 division, state attorneys’ offices, the statewide prosecutor,
397 the Agency for Health Care Administration, and the Department of
398 Health to the extent that such grants and expenditures are used
399 exclusively to advance the prosecution, investigation, or
400 prevention of motor vehicle insurance fraud. Grants and
401 expenditures may include the cost of salaries or benefits of
402 motor vehicle insurance fraud investigators, prosecutors, or
403 support personnel if such grants and expenditures do not
404 interfere with prosecutorial independence or otherwise create
405 conflicts of interest which threaten the success of
406 prosecutions.

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407 (c) Be determined by the division to operate in a manner
408 that promotes the goals of laws relating to motor vehicle
409 insurance fraud, that is in the best interest of the state, and
410 that is in accordance with the adopted goals and mission of the
411 division.
412 (d) Use all of its grants and expenditures solely for the
413 purpose of preventing and decreasing motor vehicle insurance
414 fraud, and not for the purpose of lobbying as defined in s.
415 11.045.
416 (e) Be subject to an annual financial audit in accordance
417 with s. 215.981.
418 (3) CONTRACT.—The organization shall operate under written
419 contract with the division. The contract must provide for:
420 (a) Approval of the articles of incorporation and bylaws of
421 the organization by the division.
422 (b) Submission of an annual budget for approval of the
423 division. The budget must require the organization to minimize
424 costs to the division and its members at all times by using
425 existing personnel and property and allowing for telephonic
426 meetings if appropriate.
427 (c) Certification by the division that the organization is
428 complying with the terms of the contract and in a manner
429 consistent with the goals and purposes of the department and in
430 the best interest of the state. Such certification must be made
431 annually and reported in the official minutes of a meeting of
432 the organization.
433 (d) Allocation of funds to address motor vehicle insurance
434 fraud.
435 (e) Reversion of moneys and property held in trust by the

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436 organization for motor vehicle insurance fraud prosecution,
437 investigation, and prevention to the division if the
438 organization is no longer approved to operate for the department
439 or if the organization ceases to exist, or to the state if the
440 division ceases to exist.
441 (f) Specific criteria to be used by the organization's
442 board of directors to evaluate the effectiveness of funding used
443 to combat motor vehicle insurance fraud.
444 (g) The fiscal year of the organization, which begins July
445 1 of each year and ends June 30 of the following year.
446 (h) Disclosure of the material provisions of the contract,
447 and distinguishing between the department and the organization
448 to donors of gifts, contributions, or bequests, including
449 providing such disclosure on all promotional and fundraising
450 publications.
451 (4) BOARD OF DIRECTORS.—
452 (a) The board of directors of the organization shall
453 consist of the following eleven members:
454 1. The Chief Financial Officer, or designee, who shall
455 serve as chair.
456 2. Two state attorneys, one of whom shall be appointed by
457 the Chief Financial Officer and one of whom shall be appointed
458 by the Attorney General.
459 3. Two representatives of motor vehicle insurers appointed
460 by the Chief Financial Officer.
461 4. Two representatives of local law enforcement agencies,
462 one of whom shall be appointed by the Chief Financial Officer
463 and one of whom shall be appointed by the Attorney General.
464 5. Two representatives of the types of health care

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465 providers who regularly make claims for benefits under ss.
466 627.730-627.7405, one of whom shall be appointed by the
467 President of the Senate and one of whom shall be appointed by
468 the Speaker of the House of Representatives. The appointees may
469 not represent the same type of health care provider.
470 6. A private attorney that has experience in representing
471 claimants in actions for benefits under ss. 627.730-627.7405,
472 who shall be appointed by the President of the Senate.
473 7. A private attorney who has experience in representing
474 insurers in actions for benefits under ss. 627.730-627.7405, who
475 shall be appointed by the Speaker of the House of
476 Representatives.
477 (b) The officer who appointed a member of the board may
478 remove that member for cause. The term of office of an appointed
479 member expires at the same time as the term of the officer who
480 appointed him or her or at such earlier time as the person
481 ceases to be qualified.
482 (5) USE OF PROPERTY.—The department may authorize, without
483 charge, appropriate use of fixed property and facilities of the
484 division by the organization, subject to this subsection.
485 (a) The department may prescribe any condition with which
486 the organization must comply in order to use the division's
487 property or facilities.
488 (b) The department may not authorize the use of the
489 division's property or facilities if the organization does not
490 provide equal membership and employment opportunities to all
491 persons regardless of race, religion, sex, age, or national
492 origin.
493 (c) The department shall adopt rules prescribing the

494 procedures by which the organization is governed and any
495 conditions with which the organization must comply to use the
496 division’s property or facilities.
497 (6) CONTRIBUTIONS FROM INSURERS.—Contributions from an
498 insurer to the organization shall be allowed as an appropriate
499 business expense of the insurer for all regulatory purposes.
500 (7) DEPOSITORY ACCOUNT.—Any moneys received by the
501 organization may be held in a separate depository account in the
502 name of the organization and subject to the contract with the
503 division.
504 (8) DIVISION’S RECEIPT OF PROCEEDS.—Proceeds received by
505 the division from the organization shall be deposited into the
506 Insurance Regulatory Trust Fund.
507 Section 7. Subsections (1), (4), (5), (6), (8), (9), (10),
508 and (11) of section 627.736, Florida Statutes, are amended to
509 read:
510 627.736 Required personal injury protection benefits;
511 exclusions; priority; claims.—
512 (1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy complying
513 with the security requirements of s. 627.733 must ~~shall~~ provide
514 personal injury protection to the named insured, relatives
515 residing in the same household, persons operating the insured
516 motor vehicle, passengers in the ~~such~~ motor vehicle, and other
517 persons struck by the ~~such~~ motor vehicle and suffering bodily
518 injury while not an occupant of a self-propelled vehicle,
519 subject to ~~the provisions of~~ subsection (2) and paragraph
520 (4)(e), to a limit of $10,000 for loss sustained by ~~any~~ such
521 person as a result of bodily injury, sickness, disease, or death
522 arising out of the ownership, maintenance, or use of a motor

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523 vehicle as follows:
524 (a) *Medical benefits.*—Eighty percent of all reasonable
525 expenses for medically necessary medical, surgical, X-ray,
526 dental, and rehabilitative services, including prosthetic
527 devices~~,~~ and medically necessary ambulance, hospital, and
528 nursing services. <u>Medical benefits do not include massage as</u>
529 <u>defined in s. 480.033 or acupuncture as defined in s. 457.102.</u>
530 ~~However,~~ The medical benefits ~~shall~~ provide reimbursement only
531 for ~~such~~ services and care that are lawfully provided,
532 supervised, ordered, or prescribed by a physician licensed under
533 chapter 458 or chapter 459, a dentist licensed under chapter
534 466, or a chiropractic physician licensed under chapter 460 or
535 that are provided by any of the following ~~persons or entities~~:
536 1. A hospital or ambulatory surgical center licensed under
537 chapter 395.
538 2. A person or entity licensed under <u>part III of chapter</u>
539 <u>401 which</u> ~~ss. 401.2101-401.45 that~~ provides emergency
540 transportation and treatment.
541 3. An entity wholly owned by one or more physicians
542 licensed under chapter 458 or chapter 459, chiropractic
543 physicians licensed under chapter 460, or dentists licensed
544 under chapter 466 or by such ~~practitioner or~~ practitioners and
545 the spouse, parent, child, or sibling of <u>such</u> ~~that practitioner~~
546 ~~or those~~ practitioners.
547 4. An entity wholly owned, directly or indirectly, by a
548 hospital or hospitals.
549 5. A health care clinic licensed under <u>part X of chapter</u>
550 <u>400 which</u> ~~ss. 400.990-400.995 that~~ is:
551 a. <u>A health care clinic</u> accredited by the Joint Commission

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552 on Accreditation of Healthcare Organizations, the American
553 Osteopathic Association, the Commission on Accreditation of
554 Rehabilitation Facilities, or the Accreditation Association for
555 Ambulatory Health Care, Inc.; or
556 b. A health care clinic that:
557 (I) Has a medical director licensed under chapter 458,
558 chapter 459, or chapter 460;
559 (II) Has been continuously licensed for more than 3 years
560 or is a publicly traded corporation that issues securities
561 traded on an exchange registered with the United States
562 Securities and Exchange Commission as a national securities
563 exchange; and
564 (III) Provides at least four of the following medical
565 specialties:
566 (A) General medicine.
567 (B) Radiography.
568 (C) Orthopedic medicine.
569 (D) Physical medicine.
570 (E) Physical therapy.
571 (F) Physical rehabilitation.
572 (G) Prescribing or dispensing outpatient prescription
573 medication.
574 (H) Laboratory services.
575
576 The Financial Services Commission shall adopt by rule the form
577 that must be used by an insurer and a health care provider
578 specified in subparagraph 3., subparagraph 4., or subparagraph
579 5. to document that the health care provider meets the criteria
580 of this paragraph, which rule must include a requirement for a

581 sworn statement or affidavit.
582 (b) *Disability benefits.*—Sixty percent of any loss of gross
583 income and loss of earning capacity per individual from
584 inability to work proximately caused by the injury sustained by
585 the injured person, plus all expenses reasonably incurred in
586 obtaining from others ordinary and necessary services in lieu of
587 those that, but for the injury, the injured person would have
588 performed without income for the benefit of his or her
589 household. All disability benefits payable under this provision
590 must ~~shall~~ be paid at least ~~not less than~~ every 2 weeks.
591 (c) *Death benefits.*—Death benefits equal to the lesser of
592 $5,000 or the remainder of unused personal injury protection
593 benefits per individual. The insurer shall give priority to the
594 payment of death benefits over the payment of other benefits of
595 the deceased and, upon learning of the death of the individual,
596 stop paying the other benefits until the death benefits are
597 paid. The insurer may pay death ~~such~~ benefits to the executor or
598 administrator of the deceased, to any of the deceased's
599 relatives by blood, ~~or~~ legal adoption, or ~~connection by~~
600 marriage, or to any person appearing to the insurer to be
601 equitably entitled ~~thereto~~.
602
603 Only insurers writing motor vehicle liability insurance in this
604 state may provide the required benefits of this section, and ~~no~~
605 such insurer may not ~~shall~~ require the purchase of any other
606 motor vehicle coverage other than the purchase of property
607 damage liability coverage as required by s. 627.7275 as a
608 condition for providing such ~~required~~ benefits. Insurers may not
609 require that property damage liability insurance in an amount

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610 greater than $10,000 be purchased in conjunction with personal
611 injury protection. Such insurers shall make benefits and
612 required property damage liability insurance coverage available
613 through normal marketing channels. An ~~Any~~ insurer writing motor
614 vehicle liability insurance in this state who fails to comply
615 with such availability requirement as a general business
616 practice violates ~~shall be deemed to have violated~~ part IX of
617 chapter 626, and such violation constitutes ~~shall constitute~~ an
618 unfair method of competition or an unfair or deceptive act or
619 practice involving the business of insurance. An~~; and any such~~
620 insurer committing such violation is ~~shall be~~ subject to the
621 penalties provided under that ~~afforded in such~~ part, as well as
622 those provided ~~which may be afforded~~ elsewhere in the insurance
623 code.
624 (4) PAYMENT OF BENEFITS~~; WHEN DUE~~.—Benefits due from an
625 insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except
626 that benefits received under any workers' compensation law must
627 ~~shall~~ be credited against the benefits provided by subsection
628 (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon
629 receipt of reasonable proof of such loss and the amount of
630 expenses and loss incurred which are covered by the policy
631 issued under ss. 627.730-627.7405. If ~~When~~ the Agency for Health
632 Care Administration provides, pays, or becomes liable for
633 medical assistance under the Medicaid program related to injury,
634 sickness, disease, or death arising out of the ownership,
635 maintenance, or use of a motor vehicle, the benefits under ss.
636 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of~~ the
637 Medicaid program. However, within 30 days after receiving notice
638 that the Medicaid program paid such benefits, the insurer shall

639 repay the full amount of the benefits to the Medicaid program.
640 (a) An insurer may require written notice to be given as
641 soon as practicable after an accident involving a motor vehicle
642 with respect to which the policy affords the security required
643 by ss. 627.730-627.7405.
644 (b) Personal injury protection insurance benefits paid
645 pursuant to this section are ~~shall be~~ overdue if not paid within
646 30 days after the insurer is furnished written notice of the
647 fact of a covered loss and of the amount of same. However:
648 1. If ~~such~~ written notice of the entire claim is not
649 furnished to the insurer ~~as to the entire claim~~, any partial
650 amount supported by written notice is overdue if not paid within
651 30 days after ~~such~~ written notice is furnished to the insurer.
652 Any part or all of the remainder of the claim that is
653 subsequently supported by written notice is overdue if not paid
654 within 30 days after ~~such~~ written notice is furnished to the
655 insurer.
656 2. If ~~When~~ an insurer pays only a portion of a claim or
657 rejects a claim, the insurer shall provide at the time of the
658 partial payment or rejection an itemized specification of each
659 item that the insurer had reduced, omitted, or declined to pay
660 and any information that the insurer desires the claimant to
661 consider related to the medical necessity of the denied
662 treatment or to explain the reasonableness of the reduced charge
663 if~~, provided that~~ this does ~~shall~~ not limit the introduction of
664 evidence at trial.~~; and~~ The insurer must also ~~shall~~ include the
665 name and address of the person to whom the claimant should
666 respond and a claim number to be referenced in future
667 correspondence.

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668 3. If an insurer pays only a portion of a claim or rejects
669 a claim due to an alleged error in the claim, the insurer shall
670 provide at the time of the partial payment or rejection an
671 itemized specification or explanation of benefits of the
672 specified error. Upon receiving the specification or
673 explanation, the person making the claim has, at the person's
674 option and without waiving any other legal remedy for payment,
675 15 days to submit a revised claim, and the revised claim shall
676 be considered a timely submission of written notice of a claim.
677 The insurer has 15 days after receipt of the resubmitted or
678 revised claim to issue payment. If the claim is not paid,
679 payment is overdue unless the insurer has reasonable proof
680 establishing that it is not responsible for payment of the
681 claim.
682 4. ~~However,~~ Notwithstanding the fact that written notice
683 has been furnished to the insurer, ~~any~~ payment is ~~shall~~ not ~~be~~
684 ~~deemed~~ overdue if ~~when~~ the insurer has reasonable proof ~~to~~
685 ~~establish~~ that the insurer is not responsible for the payment.
686 5. For the purpose of calculating the extent to which ~~any~~
687 benefits are overdue, payment shall be treated as being made on
688 the date a draft or other valid instrument that ~~which~~ is
689 equivalent to payment was placed in the United States mail in a
690 properly addressed, postpaid envelope or, if not so posted, on
691 the date of delivery.
692 6. This paragraph does not preclude or limit the ability of
693 the insurer to assert that the claim was unrelated, was not
694 medically necessary, or was unreasonable or that the amount of
695 the charge was in excess of that permitted under, or in
696 violation of, subsection (5). Such assertion ~~by the insurer~~ may

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697 be made at any time, including after payment of the claim or
698 after the 30-day ~~time~~ period for payment set forth in this
699 paragraph.
700 (c) Upon receiving notice of an accident that is
701 potentially covered by personal injury protection benefits, the
702 insurer must reserve $5,000 of personal injury protection
703 benefits for payment to:
704 1. Physicians licensed under chapter 458 or chapter 459 or
705 dentists licensed under chapter 466 who provide emergency
706 services and care, as defined in s. 395.002~~(9)~~, or who provide
707 hospital inpatient care.
708 2. Hospitals licensed under chapter 395.
709
710 The amount required to be held in reserve may be used only to
711 pay claims from such physicians, ~~or~~ dentists, or hospitals until
712 30 days after the date the insurer receives notice of the
713 accident. After the 30-day period, any amount of the reserve for
714 which the insurer has not received notice of such claims ~~a claim~~
715 ~~from a physician or dentist who provided emergency services and~~
716 ~~care or who provided hospital inpatient care~~ may ~~then~~ be used by
717 the insurer to pay other claims. The time periods specified in
718 paragraph (b) for ~~required~~ payment of personal injury protection
719 benefits are ~~shall be~~ tolled for the period of time that an
720 insurer is required ~~by this paragraph~~ to hold payment of a claim
721 that is not from such ~~a~~ physician, ~~or~~ dentist, or hospital ~~who~~
722 ~~provided emergency services and care or who provided hospital~~
723 ~~inpatient care~~ to the extent that the personal injury protection
724 benefits not held in reserve are insufficient to pay the claim.
725 This paragraph does not require an insurer to establish a claim

726 reserve for insurance accounting purposes.
727 (d) All overdue payments ~~shall~~ bear simple interest at the
728 rate established under s. 55.03 or the rate established in the
729 insurance contract, whichever is greater, for the year in which
730 the payment became overdue, calculated from the date the insurer
731 was furnished with written notice of the amount of covered loss.
732 Interest is ~~shall be~~ due at the time payment of the overdue
733 claim is made.
734 (e) The insurer of the owner of a motor vehicle shall pay
735 personal injury protection benefits for:
736 1. Accidental bodily injury sustained in this state by the
737 owner while occupying a motor vehicle, or while not an occupant
738 of a self-propelled vehicle if the injury is caused by physical
739 contact with a motor vehicle.
740 2. Accidental bodily injury sustained outside this state,
741 but within the United States of America or its territories or
742 possessions or Canada, by the owner while occupying the owner's
743 motor vehicle.
744 3. Accidental bodily injury sustained by a relative of the
745 owner residing in the same household, under the circumstances
746 described in subparagraph 1. or subparagraph 2., if ~~provided~~ the
747 relative at the time of the accident is domiciled in the owner's
748 household and is not ~~himself or herself~~ the owner of a motor
749 vehicle with respect to which security is required under ss.
750 627.730-627.7405.
751 4. Accidental bodily injury sustained in this state by any
752 other person while occupying the owner's motor vehicle or, if a
753 resident of this state, while not an occupant of a self-
754 propelled vehicle~~,~~ if the injury is caused by physical contact

755 with such motor vehicle, if ~~provided~~ the injured person is not
756 ~~himself or herself~~:
757 a. The owner of a motor vehicle with respect to which
758 security is required under ss. 627.730-627.7405; or
759 b. Entitled to personal injury benefits from the insurer of
760 the owner ~~or owners~~ of such a motor vehicle.
761 (f) If two or more insurers are liable for paying ~~to pay~~
762 personal injury protection benefits for the same injury to any
763 one person, the maximum payable is ~~shall be~~ as specified in
764 subsection (1), and the ~~any~~ insurer paying the benefits is ~~shall~~
765 ~~be~~ entitled to recover from each of the other insurers an
766 equitable pro rata share of the benefits paid and expenses
767 incurred in processing the claim.
768 (g) It is a violation of the insurance code for an insurer
769 to fail to timely provide benefits as required by this section
770 with such frequency as to constitute a general business
771 practice.
772 (h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the
773 behalf of an insured person if that person has committed, by a
774 material act or omission, ~~any~~ insurance fraud relating to
775 personal injury protection coverage under his or her policy, if
776 the fraud is admitted to in a sworn statement by the insured or
777 ~~if it is~~ established in a court of competent jurisdiction. Any
778 insurance fraud voids ~~shall void~~ all coverage arising from the
779 claim related to such fraud under the personal injury protection
780 coverage of the insured person who committed the fraud,
781 irrespective of whether a portion of the insured person’s claim
782 may be legitimate, and any benefits paid before ~~prior to~~ the
783 discovery of the ~~insured person’s insurance~~ fraud is ~~shall be~~

784 recoverable by the insurer in its entirety from the person who
785 committed insurance fraud ~~in their entirety~~. The prevailing
786 party is entitled to its costs and attorney ~~attorney's~~ fees in
787 any action in which it prevails in an insurer's action to
788 enforce its right of recovery under this paragraph.
789 (i) An insurer shall create and maintain for each insured a
790 log of personal injury protection benefits paid by the insurer
791 on behalf of the insured. The insurer shall provide to the
792 insured, or an assignee of the insured, a copy of the log within
793 30 days after receiving a request for the log from the insured
794 or the assignee.
795 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
796 (a)~~1.~~ A ~~Any~~ physician, hospital, clinic, or other person or
797 institution lawfully rendering treatment to an injured person
798 for a bodily injury covered by personal injury protection
799 insurance may charge the insurer and injured party only a
800 reasonable amount pursuant to this section for the services and
801 supplies rendered, and the insurer providing such coverage may
802 pay for such charges directly to such person or institution
803 lawfully rendering such treatment~~,~~ if the insured receiving such
804 treatment or his or her guardian has countersigned the properly
805 completed invoice, bill, or claim form approved by the office
806 upon which such charges are to be paid for as having actually
807 been rendered, to the best knowledge of the insured or his or
808 her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not
809 exceed ~~be in excess of~~ the amount the person or institution
810 customarily charges for like services or supplies. In
811 determining ~~With respect to a determination of~~ whether a charge
812 for a particular service, treatment, or otherwise is reasonable,

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813 consideration may be given to evidence of usual and customary
814 charges and payments accepted by the provider involved in the
815 dispute, ~~and~~ reimbursement levels in the community and various
816 federal and state medical fee schedules applicable to motor
817 vehicle ~~automobile~~ and other insurance coverages, and other
818 information relevant to the reasonableness of the reimbursement
819 for the service, treatment, or supply.

820 1.~~2.~~ The insurer may limit reimbursement to 80 percent of
821 the following schedule of maximum charges:

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

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

827 c. For emergency services and care as defined by s.
828 395.002~~(9)~~ provided in a facility licensed under chapter 395
829 rendered by a physician or dentist, and related hospital
830 inpatient services rendered by a physician or dentist, the usual
831 and customary charges in the community.

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

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

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

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842 (I) The participating physicians fee schedule of Medicare
843 Part B, except as provided in sub-sub-subparagraphs (II) and
844 (III).
845 (II) Medicare Part B, in the case of services, supplies,
846 and care provided by ambulatory surgical centers and clinical
847 laboratories.
848 (III) The Durable Medical Equipment Prosthetics/Orthotics
849 and Supplies fee schedule of Medicare Part B, in the case of
850 durable medical equipment.
851
852 However, if such services, supplies, or care is not reimbursable
853 under Medicare Part B, as provided in this sub-subparagraph, the
854 insurer may limit reimbursement to 80 percent of the maximum
855 reimbursable allowance under workers' compensation, as
856 determined under s. 440.13 and rules adopted thereunder which
857 are in effect at the time such services, supplies, or care is
858 provided. Services, supplies, or care that is not reimbursable
859 under Medicare or workers' compensation is not required to be
860 reimbursed by the insurer.
861 2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee
862 schedule or payment limitation under Medicare is the fee
863 schedule or payment limitation in effect on January 1 of the
864 year in which ~~at the time~~ the services, supplies, or care is ~~was~~
865 rendered and for the area in which such services, supplies, or
866 care is ~~were~~ rendered, and the applicable fee schedule or
867 payment limitation applies throughout the remainder of that
868 year, notwithstanding any subsequent change made to the fee
869 schedule or payment limitation, except that it may not be less
870 than the allowable amount under the applicable ~~participating~~

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871 ~~physicians~~ schedule of Medicare Part B for 2007 for medical
872 services, supplies, and care subject to Medicare Part B.
873 3.~~4.~~ Subparagraph 1. ~~2.~~ does not allow the insurer to apply
874 any limitation on the number of treatments or other utilization
875 limits that apply under Medicare or workers' compensation. An
876 insurer that applies the allowable payment limitations of
877 subparagraph 1. ~~2.~~ must reimburse a provider who lawfully
878 provided care or treatment under the scope of his or her
879 license, regardless of whether such provider is ~~would be~~
880 entitled to reimbursement under Medicare due to restrictions or
881 limitations on the types or discipline of health care providers
882 who may be reimbursed for particular procedures or procedure
883 codes. However, subparagraph 1. does not prohibit an insurer
884 from using the Medicare coding policies and payment
885 methodologies of the federal Centers for Medicare and Medicaid
886 Services, including applicable modifiers, to determine the
887 appropriate amount of reimbursement for medical services,
888 supplies, or care if the coding policy or payment methodology
889 does not constitute a utilization limit.
890 4.~~5.~~ If an insurer limits payment as authorized by
891 subparagraph 1. ~~2.~~, the person providing such services,
892 supplies, or care may not bill or attempt to collect from the
893 insured any amount in excess of such limits, except for amounts
894 that are not covered by the insured's personal injury protection
895 coverage due to the coinsurance amount or maximum policy limits.
896 5. Effective July 1, 2012, an insurer may limit payment as
897 authorized by this paragraph only if the insurance policy
898 includes a notice at the time of issuance or renewal that the
899 insurer may limit payment pursuant to the schedule of charges

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900 specified in this paragraph. A policy form approved by the
901 office satisfies this requirement. If a provider submits a
902 charge for an amount less than the amount allowed under
903 subparagraph 1., the insurer may pay the amount of the charge
904 submitted.
905 (b)1. An insurer or insured is not required to pay a claim
906 or charges:
907 a. Made by a broker or by a person making a claim on behalf
908 of a broker;
909 b. For any service or treatment that was not lawful at the
910 time rendered;
911 c. To any person who knowingly submits a false or
912 misleading statement relating to the claim or charges;
913 d. With respect to a bill or statement that does not
914 substantially meet the applicable requirements of paragraph (d);
915 e. For any treatment or service that is upcoded, or that is
916 unbundled when such treatment or services should be bundled, in
917 accordance with paragraph (d). To facilitate prompt payment of
918 lawful services, an insurer may change codes that it determines
919 ~~to~~ have been improperly or incorrectly upcoded or unbundled~~,~~ and
920 may make payment based on the changed codes, without affecting
921 the right of the provider to dispute the change by the insurer,
922 if, ~~provided that~~ before doing so, the insurer contacts ~~must~~
923 ~~contact~~ the health care provider and discusses ~~discuss~~ the
924 reasons for the insurer’s change and the health care provider’s
925 reason for the coding, or makes ~~make~~ a reasonable good faith
926 effort to do so, as documented in the insurer’s file; and
927 f. For medical services or treatment billed by a physician
928 and not provided in a hospital unless such services are rendered

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929 by the physician or are incident to his or her professional
930 services and are included on the physician's bill, including
931 documentation verifying that the physician is responsible for
932 the medical services that were rendered and billed.
933 2. The Department of Health, in consultation with the
934 appropriate professional licensing boards, shall adopt, by rule,
935 a list of diagnostic tests deemed not to be medically necessary
936 for use in the treatment of persons sustaining bodily injury
937 covered by personal injury protection benefits under this
938 section. The ~~initial~~ list ~~shall be adopted by January 1, 2004,~~
939 ~~and~~ shall be revised from time to time as determined by the
940 Department of Health, in consultation with the respective
941 professional licensing boards. Inclusion of a test on the list
942 ~~of invalid diagnostic tests~~ shall be based on lack of
943 demonstrated medical value and a level of general acceptance by
944 the relevant provider community and may ~~shall~~ not be dependent
945 for results entirely upon subjective patient response.
946 Notwithstanding its inclusion on a fee schedule in this
947 subsection, an insurer or insured is not required to pay any
948 charges or reimburse claims for an ~~any~~ invalid diagnostic test
949 as determined by the Department of Health.
950 (c)~~1.~~ With respect to any treatment or service, other than
951 medical services billed by a hospital or other provider for
952 emergency services and care as defined in s. 395.002 or
953 inpatient services rendered at a hospital-owned facility, the
954 statement of charges must be furnished to the insurer by the
955 provider and may not include, and the insurer is not required to
956 pay, charges for treatment or services rendered more than 35
957 days before the postmark date or electronic transmission date of

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958 the statement, except for past due amounts previously billed on
959 a timely basis under this paragraph, and except that, if the
960 provider submits to the insurer a notice of initiation of
961 treatment within 21 days after its first examination or
962 treatment of the claimant, the statement may include charges for
963 treatment or services rendered up to, but not more than, 75 days
964 before the postmark date of the statement. The injured party is
965 not liable for, and the provider may ~~shall~~ not bill the injured
966 party for, charges that are unpaid because of the provider's
967 failure to comply with this paragraph. Any agreement requiring
968 the injured person or insured to pay for such charges is
969 unenforceable.
970 1.~~2.~~ If~~, however,~~ the insured fails to furnish the provider
971 with the correct name and address of the insured's personal
972 injury protection insurer, the provider has 35 days from the
973 date the provider obtains the correct information to furnish the
974 insurer with a statement of the charges. The insurer is not
975 required to pay for such charges unless the provider includes
976 with the statement documentary evidence that was provided by the
977 insured during the 35-day period demonstrating that the provider
978 reasonably relied on erroneous information from the insured and
979 either:
980 a. A denial letter from the incorrect insurer; or
981 b. Proof of mailing, which may include an affidavit under
982 penalty of perjury, reflecting timely mailing to the incorrect
983 address or insurer.
984 2.~~3.~~ For emergency services and care ~~as defined in s.~~
985 ~~395.002~~ rendered in a hospital emergency department or for
986 transport and treatment rendered by an ambulance provider

987 licensed pursuant to part III of chapter 401, the provider is
988 not required to furnish the statement of charges within the time
989 periods established by this paragraph,~~;~~ and the insurer is ~~shall~~
990 not ~~be~~ considered to have been furnished with notice of the
991 amount of covered loss for purposes of paragraph (4)(b) until it
992 receives a statement complying with paragraph (d), or copy
993 thereof, which specifically identifies the place of service to
994 be a hospital emergency department or an ambulance in accordance
995 with billing standards recognized by the federal Centers for
996 Medicare and Medicaid Services ~~Health Care Finance~~
997 ~~Administration~~.
998 3.~~4.~~ Each notice of the insured's rights under s. 627.7401
999 must include the following statement in at least 12-point type
1000 ~~in type no smaller than 12 points~~:
1001
1002 BILLING REQUIREMENTS.—Florida law provides ~~Statutes~~
1003 ~~provide~~ that with respect to any treatment or
1004 services, other than certain hospital and emergency
1005 services, the statement of charges furnished to the
1006 insurer by the provider may not include, and the
1007 insurer and the injured party are not required to pay,
1008 charges for treatment or services rendered more than
1009 35 days before the postmark date of the statement,
1010 except for past due amounts previously billed on a
1011 timely basis, and except that, if the provider submits
1012 to the insurer a notice of initiation of treatment
1013 within 21 days after its first examination or
1014 treatment of the claimant, the statement may include
1015 charges for treatment or services rendered up to, but

1016 not more than, 75 days before the postmark date of the
1017 statement.
1018
1019 (d) All statements and bills for medical services rendered
1020 by a ~~any~~ physician, hospital, clinic, or other person or
1021 institution shall be submitted to the insurer on a properly
1022 completed Centers for Medicare and Medicaid Services (CMS) 1500
1023 form, UB 92 forms, or any other standard form approved by the
1024 office or adopted by the commission for purposes of this
1025 paragraph. All billings for such services rendered by providers
1026 must ~~shall~~, to the extent applicable, follow the Physicians’
1027 Current Procedural Terminology (CPT) or Healthcare Correct
1028 Procedural Coding System (HCPCS), or ICD-9 in effect for the
1029 year in which services are rendered and comply with the ~~Centers~~
1030 ~~for Medicare and Medicaid Services (~~CMS~~)~~ 1500 form instructions,
1031 ~~and~~ the American Medical Association ~~Current Procedural~~
1032 ~~Terminology (~~CPT~~)~~ Editorial Panel, and the ~~Healthcare Correct~~
1033 ~~Procedural Coding System (~~HCPCS~~)~~. All providers, other than
1034 hospitals, must ~~shall~~ include on the applicable claim form the
1035 professional license number of the provider in the line or space
1036 provided for “Signature of Physician or Supplier, Including
1037 Degrees or Credentials.” In determining compliance with
1038 applicable CPT and HCPCS coding, guidance shall be provided by
1039 the Physicians’ Current Procedural Terminology (CPT) or the
1040 Healthcare Correct Procedural Coding System (HCPCS) in effect
1041 for the year in which services were rendered, the Office of the
1042 Inspector General ~~(OIG)~~, Physicians Compliance Guidelines, and
1043 other authoritative treatises designated by rule by the Agency
1044 for Health Care Administration. A ~~No~~ statement of medical

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1045 services may not include charges for medical services of a
1046 person or entity that performed such services without possessing
1047 the valid licenses required to perform such services. For
1048 purposes of paragraph (4)(b), an insurer is ~~shall~~ not ~~be~~
1049 considered to have been furnished with notice of the amount of
1050 covered loss or medical bills due unless the statements or bills
1051 comply with this paragraph~~,~~ and ~~unless the statements or bills~~
1052 are properly completed in their entirety as to all material
1053 provisions, with all relevant information being provided
1054 therein.

1055 (e)1. At the initial treatment or service provided, each
1056 physician, other licensed professional, clinic, or other medical
1057 institution providing medical services upon which a claim for
1058 personal injury protection benefits is based shall require an
1059 insured person, or his or her guardian, to execute a disclosure
1060 and acknowledgment form, which reflects at a minimum that:

1061 a. The insured, or his or her guardian, must countersign
1062 the form attesting to the fact that the services set forth
1063 therein were actually rendered;

1064 b. The insured, or his or her guardian, has both the right
1065 and affirmative duty to confirm that the services were actually
1066 rendered;

1067 c. The insured, or his or her guardian, was not solicited
1068 by any person to seek any services from the medical provider;

1069 d. The physician, other licensed professional, clinic, or
1070 other medical institution rendering services for which payment
1071 is being claimed explained the services to the insured or his or
1072 her guardian; and

1073 e. If the insured notifies the insurer in writing of a

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1074 billing error, the insured may be entitled to a certain
1075 percentage of a reduction in the amounts paid by the insured's
1076 motor vehicle insurer.

1077 2. The physician, other licensed professional, clinic, or
1078 other medical institution rendering services for which payment
1079 is being claimed has the affirmative duty to explain the
1080 services rendered to the insured, or his or her guardian, so
1081 that the insured, or his or her guardian, countersigns the form
1082 with informed consent.

1083 3. Countersignature by the insured, or his or her guardian,
1084 is not required for the reading of diagnostic tests or other
1085 services that are of such a nature that they are not required to
1086 be performed in the presence of the insured.

1087 4. The licensed medical professional rendering treatment
1088 for which payment is being claimed must sign, by his or her own
1089 hand, the form complying with this paragraph.

1090 5. The original completed disclosure and acknowledgment
1091 form shall be furnished to the insurer pursuant to paragraph
1092 (4)(b) and may not be electronically furnished.

1093 6. <u>The</u> ~~This~~ disclosure and acknowledgment form is not
1094 required for services billed by a provider ~~for emergency~~
1095 ~~services as defined in s. 395.002,~~ for emergency services and
1096 care as defined in s. 395.002 rendered in a hospital emergency
1097 department, or for transport and treatment rendered by an
1098 ambulance provider licensed pursuant to part III of chapter 401.

1099 7. The Financial Services Commission shall adopt, by rule,
1100 a standard disclosure and acknowledgment form <u>to</u> ~~that shall~~ be
1101 used to fulfill the requirements of this paragraph~~, effective 90~~
1102 ~~days after such form is adopted and becomes final~~. ~~The~~

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1103 ~~commission shall adopt a proposed rule by October 1, 2003. Until~~
1104 ~~the rule is final, the provider may use a form of its own which~~
1105 ~~otherwise complies with the requirements of this paragraph.~~
1106 8. As used in this paragraph, the term “countersign” or
1107 “countersignature” ~~“countersigned”~~ means a second or verifying
1108 signature, as on a previously signed document, and is not
1109 satisfied by the statement “signature on file” or any similar
1110 statement.
1111 9. The requirements of this paragraph apply only with
1112 respect to the initial treatment or service of the insured by a
1113 provider. For subsequent treatments or service, the provider
1114 must maintain a patient log signed by the patient, in
1115 chronological order by date of service, which ~~that~~ is consistent
1116 with the services being rendered to the patient as claimed. The
1117 requirement to maintain ~~requirements of this subparagraph for~~
1118 ~~maintaining~~ a patient log signed by the patient may be met by a
1119 hospital that maintains medical records as required by s.
1120 395.3025 and applicable rules and makes such records available
1121 to the insurer upon request.
1122 (f) Upon written notification by any person, an insurer
1123 shall investigate any claim of improper billing by a physician
1124 or other medical provider. The insurer shall determine if the
1125 insured was properly billed for only those services and
1126 treatments that the insured actually received. If the insurer
1127 determines that the insured has been improperly billed, the
1128 insurer shall notify the insured, the person making the written
1129 notification, and the provider of its findings and ~~shall~~ reduce
1130 the amount of payment to the provider by the amount determined
1131 to be improperly billed. If a reduction is made due to a ~~such~~

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1132 written notification by any person, the insurer shall pay to the
1133 person 20 percent of the amount of the reduction, up to $500. If
1134 the provider is arrested due to the improper billing, ~~then~~ the
1135 insurer shall pay to the person 40 percent of the amount of the
1136 reduction, up to $500.
1137 (g) An insurer may not systematically downcode with the
1138 intent to deny reimbursement otherwise due. Such action
1139 constitutes a material misrepresentation under s.
1140 626.9541(1)(i)2.
1141 (h) As provided in s. 400.9905, an entity excluded from the
1142 definition of a clinic shall be deemed a clinic and must be
1143 licensed under part X of chapter 400 in order to receive
1144 reimbursement under ss. 627.730-627.7405. However, this
1145 licensing requirement does not apply to:
1146 1. An entity wholly owned by a physician licensed under
1147 chapter 458 or chapter 459, or by the physician and the spouse,
1148 parent, child, or sibling of the physician;
1149 2. An entity wholly owned by a dentist licensed under
1150 chapter 466, or by the dentist and the spouse, parent, child, or
1151 sibling of the dentist;
1152 3. An entity wholly owned by a chiropractic physician
1153 licensed under chapter 460, or by the chiropractic physician and
1154 the spouse, parent, child, or sibling of the chiropractic
1155 physician;
1156 4. A hospital or ambulatory surgical center licensed under
1157 chapter 395; or
1158 5. An entity wholly owned, directly or indirectly, by a
1159 hospital or hospitals licensed under chapter 395.
1160 (6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.—

1161 (a) ~~Every employer shall,~~ If a request is made by an
1162 insurer providing personal injury protection benefits under ss.
1163 627.730-627.7405 against whom a claim has been made, an employer
1164 must furnish ~~forthwith~~, in a form approved by the office, a
1165 sworn statement of the earnings, since the time of the bodily
1166 injury and for a reasonable period before the injury, of the
1167 person upon whose injury the claim is based.
1168 (b) Every physician, hospital, clinic, or other medical
1169 institution providing, before or after bodily injury upon which
1170 a claim for personal injury protection insurance benefits is
1171 based, any products, services, or accommodations in relation to
1172 that or any other injury, or in relation to a condition claimed
1173 to be connected with that or any other injury, shall, if
1174 requested ~~to do so~~ by the insurer against whom the claim has
1175 been made, furnish ~~forthwith~~ a written report of the history,
1176 condition, treatment, dates, and costs of such treatment of the
1177 injured person and why the items identified by the insurer were
1178 reasonable in amount and medically necessary, together with a
1179 sworn statement that the treatment or services rendered were
1180 reasonable and necessary with respect to the bodily injury
1181 sustained and identifying which portion of the expenses for such
1182 treatment or services was incurred as a result of such bodily
1183 injury, and produce ~~forthwith~~, and allow ~~permit~~ the inspection
1184 and copying of, his or her or its records regarding such
1185 history, condition, treatment, dates, and costs of treatment if~~;~~
1186 ~~provided that~~ this does ~~shall~~ not limit the introduction of
1187 evidence at trial. Such sworn statement must ~~shall~~ read as
1188 follows: "Under penalty of perjury, I declare that I have read
1189 the foregoing, and the facts alleged are true, to the best of my

1190 knowledge and belief.” A ~~No~~ cause of action for violation of the
1191 physician-patient privilege or invasion of the right of privacy
1192 may not be brought ~~shall be permitted~~ against any physician,
1193 hospital, clinic, or other medical institution complying with
1194 ~~the provisions of~~ this section. The person requesting such
1195 records and such sworn statement shall pay all reasonable costs
1196 connected therewith. If an insurer makes a written request for
1197 documentation or information under this paragraph within 30 days
1198 after having received notice of the amount of a covered loss
1199 under paragraph (4)(a), the amount or the partial amount that
1200 ~~which~~ is the subject of the insurer’s inquiry is ~~shall become~~
1201 overdue if the insurer does not pay in accordance with paragraph
1202 (4)(b) or within 10 days after the insurer’s receipt of the
1203 requested documentation or information, whichever occurs later.
1204 As used in ~~For purposes of~~ this paragraph, the term “receipt”
1205 includes, but is not limited to, inspection and copying pursuant
1206 to this paragraph. An ~~Any~~ insurer that requests documentation or
1207 information pertaining to reasonableness of charges or medical
1208 necessity under this paragraph without a reasonable basis for
1209 such requests as a general business practice is engaging in an
1210 unfair trade practice under the insurance code.
1211 (c) In the event of a ~~any~~ dispute regarding an insurer’s
1212 right to discovery of facts under this section, the insurer may
1213 petition a court of competent jurisdiction to enter an order
1214 permitting such discovery. The order may be made only on motion
1215 for good cause shown and upon notice to all persons having an
1216 interest, and must ~~it shall~~ specify the time, place, manner,
1217 conditions, and scope of the discovery. ~~Such court may,~~ In order
1218 to protect against annoyance, embarrassment, or oppression, as

1219 justice requires, the court may enter an order refusing
1220 discovery or specifying conditions of discovery and may order
1221 payments of costs and expenses of the proceeding, including
1222 reasonable fees for the appearance of attorneys at the
1223 proceedings, as justice requires.
1224 (d) The injured person shall be furnished, upon request, a
1225 copy of all information obtained by the insurer under the
1226 provisions of this section, and shall pay a reasonable charge,
1227 if required by the insurer.
1228 (e) Notice to an insurer of the existence of a claim may
1229 shall not be unreasonably withheld by an insured.
1230 (f) In a dispute between the insured and the insurer, or
1231 between an assignee of the insured's rights and the insurer, the
1232 insurer must notify the insured or the assignee that the policy
1233 limits under this section have been reached within 15 days after
1234 the limits have been reached.
1235 (8) APPLICABILITY OF PROVISION REGULATING ATTORNEY
1236 ATTORNEY'S FEES.—With respect to any dispute under the
1237 provisions of ss. 627.730-627.7405 between the insured and the
1238 insurer, or between an assignee of an insured's rights and the
1239 insurer, the provisions of ss. s. 627.428 and 768.79 shall
1240 apply, except as provided in subsections (10) and (15).
1241 (9) PREFERRED PROVIDERS.—An insurer may negotiate and
1242 contract enter into contracts with preferred licensed health
1243 care providers for the benefits described in this section,
1244 referred to in this section as "preferred providers," which
1245 shall include health care providers licensed under chapter
1246 chapters 458, chapter 459, chapter 460, chapter 461, or chapter
1247 and 463. The insurer may provide an option to an insured to use

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1248 a preferred provider at the time of purchasing ~~purchase of~~ the
1249 policy for personal injury protection benefits, if the
1250 requirements of this subsection are met. If the insured elects
1251 to use a provider who is not a preferred provider, whether the
1252 insured purchased a preferred provider policy or a nonpreferred
1253 provider policy, the medical benefits provided by the insurer
1254 shall be as required by this section. If the insured elects to
1255 use a provider who is a preferred provider, the insurer may pay
1256 medical benefits in excess of the benefits required by this
1257 section and may waive or lower the amount of any deductible that
1258 applies to such medical benefits. If the insurer offers a
1259 preferred provider policy to a policyholder or applicant, it
1260 must also offer a nonpreferred provider policy. The insurer
1261 shall provide each insured ~~policyholder~~ with a current roster of
1262 preferred providers in the county in which the insured resides
1263 at the time of purchase of such policy, and shall make such list
1264 available for public inspection during regular business hours at
1265 the insurer's principal office ~~of the insurer~~ within the state.
1266 (10) DEMAND LETTER.—
1267 (a) As a condition precedent to filing any action for
1268 benefits under this section, ~~the insurer must be provided with~~
1269 written notice of an intent to initiate litigation must be
1270 provided to the insurer. Such notice may not be sent until the
1271 claim is overdue, including any additional time the insurer has
1272 to pay the claim pursuant to paragraph (4)(b). However, the
1273 requirements of this subsection do not apply to physicians
1274 licensed under chapter 458 or chapter 459, dentists licensed
1275 under chapter 466 who provide emergency services or care as
1276 defined in s. 395.002 or hospital inpatient care, hospitals, or

1277 an insured claiming lost wages.
1278 (b) The notice must ~~required shall~~ state that it is a
1279 "demand letter under s. 627.736~~(10)~~" and ~~shall~~ state with
1280 specificity:
1281 1. The name of the insured upon which such benefits are
1282 being sought, including a copy of the assignment giving rights
1283 to the claimant if the claimant is not the insured.
1284 2. The claim number or policy number upon which such claim
1285 was originally submitted to the insurer.
1286 3. To the extent applicable, the name of any medical
1287 provider who rendered to an insured the treatment, services,
1288 accommodations, or supplies that form the basis of such claim;
1289 and an itemized statement specifying each exact amount, the date
1290 of treatment, service, or accommodation, and the type of benefit
1291 claimed to be due. A completed form satisfying the requirements
1292 of paragraph (5)(d) or the lost-wage statement previously
1293 submitted may be used as the itemized statement. To the extent
1294 that the demand involves an insurer's withdrawal of payment
1295 under paragraph (7)(a) for future treatment not yet rendered,
1296 the claimant shall attach a copy of the insurer's notice
1297 withdrawing such payment and an itemized statement of the type,
1298 frequency, and duration of future treatment claimed to be
1299 reasonable and medically necessary.
1300 (c) A notice is not deficient merely because there are
1301 calculation errors or payments not taken into account in the
1302 demand letter. In determining compliance with this subsection,
1303 the courts shall adhere to the standard of substantial
1304 compliance and consider the purpose of the notice, which is to
1305 provide notice of the overdue claim and to allow the insurer

1306 time to pay the overdue bills before litigation is initiated. If
1307 a demand is found to be deficient for any reason and suit has
1308 commenced, the insured or the insured's assignee may abate the
1309 action to allow for compliance with this section. If the insurer
1310 is asserting that the notice is deficient, the insurer must
1311 respond to the notice by specifying each deficiency that the
1312 insurer is claiming pursuant to the notice. If the insurer fails
1313 to so specify, the insurer waives any deficiencies found in the
1314 notice.

1315 (d) ~~(c)~~ Each notice required by this subsection must be
1316 delivered to the insurer by United States certified or
1317 registered mail, return receipt requested. Such postal costs
1318 shall be reimbursed by the insurer if ~~so~~ requested by the
1319 claimant in the notice, when the insurer pays the claim. Such
1320 notice must be sent to the person and address specified by the
1321 insurer for the purposes of receiving notices under this
1322 subsection. Each licensed insurer, whether domestic, foreign, or
1323 alien, shall file with the office designation of the name and
1324 address of the person to whom notices must ~~pursuant to this~~
1325 ~~subsection shall~~ be sent which the office shall make available
1326 on its Internet website. The name and address on file with the
1327 office pursuant to s. 624.422 are ~~shall be~~ deemed the authorized
1328 representative to accept notice pursuant to this subsection if
1329 ~~in the event~~ no other designation has been made.

1330 (e) ~~(d)~~ If, within 30 days after receipt of notice by the
1331 insurer, the overdue claim specified in the notice is paid by
1332 the insurer together with applicable interest and a penalty of
1333 10 percent of the overdue amount paid by the insurer, subject to
1334 a maximum penalty of $250, no action may be brought against the

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1335 insurer. If the demand involves an insurer's withdrawal of
1336 payment under paragraph (7)(a) for future treatment not yet
1337 rendered, no action may be brought against the insurer if,
1338 within 30 days after its receipt of the notice, the insurer
1339 mails to the person filing the notice a written statement of the
1340 insurer's agreement to pay for such treatment in accordance with
1341 the notice and to pay a penalty of 10 percent, subject to a
1342 maximum penalty of $250, when it pays for such future treatment
1343 in accordance with the requirements of this section. To the
1344 extent the insurer determines not to pay any amount demanded,
1345 the penalty is ~~shall~~ not ~~be~~ payable in any subsequent action.
1346 For purposes of this subsection, payment or the insurer's
1347 agreement shall be treated as being made on the date a draft or
1348 other valid instrument that is equivalent to payment, or the
1349 insurer's written statement of agreement, is placed in the
1350 United States mail in a properly addressed, postpaid envelope,
1351 or if not so posted, on the date of delivery. The insurer is not
1352 obligated to pay any attorney ~~attorney's~~ fees if the insurer
1353 pays the claim or mails its agreement to pay for future
1354 treatment within the time prescribed by this subsection.

1355 (f)~~(e)~~ The applicable statute of limitation for an action
1356 under this section shall be tolled for ~~a period of~~ 30 business
1357 days by the mailing of the notice required by this subsection.

1358 ~~(f) Any insurer making a general business practice of not~~
1359 ~~paying valid claims until receipt of the notice required by this~~
1360 ~~subsection is engaging in an unfair trade practice under the~~
1361 ~~insurance code.~~

1362 (11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE
1363 PRACTICE.—

1364 (a) ~~If~~ An insurer ~~fails to pay valid claims for personal~~
1365 ~~injury protection with such frequency so as to indicate a~~
1366 ~~general business practice, the insurer~~ is engaging in a
1367 prohibited unfair or deceptive practice that is subject to the
1368 penalties provided in s. 626.9521 and the office has the powers
1369 and duties specified in ss. 626.9561-626.9601 if the insurer,
1370 with such frequency so as to indicate a general business
1371 practice: ~~with respect thereto~~
1372 1. Fails to pay valid claims for personal injury
1373 protection; or
1374 2. Fails to pay valid claims until receipt of the notice
1375 required by subsection (10).
1376 (b) Notwithstanding s. 501.212, the Department of Legal
1377 Affairs may investigate and initiate actions for a violation of
1378 this subsection, including, but not limited to, the powers and
1379 duties specified in part II of chapter 501.
1380 Section 8. Effective December 1, 2012, subsection (16) of
1381 section 627.736, Florida Statutes, is amended to read:
1382 627.736 Required personal injury protection benefits;
1383 exclusions; priority; claims.—
1384 (16) SECURE ELECTRONIC DATA TRANSFER.~~—If all parties~~
1385 ~~mutually and expressly agree,~~ A notice, documentation,
1386 transmission, or communication of any kind required or
1387 authorized under ss. 627.730-627.7405 may be transmitted
1388 electronically if it is transmitted by secure electronic data
1389 transfer that is consistent with state and federal privacy and
1390 security laws.
1391 Section 9. Subsections (1), (10), and (13) of section
1392 817.234, Florida Statutes, are amended to read:

1393 817.234 False and fraudulent insurance claims.—
1394 (1)(a) A person commits insurance fraud punishable as
1395 provided in subsection (11) if that person, with the intent to
1396 injure, defraud, or deceive any insurer:
1397 1. Presents or causes to be presented any written or oral
1398 statement as part of, or in support of, a claim for payment or
1399 other benefit pursuant to an insurance policy or a health
1400 maintenance organization subscriber or provider contract,
1401 knowing that such statement contains any false, incomplete, or
1402 misleading information concerning any fact or thing material to
1403 such claim;
1404 2. Prepares or makes any written or oral statement that is
1405 intended to be presented to any insurer in connection with, or
1406 in support of, any claim for payment or other benefit pursuant
1407 to an insurance policy or a health maintenance organization
1408 subscriber or provider contract, knowing that such statement
1409 contains any false, incomplete, or misleading information
1410 concerning any fact or thing material to such claim; ~~or~~
1411 3.a. Knowingly presents, causes to be presented, or
1412 prepares or makes with knowledge or belief that it will be
1413 presented to any insurer, purported insurer, servicing
1414 corporation, insurance broker, or insurance agent, or any
1415 employee or agent thereof, any false, incomplete, or misleading
1416 information or written or oral statement as part of, or in
1417 support of, an application for the issuance of, or the rating
1418 of, any insurance policy, or a health maintenance organization
1419 subscriber or provider contract; or
1420 b. ~~Who~~ Knowingly conceals information concerning any fact
1421 material to such application; or~~.~~

1422 4. Knowingly presents, causes to be presented, or prepares
1423 or makes with knowledge or belief that it will be presented to
1424 any insurer a claim for payment or other benefit under a
1425 personal injury protection insurance policy if the person knows
1426 that the payee knowingly submitted a false, misleading, or
1427 fraudulent application or other document when applying for
1428 licensure as a health care clinic, seeking an exemption from
1429 licensure as a health care clinic, or demonstrating compliance
1430 with part X of chapter 400.
1431 (b) All claims and application forms must ~~shall~~ contain a
1432 statement that is approved by the Office of Insurance Regulation
1433 of the Financial Services Commission which clearly states in
1434 substance the following: "Any person who knowingly and with
1435 intent to injure, defraud, or deceive any insurer files a
1436 statement of claim or an application containing any false,
1437 incomplete, or misleading information is guilty of a felony of
1438 the third degree." This paragraph does ~~shall~~ not apply to
1439 reinsurance contracts, reinsurance agreements, or reinsurance
1440 claims transactions.
1441 (10) A licensed health care practitioner who is found
1442 guilty of insurance fraud under this section for an act relating
1443 to a personal injury protection insurance policy loses his or
1444 her license to practice for 5 years and may not receive
1445 reimbursement for personal injury protection benefits for 10
1446 years. ~~As used in this section, the term "insurer" means any~~
1447 ~~insurer, health maintenance organization, self-insurer, self-~~
1448 ~~insurance fund, or other similar entity or person regulated~~
1449 ~~under chapter 440 or chapter 641 or by the Office of Insurance~~
1450 ~~Regulation under the Florida Insurance Code.~~

1451 (13) As used in this section, the term:
1452 (a) "Insurer" means any insurer, health maintenance
1453 organization, self-insurer, self-insurance fund, or similar
1454 entity or person regulated under chapter 440 or chapter 641 or
1455 by the Office of Insurance Regulation under the Florida
1456 Insurance Code.
1457 (b) ~~(a)~~ "Property" means property as defined in s. 812.012.
1458 (c) ~~(b)~~ "Value" means value as defined in s. 812.012.
1459 Section 10. Subsection (4) of section 316.065, Florida
1460 Statutes, is amended to read:
1461 316.065 Crashes; reports; penalties.—
1462 (4) Any person who knowingly repairs a motor vehicle
1463 without having made a report as required by subsection (3) is
1464 guilty of a misdemeanor of the first degree, punishable as
1465 provided in s. 775.082 or s. 775.083. The owner and driver of a
1466 vehicle involved in a crash who makes a report thereof in
1467 accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable
1468 under this section.
1469 Section 11. The Office of Insurance Regulation shall
1470 perform a comprehensive personal injury protection data call and
1471 publish the results by January 1, 2015. It is the intent of the
1472 Legislature that the office design the data call with the
1473 expectation that the Legislature will use the data to help
1474 evaluate market conditions relating to the Florida Motor Vehicle
1475 No-Fault Law and the impact on the market of reforms to the law
1476 made by this act. The elements of the data call must address,
1477 but need not be limited to, the following components of the
1478 Florida Motor Vehicle No-Fault Law:
1479 (1) Quantity of personal injury protection claims.

1480 (2) Type or nature of claimants.
1481 (3) Amount and type of personal injury protection benefits
1482 paid and expenses incurred.
1483 (4) Type and quantity of, and charges for, medical
1484 benefits.
1485 (5) Attorney fees related to bringing and defending actions
1486 for benefits.
1487 (6) Direct earned premiums for personal injury protection
1488 coverage, pure loss ratios, pure premiums, and other information
1489 related to premiums and losses.
1490 (7) Licensed drivers and accidents.
1491 (8) Fraud and enforcement.
1492 Section 12. If any provision of this act or its application
1493 to any person or circumstance is held invalid, the invalidity
1494 does not affect other provisions or applications of the act
1495 which can be given effect without the invalid provision or
1496 application, and to this end the provisions of this act are
1497 severable.
1498 Section 13. Except as otherwise expressly provided in this
1499 act, this act shall take effect July 1, 2012.