An act relating to motor vehicle personal injury protection insurance; amending s. 316.066, F.S.; revising the conditions for completing the long-form traffic crash report; revising the information contained in the short-form and long-form reports; revising the requirements relating to the driver's responsibility for submitting a report for crashes not requiring a law enforcement report; amending s. 400.9905, F.S.; providing that certain entities exempt from licensure as a health care clinic must nonetheless be licensed in order to receive reimbursement for the provision of personal injury protection benefits; amending s. 400.991, F.S.; requiring that an application for licensure, or exemption from licensure, as a health care clinic include a statement regarding insurance fraud; amending s. 626.989, F.S.; providing that knowingly submitting false, misleading, or fraudulent documents relating to licensure as a health care clinic, or submitting a claim for personal injury protection relating to clinic licensure documents, is a fraudulent insurance act under certain conditions; amending s. 626.9541, F.S.; specifying an additional unfair claim settlement practice; creating s. 626.9895, F.S.; providing definitions; authorizing the Division of Insurance Fraud of the Department of Financial Services to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud; providing requirements for, and duties of, the organization; requiring that the organization operate pursuant to a contract with the division; providing for the requirements of the contract; providing for a board of directors; authorizing the organization to use the division's property and facilities subject to certain requirements; requiring that the department adopt rules relating to procedures for the organization's governance and relating to conditions for the use of the division's property or facilities; authorizing contributions from insurers; authorizing any moneys received by the organization to be held in a separate depository account in the name of the organization; requiring that the division deposit certain proceeds into the Insurance Regulatory Trust Fund; creating s. 627.7311, F.S.; specifying the effects of the Florida Motor Vehicle No-Fault Law; requiring compliance with provisions regardless of their expression in policy forms; amending s. 627.732, F.S.; providing definitions; amending s. 627.736, F.S.; revising the cap on benefits to provide that death benefits are in addition to medical and disability benefits; revising medical benefits; distinguishing between initial and followup services; excluding massage and acupuncture from medical benefits that may be reimbursed under the Florida

Motor Vehicle No-Fault Law; adding physical therapists to the list of providers that may provide services; requiring that an insurer repay any benefits covered by the Medicaid program; requiring that an insurer provide a claimant an opportunity to revise claims that contain errors; authorizing an insurer to provide notice to the claimant and conduct an investigation if fraud is suspected; requiring that an insurer create and maintain a log of personal injury protection benefits paid and that the insurer provide to the insured or an assignee of the insured, upon request, a copy of the log if litigation is commenced; revising the Medicare fee schedules that an insurer may use as a basis for limiting reimbursement of personal injury protection benefits; providing that the Medicare fee schedule in effect on a specific date applies for purposes of limiting reimbursement; requiring that an insurer that limits payments based on the statutory fee schedule include a notice in insurance policies at the time of issuance or renewal; deleting obsolete provisions; providing that certain entities exempt from licensure as a clinic must nonetheless be licensed to receive reimbursement for the provision of personal injury protection benefits; providing exceptions; requiring that an insurer notify parties in disputes over personal injury protection claims when policy limits are reached; providing that an insured must comply with the terms of the policy, including submission to examinations under oath; requiring that an insured not fail to appear at an examination; providing for a rebuttable presumption that a refusal of or failure to appear at an examination is unreasonable in certain circumstances; providing criteria for the award of attorney fees; providing a presumption regarding the use of a contingency risk multiplier; consolidating provisions relating to unfair or deceptive practices under certain conditions; specifying that claims generated as a result of certain unlawful activities are not reimbursable; eliminating a requirement that all parties mutually and expressly agree to the use of electronic transmission of data; amending s. 627.7405, F.S.; providing an exception from an insurer's right of reimbursement for certain owners or registrants; amending s. 817.234, F.S.; providing that it is insurance fraud to present a claim for personal injury protection benefits payable to a person or entity that knowingly submitted false, misleading, or fraudulent documents relating to licensure as a health care clinic; providing that a licensed health care practitioner guilty of certain insurance fraud loses his or her license and may not receive reimbursement for personal injury protection benefits for a specified period; defining the term "insurer"; amending s. 316.065, F.S.; conforming a cross-reference; authorizing the Office of Insurance

Regulation to make contracts for certain purposes; requiring a report; requiring insurers writing private passenger automobile personal injury protection insurance to make certain rate filings; providing sanctions for failure to make the filings as required; providing an appropriation; providing for carryforward of any unexpended balance of the appropriation; requiring that the Office of Insurance Regulation perform a data call relating to personal injury protection; prescribing required elements of the data call; providing for severability; providing effective dates.

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

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

316.066 Written reports of crashes.—

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

1. Resulted in death of, ~~or~~ personal injury to, or any indication of complaints of pain or discomfort by any of the parties or passengers involved in the crash;~~.~~

2. Involved a violation of s. 316.061(1) or s. 316.193;~~.~~

3. Rendered a vehicle inoperable to a degree that required a wrecker to remove it from the scene of the crash; or

4. Involved a commercial motor vehicle.

(b) The Florida Traffic Crash Report, Long Form must include:

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

2. A description of the vehicles involved.

3. The names and addresses of the parties involved, including all drivers and passengers, and the identification of the vehicle in which each was a driver or a passenger.

4. The names and addresses of witnesses.

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

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

(c) ~~(b)~~ In any ~~every~~ crash for which a Florida Traffic Crash Report, Long Form is not required by this section and which occurs on the public roadways of this state, the law enforcement officer shall ~~may~~ complete a short-form crash report or provide a driver exchange-of-information form, to be completed by all drivers and passengers ~~each party~~ involved in the crash, which requires the identification of each vehicle that the drivers and passengers were in. The short-form report must include:

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

2. A description of the vehicles involved.

3. The names and addresses of the parties involved, including all drivers and passengers, and the identification of the vehicle in which each was a driver or a passenger.

4. The names and addresses of witnesses.

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

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

(d) ~~(c)~~ Each party to the crash must provide the law enforcement officer with proof of insurance, which must be documented in the crash report. If a law enforcement officer submits a report on the crash, proof of insurance must be provided to the officer by each party involved in the crash. Any party who fails to provide the required information commits a noncriminal traffic infraction, punishable as a nonmoving violation as provided in chapter 318, unless the officer determines that due to injuries or other special circumstances such insurance information cannot be provided immediately. If the person provides the law enforcement agency, within 24 hours after the crash, proof of insurance that was valid at the time of the crash, the law enforcement agency may void the citation.

(e) ~~(d)~~ The driver of a vehicle that was in any manner involved in a crash resulting in damage to a ~~any~~ vehicle or other property which does not require a law enforcement report ~~in an amount of $500 or more which was not investigated by a law enforcement agency,~~ shall, within 10 days after the crash, submit a written report of the crash to the department. The report shall be submitted on a form approved by the department.

~~The entity receiving the report may require witnesses of the crash to render reports and may require any driver of a vehicle involved in a crash of which a written report must be made to file supplemental written reports if the original report is deemed insufficient by the receiving entity.~~

(f) ~~(e)~~ Long-form and short-form crash reports prepared by law enforcement must be submitted to the department and may ~~shall~~ be maintained by the law enforcement officer's agency.

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

400.9905 Definitions.—

(4) "Clinic" means an entity where ~~at which~~ health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. As used in ~~For purposes of~~ this part, the term does not include and the licensure requirements of this part do not apply to:

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

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

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

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

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

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

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is ~~which are~~ wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if~~, so long as~~ one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) which ~~that~~ provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

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

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

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

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

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

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

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

400.991 License requirements; background screenings; prohibitions.—

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

INSURANCE FRAUD NOTICE.—A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with part X of chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law, commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for personal injury protection benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in s. 817.234, Florida Statutes.

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

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

(1) For the purposes of this section:~~,~~

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

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

2. Knowingly submits:

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

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

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

Section 5. Paragraph (i) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

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

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

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such

contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

Section 6. Subsection (5) of section 626.9894, Florida Statutes, is amended to read:

626.9894 Gifts and grants.—

(5) Notwithstanding ~~the provisions of~~ s. 216.301 and pursuant to s. 216.351, any balance of moneys deposited into the Insurance Regulatory Trust Fund pursuant to this section or s. 626.9895 remaining at the end of any fiscal year is ~~shall be~~ available for carrying out the duties and responsibilities of the division. The department may request annual appropriations

from the grants and donations received pursuant to this section or s. 626.9895 and cash balances in the Insurance Regulatory Trust Fund for the purpose of carrying out its duties and responsibilities related to the division's anti-fraud efforts, including the funding of dedicated prosecutors and related personnel.

Section 7. Section 626.9895, Florida Statutes, is created to read:

626.9895 Motor vehicle insurance fraud direct-support organization.—

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

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

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

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

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

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

(b) Be organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, invest, and administer, in its own name, securities, funds, objects of value, or other property, real or personal; and make grants and expenditures to or for the direct or indirect benefit of the division, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration, and the Department of Health to the extent that such grants and expenditures are used exclusively to advance the prosecution, investigation, or prevention of motor vehicle insurance fraud. Grants and expenditures may include the cost of salaries or benefits of motor vehicle insurance fraud investigators, prosecutors, or support personnel if such grants and expenditures do not interfere with prosecutorial independence or otherwise create conflicts of interest which threaten the success of prosecutions.

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

(d) Use all of its grants and expenditures solely for the purpose of preventing and decreasing motor vehicle insurance fraud, and not for advertising using the likeness or name of any elected official nor for the purpose of lobbying as defined in s. 11.045.

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

<u>(3) CONTRACT.—The organization shall operate under written contract with the division. The contract must provide for:</u>

<u>(a) Approval of the articles of incorporation and bylaws of the organization by the division.</u>

<u>(b) Submission of an annual budget for approval of the division. The budget must require the organization to minimize costs to the division and its members at all times by using existing personnel and property and allowing for telephonic meetings if appropriate.</u>

<u>(c) Certification by the division that the organization is complying with the terms of the contract and in a manner consistent with the goals and purposes of the department and in the best interest of the state. Such certification must be made annually and reported in the official minutes of a meeting of the organization.</u>

<u>(d) Allocation of funds to address motor vehicle insurance fraud.</u>

<u>(e) Reversion of moneys and property held in trust by the organization for motor vehicle insurance fraud prosecution, investigation, and prevention to the division if the organization is no longer approved to operate for the department or if the organization ceases to exist, or to the state if the division ceases to exist.</u>

<u>(f) Specific criteria to be used by the organization's board of directors to evaluate the effectiveness of funding used to combat motor vehicle insurance fraud.</u>

<u>(g) The fiscal year of the organization, which begins July 1 of each year and ends June 30 of the following year.</u>

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

(4) BOARD OF DIRECTORS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 8. Section 627.7311, Florida Statutes, is created to read:

627.7311 Effect of law on personal injury protection policies.—The provisions and procedures authorized in ss. 627.730-627.7405 shall be implemented by insurers offering policies pursuant to the Florida Motor Vehicle No-Fault Law. The Legislature intends that these provisions and procedures have full force and effect regardless of their express inclusion in an insurance policy form, and a specific provision or procedure authorized in ss. 627.730-627.7405 shall control over general provisions in an insurance policy form. An insurer is not required to amend its policy form or to expressly notify providers, claimants, or insureds in order to implement and apply such provisions or procedures.

Section 9. Effective January 1, 2013, subsections (16) and (17) are added to section 627.732, Florida Statutes, to read:

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

(16) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence

of immediate medical attention could reasonably be expected to result in any of the following:

(a) Serious jeopardy to patient health.

(b) Serious impairment to bodily functions.

(c) Serious dysfunction of any bodily organ or part.

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

Section 10. Effective January 1, 2013, subsections (1), (4), (5), (6), (7), (8), (9), (10), and (11) of section 627.736, Florida Statutes, are amended, and subsection (17) is added to that section, to read:

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

(1) REQUIRED BENEFITS.—An ~~Every~~ insurance policy complying with the security requirements of s. 627.733 must ~~shall~~ provide personal injury protection to the named insured, relatives

residing in the same household, persons operating the insured motor vehicle, passengers in the ~~such~~ motor vehicle, and other persons struck by the ~~such~~ motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to ~~the provisions of~~ subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from ~~for loss sustained by any such person as a result of~~ bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices~~,~~ and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. ~~However,~~ The medical benefits ~~shall~~ provide reimbursement only for: ~~such~~

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by any of the following persons or entities:

a.~~1.~~ A hospital or ambulatory surgical center licensed under chapter 395.

~~2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.~~

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

c.~~4.~~ An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in subparagraph 2.

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

~~a.~~ accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.,~~;~~ or

~~b. A health care clinic that~~:

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

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

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

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician

licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if any provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. ~~subparagraph 3., subparagraph 4., or subparagraph 5.~~ to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

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

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

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurer may not ~~shall~~ require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such ~~required~~ benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An ~~Any~~ insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates ~~shall be deemed to have violated~~ part IX of chapter 626, and such violation constitutes ~~shall constitute~~ an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An~~; and any such~~ insurer committing such violation is ~~shall be~~ subject to the penalties provided under that ~~afforded in such~~ part, as well as those provided ~~which may be afforded~~ elsewhere in the insurance code.

(4) PAYMENT OF BENEFITS~~; WHEN DUE~~.—Benefits due from an insurer under ss. 627.730-627.7405 are ~~shall be~~ primary, except that benefits received under any workers' compensation law must ~~shall~~ be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. If ~~When~~ the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, the benefits under ss. 627.730-627.7405 are ~~shall be~~ subject to ~~the provisions of~~ the Medicaid program. However, within 30 days after receiving notice that the Medicaid program paid such benefits, the insurer shall repay the full amount of the benefits to the Medicaid program.

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

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

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

2. If ~~When~~ an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge if~~, provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must also ~~shall~~ include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence.

3. If an insurer pays only a portion of a claim or rejects a claim due to an alleged error in the claim, the insurer, at the time of the partial payment or rejection, shall provide an itemized specification or explanation of benefits due to the

specified error. Upon receiving the specification or explanation, the person making the claim, at the person's option and without waiving any other legal remedy for payment, has 15 days to submit a revised claim, which shall be considered a timely submission of written notice of a claim.

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

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

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

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002~~(9)~~, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of such claims ~~a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care~~ may ~~then~~ be used by the insurer to pay other claims. The time periods specified in paragraph (b) for ~~required~~ payment of personal injury protection benefits are ~~shall be~~ tolled for the period of time that an insurer is required ~~by this paragraph~~ to hold payment of a claim that is not from such ~~a~~ physician or dentist ~~who provided emergency services and care or who provided hospital inpatient care~~ to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

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

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

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

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

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

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

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

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

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

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

(h) Benefits are ~~shall~~ not ~~be~~ due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, ~~any~~ insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or ~~if it is~~ established in a court of competent jurisdiction. Any insurance fraud voids ~~shall void~~ all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid before ~~prior to~~ the discovery of the ~~insured person's insurance~~ fraud is ~~shall be~~ recoverable by the insurer in its entirety from the person who committed insurance fraud ~~in their entirety~~. The prevailing party is entitled to its costs and attorney ~~attorney's~~ fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(i) If an insurer has a reasonable belief that a fraudulent insurance act, for the purposes of s. 626.989 or s. 817.234, has been committed, the insurer shall notify the claimant, in writing, within 30 days after submission of the claim that the claim is being investigated for suspected fraud. Beginning at the end of the initial 30-day period, the insurer has an additional 60 days to conduct its fraud investigation. Notwithstanding subsection (10), no later than 90 days after the submission of the claim, the insurer must deny the claim or pay the claim with simple interest as provided in paragraph (d). Interest shall be assessed from the day the claim was submitted until the day the claim is paid. All claims denied for suspected fraudulent insurance acts shall be reported to the Division of Insurance Fraud.

(j) An insurer shall create and maintain for each insured a log of personal injury protection benefits paid by the insurer on behalf of the insured. If litigation is commenced, the insurer shall provide to the insured a copy of the log within 30 days after receiving a request for the log from the insured.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)~~1.~~ A ~~Any~~ physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment~~,~~ if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. ~~In no event,~~ However, ~~may~~ such a charge may not exceed ~~be in excess of~~ the amount the person or institution customarily charges for like services or supplies. In determining ~~With respect to a determination of~~ whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, ~~and~~ reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle ~~automobile~~ and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

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

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

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

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

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

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

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

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

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

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

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

2.~~3.~~ For purposes of subparagraph 1. ~~2.~~, the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which ~~at the time~~ the services, supplies, or care is ~~was~~ rendered and for the area in which such services, supplies, or care is ~~were~~ rendered, and the applicable fee schedule or payment limitation applies throughout the remainder of that year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable ~~participating physicians~~ schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

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

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

5. Effective July 1, 2012, an insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

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

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

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

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

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

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

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

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The ~~initial~~ list ~~shall be adopted by January 1, 2004, and~~ shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list

~~of invalid diagnostic tests~~ shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and may ~~shall~~ not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for an ~~any~~ invalid diagnostic test as determined by the Department of Health.

(c)~~1.~~ With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services and care as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider may ~~shall~~ not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

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

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

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

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

BILLING REQUIREMENTS.—Florida law provides ~~Statutes provide~~ that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

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

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

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

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

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

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

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

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so

that the insured, or his or her guardian, countersigns the form with informed consent.

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

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

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

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

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

8. As used in this paragraph, the term "countersign" or "countersignature" ~~"countersigned"~~ means a second or verifying signature, as on a previously signed document, and is not

satisfied by the statement "signature on file" or any similar statement.

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

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification<u>,</u> and the provider of its findings and ~~shall~~ reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to <u>a</u> ~~such~~ written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, ~~then~~ the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

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

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

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

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

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

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

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; or

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

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

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

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested ~~to do so~~ by the insurer against whom the claim has been made, furnish ~~forthwith~~ a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce ~~forthwith~~, and allow ~~permit~~ the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment if~~;~~ ~~provided that~~ this does ~~shall~~ not limit the introduction of evidence at trial. Such sworn statement must ~~shall~~ read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." A ~~No~~ cause of action for violation of the physician-patient privilege or invasion of the right of privacy may not be brought ~~shall be permitted~~ against any physician, hospital, clinic, or other medical institution complying with ~~the provisions of~~ this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount that ~~which~~ is the subject of the insurer's inquiry is ~~shall become~~ overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. As used in ~~For purposes of~~ this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. An ~~Any~~ insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

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

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

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

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

(g) An insured seeking benefits under ss. 627.730-627.7405, including an omnibus insured, must comply with the terms of the policy, which include, but are not limited to, submitting to an examination under oath. The scope of questioning during the examination under oath is limited to relevant information or information that could reasonably be expected to lead to relevant information. Compliance with this paragraph is a condition precedent to receiving benefits. An insurer that, as a general business practice as determined by the office, requests an examination under oath of an insured or an omnibus insured without a reasonable basis is subject to s. 626.9541.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.—

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, ~~then~~ such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to <u>or fails to appear at</u> an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits. An insured's refusal to submit to or failure to appear at two examinations raises a rebuttable presumption that the insured's refusal or failure was unreasonable.

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

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. Notwithstanding s. 627.428, attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

(9) PREFERRED PROVIDERS.—An insurer may negotiate and contract ~~enter into contracts~~ with preferred ~~licensed health care~~ providers for the benefits described in this section, ~~referred to in this section as "preferred providers,"~~ which

~~shall~~ include health care providers licensed under chapter ~~chapters~~ 458, chapter 459, chapter 460, chapter 461, or chapter ~~and~~ 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchasing ~~purchase of~~ the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each insured ~~policyholder~~ with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the insurer's principal office ~~of the insurer~~ within the state.

(10) 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 must be provided to the insurer. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

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

1. The name of the insured upon which 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 paragraph (5)(d) 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 paragraph (7)(a) 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 to be reasonable and medically necessary.

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

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

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

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

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

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

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

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

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

(17) NONREIMBURSIBLE CLAIMS.-Claims generated as a result of activities that are unlawful pursuant to s. 817.505 are not reimbursable under the Florida Motor Vehicle No-Fault Law.

Section 11. Effective December 1, 2012, subsection (16) of section 627.736, Florida Statutes, is amended to read:

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

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

Section 12. Section 627.7405, Florida Statutes, is amended to read:

627.7405 Insurers' right of reimbursement.—

(1) Notwithstanding ~~any other provisions of~~ ss. 627.730-627.7405, an ~~any~~ insurer providing personal injury protection benefits on a private passenger motor vehicle shall have, to the extent of any personal injury protection benefits paid to any person as a benefit arising out of such private passenger motor vehicle insurance, a right of reimbursement against the owner or the insurer of the owner of a commercial motor vehicle, if the

benefits paid result from such person having been an occupant of the commercial motor vehicle or having been struck by the commercial motor vehicle while not an occupant of any self-propelled vehicle.

<u>(2) The insurer's right of reimbursement under this section does not apply to an owner or registrant as identified in s. 627.733(1)(b).</u>

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

817.234 False and fraudulent insurance claims.—

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

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

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

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

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

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

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

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

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

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

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

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

Section 14. Subsection (4) of section 316.065, Florida Statutes, is amended to read:

316.065 Crashes; reports; penalties.—

(4) Any person who knowingly repairs a motor vehicle without having made a report as required by subsection (3) is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. The owner and driver of a vehicle involved in a crash who makes a report thereof in

accordance with subsection (1) ~~or s. 316.066(1)~~ is not liable under this section.

Section 15. (1) Within 60 days after the effective date of this section, the Office of Insurance Regulation shall enter into a contract with an independent consultant to calculate the savings expected as a result of this act. The contract shall require the use of generally accepted actuarial techniques and standards as provided in s. 627.0651, Florida Statutes, in determining the expected impact on losses and expenses. By September 15, 2012, the office shall submit to the Governor, the President of Senate, and the Speaker of the House of Representatives a report concerning the results of the independent consultant's calculations.

(2) By October 1, 2012, an insurer writing private passenger automobile personal injury protection insurance in this state shall make a rate filing with the Office of Insurance Regulation. A rate certification is not sufficient to satisfy this requirement. If the insurer requests a rate in excess of a 10-percent reduction as applied to the current rate in its overall base rate for personal injury protection insurance, the insurer must include in its rate filing a detailed explanation of the reasons for failure to achieve a 10-percent reduction.

(3) By January 1, 2014, an insurer writing private passenger automobile personal injury protection insurance in this state shall make a rate filing with the Office of Insurance Regulation. A rate certification is not sufficient to satisfy this requirement. If the insurer requests a rate in excess of a 25-percent reduction as applied to the rate in effect as of the

effective date of this act in its overall base rate for personal injury protection insurance since the effective date of this act, the insurer must include in its rate filing a detailed explanation of the reasons for failure to achieve a 25-percent reduction.

(4) If an insurer fails to provide the detailed explanation required by subsection (2) or subsection (3), the Office of Insurance Regulation shall order the insurer to stop writing new personal injury protection policies in this state until it provides the required explanation.

(5) The sum of $200,000 of nonrecurring revenue is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation for the purpose of implementing the requirements of subsection (1) during the 2011-2012 fiscal year. Any unexpended balance of the appropriation at the end of the fiscal year shall be carried forward and be available for expenditure during the 2012-2013 fiscal year. Notwithstanding s. 287.057, Florida Statutes, the office may retain an independent consultant to implement the requirements of subsection (1) without a competitive solicitation.

(6) This section shall take effect upon this act becoming a law.

Section 16. The Office of Insurance Regulation shall perform a comprehensive personal injury protection data call and publish the results by January 1, 2015. It is the intent of the Legislature that the office design the data call with the expectation that the Legislature will use the data to help evaluate market conditions relating to the Florida Motor Vehicle

No-Fault Law and the impact on the market of reforms to the law made by this act. The elements of the data call must address, but need not be limited to, the following components of the Florida Motor Vehicle No-Fault Law:

(1) Quantity of personal injury protection claims.

(2) Type or nature of claimants.

(3) Amount and type of personal injury protection benefits paid and expenses incurred.

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

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

(6) Direct earned premiums for personal injury protection coverage, pure loss ratios, pure premiums, and other information related to premiums and losses.

(7) Licensed drivers and accidents.

(8) Fraud and enforcement.

Section 17. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 18. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2012.