

Bill No. SB 2114

Barcode 340598

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Proposed Committee Substitute by the Committee on Banking and Insurance

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.

8 627.736, F.S.; providing that a self-employed

9 injured person or an injured person owning 25

10 percent or more interest in an employer offer

11 proof of income and lost wages to insurers as a

12 condition precedent for payment; providing for

13 a statement of earnings; requiring an insured

14 to notify an insurer in writing of election to

15 reserve benefits for lost wages; specifying

16 that such notification takes priority over

17 other claims, except specified hospital liens;

18 providing for Medicaid benefits; requiring the

19 Department of Health to determine by rule tests

20 deemed not to be medically necessary; providing

21 guidance as to criteria to be considered;

22 providing for required payment of benefits;

23 authorizing a parent or legal guardian of an

24 injured minor to complete application for

25 personal injury protection benefits; providing

26 for changes for treatment of injured persons;

27 providing requirements for compliance with

28 billing procedures; specifying the time period

29 within which a health care provider or other

30 specified provider must submit a statement of

31 charges; prohibiting providers from billing an

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1 injured person under specified conditions for
2 emergency services and care; requiring a
3 provider to submit a written bill at the time
4 of treatment which the injured patient must
5 sign; providing exceptions; requiring insurers
6 to provide specified documents to insureds;
7 requiring that amounts repayable to an insurer
8 include the statutory interest penalty;
9 increasing the time period for an insurer to
10 respond to a demand letter; providing
11 requirements for the production and inspection
12 of an injured person's medical records from a
13 provider; eliminating the application of a
14 contingency risk multiplier as to attorney-fee
15 awards in specified disputes; providing that
16 persons notifying insurers of improper billing
17 may obtain a reward; restricting venue for any
18 personal injury protection claim to specified
19 jurisdictions and providing for costs of
20 transferring venue; amending s. 316.068, F.S.;
21 specifying information to be included in a
22 crash report; creating a rebuttable presumption
23 regarding the existence of passengers;
24 specifying conditions relating to reporting
25 passengers; amending s. 322.26, F.S.; providing
26 an additional circumstance relating to
27 insurance crimes for mandatory revocation of a
28 person's driver's license; amending s. 817.234,
29 F.S.; revising provisions specifying material
30 omission and insurance fraud; prohibiting
31 scheming to create documentation of a motor

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1 vehicle crash that did not occur; providing a
 2 criminal penalty; amending s. 817.2361, F.S.;
 3 providing that creating, marketing, or
 4 presenting fraudulent proof of motor vehicle
 5 insurance is a felony of the third degree;
 6 providing appropriations for law enforcement
 7 and investigative personnel in the Division of
 8 Insurance Fraud and for assistant state
 9 attorney positions in specified circuits;
 10 abrogating the repeal of provisions pertaining
 11 to the Florida Motor Vehicle No-Fault Law;
 12 providing an effective date.

13
14 Be It Enacted by the Legislature of the State of Florida:

15
16 Section 1. Section 627.736, Florida Statutes, is
17 amended to read:

18 627.736 Required personal injury protection benefits;
19 exclusions; priority; claims.--

20 (1) REQUIRED PERSONAL INJURY PROTECTION
 21 BENEFITS.--Every insurance policy complying with the security
 22 requirements of s. 627.733 shall provide personal injury
 23 protection to the named insured, relatives residing in the
 24 same household, persons operating the insured motor vehicle,
 25 passengers in such motor vehicle, and other persons struck by
 26 such motor vehicle and suffering bodily injury while not an
 27 occupant of a self-propelled vehicle, subject to the
 28 provisions of subsections (3) ~~subsection (2)~~ and ~~(6) paragraph~~
 29 ~~(4)(d)~~, to a limit of \$10,000 for loss sustained by any such
 30 person as a result of bodily injury, sickness, disease, or
 31 death arising out of the ownership, maintenance, or use of a

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1 motor vehicle as follows:

2 (a) Medical benefits.--Eighty percent of all
 3 reasonable expenses for medically necessary medical, surgical,
 4 X-ray, dental, and rehabilitative services, including
 5 prosthetic devices, and medically necessary ambulance,
 6 hospital, and nursing services. Such benefits shall also
 7 include necessary remedial treatment and services recognized
 8 and permitted under the laws of the state for an injured
 9 person who relies upon spiritual means through prayer alone
 10 for healing, in accordance with his or her religious beliefs;
 11 however, this sentence does not affect the determination of
 12 what other services or procedures are medically necessary.

13 (b) Disability benefits.--

14 1. Sixty percent of any loss of gross income and loss
 15 of earning capacity per ~~injured person~~ ~~individual~~ from
 16 inability to work proximately caused by the injury sustained
 17 by the injured person, plus all expenses reasonably incurred
 18 in obtaining from others ordinary and necessary services in
 19 lieu of those that, but for the injury, the injured person
 20 would have performed without income for the benefit of his or
 21 her household. All disability benefits payable under this
 22 provision shall be paid not less than every 2 weeks.

23 2. For an injured person who is self employed or an
 24 injured person who owns over a 25-percent interest in his or
 25 her employer, as a condition precedent to payment for lost
 26 wages, the injured person must produce to the insurer
 27 reasonable proof as to the injured person's income and loss of
 28 earning capacity or additional expense, such that the insurer
 29 may reasonably calculate the amount of the loss of income.

30 3. Every employer shall, if a request is made by an
 31 insurer providing personal injury protection benefits under

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1 ss. 627.730-627.7405 against whom a claim has been made,
2 furnish forthwith, in a form approved by the office, a sworn
3 statement of the earnings, since the time of the bodily injury
4 and for a 13-week time period before the injury, of the person
5 upon whose injury the claim is based.

6 4. If the insured elects to have disability benefits
7 reserved for lost wages, the insured shall notify the insurer
8 in writing, which shall be binding on the insurer. Receipt of
9 such notification shall take priority over all claims subject
10 to an assignment of benefits received after receipt of such
11 notice, except that receipt by the insurer of a properly
12 perfected hospital lien, prior to payment of the lost wage
13 claim, shall take priority over the insured's election to
14 reserve all benefits for lost wages.

15 (c) Death benefits.--The insurer shall pay death
16 benefits in the amount of \$5,000 per individual. The insurer
17 may pay such benefits to the executor or administrator of the
18 deceased, to any of the deceased's relatives by blood or legal
19 adoption or connection by marriage, or to any person appearing
20 to the insurer to be equitably entitled thereto.

21 (d) Medicaid benefits.--When the Agency for Health
22 Care Administration provides, pays, or becomes liable for
23 medical assistance under the Medicaid program related to
24 injury, sickness, disease, or death arising out of the
25 ownership, maintenance, or use of a motor vehicle, benefits
26 under ss. 627.730-627.7405 shall be subject to the provisions
27 of the Medicaid program.

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

29 (a) Only insurers writing motor vehicle liability
30 insurance in this state may provide the required benefits of
31 this section, and no such insurer shall require the purchase

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1 of any other motor vehicle coverage other than the purchase of
2 property damage liability coverage as required by s. 627.7275
3 as a condition for providing such required benefits.

4 **(b)** Insurers may not require that property damage
5 liability insurance in an amount greater than \$10,000 be
6 purchased in conjunction with personal injury protection.
7 Such insurers shall make benefits and required property damage
8 liability insurance coverage available through normal
9 marketing channels. Any insurer writing motor vehicle
10 liability insurance in this state who fails to comply with
11 such availability requirement as a general business practice
12 shall be deemed to have violated part IX of chapter 626, and
13 such violation shall constitute an unfair method of
14 competition or an unfair or deceptive act or practice
15 involving the business of insurance; and any such insurer
16 committing such violation shall be subject to the penalties
17 afforded in such part, as well as those which may be afforded
18 elsewhere in the insurance code.

19 ~~(3)(2)~~ **AUTHORIZED EXCLUSIONS.**--Any insurer may exclude
20 benefits:

21 (a) For injury sustained by the named insured and
22 relatives residing in the same household while occupying
23 another motor vehicle owned by the named insured and not
24 insured under the policy or for injury sustained by any person
25 operating the insured motor vehicle without the express or
26 implied consent of the insured.

27 (b) To any injured person, if such person's conduct
28 contributed to his or her injury under any of the following
29 circumstances:

30 1. Causing injury to himself or herself intentionally;
31 or

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1 2. Being injured while committing a felony.

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3 Whenever an insured is charged with conduct as set forth in
4 subparagraph 2., the 30-day payment provision of subsection
5 ~~(8) paragraph (4)(b)~~ shall be held in abeyance, and the
6 insurer shall withhold payment of any personal injury
7 protection benefits pending the outcome of the case at the
8 trial level. If the charge is nolle prossed or dismissed or
9 the insured is acquitted, the 30-day payment provision shall
10 run from the date the insurer is notified of such action.

11 ~~(4)(3)~~ INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES
12 IN TORT CLAIMS.--No insurer shall have a lien on any recovery
13 in tort by judgment, settlement, or otherwise for personal
14 injury protection benefits, whether suit has been filed or
15 settlement has been reached without suit. An injured person
16 ~~party~~ who is entitled to bring suit under ~~the provisions of~~
17 ss. 627.730-627.7405, or his or her legal representative, has
18 ~~shall have~~ no right to recover any damages for which personal
19 injury protection benefits are paid or payable. The plaintiff
20 may prove all of his or her special damages notwithstanding
21 this limitation, but if special damages are introduced in
22 evidence, the trier of facts, whether judge or jury, shall not
23 award damages for personal injury protection benefits paid or
24 payable. In all cases in which a jury is required to fix
25 damages, the court shall instruct the jury that the plaintiff
26 shall not recover such special damages for personal injury
27 protection benefits paid or payable.

28 (5) NONREIMBURSABLE SERVICES.--The Department of
29 Health, in consultation with the appropriate professional
30 licensing boards, shall adopt, by rule, a list of diagnostic
31 tests deemed not to be medically necessary as defined in s.

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1 627.732 for use in either the diagnosis or treatment of
2 persons sustaining bodily injury covered by personal injury
3 protection benefits under this section. The list shall be
4 revised from time to time as determined by the Department of
5 Health, in consultation with the appropriate professional
6 licensing boards. In determining whether a test is medically
7 necessary for purposes of this subsection, the department may
8 consider the degree of positive diagnostic or treatment
9 benefits in relation to costs; whether there is substantial
10 demonstrated medical value for the injured person; the
11 availability of alternative methods of treatment or diagnosis;
12 the immediacy or remoteness of likely benefit for the injured
13 person; whether there is evidence of overuse by providers
14 primarily for financial gain; whether there is acceptance of
15 the use of the tests for injured persons; and whether there
16 are reservations regarding such use as reported to the
17 department by the appropriate professional licensing boards.
18 The department shall give greater weight to the advice of the
19 appropriate licensing boards on whether a test is medically
20 unnecessary than to a degree of acceptance by some individuals
21 or groups within the relevant provider communities.

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

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

29 (b) Accidental bodily injury sustained outside this
30 state, but within the United States of America or its
31 territories or possessions or Canada, by the owner while

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1 occupying the owner's motor vehicle.

2 (c) Accidental bodily injury sustained by a relative
3 of the owner residing in the same household, under the
4 circumstances described in paragraphs (a) and (b), provided
5 the relative at the time of the accident is domiciled in the
6 owner's household and is not himself or herself the owner of a
7 motor vehicle with respect to which security is required under
8 ss. 627.730-627.7405.

9 (d) Accidental bodily injury sustained in this state
10 by any other person while occupying the owner's motor vehicle
11 or, if a resident of this state, while not an occupant of a
12 self-propelled vehicle, if the injury is caused by physical
13 contact with such motor vehicle, provided the injured person
14 is not himself or herself:

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

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

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

26 (7) CLAIMS SUBMISSION ~~(4) BENEFITS; WHEN~~
27 ~~DUE.~~--Benefits due from an insurer under ss. 627.730-627.7405
28 shall be primary, except that benefits received under any
29 workers' compensation law shall be credited against the
30 benefits provided by subsection (1), and shall be due and
31 payable as loss accrues, upon receipt of reasonable proof of

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1 such loss and the amount of expenses and loss incurred which
2 are covered by the policy issued under ss. 627.730-627.7405,
3 subject to the following: ~~When the Agency for Health Care~~
4 ~~Administration provides, pays, or becomes liable for medical~~
5 ~~assistance under the Medicaid program related to injury,~~
6 ~~sickness, disease, or death arising out of the ownership,~~
7 ~~maintenance, or use of a motor vehicle, benefits under ss.~~
8 ~~627.730-627.7405 shall be subject to the provisions of the~~
9 ~~Medicaid program.~~

10 (a) Personal injury protection application.--An
11 insurer may require written notice to be given as soon as
12 practicable after an accident involving a motor vehicle with
13 respect to which the policy affords the security required by
14 ss. 627.730-627.7405. If the injured person is a minor, the
15 parent or legal guardian of the minor, if requested by the
16 insurer, must accurately complete the personal injury
17 protection application.

18 (b) Charges for treatment of injured persons; billing
19 requirements.--

20 1. Any physician, hospital, clinic, or other person or
21 institution lawfully rendering treatment to an injured person
22 for a bodily injury covered by personal injury protection
23 insurance may charge the insurer and injured party only a
24 reasonable amount pursuant to this section for the services
25 and supplies rendered, and the insurer providing such coverage
26 may pay for such charges directly to such person or
27 institution lawfully rendering such treatment, if the insured
28 receiving such treatment or his or her guardian has
29 countersigned the properly completed invoice, bill, or claim
30 form approved by the office upon which such charges are to be
31 paid for as having actually been rendered, to the best

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1 knowledge of the insured or his or her guardian. In no event,
2 however, may such a charge be in excess of the amount the
3 person or institution customarily charges for like services or
4 supplies. With respect to a determination of whether a charge
5 for a particular service, treatment, or otherwise is
6 reasonable, consideration may be given to evidence of usual
7 and customary charges and payments accepted by the provider
8 involved in the dispute, and reimbursement levels in the
9 community and various federal and state medical fee schedules
10 applicable to automobile and other insurance coverages, and
11 other information relevant to the reasonableness of the
12 reimbursement for the service, treatment, or supply.

13 2. All statements and bills for medical services
14 rendered by any physician, hospital, clinic, or other person
15 or institution shall be submitted to the insurer on a properly
16 completed Centers for Medicare and Medicaid Services (CMS)
17 1500 form or its successor or a UB 92 form or its successor.

18 3. All billings for such services, procedures, and
19 supplies submitted by health care providers and medical
20 suppliers shall comply with the Healthcare Correct Procedural
21 Coding System (HCPCS) and International Classification of
22 Diseases (ICD-9-CM) or their successors in effect at the time
23 of patient discharge, if applicable, or when the service was
24 rendered, if applicable, for the year in which services are
25 rendered.

26 4. All claims forms submitted by health care providers
27 and medical suppliers other than hospitals shall include on
28 the applicable claim form the signature and professional
29 license number of the provider who rendered services in the
30 line or space provided for "Signature of Physician or
31 Supplier, Including Degrees or Credentials" and the date of

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1 the signature.

2 5. In determining compliance with applicable HCPCS and
3 ICD-9-CM coding, or their successors, guidance shall be
4 provided by the Healthcare Correct Procedural Coding System
5 (HCPCS) or its successor, International Classification of
6 Diseases (ICD-9-CM) or its successor, the Office of the
7 Inspector General (OIG), Physicians Compliance Guidelines,
8 rules of the Agency for Health Care Administration, the
9 Florida Health Information Management Association (FHIMA), and
10 other authoritative treatises.

11 6. Charges for medically necessary cephalic
12 thermograms, peripheral thermograms, spinal ultrasounds,
13 extremity ultrasounds, video fluoroscopy, and surface
14 electromyography shall not exceed the maximum reimbursement
15 allowance for such procedures as set forth in the applicable
16 fee schedule or other payment methodology established pursuant
17 to s. 440.13.

18 7. Allowable amounts that may be charged to a personal
19 injury protection insurance insurer and insured for medically
20 necessary nerve conduction testing when done in conjunction
21 with a needle electromyography procedure and both are
22 performed and billed solely by a physician licensed under
23 chapter 458, chapter 459, chapter 460, or chapter 461 who is
24 also certified by the American Board of Electrodiagnostic
25 Medicine or by a board recognized by the American Board of
26 Medical Specialties or the American Osteopathic Association or
27 who holds diplomate status with the American Chiropractic
28 Neurology Board or its predecessors shall not exceed 200
29 percent of the allowable amount under the participating
30 physician fee schedule of Medicare Part B for year 2001, for
31 the area in which the treatment was rendered, adjusted

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1 annually on August 1 to reflect the prior calendar year's
2 changes in the annual Medical Care Item of the Consumer Price
3 Index for All Urban Consumers in the South Region as
4 determined by the Bureau of Labor Statistics of the United
5 States Department of Labor.

6 8. Allowable amounts that may be charged to a personal
7 injury protection insurance insurer and insured for medically
8 necessary nerve conduction testing that does not meet the
9 requirements of subparagraph 7. shall not exceed the
10 applicable fee schedule or other payment methodology
11 established pursuant to s. 440.13.

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

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1 annually on August 1 to reflect the prior calendar year's
2 changes in the annual Medical Care Item of the Consumer Price
3 Index for All Urban Consumers in the South Region as
4 determined by the Bureau of Labor Statistics of the United
5 States Department of Labor for the 12-month period ending June
6 30 of that year. This paragraph does not apply to charges for
7 magnetic resonance imaging services and nerve conduction
8 testing for inpatients and emergency services and care as
9 defined in chapter 395 rendered by facilities licensed under
10 chapter 395.

11 10. A statement of medical services may not include
12 charges for medical services of a person or entity that
13 rendered such services without possessing all valid
14 qualifications and licenses required to lawfully provide and
15 bill for such services.

16 11. For purposes of subsection (8), an insurer shall
17 not be considered to have been furnished with notice of the
18 amount of covered loss or medical bills due unless the
19 statements or bills comply with this paragraph, and unless the
20 statements or bills are properly completed in their entirety
21 as to all material provisions, with all required information
22 being provided therein.

23 12. An insurer may not systematically downcode with
24 the intent to deny reimbursement otherwise due. Such action
25 constitutes a material misrepresentation under s.
26 626.9541(1)(i)2.

27 (c) Direct billing an insurer for personal injury
28 protection benefits.--

29 1. The insurer providing coverage may pay for charges
30 directly to the insured or the insured's assignee.

31 2. Except for hospital and emergency services and care

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1 rendered pursuant to s. 395.002, the insured receiving such
2 treatment or his or her guardian, if a minor, shall
3 countersign the properly completed CMS 1500 form or its
4 successor or UB 92 form or its successor submitted for
5 payment. Health care providers or service providers who do not
6 render services in the presence of the insured are not
7 required to comply with this paragraph.

8 (d) Timely billing for nonemergency services.--With
9 respect to any treatment or service, other than medical
10 services billed by a hospital or other provider for emergency
11 services as defined in s. 395.002 or inpatient services
12 rendered at a hospital-owned facility, the statement of
13 charges must be furnished to the insurer by the provider and
14 may not include, and the insurer is not required to pay,
15 charges for treatment or services rendered more than 35 days
16 before the postmark date of the statement, except for the
17 following:

18 1. Past due amounts previously billed on a timely
19 basis under this subsection.

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

30 3. If the insured fails to furnish the provider with
31 the correct name and address of the insured's personal injury

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1 protection insurer, the provider has 35 days from the date the
2 provider obtains the correct information to furnish the
3 insurer with a statement of the charges. The insurer is not
4 required to pay for such charges unless the provider includes
5 with the statement documentary evidence that was provided by
6 the insured during the 35-day period demonstrating that the
7 provider reasonably relied on erroneous information from the
8 insured and either:

9 a. A denial letter from the incorrect insurer; or
10 b. Proof of mailing, which may include an affidavit
11 under penalty of perjury, reflecting timely mailing to the
12 incorrect address or insurer.

13 (e) Timely billing for emergency services.--

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

27 2. The injured person is not liable for, and the
28 provider shall not bill the injured person for, charges that
29 are unpaid because of the provider's failure to comply with
30 this paragraph. Any agreement requiring the injured person or
31 insured to pay for such charges is unenforceable.

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1 (f) Billing notice and disclosures.--

2 1. Each notice of insured's rights under s. 627.7401
3 must include the following statement in type no smaller than
4 12-point font:

5
6 BILLING REQUIREMENTS.--Florida Statutes provide
7 that with respect to any treatment or services,
8 other than certain hospital and emergency
9 services, the statement of charges furnished to
10 the insurer by the provider may not include,
11 and the insurer and the injured person are not
12 required to pay, charges for treatment or
13 services rendered more than 35 days before the
14 postmark date of the statement, except for past
15 due amounts previously billed on a timely
16 basis, and except that, if the provider submits
17 to the insurer a notice of initiation of
18 treatment within 21 days after its first
19 examination or treatment of the claimant, the
20 statement may include charges for treatment or
21 services rendered up to, but not more than, 50
22 days before the postmark date of the statement.

23
24 2. Except for hospital and emergency services and care
25 rendered pursuant to s. 395.002, on each date services are
26 rendered the health care provider shall provide to the insured
27 patient a written bill, superbill, fee slip, or other similar
28 document that establishes in plain language a detailed
29 description of the service provided and the cost associated
30 with the service. The insured must sign the written bill,
31 superbill, fee slip, or other similar document immediately

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1 after having received services. Copies of such disclosures
2 shall be maintained as part of the patient's medical records
3 in accordance with minimal record keeping standards. Health
4 care providers or service providers who do not render services
5 in the presence of the insured are not required to comply with
6 this section.

7 (g) Upon request, the insured and his or her assigns
8 shall be sent a letter containing a payment log itemizing all
9 payments made, the applicable insurance declarations page, and
10 a copy of the insurance policy within 30 days after the
11 written request. Such request shall state that it is a
12 "request under s. 627.736(7)" and shall state with
13 specificity:

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

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

19
20 Such request must be sent to the person and address specified
21 by the insurer for the purposes of receiving notices or
22 requests under this section.

23 (h) 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

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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 (8) OVERDUE PERSONAL INJURY PROTECTION BENEFITS.--

10 (a)(b) Personal injury protection insurance benefits
11 paid pursuant to this section shall be overdue if not paid
12 within 30 days after the insurer is furnished written notice
13 of the amount fact of a covered loss, including a properly
14 completed CMS 1500 form or its successor or UB 92 form or its
15 successor, assignment of benefits, or, in the case of
16 disability benefits, proper written documentation of the claim
17 and of the amount of same. If such written notice is not
18 furnished to the insurer as to the entire claim, any partial
19 amount supported by written notice is overdue if not paid
20 within 30 days after such written notice is furnished to the
21 insurer. Any part or all of the remainder of the claim that
22 is subsequently supported by written notice is overdue if not
23 paid within 30 days after such written notice is furnished to
24 the insurer. When an insurer pays only a portion of a claim or
25 rejects a claim, the insurer shall provide at the time of the
26 partial payment or rejection an itemized specification of each
27 item that the insurer had reduced, omitted, or declined to pay
28 and any information that the insurer desires the claimant to
29 consider related to the medical necessity of the denied
30 treatment or to explain the reasonableness of the reduced
31 charge, provided that this shall not limit the introduction of

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1 evidence at trial; and the insurer shall include the name and
2 address of the person to whom the claimant should respond and
3 a claim number to be referenced in future correspondence.
4 However, notwithstanding the fact that written notice has been
5 furnished to the insurer, any payment shall not be deemed
6 overdue when the insurer has reasonable proof to establish
7 that the insurer is not responsible for the payment. ~~For the~~
8 ~~purpose of calculating the extent to which any benefits are~~
9 ~~overdue, payment shall be treated as being made on the date a~~
10 ~~draft or other valid instrument which is equivalent to payment~~
11 ~~was placed in the United States mail in a properly addressed,~~
12 ~~postpaid envelope or, if not so posted, on the date of~~
13 ~~delivery.~~

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

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

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

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

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

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

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

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

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

26 ~~(e) If two or more insurers are liable to pay personal~~
27 ~~injury protection benefits for the same injury to any one~~
28 ~~person, the maximum payable shall be as specified in~~
29 ~~subsection (1), and any insurer paying the benefits shall be~~
30 ~~entitled to recover from each of the other insurers an~~
31 ~~equitable pro rata share of the benefits paid and expenses~~

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1 ~~incurred in processing the claim.~~

2 ~~(c)(f)~~ It is a violation of the insurance code for an
 3 insurer to fail to timely provide benefits as required by this
 4 section with such frequency as to constitute a general
 5 business practice.

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

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

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

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

12 ~~(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--~~

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

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1 ~~involved in the dispute, and reimbursement levels in the~~
 2 ~~community and various federal and state medical fee schedules~~
 3 ~~applicable to automobile and other insurance coverages, and~~
 4 ~~other information relevant to the reasonableness of the~~
 5 ~~reimbursement for the service, treatment, or supply.~~

6 (11) CLAIMS NOT PROPERLY PAYABLE.--

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

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

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

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

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

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

31 ~~(f)f.~~ For medical services or treatment billed by a

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1 physician and not provided in a hospital unless such services
2 are rendered by the physician or are incident to his or her
3 professional services and are included on the physician's
4 bill, including documentation verifying that the physician is
5 responsible for the medical services that were rendered and
6 billed.

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

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

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1 ~~States Department of Labor.~~

2 4. ~~Allowable amounts that may be charged to a personal~~
3 ~~injury protection insurance insurer and insured for medically~~
4 ~~necessary nerve conduction testing that does not meet the~~
5 ~~requirements of subparagraph 3. shall not exceed the~~
6 ~~applicable fee schedule or other payment methodology~~
7 ~~established pursuant to s. 440.13.~~

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

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1 ~~States Department of Labor for the 12-month period ending June~~
2 ~~30 of that year. This paragraph does not apply to charges for~~
3 ~~magnetic resonance imaging services and nerve conduction~~
4 ~~testing for inpatients and emergency services and care as~~
5 ~~defined in chapter 395 rendered by facilities licensed under~~
6 ~~chapter 395.~~

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

24 ~~(c)1. With respect to any treatment or service, other~~
25 ~~than medical services billed by a hospital or other provider~~
26 ~~for emergency services as defined in s. 395.002 or inpatient~~
27 ~~services rendered at a hospital-owned facility, the statement~~
28 ~~of charges must be furnished to the insurer by the provider~~
29 ~~and may not include, and the insurer is not required to pay,~~
30 ~~charges for treatment or services rendered more than 35 days~~
31 ~~before the postmark date of the statement, except for past due~~

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1 ~~amounts previously billed on a timely basis under this~~
2 ~~paragraph, and except that, if the provider submits to the~~
3 ~~insurer a notice of initiation of treatment within 21 days~~
4 ~~after its first examination or treatment of the claimant, the~~
5 ~~statement may include charges for treatment or services~~
6 ~~rendered up to, but not more than, 75 days before the postmark~~
7 ~~date of the statement. The injured party is not liable for,~~
8 ~~and the provider shall not bill the injured party for, charges~~
9 ~~that are unpaid because of the provider's failure to comply~~
10 ~~with this paragraph. Any agreement requiring the injured~~
11 ~~person or insured to pay for such charges is unenforceable.~~

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

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

26 ~~3. For emergency services and care as defined in s.~~
27 ~~395.002 rendered in a hospital emergency department or for~~
28 ~~transport and treatment rendered by an ambulance provider~~
29 ~~licensed pursuant to part III of chapter 401, the provider is~~
30 ~~not required to furnish the statement of charges within the~~
31 ~~time periods established by this paragraph; and the insurer~~

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1 ~~shall not be considered to have been furnished with notice of~~
 2 ~~the amount of covered loss for purposes of paragraph (4)(b)~~
 3 ~~until it receives a statement complying with paragraph (d), or~~
 4 ~~copy thereof, which specifically identifies the place of~~
 5 ~~service to be a hospital emergency department or an ambulance~~
 6 ~~in accordance with billing standards recognized by the Health~~
 7 ~~Care Finance Administration.~~

8 ~~4. Each notice of insured's rights under s. 627.7401~~
 9 ~~must include the following statement in type no smaller than~~
 10 ~~12 points:~~

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

29
 30 ~~(d) All statements and bills for medical services~~
 31 ~~rendered by any physician, hospital, clinic, or other person~~

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1 ~~or institution shall be submitted to the insurer on a properly~~
2 ~~completed Centers for Medicare and Medicaid Services (CMS)~~
3 ~~1500 form, UB 92 forms, or any other standard form approved by~~
4 ~~the office or adopted by the commission for purposes of this~~
5 ~~paragraph. All billings for such services rendered by~~
6 ~~providers shall, to the extent applicable, follow the~~
7 ~~Physicians' Current Procedural Terminology (CPT) or Healthcare~~
8 ~~Correct Procedural Coding System (HCPCS), or ICD-9 in effect~~
9 ~~for the year in which services are rendered and comply with~~
10 ~~the Centers for Medicare and Medicaid Services (CMS) 1500 form~~
11 ~~instructions and the American Medical Association Current~~
12 ~~Procedural Terminology (CPT) Editorial Panel and Healthcare~~
13 ~~Correct Procedural Coding System (HCPCS). All providers other~~
14 ~~than hospitals shall include on the applicable claim form the~~
15 ~~professional license number of the provider in the line or~~
16 ~~space provided for "Signature of Physician or Supplier,~~
17 ~~Including Degrees or Credentials." In determining compliance~~
18 ~~with applicable CPT and HCPCS coding, guidance shall be~~
19 ~~provided by the Physicians' Current Procedural Terminology~~
20 ~~(CPT) or the Healthcare Correct Procedural Coding System~~
21 ~~(HCPCS) in effect for the year in which services were~~
22 ~~rendered, the Office of the Inspector General (OIG),~~
23 ~~Physicians Compliance Guidelines, and other authoritative~~
24 ~~treatises designated by rule by the Agency for Health Care~~
25 ~~Administration. No statement of medical services may include~~
26 ~~charges for medical services of a person or entity that~~
27 ~~performed such services without possessing the valid licenses~~
28 ~~required to perform such services. For purposes of paragraph~~
29 ~~(4)(b), an insurer shall not be considered to have been~~
30 ~~furnished with notice of the amount of covered loss or medical~~
31 ~~bills due unless the statements or bills comply with this~~

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~~paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.~~

~~(12) DEMAND LETTER.--~~

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to subsection (8).

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

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

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

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of subsection (7) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under subsection (15) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed

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1 to be reasonable and medically necessary.

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

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

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1 amount demanded, the penalty shall not be payable in any
 2 subsequent action. For purposes of this subsection, payment or
 3 the insurer's agreement shall be treated as being made on the
 4 date a draft or other valid instrument that is equivalent to
 5 payment, or the insurer's written statement of agreement, is
 6 placed in the United States mail in a properly addressed,
 7 postpaid envelope, or if not so posted, on the date of
 8 delivery. The insurer is not obligated to pay any attorney's
 9 fees if the insurer pays the claim or mails its agreement to
 10 pay for future treatment within the time prescribed by this
 11 subsection.

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

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

19 (13) DISCLOSURE AND ACKNOWLEDGEMENT FORM.--

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

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

30 2.b. The insured, or his or her guardian, has both the
 31 right and affirmative duty to confirm that the services were

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1 actually rendered;

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

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

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

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

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

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

27 ~~(e)5.~~ The original completed disclosure and
28 acknowledgment form shall be furnished to the insurer pursuant
29 to subsection (8) ~~paragraph (4)(b)~~ and may not be
30 electronically furnished.

31 ~~(f)6.~~ This disclosure and acknowledgment form is not

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1 required for services billed by a provider for emergency
2 services as defined in s. 395.002, for emergency services and
3 care as defined in s. 395.002 rendered in a hospital emergency
4 department, or for transport and treatment rendered by an
5 ambulance provider licensed pursuant to part III of chapter
6 401.

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

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

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

30 ~~(f)~~ ~~Upon written notification by any person, an~~
31 ~~insurer shall investigate any claim of improper billing by a~~

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

15 ~~(g) An insurer may not systematically downcode with~~
 16 ~~the intent to deny reimbursement otherwise due. Such action~~
 17 ~~constitutes a material misrepresentation under s.~~
 18 ~~626.9541(1)(i)2.~~

19 ~~(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;~~
 20 ~~DISPUTES.--~~

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

28 ~~(14) DISCOVERY OF FACTS ABOUT AN INJURED PERSON;~~
 29 ~~DISPUTES.--~~

30 ~~(a)(b) Every physician, hospital, clinic, or other~~
 31 ~~medical institution providing, before or after bodily injury~~

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1 upon which a claim for personal injury protection insurance
 2 benefits is based, any products, services, or accommodations
 3 in relation to that or any other injury, or in relation to a
 4 condition claimed to be connected with that or any other
 5 injury, shall, if requested to do so by the insurer against
 6 whom the claim has been made:⁷

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

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

17 3. ~~Identify and identifying~~ which portion of the
 18 expenses for such treatment or services was incurred as a
 19 result of such bodily injury.⁷

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

28 (b) However, if the records are maintained at an
 29 alternative location, the requested records shall be made
 30 available at the principal place of business within 25 working
 31 days after the request. If the requested records are not made

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1 available within this time period and such records are later
2 admitted into evidence or otherwise used to support a claim by
3 the health care provider against the insurer, the court shall
4 not award attorney's fees to the provider pursuant to this
5 section or s. 627.428. At the time of the records inspection,
6 the health care provider shall allow the insurer to inspect
7 records and photograph the equipment and associated documents
8 associated with the insured's treatment, services, or
9 supplies.

10 (c) A ~~no~~ cause of action for violation of the
11 physician-patient privilege or invasion of the right of
12 privacy is not ~~shall be~~ permitted against any physician,
13 hospital, clinic, or other medical institution complying with
14 ~~the provisions of~~ this section.

15 (d) The person requesting such records and such sworn
16 statement shall pay all reasonable costs connected therewith.

17 (e) If an insurer makes a written request for
18 documentation or information under this paragraph within 30
19 days after having received notice of the amount of a covered
20 loss under subsection (7) ~~paragraph (4)(a)~~, the amount or the
21 partial amount that ~~which~~ is the subject of the insurer's
22 inquiry shall become overdue if the insurer does not pay in
23 accordance with subsection (8) ~~paragraph (4)(b)~~ or within 15
24 ~~10~~ days after the insurer's receipt of the requested
25 documentation or information, whichever occurs later. For
26 purposes of this paragraph, the term "receipt" includes, but
27 is not limited to, inspection and copying pursuant to this
28 subsection ~~paragraph~~.

29 (f) Any insurer that requests documentation or
30 information pertaining to reasonableness of charges or medical
31 necessity under this subsection ~~paragraph~~ without a reasonable

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1 basis for such requests as a general business practice is
2 engaging in an unfair trade practice under the insurance code.

3 ~~(g)(e)~~ In the event of any dispute regarding an
4 insurer's right to discovery of facts under this section, the
5 insurer may petition a court of competent jurisdiction to
6 enter an order permitting such discovery. The order may be
7 made only on motion for good cause shown and upon notice to
8 all persons having an interest, and it shall specify the time,
9 place, manner, conditions, and scope of the discovery. Such
10 court may, in order to protect against annoyance,
11 embarrassment, or oppression, as justice requires, enter an
12 order refusing discovery or specifying conditions of discovery
13 and may order payments of costs and expenses of the
14 proceeding, including reasonable fees for the appearance of
15 attorneys at the proceedings, as justice requires.

16 ~~(h)(d)~~ The injured person shall be furnished, upon
17 request, a copy of all information obtained by the insurer
18 under the provisions of this section, and shall pay a
19 reasonable charge, if required by the insurer.

20 ~~(i)(e)~~ Notice to an insurer of the existence of a
21 claim shall not be unreasonably withheld by an insured.

22 ~~(15)(7)~~ MENTAL AND PHYSICAL EXAMINATION OF INJURED
23 PERSON; REPORTS.--

24 (a) Whenever the mental or physical condition of an
25 injured person covered by personal injury protection is
26 material to any claim that has been or may be made for past or
27 future personal injury protection insurance benefits, such
28 person shall, upon the request of an insurer, submit to mental
29 or physical examination by a physician or physicians.

30 (b) The costs of any examinations requested by an
31 insurer shall be borne entirely by the insurer.

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1 (c) Such examination shall be conducted within the
2 municipality where the insured is receiving treatment, or in a
3 location reasonably accessible to the insured, which, for
4 purposes of this paragraph, means any location within the
5 municipality in which the insured resides, or any location
6 within 10 miles by road of the insured's residence, provided
7 such location is within the county in which the insured
8 resides.

9 (d) If the examination is to be conducted in a
10 location reasonably accessible to the insured, and if there is
11 no qualified physician to conduct the examination in a
12 location reasonably accessible to the insured, then such
13 examination shall be conducted in an area of the closest
14 proximity to the insured's residence.

15 (e) ~~Personal protection~~ Insurers are authorized to
16 include reasonable provisions in personal injury protection
17 insurance policies for mental and physical examination of
18 those claiming personal injury protection insurance benefits.

19 (f) An insurer may not withdraw payment of a treating
20 physician without the consent of the injured person covered by
21 the personal injury protection, unless the insurer first
22 obtains a valid report by a Florida physician licensed under
23 the same chapter as the treating physician whose treatment
24 authorization is sought to be withdrawn, stating that
25 treatment was not reasonable, related, or necessary.

26 (g) A valid report is one that is prepared and signed
27 by the physician examining the injured person or reviewing the
28 treatment records of the injured person and is factually
29 supported by the examination and treatment records if reviewed
30 and that has not been modified by anyone other than the
31 physician.

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1 (h) The physician preparing the report must be in
2 active practice, unless the physician is physically disabled.
3 Active practice means that during the 3 years immediately
4 preceding the date of the physical examination or review of
5 the treatment records the physician must have devoted
6 professional time to the active clinical practice of
7 evaluation, diagnosis, or treatment of medical conditions or
8 to the instruction of students in an accredited health
9 professional school or accredited residency program or a
10 clinical research program that is affiliated with an
11 accredited health professional school or teaching hospital or
12 accredited residency program.

13 (i) The physician preparing a report at the request of
14 an insurer and physicians rendering expert opinions on behalf
15 of persons claiming medical benefits for personal injury
16 protection, or on behalf of an insured through an attorney or
17 another entity, shall maintain, for at least 3 years, copies
18 of all examination reports as medical records and shall
19 maintain, for at least 3 years, records of all payments for
20 the examinations and reports.

21 (j) Neither an insurer nor any person acting at the
22 direction of or on behalf of an insurer may materially change
23 an opinion in a report prepared under this subsection
24 ~~paragraph~~ or direct the physician preparing the report to
25 change such opinion. The denial of a payment as the result of
26 such a changed opinion constitutes a material
27 misrepresentation under s. 626.9541(1)(i)2.; however, this
28 provision does not preclude the insurer from calling to the
29 attention of the physician errors of fact in the report based
30 upon information in the claim file.

31 (k)~~(b)~~ If requested by the person examined, a party

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1 causing an examination to be made shall deliver to him or her
2 a copy of every written report concerning the examination
3 rendered by an examining physician, at least one of which
4 reports must set out the examining physician's findings and
5 conclusions in detail. After such request and delivery, the
6 party causing the examination to be made is entitled, upon
7 request, to receive from the person examined every written
8 report available to him or her or his or her representative
9 concerning any examination, previously or thereafter made, of
10 the same mental or physical condition. By requesting and
11 obtaining a report of the examination so ordered, or by taking
12 the deposition of the examiner, the person examined waives any
13 privilege he or she may have, in relation to the claim for
14 benefits, regarding the testimony of every other person who
15 has examined, or may thereafter examine, him or her in respect
16 to the same mental or physical condition. If a person
17 unreasonably refuses to submit to an examination, the personal
18 injury protection carrier is no longer liable for subsequent
19 personal injury protection benefits.

20 ~~(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S~~
21 ~~FEES.--With respect to any dispute under the provisions of ss.~~
22 ~~627.730-627.7405 between the insured and the insurer, or~~
23 ~~between an assignee of an insured's rights and the insurer,~~
24 ~~the provisions of s. 627.428 shall apply, except as provided~~
25 ~~in subsection (11).~~

26 ~~(16)(9) CANCELLATION OR NONRENEWAL.--~~

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

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1 **(b)** Upon the issuance of a policy providing personal
2 injury protection benefits to a named insured not previously
3 insured by the insurer thereof during that calendar year, the
4 insurer shall report the issuance of the new policy to the
5 Department of Highway Safety and Motor Vehicles within 30
6 days. The report shall be in such form and format and contain
7 such information as is ~~may be~~ required by the Department of
8 Highway Safety and Motor Vehicles which shall include a format
9 compatible with the data processing capabilities of such ~~said~~
10 department, and the Department of Highway Safety and Motor
11 Vehicles is authorized to adopt rules necessary with respect
12 thereto. Failure by an insurer to file proper reports with the
13 Department of Highway Safety and Motor Vehicles as required by
14 this subsection or rules adopted with respect to the
15 requirements of this subsection constitutes a violation of the
16 Florida Insurance Code.

17 **(c)** Reports of cancellations and policy renewals and
18 reports of the issuance of new policies received by the
19 Department of Highway Safety and Motor Vehicles are
20 confidential and exempt from the provisions of s. 119.07(1).

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

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1 the appropriate accident form as provided in s. 316.065, s.
2 316.066, or s. 316.068.

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

18 (17) ATTORNEY'S FEES.--With respect to any dispute
19 under ss. 627.730-627.7405 between the insured and the
20 insurer, or between an assignee of an insured's rights and the
21 insurer, s. 627.428 shall apply, except as provided in
22 subsection (12). A contingency risk multiplier shall not be
23 applied to any attorney's fee award in any dispute under ss.
24 627.730-627.7405.

25 ~~(18)(10)~~ PREFERRED PROVIDERS.--An insurer may
26 negotiate and enter into contracts with licensed health care
27 providers for the benefits described in this section, referred
28 to in this section as "preferred providers," which shall
29 include health care providers licensed under chapters 458,
30 459, 460, 461, and 463. The insurer may provide an option to
31 an insured to use a preferred provider at the time of purchase

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1 of the policy for personal injury protection benefits, if the
 2 requirements of this subsection are met. If the insured
 3 elects to use a provider who is not a preferred provider,
 4 whether the insured purchased a preferred provider policy or a
 5 nonpreferred provider policy, the medical benefits provided by
 6 the insurer shall be as required by this section. If the
 7 insured elects to use a provider who is a preferred provider,
 8 the insurer may pay medical benefits in excess of the benefits
 9 required by this section and may waive or lower the amount of
 10 any deductible that applies to such medical benefits. If the
 11 insurer offers a preferred provider policy to a policyholder
 12 or applicant, it must also offer a nonpreferred provider
 13 policy. The insurer shall provide each policyholder with a
 14 current roster of preferred providers in the county in which
 15 the insured resides at the time of purchase of such policy,
 16 and shall make such list available for public inspection
 17 during regular business hours at the principal office of the
 18 insurer within the state.

19 ~~(11) DEMAND LETTER.--~~

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

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

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

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

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

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

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

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

30 ~~(f) Any insurer making a general business practice of~~
31 ~~not paying valid claims until receipt of the notice required~~

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1 ~~by this subsection is engaging in an unfair trade practice~~
2 ~~under the insurance code.~~

3 ~~(19)(12)~~ CIVIL ACTION FOR INSURANCE FRAUD.--An insurer
4 shall have a cause of action against any person convicted of,
5 or who, regardless of adjudication of guilt, pleads guilty or
6 nolo contendere to insurance fraud under s. 817.234, patient
7 brokering under s. 817.505, or kickbacks under s. 456.054,
8 associated with a claim for personal injury protection
9 benefits in accordance with this section. An insurer
10 prevailing in an action brought under this subsection may
11 recover compensatory, consequential, and punitive damages
12 subject to the requirements and limitations of part II of
13 chapter 768, and attorney's fees and costs incurred in
14 litigating a cause of action against any person convicted of,
15 or who, regardless of adjudication of guilt, pleads guilty or
16 nolo contendere to insurance fraud under s. 817.234, patient
17 brokering under s. 817.505, or kickbacks under s. 456.054,
18 associated with a claim for personal injury protection
19 benefits in accordance with this section.

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

31 ~~(21)~~ REWARD.--Upon written notification by any person,

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1 an insurer shall investigate any claim of improper billing by
2 a physician or other medical provider. The insurer shall
3 determine if the insured was properly billed for only those
4 services and treatments that the insured actually received. If
5 the insurer determines that the insured has been improperly
6 billed, the insurer shall notify the insured, the person
7 making the written notification and the provider of its
8 findings and shall reduce the amount of payment to the
9 provider by the amount determined to be improperly billed. If
10 a reduction is made due to such written notification by any
11 person, the insurer shall pay to the person 20 percent of the
12 amount of the reduction up to \$500. If the provider is
13 arrested due to the improper billing, the insurer shall pay to
14 the person 40 percent of the amount of the reduction up to
15 \$500.

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

23 Section 2. Subsection (2) of section 316.068, Florida
24 Statutes, is amended to read:

25 316.068 Crash report forms.--

26 (2) Every crash report required to be made in writing
27 must be made on the appropriate form approved by the
28 department and must contain all the information required
29 therein to include:

30 (a) The date, time, and location of the crash;

31 (b) A description of the vehicles involved;

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1 (c) The names and addresses of the parties involved;

2 (d) The names and addresses of all drivers and

3 passengers in the vehicles involved;

4 (e) The names and addresses of witnesses;

5 (f) The name, badge number, and law enforcement agency

6 of the officer investigating the crash; and

7 (g) The names of the insurance companies for the

8 respective parties involved in the crash unless not available.

9

10 The absence of information in such written crash reports

11 regarding the existence of passengers in the vehicles involved

12 in the crash constitutes a rebuttable presumption that no such

13 passengers were involved in the reported crash.

14 Notwithstanding any other provisions of this section, a crash

15 report produced electronically by a law enforcement officer

16 must, at a minimum, contain the same information as is called

17 for on those forms approved by the department.

18 Section 3. Subsection (9) is added to section 322.26,
19 Florida Statutes, to read:

20 322.26 Mandatory revocation of license by

21 department.--The department shall forthwith revoke the license

22 or driving privilege of any person upon receiving a record of

23 such person's conviction of any of the following offenses:

24 (9) Conviction in any court having jurisdiction over

25 offenses committed under s. 817.234(8) or (9) or s. 817.505.

26 Section 4. Paragraph (a) of subsection (7) and
27 subsection (9) of section 817.234, Florida Statutes, are

28 amended to read:

29 817.234 False and fraudulent insurance claims.--

30 (7)(a) It shall constitute a material omission and

31 insurance fraud, punishable as provided in subsection (11),

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1 for any service ~~physician or other~~ provider, other than a
2 hospital, to engage in a general business practice of billing
3 amounts as its usual and customary charge, if such provider
4 has agreed with the insured ~~patient~~ or intends to waive
5 deductibles or copayments, or does not for any other reason
6 intend to collect the total amount of such charge. With
7 respect to a determination as to whether a service ~~physician~~
8 ~~or other~~ provider has engaged in such general business
9 practice, consideration shall be given to evidence of whether
10 the physician or other provider made a good faith attempt to
11 collect such deductible or copayment. This paragraph does not
12 apply to physicians or other providers who waive deductibles
13 or copayments or reduce their bills as part of a bodily injury
14 settlement or verdict.

15 (9) A person may not organize, plan, or knowingly
16 participate in an intentional motor vehicle crash or a scheme
17 to create documentation of a motor vehicle crash that did not
18 occur for the purpose of making motor vehicle tort claims or
19 claims for personal injury protection benefits as required by
20 s. 627.736. Any person who violates this subsection commits a
21 felony of the second degree, punishable as provided in s.
22 775.082, s. 775.083, or s. 775.084. A person who is convicted
23 of a violation of this subsection shall be sentenced to a
24 minimum term of imprisonment of 2 years.

25 Section 5. Section 817.2361, Florida Statutes, is
26 amended to read:

27 817.2361 False or fraudulent proof of motor vehicle
28 insurance ~~card~~.--Any person who, with intent to deceive any
29 other person, creates, markets, or presents a false or
30 fraudulent proof of motor vehicle insurance ~~card~~ commits a
31 felony of the third degree, punishable as provided in s.

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1 775.082, s. 775.083, or s. 775.084.

2 Section 6. For the 2006-2007 fiscal year, the sum of
3 \$1,533,296 million is appropriated on a recurring basis and an
4 associated salary rate of 1,220,000 is authorized from the
5 Insurance Regulatory Trust Fund to the Division of Insurance
6 Fraud within the Department of Financial Services for the
7 purpose of providing a competitive pay adjustment of \$10,000
8 plus benefits for each of the existing sworn law enforcement
9 officer positions in the division in order to achieve relative
10 parity with sworn law enforcement investigators who have
11 similar responsibilities at other state agencies. This
12 appropriation is for the purposes provided in s. 626.989,
13 Florida Statutes.

14 Section 7. For the 2006-2007 fiscal year, the sums of
15 \$510,276 in recurring funds and \$111,455 in nonrecurring funds
16 are appropriated from the Insurance Regulatory Trust Fund of
17 the Department of Financial Services to the Division of
18 Insurance Fraud within the department for the purpose of
19 providing a new fraud unit within the division consisting of
20 six sworn law enforcement officers, one non-sworn
21 investigator, one crime analyst, and one clerical position. A
22 total of nine full-time equivalent positions and associated
23 salary rate of 381,500 are authorized. This appropriation is
24 for the purposes provided in s. 626.989, Florida Statutes.

25 Section 8. For the 2006-2007 fiscal year, the sums of
26 \$415,291 in recurring funds and \$52,430 in nonrecurring funds
27 are appropriated from the Insurance Regulatory Trust Fund of
28 the Department of Financial Services to the Division of
29 Insurance Fraud within the department and 10 full-time
30 equivalent positions and associated salary rate of 342,500 are
31 authorized. This appropriation is for the purposes provided in

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1 s. 626.989, Florida Statutes.

2 Section 9. For the 2006-2007 fiscal year, the sum of
3 \$750,000 in recurring funds is appropriated from the Insurance
4 Regulatory Trust Fund in equal amounts to the State Attorneys
5 for the 4th, 6th, 9th, 13th, 15th, and 17th Circuits to
6 establish and fund an additional assistant state attorney
7 position in each circuit for the purpose of prosecuting cases
8 of insurance fraud.

9 Section 10. Effective January 1, 2009, sections
10 627.730, 627.731, 627.732, 627.733, 627.734, 627.736, 627.737,
11 627.739, 627.7401, 627.7403, and 627.7405, Florida Statutes,
12 constituting the Florida Motor Vehicle No-Fault Law, are
13 repealed, unless reviewed and reenacted by the Legislature
14 before that date.

15 Section 11. Section 19 of chapter 2003-411, Laws of
16 Florida, is repealed.

17 Section 12. This act shall take effect October 1,
18 2006.

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