

597-1265D-06

1 A bill to be entitled  
2 An act relating to motor vehicle insurance;  
3 reorganizing provisions pertaining to personal  
4 injury protection benefits under the Florida  
5 Motor Vehicle No-Fault Law for the purpose of  
6 clarifying its meaning and intent and for the  
7 purpose of better comprehension; amending s.  
8 627.732, F.S.; defining the terms "services,"  
9 "contracted services," and "rendered"; amending  
10 s. 627.736, F.S.; providing that a  
11 self-employed injured person or an injured  
12 person owning 25 percent or more interest in an  
13 employer offer proof of income and lost wages  
14 to insurers as a condition precedent for  
15 payment; requiring an insured to notify an  
16 insurer in writing of election to reserve  
17 benefits for lost wages; specifying that such  
18 notification takes priority over other claims,  
19 except specified hospital liens; clarifying  
20 that personal injury protection benefits are  
21 primary, except for workers' compensation  
22 benefits; authorizing a parent or legal  
23 guardian of an injured minor to complete  
24 application for personal injury protection  
25 benefits; providing requirements for compliance  
26 with billing procedures; providing that charges  
27 for medical services and supplies shall not  
28 exceed the allowance under the Medicare fee  
29 schedule; providing that specified charges are  
30 noncompensable; specifying the time period  
31 within which a health care provider or other

1 specified provider must submit a statement of  
2 charges; prohibiting providers from billing an  
3 injured person under specified conditions for  
4 emergency services and care; requiring a  
5 provider to submit a written bill at the time  
6 of treatment which the injured patient must  
7 sign; requiring insurers to provide specified  
8 documents to insureds; providing for a valid,  
9 binding assignment of benefits and for priority  
10 of payment under multiple assignments of  
11 benefits; requiring that amounts repayable to  
12 an insurer include the statutory interest  
13 penalty; deleting provisions relating to  
14 charges for personal injury protection  
15 benefits; increasing the time period for an  
16 insurer to respond to a demand letter;  
17 providing requirements for the production and  
18 inspection of an injured person's medical  
19 records from a provider; specifying persons  
20 subject to an examination under oath and  
21 providing for compensation; providing that, if  
22 requested, an examination under oath is a  
23 condition precedent to filing a suit; requiring  
24 an insured to provide notice of a claim within  
25 1 year after incident; providing that an  
26 insurer may contract for a notice to be less  
27 than 1 year; providing requirements relating to  
28 a mental or physical examination; eliminating  
29 the application of a contingency risk  
30 multiplier as to attorney-fee awards in  
31 specified disputes; creating provisions

1 allowing an insurer to bring a civil action to  
2 recover amounts paid and expenses incurred  
3 against persons presenting claims that a court  
4 determines meet specified criteria; deleting  
5 specified civil actions; removing the monetary  
6 limit on the amount that may be provided to  
7 persons notifying insurers of improper billing;  
8 restricting venue for any personal injury  
9 protection claim to specified jurisdictions and  
10 providing for costs of transferring venue;  
11 providing that this section not be deemed to  
12 preempt or supersede any causes of action that  
13 are otherwise available; abrogating the repeal  
14 of provisions pertaining to the Florida Motor  
15 Vehicle No-Fault Law; providing an effective  
16 date.

17

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

19

20 Section 1. Subsections (16), (17) and (18) are added  
21 to section 627.732, Florida Statutes, to read:

22 627.732 Definitions.--As used in ss. 627.730-627.7405,  
23 the term:

24 (16) "Services" includes treatment, procedures,  
25 supplies, and equipment.

26 (17) "Contracted services" means goods or services  
27 provided or performed by anyone other than a statutory  
28 employee of the supplier or provider.

29 (18) "Rendered" means actually performed a treatment  
30 or a service.

31

1 Section 2. Section 627.736, Florida Statutes, is  
2 amended to read:

3 627.736 Required personal injury protection benefits;  
4 exclusions; priority; claims.--

5 (1) REQUIRED PERSONAL INJURY PROTECTION  
6 BENEFITS.--Every insurance policy complying with the security  
7 requirements of s. 627.733 shall provide personal injury  
8 protection to the named insured, relatives residing in the  
9 same household, persons operating the insured motor vehicle,  
10 passengers in such motor vehicle, and other persons struck by  
11 such motor vehicle and suffering bodily injury while not an  
12 occupant of a self-propelled vehicle, subject to the  
13 provisions of subsections (3) ~~subsection (2)~~ and ~~(6) paragraph~~  
14 ~~(4)(d)~~, to a limit of \$10,000 for loss sustained by any such  
15 person as a result of bodily injury, sickness, disease, or  
16 death arising out of the ownership, maintenance, or use of a  
17 motor vehicle as follows:

18 (a) Medical benefits.--Eighty percent of all  
19 reasonable expenses for medically necessary medical, surgical,  
20 X-ray, dental, and rehabilitative services, including  
21 prosthetic devices, and medically necessary ambulance,  
22 hospital, and nursing services. Such benefits shall also  
23 include necessary remedial treatment and services recognized  
24 and permitted under the laws of the state for an injured  
25 person who relies upon spiritual means through prayer alone  
26 for healing, in accordance with his or her religious beliefs;  
27 however, this sentence does not affect the determination of  
28 what other services or procedures are medically necessary.

29 (b) Disability benefits.--  
30 1. Sixty percent of any loss of gross income and loss  
31 of earning capacity per injured person ~~individual~~ from

1 inability to work proximately caused by the injury sustained  
2 by the injured person, plus all expenses reasonably incurred  
3 in obtaining from others ordinary and necessary services in  
4 lieu of those that, but for the injury, the injured person  
5 would have performed without income for the benefit of his or  
6 her household. All disability benefits payable under this  
7 provision shall be paid not less than every 2 weeks.

8 2. For an injured person who is self employed or an  
9 injured person who owns over a 25-percent interest in his or  
10 her employer, as a condition precedent to payment for lost  
11 wages, the injured person must produce to the insurer  
12 reasonable proof as to the injured person's net income and  
13 loss of earning capacity or additional expense, such that the  
14 insurer may reasonably calculate the amount of the loss of  
15 income.

16 3. Every employer shall, if a request is made by an  
17 insurer providing personal injury protection benefits under  
18 ss. 627.730-627.7405 against whom a claim has been made,  
19 furnish forthwith, in a form approved by the office, a sworn  
20 statement of the earnings, since the time of the bodily injury  
21 and for a reasonable period before the injury, of the person  
22 upon whose injury the claim is based.

23 4. If the insured elects to have disability benefits  
24 reserved for lost wages, the insured shall notify the insurer  
25 in writing. Receipt of such notification shall take priority  
26 over all claims subject to an assignment of benefits received  
27 after receipt of such notice, except that a properly perfected  
28 hospital lien shall take priority over the insured's election  
29 to reserve all benefits for lost wages.

30 (c) Death benefits.--The insurer shall pay death  
31 benefits in the amount of \$5,000 per individual. The insurer

1 may pay such benefits to the executor or administrator of the  
2 deceased, to any of the deceased's relatives by blood or legal  
3 adoption or connection by marriage, or to any person appearing  
4 to the insurer to be equitably entitled thereto.

5 (d) Medicaid benefits.--When the Agency for Health  
6 Care Administration provides, pays, or becomes liable for  
7 medical assistance under the Medicaid program related to  
8 injury, sickness, disease, or death arising out of the  
9 ownership, maintenance, or use of a motor vehicle, benefits  
10 under ss. 627.730-627.7405 shall be subject to the provisions  
11 of the Medicaid program.

12 (2) AMOUNT OF PROPERTY DAMAGE COVERAGE.--

13 (a) Only insurers writing motor vehicle liability  
14 insurance in this state may provide the required benefits of  
15 this section, and no such insurer shall require the purchase  
16 of any other motor vehicle coverage other than the purchase of  
17 property damage liability coverage as required by s. 627.7275  
18 as a condition for providing such required benefits.

19 (b) Insurers may not require that property damage  
20 liability insurance in an amount greater than \$10,000 be  
21 purchased in conjunction with personal injury protection.  
22 Such insurers shall make benefits and required property damage  
23 liability insurance coverage available through normal  
24 marketing channels. Any insurer writing motor vehicle  
25 liability insurance in this state who fails to comply with  
26 such availability requirement as a general business practice  
27 shall be deemed to have violated part IX of chapter 626, and  
28 such violation shall constitute an unfair method of  
29 competition or an unfair or deceptive act or practice  
30 involving the business of insurance; and any such insurer  
31 committing such violation shall be subject to the penalties

1 | afforded in such part, as well as those which may be afforded  
2 | elsewhere in the insurance code.

3 | ~~(3)(2)~~ AUTHORIZED EXCLUSIONS.--Any insurer may exclude  
4 | benefits:

5 | (a) For injury sustained by the named insured and  
6 | relatives residing in the same household while occupying  
7 | another motor vehicle owned by the named insured and not  
8 | insured under the policy or for injury sustained by any person  
9 | operating the insured motor vehicle without the express or  
10 | implied consent of the insured.

11 | (b) To any injured person, if such person's conduct  
12 | contributed to his or her injury under any of the following  
13 | circumstances:

- 14 | 1. Causing injury to himself or herself intentionally;  
15 | or  
16 | 2. Being injured while committing a felony.

17 |  
18 | Whenever an insured is charged with conduct as set forth in  
19 | subparagraph 2., the 30-day payment provision of paragraph  
20 | ~~(9)(a)(4)(b)~~ shall be held in abeyance, and the insurer shall  
21 | withhold payment of any personal injury protection benefits  
22 | pending the outcome of the case at the trial level. If the  
23 | charge is nolle prossed or dismissed or the insured is  
24 | acquitted, the 30-day payment provision shall run from the  
25 | date the insurer is notified of such action.

26 | ~~(4)(3)~~ INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES  
27 | IN TORT CLAIMS.--No insurer shall have a lien on any recovery  
28 | in tort by judgment, settlement, or otherwise for personal  
29 | injury protection benefits, whether suit has been filed or  
30 | settlement has been reached without suit. An injured person  
31 | ~~party~~ who is entitled to bring suit under ~~the provisions of~~

1 ss. 627.730-627.7405, or his or her legal representative, has  
2 ~~shall have~~ no right to recover any damages for which personal  
3 injury protection benefits are paid, ~~or payable,~~ or otherwise  
4 available. The plaintiff may prove all of his or her special  
5 damages notwithstanding this limitation, but if special  
6 damages are introduced in evidence, the trier of facts,  
7 whether judge or jury, shall not award damages for personal  
8 injury protection benefits paid, ~~or payable,~~ or otherwise  
9 available. In all cases in which a jury is required to fix  
10 damages, the court shall instruct the jury that the plaintiff  
11 shall not recover such special damages for personal injury  
12 protection benefits paid, ~~or payable,~~ or otherwise available.

13 (5) NONREIMBURSABLE SERVICES.--The Department of  
14 Health, in consultation with the appropriate professional  
15 licensing boards, shall adopt, by rule, a list of diagnostic  
16 tests deemed not to be medically necessary for use in the  
17 treatment of persons sustaining bodily injury covered by  
18 personal injury protection benefits under this section. The  
19 list shall be revised from time to time as determined by the  
20 Department of Health, in consultation with the respective  
21 professional licensing boards. Inclusion of a test on the list  
22 of invalid diagnostic tests shall be based on lack of  
23 demonstrated medical value and a level of general acceptance  
24 by the relevant provider community and shall not be dependent  
25 for results entirely upon subjective patient response.  
26 Notwithstanding its inclusion on a fee schedule in this  
27 section, an insurer or insured is not required to pay any  
28 charges or reimburse claims for any invalid diagnostic test as  
29 determined by the Department of Health.

30  
31



1           (6) REQUIRED PAYMENT OF BENEFITS.--The insurer of the  
2 owner of a motor vehicle shall pay personal injury protection  
3 benefits for:

4           (a) Accidental bodily injury sustained in this state  
5 by the owner while occupying a motor vehicle, or while not an  
6 occupant of a self-propelled vehicle if the injury is caused  
7 by physical contact with a motor vehicle.

8           (b) Accidental bodily injury sustained outside this  
9 state, but within the United States of America or its  
10 territories or possessions or Canada, by the owner while  
11 occupying the owner's motor vehicle.

12           (c) Accidental bodily injury sustained by a relative  
13 of the owner residing in the same household, under the  
14 circumstances described in paragraphs (a) and (b), provided  
15 the relative at the time of the accident is domiciled in the  
16 owner's household and is not himself or herself the owner of a  
17 motor vehicle with respect to which security is required under  
18 ss. 627.730-627.7405.

19           (d) Accidental bodily injury sustained in this state  
20 by any other person while occupying the owner's motor vehicle  
21 or, if a resident of this state, while not an occupant of a  
22 self-propelled vehicle, if the injury is caused by physical  
23 contact with such motor vehicle, provided the injured person  
24 is not himself or herself:

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

27           2. Entitled to personal injury benefits from the  
28 insurer of the owner or owners of such a motor vehicle.

29           (e) If two or more insurers are liable to pay personal  
30 injury protection benefits for the same injury to any one  
31 person, the maximum payable shall be as specified in

1 subsection (1), and any insurer paying the benefits shall be  
2 entitled to recover from each of the other insurers an  
3 equitable pro rata share of the benefits paid and expenses  
4 incurred in processing the claim.

5 (7) CLAIMS SUBMISSION~~(4) BENEFITS; WHEN~~

6 ~~DUE.--Benefits due from an insurer under ss. 627.730-627.7405~~  
7 ~~shall be primary, except for that benefits received under any~~  
8 ~~workers' compensation benefits that are primary over personal~~  
9 ~~injury protection benefits, law shall be credited against the~~  
10 ~~benefits provided by subsection (1), and shall be due and~~  
11 ~~payable as loss accrues, upon receipt of reasonable proof of~~  
12 ~~such loss and the amount of expenses and loss incurred which~~  
13 ~~are covered by the policy issued under ss. 627.730-627.7405,~~  
14 ~~subject to the following:-- When the Agency for Health Care~~  
15 ~~Administration provides, pays, or becomes liable for medical~~  
16 ~~assistance under the Medicaid program related to injury,~~  
17 ~~sickness, disease, or death arising out of the ownership,~~  
18 ~~maintenance, or use of a motor vehicle, benefits under ss.~~  
19 ~~627.730-627.7405 shall be subject to the provisions of the~~  
20 ~~Medicaid program.~~

21 (a) Personal injury protection application.--An  
22 insurer may require written notice to be given as soon as  
23 practicable after an accident involving a motor vehicle with  
24 respect to which the policy affords the security required by  
25 ss. 627.730-627.7405. If the injured person is a minor, the  
26 parent or legal guardian of the minor, if requested by the  
27 insurer, must accurately complete the personal injury  
28 protection application.

29 (b) Billing requirements.--

30 1. All statements and bills for medical services  
31 rendered by any physician, hospital, clinic, or other person

1 or institution shall be submitted to the insurer on a properly  
2 completed Centers for Medicare and Medicaid Services (CMS)  
3 1500 form or a UB 92 form.

4 2. All billings for such services, procedures, and  
5 supplies submitted by health care providers and medical  
6 suppliers shall comply with the Healthcare Correct Procedural  
7 Coding System (HCPCS) and International Classification of  
8 Diseases (ICD-9-CM) in effect for the year in which services  
9 are rendered.

10 3. All claims forms submitted by health care providers  
11 and medical suppliers other than hospitals shall include on  
12 the applicable claim form the signature and professional  
13 license number of the provider in the line or space provided  
14 for "Signature of Physician or Supplier, Including Degrees or  
15 Credentials" and the date of the signature.

16 4. In determining compliance with applicable HCPCS and  
17 ICD-9-CM coding, guidance shall be provided by the Healthcare  
18 Correct Procedural Coding System (HCPCS), International  
19 Classification of Diseases (ICD-9-CM), National Correct Coding  
20 Initiative, the Office of the Inspector General (OIG),  
21 Physicians Compliance Guidelines, rules of the Agency for  
22 Health Care Administration, the Florida Health Information  
23 Management Association (FHIMA), and other authoritative  
24 treatises.

25 5. A statement of medical services may not include  
26 charges for medical services of a person or entity that  
27 performed such services without possessing all valid  
28 qualifications and licenses required to lawfully provide and  
29 bill for such services.

30 6. For purposes of subsection (9), an insurer shall  
31 not be considered to have been furnished with notice of the

1 amount of covered loss or medical bills due unless the  
2 statements or bills comply with this paragraph, and unless the  
3 statements or bills are properly completed in their entirety  
4 as to all material provisions, with all required information  
5 being provided therein.

6 7. An insurer may not systematically downcode with the  
7 intent to deny reimbursement otherwise due. Such action  
8 constitutes a material misrepresentation under s.  
9 626.9541(1)(i)2.

10 (c) Direct billing an insurer for personal injury  
11 protection benefits.--

12 1. Any physician, hospital, clinic, or other person or  
13 institution lawfully rendering treatment to an injured person  
14 for a bodily injury covered by personal injury protection  
15 insurance may charge the insurer and injured person only a  
16 reasonable amount pursuant to this section for the services  
17 and supplies rendered.

18 2. The insurer providing such coverage may pay for  
19 such charges directly to such person or institution lawfully  
20 rendering such treatment.

21 3. The insured receiving such treatment or his or her  
22 guardian, if a minor, shall countersign the properly completed  
23 CMS 1500 or UB 92 form submitted for payment.

24 4. In no event, however, may such a charge be in  
25 excess of \_\_\_\_\_ percent of the maximum allowance for each  
26 procedure as set forth in the Medicare Parts A and B  
27 participating fee schedule in effect at the time services are  
28 performed for the region in which services are performed.  
29 Treatment and charges not compensable under the Medicare fee  
30 schedules are not compensable by the insurer.

31

1           (d) Nonemergency services.--With respect to any  
2 treatment or service, other than medical services billed by a  
3 hospital or other provider for emergency services as defined  
4 in s. 395.002 or inpatient services rendered at a  
5 hospital-owned facility, the statement of charges must be  
6 furnished to the insurer by the provider and may not include,  
7 and the insurer is not required to pay, charges for treatment  
8 or services rendered more than 35 days before the postmark  
9 date of the statement, except for the following:

10           1. Past due amounts previously billed on a timely  
11 basis under this subsection.

12           2. If the provider submits to the insurer a notice of  
13 initiation of treatment within 21 days after its first  
14 examination or treatment of the claimant, the statement may  
15 include charges for treatment or services rendered up to, but  
16 not more than, 50 days before the postmark date of the  
17 statement. The injured person is not liable for, and the  
18 provider shall not bill the injured person for, charges that  
19 are unpaid because of the provider's failure to comply with  
20 this paragraph. Any agreement requiring the injured person or  
21 insured to pay for such charges is unenforceable.

22           3. If the insured fails to furnish the provider with  
23 the correct name and address of the insured's personal injury  
24 protection insurer, the provider has 35 days from the date the  
25 provider obtains the correct information to furnish the  
26 insurer with a statement of the charges. The insurer is not  
27 required to pay for such charges unless the provider includes  
28 with the statement documentary evidence that was provided by  
29 the insured during the 35-day period demonstrating that the  
30 provider reasonably relied on erroneous information from the  
31 insured and either:

1           a. A denial letter from the incorrect insurer; or  
2           b. Proof of mailing, which may include an affidavit  
3 under penalty of perjury, reflecting timely mailing to the  
4 incorrect address or insurer.

5           (e) Emergency services.--

6           1. For emergency services and care as defined in s.  
7 395.002 rendered in a hospital emergency department or for  
8 transport and treatment rendered by an ambulance provider  
9 licensed pursuant to part III of chapter 401, the provider is  
10 not required to furnish the statement of charges within the  
11 time periods established by this subsection; however, such  
12 charges must be submitted within 75 days after the date the  
13 treatment was rendered, and the insurer shall not be  
14 considered to have been furnished with notice of the amount of  
15 covered loss for purposes of subsection (9) until it receives  
16 a statement complying with subsection (7), or copy thereof,  
17 which specifically identifies the place of service to be a  
18 hospital emergency department or an ambulance.

19           2. The injured person is not liable for, and the  
20 provider shall not bill the injured person for, charges that  
21 are unpaid because of the provider's failure to comply with  
22 this paragraph. Any agreement requiring the injured person or  
23 insured to pay for such charges is unenforceable.

24           (f) Billing notice and disclosures.--

25           1. Each notice of insured's rights under s. 627.7401  
26 must include the following statement in type no smaller than  
27 12-point font:

28  
29           BILLING REQUIREMENTS.--Florida Statutes provide  
30 that with respect to any treatment or services,  
31 other than certain hospital and emergency

1 services, the statement of charges furnished to  
2 the insurer by the provider may not include,  
3 and the insurer and the injured person are not  
4 required to pay, charges for treatment or  
5 services rendered more than 35 days before the  
6 postmark date of the statement, except for past  
7 due amounts previously billed on a timely  
8 basis, and except that, if the provider submits  
9 to the insurer a notice of initiation of  
10 treatment within 21 days after its first  
11 examination or treatment of the claimant, the  
12 statement may include charges for treatment or  
13 services rendered up to, but not more than, 50  
14 days before the postmark date of the statement.

15  
16 2. At the time of service and immediately following  
17 the service, the health care provider shall provide to the  
18 insured patient a written bill, superbill, fee slip, or other  
19 similar document that establishes in plain language a detailed  
20 description of the service provided and the cost associated  
21 with the service. The insured must sign the written bill,  
22 superbill, fee slip, or other similar document immediately  
23 after having received services. Copies of such disclosures  
24 shall be maintained as part of the patient's medical records  
25 in accordance with minimal record keeping standards.

26 (g) Upon request, the insured and his or her assigns  
27 shall be sent a copy itemizing all payments made, the  
28 applicable insurance declarations page, and a copy of the  
29 insurance policy within 30 days after the written request.  
30 Such request shall state that it is a "request under s.  
31 627.736(7)" and shall state with specificity:

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

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

6  
7 Such request must be sent to the person and address specified  
8 by the insurer for the purposes of receiving notices or  
9 requests under this section.

10           (8) ASSIGNMENT OF BENEFITS.--

11           (a) Personal injury protection benefits are  
12 nonassignable, except that the insured may assign the  
13 after-loss personal injury protection benefits to any health  
14 care provider sufficient to cover any cost or expense  
15 associated with the provision of health care. Any such  
16 assignment of benefits covers the provider's present and  
17 future medical expenses.

18           (b) An insured may execute an assignment of benefits  
19 to different health care providers. All such assignments of  
20 benefits are irrevocable. The insurer shall pay the claims  
21 when the insurer obtains sufficient information to determine  
22 that the claims are properly payable. The insurer is not  
23 required to reserve personal injury protection benefits for  
24 any provider during the investigation of its bills and shall  
25 timely pay all bills in its possession which are properly  
26 payable.

27           (c) An assignment of personal injury protection  
28 benefits to the provider shall be deemed a novation. The  
29 insured is relieved of all obligations for the medical bills  
30 once an assignment of benefits is executed. Any agreement  
31 requiring the injured person or insured to pay for charges is



1 unenforceable. Notwithstanding such assignment of benefits,  
2 the insured shall be responsible for all required copayments,  
3 any deductible, and the provider's bills once benefits have  
4 been exhausted.

5 (d) A provider's attorney's fees shall not be  
6 recoverable pursuant to s. 627.428 if the provider did not  
7 accept a valid assignment of benefits. A valid assignment of  
8 benefits must contain the words: "I irrevocably assign my  
9 benefits to..." and does not create any personal liability for  
10 the insured to the extent personal injury protection benefits  
11 are available and properly payable.

12 (e) If the insured's actions result in no coverage for  
13 the loss, or if the insured notifies the insurer in writing of  
14 his or her election to use all personal injury protection  
15 benefits for disability benefits, the assignment of benefits  
16 received after such notice shall be deemed void as a matter of  
17 law.

18 (f) To the extent that the insured's obligations in a  
19 direction to pay or a letter of protection conflict with the  
20 insured's obligation pursuant to the assignment of benefits,  
21 the assignment of benefits shall void the terms of the  
22 direction to pay and letter of protection.

23 (g) For the purposes of this subsection, the term:

24 1. "Letter of protection" means an agreement between a  
25 health care provider and an insured wherein the health care  
26 provider agrees to forbear its right to immediate payment in  
27 exchange for the insured's agreeing to pay the health care  
28 provider out of the proceeds of any settlement or judgment  
29 resulting from a bodily injury or uninsured motorist claim.

1           2. "Direction to pay" means a written instruction from  
2 the insured to the insurer directing the insurer to pay the  
3 health care provider directly.

4           (9) OVERDUE PERSONAL INJURY PROTECTION BENEFITS.--

5           ~~(a)(b)~~ Personal injury protection insurance benefits  
6 paid pursuant to this section shall be overdue if not paid  
7 within 30 days after the insurer is furnished written notice  
8 of the amount ~~fact~~ of a covered loss, including a properly  
9 completed CMS 1500 or UB 92 form, medical records, assignment  
10 of benefits, or, in the case of disability benefits, proper  
11 written documentation of the claim ~~and of the amount of same.~~

12 If such written notice is not furnished to the insurer as to  
13 the entire claim, any partial amount supported by written  
14 notice is overdue if not paid within 30 days after such  
15 written notice is furnished to the insurer. Any part or all  
16 of the remainder of the claim that is subsequently supported  
17 by written notice is overdue if not paid within 30 days after  
18 such written notice is furnished to the insurer. When an  
19 insurer pays only a portion of a claim or rejects a claim, the  
20 insurer shall provide at the time of the partial payment or  
21 rejection an itemized specification of each item that the  
22 insurer had reduced, omitted, or declined to pay and any  
23 information that the insurer desires the claimant to consider  
24 related to the medical necessity of the denied treatment or to  
25 explain the reasonableness of the reduced charge, provided  
26 that this shall not limit the introduction of evidence at  
27 trial; and the insurer shall include the name and address of  
28 the person to whom the claimant should respond and a claim  
29 number to be referenced in future correspondence. However,  
30 notwithstanding the fact that written notice has been  
31 furnished to the insurer, any payment shall not be deemed

1 overdue when the insurer has reasonable proof to establish  
2 that the insurer is not responsible for the payment. ~~For the~~  
3 ~~purpose of calculating the extent to which any benefits are~~  
4 ~~overdue, payment shall be treated as being made on the date a~~  
5 ~~draft or other valid instrument which is equivalent to payment~~  
6 ~~was placed in the United States mail in a properly addressed,~~  
7 ~~postpaid envelope or, if not so posted, on the date of~~  
8 ~~delivery.~~

9 (b) Timely payment by an insurer ~~This paragraph~~ does  
10 not preclude or limit the ability of the insurer to assert  
11 that the claim was unrelated, was for services not lawfully  
12 performed, was not medically necessary, or was unreasonable or  
13 that the amount of the charge was in excess of that permitted  
14 under, or in violation of, this section ~~subsection (5)~~. Such  
15 assertion by the insurer may be made at any time, including  
16 after payment of the claim or after the 30-day time period for  
17 payment set forth in this subsection ~~paragraph~~.

18 ~~(c) All overdue payments shall bear simple interest at~~  
19 ~~the rate established under s. 55.03 or the rate established in~~  
20 ~~the insurance contract, whichever is greater, for the year in~~  
21 ~~which the payment became overdue, calculated from the date the~~  
22 ~~insurer was furnished with written notice of the amount of~~  
23 ~~covered loss. Interest shall be due at the time payment of the~~  
24 ~~overdue claim is made.~~

25 ~~(d) The insurer of the owner of a motor vehicle shall~~  
26 ~~pay personal injury protection benefits for:~~

27 1. ~~Accidental bodily injury sustained in this state by~~  
28 ~~the owner while occupying a motor vehicle, or while not an~~  
29 ~~occupant of a self propelled vehicle if the injury is caused~~  
30 ~~by physical contact with a motor vehicle.~~

31

1           ~~2. Accidental bodily injury sustained outside this~~  
2 ~~state, but within the United States of America or its~~  
3 ~~territories or possessions or Canada, by the owner while~~  
4 ~~occupying the owner's motor vehicle.~~

5           ~~3. Accidental bodily injury sustained by a relative of~~  
6 ~~the owner residing in the same household, under the~~  
7 ~~circumstances described in subparagraph 1. or subparagraph 2.,~~  
8 ~~provided the relative at the time of the accident is domiciled~~  
9 ~~in the owner's household and is not himself or herself the~~  
10 ~~owner of a motor vehicle with respect to which security is~~  
11 ~~required under ss. 627.730 627.7405.~~

12           ~~4. Accidental bodily injury sustained in this state by~~  
13 ~~any other person while occupying the owner's motor vehicle or,~~  
14 ~~if a resident of this state, while not an occupant of a~~  
15 ~~self propelled vehicle, if the injury is caused by physical~~  
16 ~~contact with such motor vehicle, provided the injured person~~  
17 ~~is not himself or herself:~~

18           ~~a. The owner of a motor vehicle with respect to which~~  
19 ~~security is required under ss. 627.730 627.7405; or~~

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

22           ~~(c) If two or more insurers are liable to pay personal~~  
23 ~~injury protection benefits for the same injury to any one~~  
24 ~~person, the maximum payable shall be as specified in~~  
25 ~~subsection (1), and any insurer paying the benefits shall be~~  
26 ~~entitled to recover from each of the other insurers an~~  
27 ~~equitable pro rata share of the benefits paid and expenses~~  
28 ~~incurred in processing the claim.~~

29           ~~(c)(f)~~ It is a violation of the insurance code for an  
30 insurer to fail to timely provide benefits as required by this  
31

1 section with such frequency as to constitute a general  
2 business practice.

3 (10) CALCULATION OF TIME OF PAYMENT.--For the purpose  
4 of calculating the extent to which any benefits are overdue,  
5 payment shall be treated as being made on the date a draft or  
6 other valid instrument that is equivalent to payment was  
7 placed in the United States mail in a properly addressed,  
8 postpaid envelope or, if not so posted, on the date of  
9 delivery.

10 (11) INTEREST ON OVERDUE PAYMENTS.--All overdue  
11 payments shall bear simple interest at the rate established  
12 under s. 55.03 or the rate established in the insurance  
13 contract, whichever is greater, for the year in which the  
14 payment became overdue, calculated from the date the insurer  
15 was furnished with written notice of the amount of covered  
16 loss. In the case of payment made by an insurer to the  
17 insured, or insured's assignee, interest shall be due at the  
18 time payment of the overdue claim is made. All amounts  
19 repayable to the insurer shall bear simple interest at the  
20 rate established under s. 55.03 for the year in which the  
21 payment became repayable, calculated from the date the insurer  
22 tendered payment.

23 ~~(g) Benefits shall not be due or payable to or on the~~  
24 ~~behalf of an insured person if that person has committed, by a~~  
25 ~~material act or omission, any insurance fraud relating to~~  
26 ~~personal injury protection coverage under his or her policy,~~  
27 ~~if the fraud is admitted to in a sworn statement by the~~  
28 ~~insured or if it is established in a court of competent~~  
29 ~~jurisdiction. Any insurance fraud shall void all coverage~~  
30 ~~arising from the claim related to such fraud under the~~  
31 ~~personal injury protection coverage of the insured person who~~

1 ~~committed the fraud, irrespective of whether a portion of the~~  
2 ~~insured person's claim may be legitimate, and any benefits~~  
3 ~~paid prior to the discovery of the insured person's insurance~~  
4 ~~fraud shall be recoverable by the insurer from the person who~~  
5 ~~committed insurance fraud in their entirety. The prevailing~~  
6 ~~party is entitled to its costs and attorney's fees in any~~  
7 ~~action in which it prevails in an insurer's action to enforce~~  
8 ~~its right of recovery under this paragraph.~~

9 ~~(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—~~

10 ~~(a) Any physician, hospital, clinic, or other person~~  
11 ~~or institution lawfully rendering treatment to an injured~~  
12 ~~person for a bodily injury covered by personal injury~~  
13 ~~protection insurance may charge the insurer and injured party~~  
14 ~~only a reasonable amount pursuant to this section for the~~  
15 ~~services and supplies rendered, and the insurer providing such~~  
16 ~~coverage may pay for such charges directly to such person or~~  
17 ~~institution lawfully rendering such treatment, if the insured~~  
18 ~~receiving such treatment or his or her guardian has~~  
19 ~~countersigned the properly completed invoice, bill, or claim~~  
20 ~~form approved by the office upon which such charges are to be~~  
21 ~~paid for as having actually been rendered, to the best~~  
22 ~~knowledge of the insured or his or her guardian. In no event,~~  
23 ~~however, may such a charge be in excess of the amount the~~  
24 ~~person or institution customarily charges for like services or~~  
25 ~~supplies. With respect to a determination of whether a charge~~  
26 ~~for a particular service, treatment, or otherwise is~~  
27 ~~reasonable, consideration may be given to evidence of usual~~  
28 ~~and customary charges and payments accepted by the provider~~  
29 ~~involved in the dispute, and reimbursement levels in the~~  
30 ~~community and various federal and state medical fee schedules~~  
31 ~~applicable to automobile and other insurance coverages, and~~

1 ~~other information relevant to the reasonableness of the~~  
2 ~~reimbursement for the service, treatment, or supply.~~

3 (12) CLAIMS NOT PROPERLY PAYABLE.--

4 ~~(b)1.~~ An insurer or insured is not required to pay a  
5 claim or charges:

6 ~~(a)a.~~ Made by a broker or by a person making a claim  
7 on behalf of a broker;

8 ~~(b)b.~~ For any service or treatment that was not lawful  
9 at the time rendered;

10 ~~(c)c.~~ To any person who knowingly submits a false or  
11 misleading statement relating to the claim or charges;

12 ~~(d)d.~~ With respect to a bill or statement that does  
13 not substantially meet the applicable requirements of  
14 paragraph ~~(7)(b)(d)~~;

15 ~~(e)e.~~ For any treatment or service that is upcoded, or  
16 that is unbundled when such treatment or services should be  
17 bundled, in accordance with subsection (7) ~~paragraph (d)~~. To  
18 facilitate prompt payment of lawful services, an insurer may  
19 change codes that it determines to have been improperly or  
20 incorrectly upcoded or unbundled, and may make payment based  
21 on the changed codes, without affecting the right of the  
22 provider to dispute the change by the insurer, provided that  
23 before doing so, the insurer must contact the health care  
24 provider and discuss the reasons for the insurer's change and  
25 the health care provider's reason for the coding, or make a  
26 reasonable good faith effort to do so, as documented in the  
27 insurer's file; and

28 ~~(f)f.~~ For medical services or treatment billed by a  
29 physician and not provided in a hospital unless such services  
30 are rendered by the physician or are incident to his or her  
31 professional services and are included on the physician's

1 bill, including documentation verifying that the physician is  
2 responsible for the medical services that were rendered and  
3 billed.

4 ~~2. Charges for medically necessary cephalic~~  
5 ~~thermograms, peripheral thermograms, spinal ultrasounds,~~  
6 ~~extremity ultrasounds, video fluoroscopy, and surface~~  
7 ~~electromyography shall not exceed the maximum reimbursement~~  
8 ~~allowance for such procedures as set forth in the applicable~~  
9 ~~fee schedule or other payment methodology established pursuant~~  
10 ~~to s. 440.13.~~

11 ~~3. Allowable amounts that may be charged to a personal~~  
12 ~~injury protection insurance insurer and insured for medically~~  
13 ~~necessary nerve conduction testing when done in conjunction~~  
14 ~~with a needle electromyography procedure and both are~~  
15 ~~performed and billed solely by a physician licensed under~~  
16 ~~chapter 458, chapter 459, chapter 460, or chapter 461 who is~~  
17 ~~also certified by the American Board of Electrodiagnostic~~  
18 ~~Medicine or by a board recognized by the American Board of~~  
19 ~~Medical Specialties or the American Osteopathic Association or~~  
20 ~~who holds diplomate status with the American Chiropractic~~  
21 ~~Neurology Board or its predecessors shall not exceed 200~~  
22 ~~percent of the allowable amount under the participating~~  
23 ~~physician fee schedule of Medicare Part B for year 2001, for~~  
24 ~~the area in which the treatment was rendered, adjusted~~  
25 ~~annually on August 1 to reflect the prior calendar year's~~  
26 ~~changes in the annual Medical Care Item of the Consumer Price~~  
27 ~~Index for All Urban Consumers in the South Region as~~  
28 ~~determined by the Bureau of Labor Statistics of the United~~  
29 ~~States Department of Labor.~~

30 ~~4. Allowable amounts that may be charged to a personal~~  
31 ~~injury protection insurance insurer and insured for medically~~



1 ~~necessary nerve conduction testing that does not meet the~~  
2 ~~requirements of subparagraph 3. shall not exceed the~~  
3 ~~applicable fee schedule or other payment methodology~~  
4 ~~established pursuant to s. 440.13.~~

5 ~~5. Allowable amounts that may be charged to a personal~~  
6 ~~injury protection insurance insurer and insured for magnetic~~  
7 ~~resonance imaging services shall not exceed 175 percent of the~~  
8 ~~allowable amount under the participating physician fee~~  
9 ~~schedule of Medicare Part B for year 2001, for the area in~~  
10 ~~which the treatment was rendered, adjusted annually on August~~  
11 ~~1 to reflect the prior calendar year's changes in the annual~~  
12 ~~Medical Care Item of the Consumer Price Index for All Urban~~  
13 ~~Consumers in the South Region as determined by the Bureau of~~  
14 ~~Labor Statistics of the United States Department of Labor for~~  
15 ~~the 12 month period ending June 30 of that year, except that~~  
16 ~~allowable amounts that may be charged to a personal injury~~  
17 ~~protection insurance insurer and insured for magnetic~~  
18 ~~resonance imaging services provided in facilities accredited~~  
19 ~~by the Accreditation Association for Ambulatory Health Care,~~  
20 ~~the American College of Radiology, or the Joint Commission on~~  
21 ~~Accreditation of Healthcare Organizations shall not exceed 200~~  
22 ~~percent of the allowable amount under the participating~~  
23 ~~physician fee schedule of Medicare Part B for year 2001, for~~  
24 ~~the area in which the treatment was rendered, adjusted~~  
25 ~~annually on August 1 to reflect the prior calendar year's~~  
26 ~~changes in the annual Medical Care Item of the Consumer Price~~  
27 ~~Index for All Urban Consumers in the South Region as~~  
28 ~~determined by the Bureau of Labor Statistics of the United~~  
29 ~~States Department of Labor for the 12 month period ending June~~  
30 ~~30 of that year. This paragraph does not apply to charges for~~  
31 ~~magnetic resonance imaging services and nerve conduction~~

1 ~~testing for inpatients and emergency services and care as~~  
2 ~~defined in chapter 395 rendered by facilities licensed under~~  
3 ~~chapter 395.~~

4 ~~6. The Department of Health, in consultation with the~~  
5 ~~appropriate professional licensing boards, shall adopt, by~~  
6 ~~rule, a list of diagnostic tests deemed not to be medically~~  
7 ~~necessary for use in the treatment of persons sustaining~~  
8 ~~bodily injury covered by personal injury protection benefits~~  
9 ~~under this section. The initial list shall be adopted by~~  
10 ~~January 1, 2004, and shall be revised from time to time as~~  
11 ~~determined by the Department of Health, in consultation with~~  
12 ~~the respective professional licensing boards. Inclusion of a~~  
13 ~~test on the list of invalid diagnostic tests shall be based on~~  
14 ~~lack of demonstrated medical value and a level of general~~  
15 ~~acceptance by the relevant provider community and shall not be~~  
16 ~~dependent for results entirely upon subjective patient~~  
17 ~~response. Notwithstanding its inclusion on a fee schedule in~~  
18 ~~this subsection, an insurer or insured is not required to pay~~  
19 ~~any charges or reimburse claims for any invalid diagnostic~~  
20 ~~test as determined by the Department of Health.~~

21 ~~(c)1. With respect to any treatment or service, other~~  
22 ~~than medical services billed by a hospital or other provider~~  
23 ~~for emergency services as defined in s. 395.002 or inpatient~~  
24 ~~services rendered at a hospital owned facility, the statement~~  
25 ~~of charges must be furnished to the insurer by the provider~~  
26 ~~and may not include, and the insurer is not required to pay,~~  
27 ~~charges for treatment or services rendered more than 35 days~~  
28 ~~before the postmark date of the statement, except for past due~~  
29 ~~amounts previously billed on a timely basis under this~~  
30 ~~paragraph, and except that, if the provider submits to the~~  
31 ~~insurer a notice of initiation of treatment within 21 days~~

1 ~~after its first examination or treatment of the claimant, the~~  
2 ~~statement may include charges for treatment or services~~  
3 ~~rendered up to, but not more than, 75 days before the postmark~~  
4 ~~date of the statement. The injured party is not liable for,~~  
5 ~~and the provider shall not bill the injured party for, charges~~  
6 ~~that are unpaid because of the provider's failure to comply~~  
7 ~~with this paragraph. Any agreement requiring the injured~~  
8 ~~person or insured to pay for such charges is unenforceable.~~

9       ~~2. If, however, the insured fails to furnish the~~  
10 ~~provider with the correct name and address of the insured's~~  
11 ~~personal injury protection insurer, the provider has 35 days~~  
12 ~~from the date the provider obtains the correct information to~~  
13 ~~furnish the insurer with a statement of the charges. The~~  
14 ~~insurer is not required to pay for such charges unless the~~  
15 ~~provider includes with the statement documentary evidence that~~  
16 ~~was provided by the insured during the 35 day period~~  
17 ~~demonstrating that the provider reasonably relied on erroneous~~  
18 ~~information from the insured and either:~~

19           ~~a. A denial letter from the incorrect insurer; or~~  
20           ~~b. Proof of mailing, which may include an affidavit~~  
21 ~~under penalty of perjury, reflecting timely mailing to the~~  
22 ~~incorrect address or insurer.~~

23       ~~3. For emergency services and care as defined in s.~~  
24 ~~395.002 rendered in a hospital emergency department or for~~  
25 ~~transport and treatment rendered by an ambulance provider~~  
26 ~~licensed pursuant to part III of chapter 401, the provider is~~  
27 ~~not required to furnish the statement of charges within the~~  
28 ~~time periods established by this paragraph; and the insurer~~  
29 ~~shall not be considered to have been furnished with notice of~~  
30 ~~the amount of covered loss for purposes of paragraph (4)(b)~~  
31 ~~until it receives a statement complying with paragraph (d), or~~

1 ~~copy thereof, which specifically identifies the place of~~  
2 ~~service to be a hospital emergency department or an ambulance~~  
3 ~~in accordance with billing standards recognized by the Health~~  
4 ~~Care Finance Administration.~~

5 ~~4. Each notice of insured's rights under s. 627.7401~~  
6 ~~must include the following statement in type no smaller than~~  
7 ~~12 points:~~

8  
9 ~~BILLING REQUIREMENTS. Florida Statutes provide~~  
10 ~~that with respect to any treatment or services,~~  
11 ~~other than certain hospital and emergency~~  
12 ~~services, the statement of charges furnished to~~  
13 ~~the insurer by the provider may not include,~~  
14 ~~and the insurer and the injured party are not~~  
15 ~~required to pay, charges for treatment or~~  
16 ~~services rendered more than 35 days before the~~  
17 ~~postmark date of the statement, except for past~~  
18 ~~due amounts previously billed on a timely~~  
19 ~~basis, and except that, if the provider submits~~  
20 ~~to the insurer a notice of initiation of~~  
21 ~~treatment within 21 days after its first~~  
22 ~~examination or treatment of the claimant, the~~  
23 ~~statement may include charges for treatment or~~  
24 ~~services rendered up to, but not more than, 75~~  
25 ~~days before the postmark date of the statement.~~

26  
27 ~~(d) All statements and bills for medical services~~  
28 ~~rendered by any physician, hospital, clinic, or other person~~  
29 ~~or institution shall be submitted to the insurer on a properly~~  
30 ~~completed Centers for Medicare and Medicaid Services (CMS)~~  
31 ~~1500 form, UB 92 forms, or any other standard form approved by~~

1 ~~the office or adopted by the commission for purposes of this~~  
2 ~~paragraph. All billings for such services rendered by~~  
3 ~~providers shall, to the extent applicable, follow the~~  
4 ~~Physicians' Current Procedural Terminology (CPT) or Healthcare~~  
5 ~~Correct Procedural Coding System (HCPCS), or ICD 9 in effect~~  
6 ~~for the year in which services are rendered and comply with~~  
7 ~~the Centers for Medicare and Medicaid Services (CMS) 1500 form~~  
8 ~~instructions and the American Medical Association Current~~  
9 ~~Procedural Terminology (CPT) Editorial Panel and Healthcare~~  
10 ~~Correct Procedural Coding System (HCPCS). All providers other~~  
11 ~~than hospitals shall include on the applicable claim form the~~  
12 ~~professional license number of the provider in the line or~~  
13 ~~space provided for "Signature of Physician or Supplier,~~  
14 ~~Including Degrees or Credentials." In determining compliance~~  
15 ~~with applicable CPT and HCPCS coding, guidance shall be~~  
16 ~~provided by the Physicians' Current Procedural Terminology~~  
17 ~~(CPT) or the Healthcare Correct Procedural Coding System~~  
18 ~~(HCPCS) in effect for the year in which services were~~  
19 ~~rendered, the Office of the Inspector General (OIG),~~  
20 ~~Physicians Compliance Guidelines, and other authoritative~~  
21 ~~treatises designated by rule by the Agency for Health Care~~  
22 ~~Administration. No statement of medical services may include~~  
23 ~~charges for medical services of a person or entity that~~  
24 ~~performed such services without possessing the valid licenses~~  
25 ~~required to perform such services. For purposes of paragraph~~  
26 ~~(4)(b), an insurer shall not be considered to have been~~  
27 ~~furnished with notice of the amount of covered loss or medical~~  
28 ~~bills due unless the statements or bills comply with this~~  
29 ~~paragraph, and unless the statements or bills are properly~~  
30 ~~completed in their entirety as to all material provisions,~~  
31 ~~with all relevant information being provided therein.~~

1           (14) DEMAND LETTER.--

2           (a) As a condition precedent to filing any action for  
3 benefits under this section, the insurer must be provided with  
4 written notice of an intent to initiate litigation. Such  
5 notice may not be sent until the claim is overdue, including  
6 any additional time the insurer has to pay the claim pursuant  
7 to subsection (9).

8           (b) The notice required shall state that it is a  
9 "demand letter under s. 627.736(14)" and shall state with  
10 specificity:

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

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

16           3. To the extent applicable, the name of any medical  
17 provider who rendered to an insured the treatment, services,  
18 accommodations, or supplies that form the basis of such claim;  
19 and an itemized statement specifying each exact amount, the  
20 date of treatment, service, or accommodation, and the type of  
21 benefit claimed to be due. A completed form satisfying the  
22 requirements of subsection (7) or the lost-wage statement  
23 previously submitted may be used as the itemized statement. To  
24 the extent that the demand involves an insurer's withdrawal of  
25 payment under subsection (17) for future treatment not yet  
26 rendered, the claimant shall attach a copy of the insurer's  
27 notice withdrawing such payment and an itemized statement of  
28 the type, frequency, and duration of future treatment claimed  
29 to be reasonable and medically necessary.

30           (c) Each notice required by this subsection must be  
31 delivered to the insurer by United States certified or

1 registered mail, return receipt requested. Such postal costs  
2 shall be reimbursed by the insurer if so requested by the  
3 claimant in the notice, when the insurer pays the claim. Such  
4 notice must be sent to the person and address specified by the  
5 insurer for the purposes of receiving notices under this  
6 subsection. Each licensed insurer, whether domestic, foreign,  
7 or alien, shall file with the office designation of the name  
8 and address of the person to whom notices pursuant to this  
9 subsection shall be sent which the office shall make available  
10 on its Internet website. The name and address on file with the  
11 office pursuant to s. 624.422 shall be deemed the authorized  
12 representative to accept notice pursuant to this subsection in  
13 the event no other designation has been made.

14 (d) If, within 21 days after receipt of notice by the  
15 insurer, the overdue claim specified in the notice is paid by  
16 the insurer together with applicable interest and a penalty of  
17 10 percent of the overdue amount paid by the insurer, subject  
18 to a maximum penalty of \$250, no action may be brought against  
19 the insurer. If the demand involves an insurer's withdrawal of  
20 payment under subsection (17) for future treatment not yet  
21 rendered, no action may be brought against the insurer if,  
22 within 21 days after its receipt of the notice, the insurer  
23 mails to the person filing the notice a written statement of  
24 the insurer's agreement to pay for such treatment in  
25 accordance with the notice and to pay a penalty of 10 percent,  
26 subject to a maximum penalty of \$250, when it pays for such  
27 future treatment in accordance with the requirements of this  
28 section. To the extent the insurer determines not to pay any  
29 amount demanded, the penalty shall not be payable in any  
30 subsequent action. For purposes of this subsection, payment or  
31 the insurer's agreement shall be treated as being made on the

1 date a draft or other valid instrument that is equivalent to  
2 payment, or the insurer's written statement of agreement, is  
3 placed in the United States mail in a properly addressed,  
4 postpaid envelope, or if not so posted, on the date of  
5 delivery. The insurer is not obligated to pay any attorney's  
6 fees if the insurer pays the claim or mails its agreement to  
7 pay for future treatment within the time prescribed by this  
8 subsection.

9 (e) The applicable statute of limitation for an action  
10 under this section shall be tolled for a period of 21 business  
11 days by the mailing of the notice required by this subsection.

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

16 (15) DISCLOSURE AND ACKNOWLEDGEMENT FORM.--

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

24 1.a. The insured, or his or her guardian, must  
25 countersign the form attesting to the fact that the services  
26 set forth therein were actually rendered;

27 2.b. The insured, or his or her guardian, has both the  
28 right and affirmative duty to confirm that the services were  
29 actually rendered;



1           ~~3.e.~~ The insured, or his or her guardian, was not  
2 solicited by any person to seek any services from the medical  
3 provider;

4           ~~4.d.~~ That the physician, other licensed professional,  
5 clinic, or other medical institution rendering services for  
6 which payment is being claimed explained the services to the  
7 insured or his or her guardian; and

8           ~~5.e.~~ If the insured notifies the insurer in writing of  
9 a billing error, the insured may be entitled to a certain  
10 percentage of a reduction in the amounts paid by the insured's  
11 motor vehicle insurer.

12           ~~(b)2.~~ The physician, other licensed professional,  
13 clinic, or other medical institution rendering services for  
14 which payment is being claimed has the affirmative duty to  
15 explain the services rendered to the insured, or his or her  
16 guardian, so that the insured, or his or her guardian,  
17 countersigns the form with informed consent.

18           ~~(c)3.~~ Countersignature by the insured, or his or her  
19 guardian, is not required for the reading of diagnostic tests  
20 or other services that are of such a nature that they are not  
21 required to be performed in the presence of the insured.

22           ~~(d)4.~~ The licensed medical professional rendering  
23 treatment for which payment is being claimed must sign, by his  
24 or her own hand, the form complying with this subsection  
25 ~~paragraph~~.

26           ~~(e)5.~~ The original completed disclosure and  
27 acknowledgment form shall be furnished to the insurer pursuant  
28 to subsection (9) ~~paragraph (4)(b)~~ and may not be  
29 electronically furnished.

30           ~~(f)6.~~ This disclosure and acknowledgment form is not  
31 required for services billed by a provider for emergency

1 services as defined in s. 395.002, for emergency services and  
2 care as defined in s. 395.002 rendered in a hospital emergency  
3 department, or for transport and treatment rendered by an  
4 ambulance provider licensed pursuant to part III of chapter  
5 401.

6 ~~(g)7-~~ The Financial Services Commission shall adopt,  
7 by rule, a standard disclosure and acknowledgment form that  
8 shall be used to fulfill the requirements of this subsection  
9 ~~paragraph~~, effective 90 days after such form is adopted and  
10 becomes final. ~~The commission shall adopt a proposed rule by~~  
11 ~~October 1, 2003. Until the rule is final, the provider may use~~  
12 ~~a form of its own which otherwise complies with the~~  
13 ~~requirements of this paragraph.~~

14 ~~(h)8-~~ As used in this subsection ~~paragraph~~,  
15 "countersigned" means a second or verifying signature, as on a  
16 previously signed document, and is not satisfied by the  
17 statement "signature on file" or any similar statement.

18 ~~(i)9-~~ ~~The requirements of This~~ subsection applies  
19 ~~paragraph apply~~ only with respect to the initial treatment or  
20 service of the insured by a provider. For subsequent  
21 treatments or service, the provider must maintain a patient  
22 log signed by the patient, in chronological order by date of  
23 service, that is consistent with the services being rendered  
24 to the patient as claimed. The requirements of this paragraph  
25 ~~subparagraph~~ for maintaining a patient log signed by the  
26 patient may be met by a hospital that maintains medical  
27 records as required by s. 395.3025 and applicable rules and  
28 makes such records available to the insurer upon request.

29 ~~(f) Upon written notification by any person, an~~  
30 ~~insurer shall investigate any claim of improper billing by a~~  
31 ~~physician or other medical provider. The insurer shall~~

1 ~~determine if the insured was properly billed for only those~~  
2 ~~services and treatments that the insured actually received. If~~  
3 ~~the insurer determines that the insured has been improperly~~  
4 ~~billed, the insurer shall notify the insured, the person~~  
5 ~~making the written notification and the provider of its~~  
6 ~~findings and shall reduce the amount of payment to the~~  
7 ~~provider by the amount determined to be improperly billed. If~~  
8 ~~a reduction is made due to such written notification by any~~  
9 ~~person, the insurer shall pay to the person 20 percent of the~~  
10 ~~amount of the reduction, up to \$500. If the provider is~~  
11 ~~arrested due to the improper billing, then the insurer shall~~  
12 ~~pay to the person 40 percent of the amount of the reduction,~~  
13 ~~up to \$500.~~

14 ~~(g) An insurer may not systematically downcode with~~  
15 ~~the intent to deny reimbursement otherwise due. Such action~~  
16 ~~constitutes a material misrepresentation under s.~~  
17 ~~626.9541(1)(i)2.~~

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

20 ~~(a) Every employer shall, if a request is made by an~~  
21 ~~insurer providing personal injury protection benefits under~~  
22 ~~ss. 627.730 627.7405 against whom a claim has been made,~~  
23 ~~furnish forthwith, in a form approved by the office, a sworn~~  
24 ~~statement of the earnings, since the time of the bodily injury~~  
25 ~~and for a reasonable period before the injury, of the person~~  
26 ~~upon whose injury the claim is based.~~

27 ~~(16) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;~~  
28 ~~DISPUTES.--~~

29 ~~(a)(b) Every physician, hospital, clinic, or other~~  
30 ~~medical institution providing, before or after bodily injury~~  
31 ~~upon which a claim for personal injury protection insurance~~

1 | benefits is based, any products, services, or accommodations  
2 | in relation to that or any other injury, or in relation to a  
3 | condition claimed to be connected with that or any other  
4 | injury, shall, if requested to do so by the insurer against  
5 | whom the claim has been made:<sup>7</sup>

6 |       1. Furnish forthwith a written report of the history,  
7 | condition, treatment, dates, and costs of such treatment of  
8 | the injured person and why the items identified by the insurer  
9 | were reasonable in amount and medically necessary.<sup>7</sup>

10 |       2. ~~Provide together with~~ a sworn statement that the  
11 | treatment or services rendered were reasonable and necessary  
12 | with respect to the bodily injury sustained. Such sworn  
13 | statement shall read as follows: "Under penalty of perjury, I  
14 | declare that I have read the foregoing, and the facts alleged  
15 | are true, to the best of my knowledge and belief."

16 |       3. ~~Identify and identifying~~ which portion of the  
17 | expenses for such treatment or services was incurred as a  
18 | result of such bodily injury.<sup>7</sup>

19 |       4. ~~and~~ Produce forthwith, and permit the inspection  
20 | and copying of, his or her or its records regarding such  
21 | history, condition, treatment, dates, and costs of treatment;  
22 | provided that this shall not limit the introduction of  
23 | evidence at trial. ~~Such sworn statement shall read as follows:~~  
24 | ~~"Under penalty of perjury, I declare that I have read the~~  
25 | ~~foregoing, and the facts alleged are true, to the best of my~~  
26 | ~~knowledge and belief."~~

27 |       (b) However, if the records are maintained at an  
28 | alternative location, the requested records shall be made  
29 | available at the principal place of business within 5 working  
30 | days after the request. Records not produced at the time of  
31 | the request shall be deemed to be nonexistent. At the time of

1 the records inspection, the health care provider shall allow  
2 the insurer to inspect records and photograph the equipment  
3 and associated documents associated with the insured's  
4 treatment, services, or supplies.

5 (c) The insured, the assignee of the insured, the  
6 health care provider, the providers' billing and medical  
7 records custodians, or any other person seeking payment under  
8 an automobile policy directly or as an assignee must submit to  
9 examination under oath by any person named by the insurer when  
10 and as often as the insurer may reasonably require. If an  
11 examination under oath is requested of a health care provider  
12 licensed under chapter 457, chapter 458, chapter 459, chapter  
13 460, chapter 461, chapter 462, chapter 463, chapter 466,  
14 chapter 467, chapter 484, chapter 486, chapter 490, or chapter  
15 491, part I, part III, part X, part XIII, or part XIV of  
16 chapter 468, or s. 464.012, the insurer shall pay the person  
17 \$175 per hour for attendance at the examination under oath.

18 Time spent in preparation for the examination under oath is  
19 noncompensable. Once requested, the examination under oath is  
20 a condition precedent to filing suit.

21 (d) A ~~No~~ cause of action for violation of the  
22 physician-patient privilege or invasion of the right of  
23 privacy is not ~~shall be~~ permitted against any physician,  
24 hospital, clinic, or other medical institution complying with  
25 the provisions of this section.

26 (e) The person requesting such records and such sworn  
27 statement shall pay all reasonable costs connected therewith.

28 (f) If an insurer makes a written request for  
29 documentation or information under this paragraph within 30  
30 days after having received notice of the amount of a covered  
31 loss under subsection (7) paragraph (4)(a), the amount or the

1 partial amount ~~that~~ which is the subject of the insurer's  
2 inquiry shall become overdue if the insurer does not pay in  
3 accordance with subsection (9) ~~paragraph (4)(b)~~ or within 15  
4 ~~10~~ days after the insurer's receipt of the requested  
5 documentation or information, whichever occurs later. For  
6 purposes of this paragraph, the term "receipt" includes, but  
7 is not limited to, inspection and copying pursuant to this  
8 subsection ~~paragraph~~.

9       (g) Any insurer that requests documentation or  
10 information pertaining to reasonableness of charges or medical  
11 necessity under this subsection ~~paragraph~~ without a reasonable  
12 basis for such requests as a general business practice is  
13 engaging in an unfair trade practice under the insurance code.

14       (h)(e) In the event of any dispute regarding an  
15 insurer's right to discovery of facts under this section, the  
16 insurer may petition a court of competent jurisdiction to  
17 enter an order permitting such discovery. The order may be  
18 made only on motion for good cause shown and upon notice to  
19 all persons having an interest, and it shall specify the time,  
20 place, manner, conditions, and scope of the discovery. Such  
21 court may, in order to protect against annoyance,  
22 embarrassment, or oppression, as justice requires, enter an  
23 order refusing discovery or specifying conditions of discovery  
24 and may order payments of costs and expenses of the  
25 proceeding, including reasonable fees for the appearance of  
26 attorneys at the proceedings, as justice requires.

27       (i)(d) The injured person shall be furnished, upon  
28 request, a copy of all information obtained by the insurer  
29 under the provisions of this section, and shall pay a  
30 reasonable charge, if required by the insurer.

31

1           ~~(j)(e)~~ Notice to an insurer of the existence of a  
2 claim shall not be unreasonably withheld by an insured. In no  
3 event may this notice be later than 1 year after the  
4 occurrence. The insurer may contract for such notice to be  
5 less than 1 year.

6           ~~(17) INDEPENDENT MEDICAL EXAMINATIONS(7) MENTAL AND~~  
7 ~~PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.--~~

8           (a) Whenever the mental or physical condition of an  
9 injured person covered by personal injury protection is  
10 material to any claim that has been or may be made for past or  
11 future personal injury protection insurance benefits, such  
12 person shall, upon the request of an insurer, submit to mental  
13 or physical examination by a physician or physicians.

14           **(b)** The costs of any examinations requested by an  
15 insurer shall be borne entirely by the insurer, except that,  
16 if the insured has unreasonably failed to appear for the  
17 examinations, the cost for nonappearance, if any, shall be  
18 paid from the insured's benefits.

19           **(c)** Such examination shall be conducted within the  
20 municipality where the insured is receiving treatment, or in a  
21 location reasonably accessible to the insured, which, for  
22 purposes of this paragraph, means any location within the  
23 municipality in which the insured resides, or any location  
24 within 10 miles by road of the insured's residence, provided  
25 such location is within the county in which the insured  
26 resides.

27           **(d)** If the examination is to be conducted in a  
28 location reasonably accessible to the insured, and if there is  
29 no qualified physician to conduct the examination in a  
30 location reasonably accessible to the insured, then such  
31 examination shall be conducted in an area of the closest

1 proximity to the insured's residence. The insurer shall pay  
2 lost wages for time missed from work as a result of attending  
3 any such examination.

4 ~~(e) Personal protection~~ Insurers are authorized to  
5 include reasonable provisions in personal injury protection  
6 insurance policies for mental and physical examination of  
7 those claiming personal injury protection insurance benefits.

8 (f) An insurer may not withdraw payment of a treating  
9 physician without the consent of the injured person covered by  
10 the personal injury protection, unless the insurer first  
11 obtains a valid report by a Florida physician licensed under  
12 the same chapter as the treating physician whose treatment  
13 authorization is sought to be withdrawn, stating that  
14 treatment was not reasonable, related, or necessary.

15 (g) A valid report is one that is prepared and signed  
16 by the physician examining the injured person or reviewing the  
17 treatment records of the injured person and is factually  
18 supported by the examination, ~~and~~ treatment records, or other  
19 relevant information if reviewed and that has not been  
20 modified by anyone other than the physician.

21 (h) The physician preparing the report must be in  
22 active practice, unless the physician is physically disabled.  
23 Active practice means that during the 3 years immediately  
24 preceding the date of the physical examination or review of  
25 the treatment records the physician must have devoted  
26 professional time to the active clinical practice of  
27 evaluation, diagnosis, or treatment of medical conditions or  
28 to the instruction of students in an accredited health  
29 professional school or accredited residency program or a  
30 clinical research program that is affiliated with an  
31



1 accredited health professional school or teaching hospital or  
2 accredited residency program.

3 (i) The physician preparing a report at the request of  
4 an insurer and physicians rendering expert opinions on behalf  
5 of persons claiming medical benefits for personal injury  
6 protection, or on behalf of an insured through an attorney or  
7 another entity, shall maintain, for at least 3 years, copies  
8 of all examination reports as medical records and shall  
9 maintain, for at least 3 years, records of all payments for  
10 the examinations and reports.

11 (j) Neither an insurer nor any person acting at the  
12 direction of or on behalf of an insurer may materially change  
13 an opinion in a report prepared under this subsection  
14 ~~paragraph~~ or direct the physician preparing the report to  
15 change such opinion. The denial of a payment as the result of  
16 such a changed opinion constitutes a material  
17 misrepresentation under s. 626.9541(1)(i)2.; however, this  
18 provision does not preclude the insurer from calling to the  
19 attention of the physician errors of fact in the report based  
20 upon information in the claim file or on new information that  
21 will become part of the claim file.

22 (k)~~(b)~~ If requested by the person examined, a party  
23 causing an examination to be made shall deliver to him or her  
24 a copy of every written report concerning the examination  
25 rendered by an examining physician, at least one of which  
26 reports must set out the examining physician's findings and  
27 conclusions in detail. After such request and delivery, the  
28 party causing the examination to be made is entitled, upon  
29 request, to receive from the person examined every written  
30 report available to him or her or his or her representative  
31 concerning any examination, previously or thereafter made, of

1 | the same mental or physical condition. By requesting and  
2 | obtaining a report of the examination so ordered, or by taking  
3 | the deposition of the examiner, the person examined waives any  
4 | privilege he or she may have, in relation to the claim for  
5 | benefits, regarding the testimony of every other person who  
6 | has examined, or may thereafter examine, him or her in respect  
7 | to the same mental or physical condition. If a person  
8 | unreasonably fails to attend a confirmed, scheduled  
9 | examination or unreasonably refuses to submit to an  
10 | examination, the personal injury protection carrier is no  
11 | longer liable for subsequent personal injury protection  
12 | benefits.

13 | (1) During the examination, neither the insurer, the  
14 | insured, nor the assignee of the insured may have counsel, a  
15 | court reporter, or a videographer present.

16 | ~~(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S~~  
17 | ~~FEES. With respect to any dispute under the provisions of ss.~~  
18 | ~~627.730 627.7405 between the insured and the insurer, or~~  
19 | ~~between an assignee of an insured's rights and the insurer,~~  
20 | ~~the provisions of s. 627.428 shall apply, except as provided~~  
21 | ~~in subsection (11).~~

22 | ~~(18)(9) CANCELLATION OR NONRENEWAL.--~~

23 | (a) Each insurer that ~~which~~ has issued a policy  
24 | providing personal injury protection benefits shall report the  
25 | renewal, cancellation, or nonrenewal thereof to the Department  
26 | of Highway Safety and Motor Vehicles within 45 days from the  
27 | effective date of the renewal, cancellation, or nonrenewal.

28 | (b) Upon the issuance of a policy providing personal  
29 | injury protection benefits to a named insured not previously  
30 | insured by the insurer thereof during that calendar year, the  
31 | insurer shall report the issuance of the new policy to the

1 Department of Highway Safety and Motor Vehicles within 30  
2 days. The report shall be in such form and format and contain  
3 such information as is ~~may be~~ required by the Department of  
4 Highway Safety and Motor Vehicles which shall include a format  
5 compatible with the data processing capabilities of such ~~said~~  
6 department, and the Department of Highway Safety and Motor  
7 Vehicles is authorized to adopt rules necessary with respect  
8 thereto. Failure by an insurer to file proper reports with the  
9 Department of Highway Safety and Motor Vehicles as required by  
10 this subsection or rules adopted with respect to the  
11 requirements of this subsection constitutes a violation of the  
12 Florida Insurance Code.

13 (c) Reports of cancellations and policy renewals and  
14 reports of the issuance of new policies received by the  
15 Department of Highway Safety and Motor Vehicles are  
16 confidential and exempt from the provisions of s. 119.07(1).

17 (d) These records are to be used for enforcement and  
18 regulatory purposes only, including the generation by the  
19 department of data regarding compliance by owners of motor  
20 vehicles with financial responsibility coverage requirements.  
21 In addition, the Department of Highway Safety and Motor  
22 Vehicles shall release, upon a written request by a person  
23 involved in a motor vehicle accident, by the person's  
24 attorney, or by a representative of the person's motor vehicle  
25 insurer, the name of the insurance company and the policy  
26 number for the policy covering the vehicle named by the  
27 requesting party. The written request must include a copy of  
28 the appropriate accident form as provided in s. 316.065, s.  
29 316.066, or s. 316.068.

30 (e) ~~(b)~~ Every insurer with respect to each insurance  
31 policy providing personal injury protection benefits shall

1 | notify the named insured or in the case of a commercial fleet  
2 | policy, the first named insured in writing that any  
3 | cancellation or nonrenewal of the policy will be reported by  
4 | the insurer to the Department of Highway Safety and Motor  
5 | Vehicles. The notice shall also inform the named insured that  
6 | failure to maintain personal injury protection and property  
7 | damage liability insurance on a motor vehicle when required by  
8 | law may result in the loss of registration and driving  
9 | privileges in this state, and the notice shall inform the  
10 | named insured of the amount of the reinstatement fees required  
11 | by s. 627.733(7). This notice is for informational purposes  
12 | only, and no civil liability shall attach to an insurer due to  
13 | failure to provide this notice.

14 |       (19) ATTORNEY'S FEES.--With respect to any dispute  
15 | under ss. 627.730-627.7405 between the insured and the  
16 | insurer, or between an assignee of an insured's rights and the  
17 | insurer, s. 627.428 shall apply, except as provided in  
18 | subsection (14). A contingency risk multiplier shall not be  
19 | applied to any attorney's fee award in any dispute under ss.  
20 | 627.730-627.7405.

21 |       ~~(20)~~~~(10)~~ PREFERRED PROVIDERS.--An insurer may  
22 | negotiate and enter into contracts with licensed health care  
23 | providers for the benefits described in this section, referred  
24 | to in this section as "preferred providers," which shall  
25 | include health care providers licensed under chapters 458,  
26 | 459, 460, 461, and 463. The insurer may provide an option to  
27 | an insured to use a preferred provider at the time of purchase  
28 | of the policy for personal injury protection benefits, if the  
29 | requirements of this subsection are met. If the insured  
30 | elects to use a provider who is not a preferred provider,  
31 | whether the insured purchased a preferred provider policy or a

1 nonpreferred provider policy, the medical benefits provided by  
2 the insurer shall be as required by this section. If the  
3 insured elects to use a provider who is a preferred provider,  
4 the insurer may pay medical benefits in excess of the benefits  
5 required by this section and may waive or lower the amount of  
6 any deductible that applies to such medical benefits. If the  
7 insurer offers a preferred provider policy to a policyholder  
8 or applicant, it must also offer a nonpreferred provider  
9 policy. The insurer shall provide each policyholder with a  
10 current roster of preferred providers in the county in which  
11 the insured resides at the time of purchase of such policy,  
12 and shall make such list available for public inspection  
13 during regular business hours at the principal office of the  
14 insurer within the state.

15 ~~(11) DEMAND LETTER.~~

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

22 ~~(b) The notice required shall state that it is a~~  
23 ~~"demand letter under s. 627.736(11)" and shall state with~~  
24 ~~specificity:~~

25 ~~1. The name of the insured upon which such benefits~~  
26 ~~are being sought, including a copy of the assignment giving~~  
27 ~~rights to the claimant if the claimant is not the insured.~~

28 ~~2. The claim number or policy number upon which such~~  
29 ~~claim was originally submitted to the insurer.~~

30 ~~3. To the extent applicable, the name of any medical~~  
31 ~~provider who rendered to an insured the treatment, services,~~

1 ~~accommodations, or supplies that form the basis of such claim;~~  
2 ~~and an itemized statement specifying each exact amount, the~~  
3 ~~date of treatment, service, or accommodation, and the type of~~  
4 ~~benefit claimed to be due. A completed form satisfying the~~  
5 ~~requirements of paragraph (5)(d) or the lost wage statement~~  
6 ~~previously submitted may be used as the itemized statement. To~~  
7 ~~the extent that the demand involves an insurer's withdrawal of~~  
8 ~~payment under paragraph (7)(a) for future treatment not yet~~  
9 ~~rendered, the claimant shall attach a copy of the insurer's~~  
10 ~~notice withdrawing such payment and an itemized statement of~~  
11 ~~the type, frequency, and duration of future treatment claimed~~  
12 ~~to be reasonable and medically necessary.~~

13 ~~(c) Each notice required by this subsection must be~~  
14 ~~delivered to the insurer by United States certified or~~  
15 ~~registered mail, return receipt requested. Such postal costs~~  
16 ~~shall be reimbursed by the insurer if so requested by the~~  
17 ~~claimant in the notice, when the insurer pays the claim. Such~~  
18 ~~notice must be sent to the person and address specified by the~~  
19 ~~insurer for the purposes of receiving notices under this~~  
20 ~~subsection. Each licensed insurer, whether domestic, foreign,~~  
21 ~~or alien, shall file with the office designation of the name~~  
22 ~~and address of the person to whom notices pursuant to this~~  
23 ~~subsection shall be sent which the office shall make available~~  
24 ~~on its Internet website. The name and address on file with the~~  
25 ~~office pursuant to s. 624.422 shall be deemed the authorized~~  
26 ~~representative to accept notice pursuant to this subsection in~~  
27 ~~the event no other designation has been made.~~

28 ~~(d) If, within 15 days after receipt of notice by the~~  
29 ~~insurer, the overdue claim specified in the notice is paid by~~  
30 ~~the insurer together with applicable interest and a penalty of~~  
31 ~~10 percent of the overdue amount paid by the insurer, subject~~

1 ~~to a maximum penalty of \$250, no action may be brought against~~  
2 ~~the insurer. If the demand involves an insurer's withdrawal of~~  
3 ~~payment under paragraph (7)(a) for future treatment not yet~~  
4 ~~rendered, no action may be brought against the insurer if,~~  
5 ~~within 15 days after its receipt of the notice, the insurer~~  
6 ~~mails to the person filing the notice a written statement of~~  
7 ~~the insurer's agreement to pay for such treatment in~~  
8 ~~accordance with the notice and to pay a penalty of 10 percent,~~  
9 ~~subject to a maximum penalty of \$250, when it pays for such~~  
10 ~~future treatment in accordance with the requirements of this~~  
11 ~~section. To the extent the insurer determines not to pay any~~  
12 ~~amount demanded, the penalty shall not be payable in any~~  
13 ~~subsequent action. For purposes of this subsection, payment or~~  
14 ~~the insurer's agreement shall be treated as being made on the~~  
15 ~~date a draft or other valid instrument that is equivalent to~~  
16 ~~payment, or the insurer's written statement of agreement, is~~  
17 ~~placed in the United States mail in a properly addressed,~~  
18 ~~postpaid envelope, or if not so posted, on the date of~~  
19 ~~delivery. The insurer shall not be obligated to pay any~~  
20 ~~attorney's fees if the insurer pays the claim or mails its~~  
21 ~~agreement to pay for future treatment within the time~~  
22 ~~prescribed by this subsection.~~

23 ~~(e) The applicable statute of limitation for an action~~  
24 ~~under this section shall be tolled for a period of 15 business~~  
25 ~~days by the mailing of the notice required by this subsection.~~

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

30 ~~(12) CIVIL ACTION FOR INSURANCE FRAUD. An insurer~~  
31 ~~shall have a cause of action against any person convicted of,~~

1 ~~or who, regardless of adjudication of guilt, pleads guilty or~~  
2 ~~nolo contendere to insurance fraud under s. 817.234, patient~~  
3 ~~brokering under s. 817.505, or kickbacks under s. 456.054,~~  
4 ~~associated with a claim for personal injury protection~~  
5 ~~benefits in accordance with this section. An insurer~~  
6 ~~prevailing in an action brought under this subsection may~~  
7 ~~recover compensatory, consequential, and punitive damages~~  
8 ~~subject to the requirements and limitations of part II of~~  
9 ~~chapter 768, and attorney's fees and costs incurred in~~  
10 ~~litigating a cause of action against any person convicted of,~~  
11 ~~or who, regardless of adjudication of guilt, pleads guilty or~~  
12 ~~nolo contendere to insurance fraud under s. 817.234, patient~~  
13 ~~brokering under s. 817.505, or kickbacks under s. 456.054,~~  
14 ~~associated with a claim for personal injury protection~~  
15 ~~benefits in accordance with this section.~~

16 (21)(13) MINIMUM BENEFIT COVERAGE.--If the Financial  
17 Services Commission determines that the cost savings under  
18 personal injury protection insurance benefits paid by insurers  
19 have been realized due to the provisions of this act, prior  
20 legislative reforms, or other factors, the commission may  
21 increase the minimum \$10,000 benefit coverage requirement. In  
22 establishing the amount of such increase, the commission must  
23 determine that the additional premium for such coverage is  
24 approximately equal to the premium cost savings that have been  
25 realized for the personal injury protection coverage with  
26 limits of \$10,000.

27 (22) CIVIL MONETARY REMEDIES.--

28 (a) An insurer has a civil cause of action to recover  
29 all amounts paid and all expenses incurred against a person  
30 who knowingly presents or causes to be presented to an insurer  
31



1 a claim for personal injury protection benefits that a court  
2 determines:  
3       1. Is for health care services, equipment, or supplies  
4 that the person knew or should have known were not provided as  
5 claimed;  
6       2. Is a claim for health care services, equipment, or  
7 supplies which the person knew or should have known was false  
8 or fraudulent;  
9       3. Is for health care services, or incident to the  
10 provision of such services, and the person knew or should have  
11 known that the individual furnishing or supervising the  
12 furnishing of health care services:  
13           a. Was not licensed as a health care provider;  
14           b. Was licensed as a health care provider, but such  
15 license was obtained through a misrepresentation of material  
16 fact; or  
17           c. Represented to the insured or legal guardian at the  
18 time the health care services were furnished that the  
19 individual was licensed or certified in a medical specialty by  
20 a medical specialty board when the individual was not so  
21 licensed or certified;  
22       4. Is for health care services, equipment, or supplies  
23 and the claim demonstrates a pattern or practice by the person  
24 of presenting or causing to be presented claims that the  
25 person knew or should have known are not medically necessary;  
26       5. Is for health care services, equipment, or supplies  
27 and the claim was based on codes that the person knew or  
28 should have known would result in greater payment to that  
29 person than the codes the person knew or should have known are  
30 applicable to the service, equipment, or supplies actually  
31 provided;

1           6. Is based on the payment or offer of payment to an  
2 individual and the person knew or should have known such  
3 payment or offer may have caused the individual to order or  
4 receive health care services, equipment, or supplies from a  
5 health care provider, in whole or in part, under a policy of  
6 insurance;

7           7. Constitutes a violation of chapter 812 or chapter  
8 817; or

9           8. Is for health care services, equipment, or supplies  
10 where the person has intentionally misrepresented a material  
11 fact whether before or after the insured loss. Such  
12 intentional misrepresentation shall void all coverage arising  
13 from the claim related to such misrepresentation under the  
14 personal injury protection coverage of the person who  
15 committed the misrepresentation, irrespective of whether a  
16 portion of the person's claim may be properly payable. Any  
17 benefits paid prior to the discovery of the misrepresentation  
18 are recoverable by the insurer in their entirety from the  
19 person who committed the misrepresentation.

20           (b) An insurer has a civil cause of action to recover  
21 all amounts paid and all expenses incurred against a person  
22 who knowingly presents or causes to be presented to an insurer  
23 a claim that is based on an application for motor vehicle  
24 insurance or is based on an application for personal injury  
25 protection benefits that contains false or fraudulent  
26 information that the person knew or should have known could  
27 reasonably be expected to influence the decision of an insurer  
28 to issue a policy of insurance or extend coverage under a  
29 policy of insurance.

30           (c) An insurer has a civil cause of action to recover  
31 all amounts paid and all expenses incurred against a person

1 who knowingly presents or causes to be presented to an insurer  
2 a claim when the person received payment under such claim and  
3 knew or should have known the payment constituted an  
4 overpayment and the overpayment had been received and retained  
5 for more than 90 days after the date of receipt of such  
6 overpayment.

7 (d) Whenever an insurer has a good faith basis to  
8 believe that a violation of this subsection has occurred, the  
9 insurer may file suit to recover all amounts previously paid.  
10 The prevailing party in any action brought under this  
11 subsection may recover compensatory, consequential, and  
12 punitive damages subject to the requirements and limitations  
13 of part II of chapter 768 and attorney's fees and costs  
14 incurred.

15 (e) The term "person" has the same meaning as in s.  
16 1.01.

17 (f) An insurer may receive direct payment on any  
18 judgment, including interest, costs, and attorney's fees  
19 thereon, by crediting the provider any amount due from any  
20 future claim. The credited amount shall be treated as payment  
21 toward the final judgment. Any amount credited towards a final  
22 judgment is not a confession of judgment in any litigation and  
23 is not recoverable from the respective insured.

24 (g) A principal is liable for damages under this  
25 section for the actions of the principal's agent acting within  
26 the scope of the agency.

27 (23) REWARD.--Upon written notification by any person,  
28 an insurer shall investigate any claim of improper billing by  
29 a physician or other medical provider. The insurer shall  
30 determine if the insured was properly billed for only those  
31 services and treatments that the insured actually received. If

1 the insurer determines that the insured has been improperly  
2 billed, the insurer shall notify the insured, the person  
3 making the written notification and the provider of its  
4 findings and shall reduce the amount of payment to the  
5 provider by the amount determined to be improperly billed. If  
6 a reduction is made due to such written notification by any  
7 person, the insurer shall pay to the person 20 percent of the  
8 amount of the reduction. If the provider is arrested due to  
9 the improper billing, the insurer shall pay to the person 40  
10 percent of the amount of the reduction.

11 (24) VENUE.--Venue for any personal injury protection  
12 claim shall be in the jurisdiction where the insured resides,  
13 where the accident occurs, or, in the case of an assignment of  
14 benefits, where the disputed health care services were  
15 performed. Venue may be raised at any time. The cost of  
16 transferring venue shall be borne by the plaintiff, and such  
17 costs shall not be recoverable as plaintiff's damages.

18 (25) NONPREEMPTION.--This section shall not be deemed  
19 to preempt or supersede any cause of action that may otherwise  
20 be available.

21 Section 3. Section 19 of chapter 2003-411, Laws of  
22 Florida, is repealed.

23 Section 4. This act shall take effect October 1, 2006.

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25  
26 SENATE SUMMARY

27 Substantially revises and reorganizes s. 627.736, F.S.,  
28 relating to personal injury protection benefits to  
29 improve comprehension. Additionally, makes substantive  
30 changes, including provisions relating to notification of  
31 insurers, priority of claims, assignment of benefits,  
time periods for various actions, and recovery of  
payments. Abrogates the repeal of the Florida Motor  
Vehicle No-Fault Law. (See bill for details.)