A bill to be entitled

An act relating to motor vehicle insurance; providing legislative intent; amending s. 316.066, F.S.; revising provisions relating to the contents of written reports of motor vehicle crashes; authorizing the investigating officer to testify at trial or provide an affidavit concerning the content of the reports; creating s. 627.7311, F.S.; providing for the effect of specified statutory provisions, schedules, and procedures on insurance policies; amending s. 627.732, F.S.; making definitional changes; amending s. 627.736, F.S.; conforming a cross-reference; authorizing personal injury protection reimbursement to acupuncturists; requiring certain entities providing medical services to document that they meet required criteria for reimbursement; revising requirements relating to the form that must be submitted by providers; requiring an entity or clinic to file a new form within a specified period after the date of a change of ownership; revising provisions relating to when payment for a benefit is due; providing that the time period for paying or denying a claim is tolled during the investigation of a fraudulent insurance act; preempting local lien laws with respect to payment of benefits to medical providers; providing for the calculation of interest on certain overdue benefits; providing that insureds, claimants, or medical providers who commit or attempt

to commit a fraudulent insurance act are not entitled to any payment of benefits; authorizing an insurer to recover payments and bring a cause of action to recover payments; forbidding medical professionals and entities barred from receiving reimbursement for certain misconduct from billing the injured person; requiring all insureds seeking benefits to comply with policy terms as a condition precedent to receiving benefits; providing that an insurer has a right to conduct reasonable investigations of claims; authorizing an insurer to require a claimant to provide certain records; permitting medical providers to charge for copies of medical records; revising the insurer's reimbursement limitation; creating a rebuttable presumption that the insured did not receive treatment when the billing form and patient log are not countersigned; authorizing providers to submit properly countersigned forms when a claim has been denied for failure to provide such forms; deleting an obsolete provision; revising billing requirements; authorizing providers to resubmit medical bills when forms have not been properly completed; defining the term "countersigned" to mean a second or verifying signature; amending provisions concerning disclosure and acknowledgment forms; providing that the failure to maintain patient logs renders the treatment provided noncompensable; revising requirements relating to discovery;

permitting onsite physical reviews and examinations by insurers of treatment locations and equipment; requiring assignees of benefits or payments to cooperate under the terms of the policy, including submitting to an examination under oath; requiring medical providers, in response to a request for examination under oath, to produce persons having the most knowledge in specified circumstances; requiring insurers to pay medical providers reasonable compensation for attending examinations under oath; requiring insurers to make a written request for information before requesting that an assignee participate in an examination under oath; providing that an insurer that requests an examination under oath without a reasonable basis is engaging in an unfair and deceptive trade practice; creating a presumption relating to the failure to appear for two or more physical or mental examinations; specifying that submitting to an examination is a condition precedent to receiving benefits; limits attorney fee awards in personal injury protection disputes; provides that a premature pre-suit demand letter is defective; requires claimants to send a second demand letter if the insurer has paid benefits in response to an earlier demand letter; provides insurers additional time to pay benefits in response to a second demand letter; bars the use of contingency risk multipliers in calculating attorney fee awards in

personal injury protection disputes; amending s. 817.234, F.S., establishing penalties against business owners and health care professionals that commit insurance fraud; providing an effective date.

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

Section 1. FINDINGS AND INTENT.—The Legislature intends to balance the insured's interest in prompt payment of valid claims for insurance benefits under the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7405, F.S., with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. To that end, the Legislature intends that the investigation and prevention of fraudulent insurance acts in this state be enhanced, that additional sanctions for such acts be imposed, and that the Florida Motor Vehicle No-Fault Law be revised to remove incentives for fraudulent insurance acts. The Legislature intends that the Florida Motor Vehicle No-Fault Law be construed according to the plain language of the statutory provisions, which are designed to meet these goals.

(1) The Legislature finds that:

(a) Motor vehicle insurance fraud remains a major problem for state consumers and insurers. According to the National Insurance Crime Bureau, in recent years this state has been among those states that have the highest number of fraudulent and questionable claims.

(b) The current regulatory process for health care clinics under part X of chapter 400, Florida Statutes, which was

originally enacted to reduce motor vehicle insurance fraud, is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance with that part.

(2) The Legislature intends that:

(a) Insurers properly investigate claims, and as such, this act clarifies that insurers are allowed to obtain examinations under oath and sworn statements from any claimant seeking no-fault insurance benefits and to request mental and physical examinations of persons seeking personal injury protection coverage or benefits.

(b) Any false, misleading, or otherwise fraudulent activity associated with a claim renders any claim brought by a claimant engaging in such activity invalid. An insurer must be able to raise fraud as a defense to a claim for no-fault insurance benefits irrespective of any prior adjudication of guilt or determination of fraud by the Department of Financial Services.

(c) Insurers toll the payment or denial of a claim with respect to any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act, as defined in s. 626.989 or s. 817.234, Florida Statutes, has been committed.

(d) Insurers discover the names of all passengers involved in a motor vehicle crash before paying claims or benefits pursuant to an insurance policy governed by the Florida Motor Vehicle No-Fault Law. A rebuttable presumption must be established that a person was not involved in the event giving rise to the claim if that person's name does not appear on the police report.

Section 2. 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:

1. That 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. That involved one or more passengers, other than the drivers of the vehicles, in any of the vehicles involved in the crash;~~.~~

3.~~2.~~ That involved a violation of s. 316.061(1) or s. 316.193; or~~.~~

4.~~3.~~ In which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if such action is appropriate, in the officer's discretion.

(b) The 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.

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.

7. The names and addresses of all passengers in all vehicles involved in the crash, each clearly identified as being a passenger, including the identification of the vehicle in which each was a passenger.

(c) ~~(b)~~ In every crash for which a Florida Traffic Crash Report, Long Form, is not required ~~by this section~~, the law enforcement officer may complete a short-form crash report or provide a short-form crash report to be completed by each party involved in the crash. The short-form report must include all of the items listed in subparagraphs (b)1.-6. Short-form crash reports prepared by the law enforcement officer shall be maintained by the officer's agency.~~:~~

~~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.~~

~~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 ~~shall~~ provide the law enforcement officer with proof of insurance to be included in the crash report. If a law enforcement officer submits a report on the accident, 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 any vehicle or other property in an amount of $500 or more~~,~~ which ~~crash~~ 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 or traffic records center. The entity receiving the report may require witnesses of the crash ~~crashes~~ to render reports and may require any driver of a vehicle involved in the ~~a~~ crash ~~of which a written report must be made as provided in this section~~ to file supplemental written reports if ~~whenever~~ the original report is deemed insufficient by the receiving entity.

(f) The investigating law enforcement officer may testify at trial or provide a signed affidavit to confirm or supplement the information included on the long-form or short-form report.

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

Section 3. Section 627.7311, Florida Statutes, is created to read:

627.7311 Effect of law on policies.— Except as provided in s.627.736(6)(a)2., the provisions, schedules, and procedures authorized in ss. 627.730-627.7405 shall be implemented by the insurers offering policies pursuant to the Florida Motor Vehicle

No-Fault Law. These provisions, schedules, and procedures have full force and effect regardless of their express inclusion in an insurance policy, and a specific provision, schedule, or procedure authorized herein will govern over general provisions in an insurance policy form. An insurer is not required to amend its policy to implement and apply such provisions, schedules, or procedures.

Section 4. Section 627.732, Florida Statutes, is amended to read:

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

(1) "Broker" means any person not possessing a license under chapter 395, chapter 400, chapter 429, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 641 who charges or receives compensation for any use of medical equipment and is not the 100-percent owner or the 100-percent lessee of such equipment. For purposes of this section, such owner or lessee may be an individual, a corporation, a partnership, or any other entity and any of its 100-percent-owned affiliates and subsidiaries. For purposes of this subsection, the term "lessee" means a long-term lessee under a capital or operating lease, but does not include a part-time lessee. The term "broker" does not include a hospital or physician management company whose medical equipment is ancillary to the practices managed, a debt collection agency, or an entity that has contracted with the insurer to obtain a discounted rate for such services; nor does the term include a management company that has contracted to provide general

management services for a licensed physician or health care facility and whose compensation is not materially affected by the usage or frequency of usage of medical equipment or an entity that is 100-percent owned by one or more hospitals or physicians. The term "broker" does not include a person or entity that certifies, upon request of an insurer, that:

(a) It is a clinic licensed under ss. 400.990-400.995;

(b) It is a 100-percent owner of medical equipment; and

(c) The owner's only part-time lease of medical equipment for personal injury protection patients is on a temporary basis, not to exceed 30 days in a 12-month period, and such lease is solely for the purposes of necessary repair or maintenance of the 100-percent-owned medical equipment or pending the arrival and installation of the newly purchased or a replacement for the 100-percent-owned medical equipment, or for patients for whom, because of physical size or claustrophobia, it is determined by the medical director or clinical director to be medically necessary that the test be performed in medical equipment that is open-style. The leased medical equipment cannot be used by patients who are not patients of the registered clinic for medical treatment of services. Any person or entity making a false certification under this subsection commits insurance fraud as defined in s. 817.234. However, the 30-day period provided in this paragraph may be extended for an additional 60 days as applicable to magnetic resonance imaging equipment if the owner certifies that the extension otherwise complies with this paragraph.

(2) ~~(7)~~ "Certify" means to swear or attest to being true or

represented in writing.

(3) "Claimant" means the person, organization, or entity seeking benefits, including all assignees.

(4) "Entity wholly owned" means a proprietorship, group practice, partnership, or corporation that provides health care services rendered by licensed health care practitioners. In order to be wholly owned, licensed health care practitioners must be 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.

(5) ~~(12)~~ "Hospital" means a facility that, at the time services or treatment were rendered, was licensed under chapter 395.

(6) ~~(8)~~ "Immediate personal supervision," as it relates to the performance of medical services by nonphysicians not in a hospital, means that an individual licensed to perform the medical service or provide the medical supplies must be present within the confines of the physical structure where the medical services are performed or where the medical supplies are provided such that the licensed individual can respond immediately to any emergencies if needed.

(7) ~~(9)~~ "Incident," with respect to services considered as incident to a physician's professional service, for a physician

licensed under chapter 458, chapter 459, chapter 460, or chapter 461, if not furnished in a hospital, means ~~such~~ services that are ~~must be~~ an integral, even if incidental, part of a covered physician's service.

(8) ~~(10)~~ "Knowingly" means that a person, with respect to information, has actual knowledge of the information, ~~;~~ acts in deliberate ignorance of the truth or falsity of the information, ~~;~~ or acts in reckless disregard of the information. ~~,~~ ~~and~~ Proof of specific intent to defraud is not required.

(9) ~~(11)~~ "Lawful" or "lawfully" means in ~~substantial~~ compliance with all relevant applicable criminal, civil, and administrative requirements of state and federal law related to the provision of medical services or treatment.

(10) ~~(2)~~ "Medically necessary" refers to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(c) Not primarily for the convenience of the patient, physician, or other health care provider.

(11) ~~(3)~~ "Motor vehicle" means a ~~any~~ self-propelled vehicle with four or more wheels that ~~which~~ is of a type both designed and required to be licensed for use on the highways of this state, and any trailer or semitrailer designed for use with such vehicle, and includes:

(a) A "private passenger motor vehicle," which is any motor vehicle that ~~which~~ is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type.

(b) A "commercial motor vehicle," which is any motor vehicle that ~~which~~ is not a private passenger motor vehicle.

The term "motor vehicle" does not include a mobile home or any motor vehicle that ~~which~~ is used in mass transit, other than public school transportation, and designed to transport more than five passengers exclusive of the operator of the motor vehicle and that ~~which~~ is owned by a municipality, a transit authority, or a political subdivision of the state.

(12) ~~(4)~~ "Named insured" means a person, usually the owner of a vehicle, identified in a policy by name as the insured under the policy.

(13) ~~(5)~~ "Owner" means a person who holds the legal title to a motor vehicle; or, if ~~in the event~~ a motor vehicle is the subject of a security agreement or lease with an option to purchase with the debtor or lessee having the right to possession, ~~then~~ the debtor or lessee is ~~shall be~~ deemed the owner for the purposes of ss. 627.730-627.7405.

(14) ~~(13)~~ "Properly completed" means providing truthful, substantially complete, and substantially accurate responses ~~as~~ to all material elements of ~~to~~ each applicable request for information or statement by a means that may lawfully be provided and that complies with this section, or as agreed by

the parties.

(15) ~~(6)~~ "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere.

(16) ~~(15)~~ "Unbundling" means submitting ~~an action that submits~~ a billing code that is properly billed under one billing code~~,~~ but that has been separated into two or more billing codes~~,~~ and would result in payment greater than the ~~in~~ amount that ~~than~~ would be paid using one billing code.

(17) ~~(14)~~ "Upcoding" means submitting ~~an action that submits~~ a billing code that would result in payment greater than the ~~in~~ amount that ~~than~~ would be paid using a billing code that accurately describes the services performed. The term does not include an otherwise lawful bill by a magnetic resonance imaging facility, which globally combines both technical and professional components, if the amount of the global bill is not more than the components if billed separately; however, payment of such a bill constitutes payment in full for all components of such service.

Section 5. Subsections (1), (3), and (4) of section 627.736, Florida Statutes, are amended, subsections (5) through (16) of that section are renumbered as subsections (6) through (17), respectively, a new subsections (5) and 18 are added to that section, and present subsections (5), (6), (8), and (10), paragraph (b) of present subsection (7), and present subsection (16) of that section are amended, to read:

627.736 Required personal injury protection benefits;

exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—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 such motor vehicle, and other persons struck by 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)(h) ~~(4)(e),~~ to a limit of $10,000 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 for medically necessary ambulance, hospital, and nursing services. However, the medical benefits ~~shall~~ provide reimbursement only for such 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 an acupuncturist licensed under chapter 457 exclusively to provide oriental medicine as defined in s 457.102, or that are provided by any of the following ~~persons or entities~~:

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

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

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 spouses, parents, children, or siblings ~~spouse, parent, child, or sibling~~ of such ~~that practitioner or those~~ practitioners.

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

5. A health care clinic licensed under part X of chapter 400 ~~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.

When any services under this paragraph are provided by an entity or clinic described in subparagraph 3., subparagraph 4., or subparagraph 5., the entity or clinic shall provide the insurer at the initial submission of the claim with a form adopted by the Department of Financial Services that documents that the entity or clinic meets the criteria of subparagraph 3., subparagraph 4., or subparagraph 5., and that includes a sworn statement or affidavit to that effect. Any changes in ownership shall require the filing of a new form within 10 days from the date of the change in ownership. If an insurer denies a claim based on the failure to submit the proper form, the insurer shall notify the provider and the provider shall have 30 days after receipt of each notice to submit a properly completed form. If the provider fails to comply with this requirement the insurer is not required to pay the claim. ~~The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in 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 paragraph must ~~provision 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. The insurer may pay 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 thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and ~~no~~ such insurers may not ~~insurer 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 afforded in such part~~,~~ as well as those that are ~~which may be~~ afforded elsewhere in the insurance code.

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

recover such special damages for personal injury protection benefits paid or payable.

(4) BENEFITS; WHEN DUE; INSURER'S DUTY TO INVESTIGATE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and are ~~shall be~~ due and payable as loss accrues~~,~~ upon the receipt of reasonable proof of such loss and the amount of expenses and loss incurred that ~~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 are ~~under ss. 627.730-627.7405 shall be~~ subject to the provisions of 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. If such written notice 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. For the purpose of calculating the extent to which benefits are overdue, payment shall be considered made on the date a draft or other valid instrument that is equivalent to payment is placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(c) 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, provided that this does ~~shall~~ not limit the introduction of evidence at trial.~~; and~~ The insurer must ~~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. An insurer's failure to send an itemized specification or explanation of benefits does not waive other grounds for rejecting an otherwise invalid claim.

(d) A ~~However, notwithstanding the fact that written notice has been furnished to the insurer, Any~~ payment shall not be deemed overdue if ~~when~~ the insurer has reasonable proof ~~to establish~~ that the insurer is not responsible for ~~the~~ payment. An insurer may obtain evidence and assert any ground for adjustment or rejection of a ~~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 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. This paragraph does not preclude or limit the ability of the insurer to assert that the~~ claim that is ~~was~~ unrelated, ~~was~~ not medically necessary, ~~or was~~ unreasonable, or submitted ~~that the amount of the charge was in excess of that permitted under, or~~ in violation of~~,~~ subsection (6) ~~(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 (b), or after the filing of a lawsuit.

(e) The 30-day period for payment is tolled while the insurer investigates a fraudulent insurance act, as defined in s. 626.989, F.S., with respect to any portions of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify the claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date it has a reasonable belief that such act has been committed. The insurer must pay or deny the claim, in full or in part, within 15 days of completion of its investigation. However, no payment is due to a claimant that has violated paragraph (k).

(f) ~~(e)~~ Notwithstanding any local lien law, 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 ~~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 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.

(g)~~(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. However, interest on a payment that is overdue pursuant to paragraph (e) shall be calculated from

the date the payment is due pursuant to paragraph (b).

(h) ~~(c)~~ 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 and 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.

(i) ~~(f)~~ If two or more insurers are liable 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 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.

(j) ~~(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.

(k) ~~(h)~~ Benefits shall not be due or payable to or on the behalf of an insured, claimant, or medical provider ~~person~~ if the insured, claimant, or medical provider has submitted ~~that person has~~:

1. A false statement, document, record, or bill;

2. False information; or

3. Has otherwise committed or attempted to commit a fraudulent insurance act as defined in s. 626.989, F.S.

A claimant who violates this paragraph is not entitled to any personal injury protection benefits or payment for any bills and services, regardless of whether a portion of the claim may be legitimate. However, a medical provider that does not violate this paragraph may not be denied benefits solely due to a violation by another medical provider or claimant.

(l) Notwithstanding any remedies afforded by law, the insurer may recover from a claimant who violates paragraph (k)

any sums previously paid to that claimant and may bring any available common law and statutory causes of action. A claimant has violated paragraph (k) ~~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 shall void all coverage arising from the claim related to the claimant ~~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 prior to the discovery of the ~~insured person's insurance~~ fraud shall be recoverable by the insurer from the claimant ~~person~~ who committed insurance fraud in their entirety. The insurer ~~prevailing party~~ is entitled to its costs and attorney's fees in any action in which it prevails enforcing ~~in an insurer's action to enforce~~ its right of recovery under this paragraph. This paragraph does not preclude or limit an insurer’s right to deny a claim based on other evidence of fraud. This paragraph does not affect an insurer’s right to plead and prove a claim or defense of fraud under the common law. In the event that a physician, hospital, clinic, or other medical institution violates paragraph (k), the physician, hospital, clinic, or other medical institution is precluded from and the injured party is not liable for, and the physician, hospital, clinic, or other medial institution shall not bill the insured for charges that are unpaid because of the physician, hospital, clinic or other medical institution’s

failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

(m) In all circumstances, an insured seeking benefits under ss. 627.730-627.7405, including omnibus insureds, must comply with the terms of the policy, which include but is not limited to, submitting to an examination under oath. Compliance with this paragraph is a condition precedent to receiving benefits.

(5) INSURER INVESTIGATIONS.—An insurer has the right and duty to conduct a reasonable investigation of a claim. In the course of the insurer's investigation of a claim:

(a) The insurer may require the insured, claimant, or medical provider to provide copies of the treatment and examination records. Any records review need not be based on a physical examination and may be obtained at any time, including after reduction or denial of the claim.

1. The 30-day period for payment under paragraph (4)(b) is tolled from the date the insurer sends its request for treatment records to the date that the insurer receives the treatment records.

2. A medical provider may impose a reasonable, cost-based fee that includes only the cost of copying and postage, but does not include the cost of labor for copying. The cost of copying may not exceed $1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages. However, a medical provider may impose the reasonable costs of reproducing X rays and other image-related records, including the actual cost of

the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

(b) An insurer may deny benefits if the insured, claimant, or medical provider fails to:

1. Cooperate in the insurer's investigation;

2. Commits a fraud or material misrepresentation; or

3. Comply with this subsection.

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

(a) ~~1~~. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person and 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. When 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 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 the participating physicians schedule of Medicare Part B. For all other supplies

and care, including care and services rendered by ambulatory surgical centers and clinical laboratories, 200 percent of the allowable amount under Medicare Part B. Durable medical equipment shall follow the Durable Medical Equipment Prosthetics/Orthotics & Supplies (DMEPOS) fee schedule of Medicare Pat B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, 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 that was in effect as of January 1 of the year in which ~~at the time~~ the services, supplies, or care was rendered and for the area in which such services were rendered, and shall apply throughout the remainder of the year, notwithstanding any subsequent changes made to such fee schedule or payment limitation, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. Effective January 1, 2012, an insurer may limit reimbursement to this paragraph only if the insurance policy provides a notice at the time of issuance or renewal that the insurer may limit reimbursement pursuant to the

schedule of charges specified in this paragraph. Policy forms approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraphs 1. and 2., the insurer is permitted to pay the amount of the charge submitted.

3.~~4.~~ Subparagraph 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.

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.

(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 paragraphs (c), ~~paragraph~~ (d) and (e);

e. Except for emergency services and care, if the insured failed to countersign the billing forms and patient log related to such claim or charges. Failure to submit a countersigned billing form or patient log creates a rebuttable presumption that the insured did not receive the alleged treatment. The insurer is not considered to have been furnished with notice of the subject treatment and loss until the insurer is able to verify that the insured received the alleged treatment. If an insurer denies a claim based on failure to a submit a countersigned billing form or patient log, the insurer shall notify the provider and the provider shall have 30 days after receipt of such notice to submit a properly countersigned billing form or patient log. If the provider fails to comply with this requirement the insurer is not required to pay the claim. As used in this sub-paragraph, "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;

f.~~e.~~ For any treatment or service that is upcoded, or that is unbundled if ~~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

g.~~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 must ~~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 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 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 Centers for Medicare and Medicaid Services (CMS) ~~Health Care Finance Administration~~.

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

BILLING REQUIREMENTS.—Florida 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 first billing cycle 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 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 Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals 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~~. If an insurer denies a claim due to a provider's failure to submit a properly completed statement or bill, the insurer shall notify the provider as to the provisions that were improperly completed, and the provider shall have 30 days after the receipt of such notice to submit a properly completed statement or bill. If the provider fails to comply with this

requirement, the insurer is not required to pay for improperly billed services.

(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. Listing CPT codes or other coding on the disclosure and acknowledgment form does not satisfy this requirement;

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. An insurer shall not be considered to have been furnished with notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgment form is ~~shall be~~ furnished to the insurer pursuant to paragraph (4)(b) and sub-paragraph 1.a. The disclosure and acknowledgment form ~~and~~ may not be electronically furnished. A disclosure and acknowledgment form that does not meet the minimum requirements of sub-paragraph 1.a. does not provide an insurer with notice of the amount of a covered loss or medical bills due until the form is in compliance.

6. 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 "countersigned" or "countersignature" 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, that is consistent with the services being rendered to the patient as claimed. Listing CPT codes or other coding on the patient log does not satisfy this requirement. The provider must provide copies of the patient logs to the insurer within 30 days of receiving a written request from the insurer. Failure to maintain patient logs as required by this subparagraph renders the treatment noncompensable. The 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, 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 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.

(7)~~(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, 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, permit the insurer or the insurer's representative to conduct an onsite physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and any other medical equipment used for the services rendered within 10 days after the insurer's request and 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 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.

1. 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. 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.

2. If an insured seeking to recover benefits pursuant to ss. 627.730-627.7405 assigns the contractual right to those benefits or payment of those benefits to any person or entity, the assignee must comply with the terms of the policy. In all circumstances the assignee is obligated to cooperate under the policy, including, but not limited to, submitting to examinations under oath. Examinations under oath may be recorded by audio, video, court reporter, or any combination thereof. Compliance with this paragraph is a condition precedent to recovery of benefits pursuant to ss. 627.730-627.7405.

a. If an insurer requests an examination under oath of a medical provider, the provider must produce the persons having the most knowledge of the issues identified by the insurers in the request for examination under oath. All claimants must produce and allow for the inspection of all documents requested by the insurer which are relevant to the service rendered and reasonably obtainable by the claimant. Prior to the commencement of the examination under oath, the insurer must pay the medical provider reasonable compensation for attending the examination under oath. Such compensation shall be based upon a good faith estimate of the time required to conduct the examinations under oath. If additional time is necessary for completion of the examination under oath, the insurer must provide compensation to the medical provider for the time that exceeds the good faith estimate within 15 days after the examination under oath so long as the provider completes the examination. The medical provider may have an attorney present at the examination under oath at the providers own expense.

b. Before requesting that an assignee participate in an examination under oath, the insurer must send a written request to the assignee requesting all information that the insurer believes is necessary to process the claim and relevant to the services rendered, including the information contemplated under the subparagraph.

c. An insurer that, as a general business practice, requests examinations under oath of an assignee without a reasonable basis is engaging in an unfair and deceptive trade practice.

(c) If there is a ~~In the event of any~~ dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition the ~~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. The ~~Such~~ court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, 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.

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

(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 an examination, the personal injury protection carrier is no longer liable for ~~subsequent~~ personal injury protection benefits incurred after the date of the first request for examination until the insured appears for the examination. Failure to appear for two scheduled examinations raises a rebuttable presumption that such failure was unreasonable. Submission to an examination is a condition precedent to benefits.

(9)~~(8)~~ APPLICABILITY OF PROVISION REGULATING 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~~ s. 627.428 applies ~~shall apply~~, except as provided in subsections (10), ~~and~~ (15), and (18), and except that any attorneys fees recovered are limited to $200 per billable hour.

(10) DEMAND LETTER.—

(a) As a condition precedent to filing any action for benefits under this section, the claimant filing suit must provide the insurer ~~must be provided~~ with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b). A premature demand letter is defective and cannot be cured unless the court first abates the action or the person, claimant, or organization first voluntarily dismisses the action.

(b) The notice 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 person to whom notices 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 shall be deemed the authorized representative to accept notice pursuant to this subsection 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 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'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) A demand letter that does not meet the minimum requirements set forth in this subsection or that is sent during the pendency of the lawsuit is defective. A defective demand letter cannot be cured unless the court first abates the action or the claimant voluntarily dismisses the action.

(g) ~~(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.

(h) If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant, insured, or organization must send a second demand letter by certified or registered mail stating the exact amount that the claimant believes the insurer owes and why it believes the amount paid is incorrect. The insurer has an additional 10 days after receipt of the second demand letter to issue any additional payment that is owed. The purpose of this provision is to avoid unnecessary litigation over miscalculated payments.

(i) Demand letters may not be used to request the production of claim documents or other records from the insurer.

(18) ATTORNEYS FEES. –Notwithstanding s. 627.428, any attorneys fees recovered for disputes arising under ss. 627.730-627.405 shall be calculated without regard to any contingency risk multiplier.

Section 6. Subsection (10) of 817.234, Florida Statutes, is amended, present subsection (12) of that section is renumbered as subsection (13), and a new subsection (12) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) (a) Any person who owns a business entity eligible for reimbursement under s. 627.736(1) and who is found guilty of insurance fraud related to motor vehicle insurance under this section shall lose his or her occupational license for such entity for 5 years and may not receive reimbursement for personal injury protection benefits for 10 years.

(b) Any licensed health care practitioner found guilty of insurance fraud relating to motor vehicle insurance under this section shall lose 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.~~

(12) In addition to any criminal liability, a person who is found by a court of competent jurisdiction to have violated any provision of this section for the purpose of receiving insurance proceeds from any personal injury protection

insurance contract is subject to a civil penalty as provided herein:

(a) For a violation of any provision of this section, except for a violation of subsection (9), the civil penalty shall be:

1. For a first offense, a fine not to exceed $5,000.

2. For a second offense, a fine of not less than $5,000 but not more than $10,000.

3. For a third and subsequent offenses, a fine of not less than $10,00 but not to exceed $15,000.

(b) Any person who is found by a court of competent jurisdiction to have violated the provisions of subsection (9) is subject to a civil penalty of not less than $15,000, but not to exceed $50,000.

(c) The civil penalty must be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services, and must be specifically used by the department for the investigation and prosecution of insurance fraud.

(d) Nothing in this subsection shall be construed to prohibit a state attorney from entering into a written agreement in which the person does not admit or deny the charges but consents to payment of the civil penalty.

(13) ~~(12)~~ As used in this section:

(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 7. This act shall take effect July 1, 2011.