By Senator Brown-Waite

10-600-00

A bill to be entitled

An act relating to health maintenance organizations; amending s. 641.315, F.S.; revising provisions relating to provider billing; amending s. 641.3155, F.S.; defining the term "clean claim"; providing timeframes for interest payment on late and overdue claim payments; providing a schedule for electronic billing; mandating acknowledgment of receipts for electronically submitted claims; specifying timeframes for duplicate billing; creating s. 641.3156, F.S.; providing for treatment authorization and payment of claims; amending s. 641.495, F.S.; revising provisions relating to treatment authorization capabilities; creating s. 408.7057, F.S.; providing for the establishment of a statewide provider and managed-care-organization claim-dispute mediation panel; granting rulemaking authority to the Agency for Health Care Administration; providing an effective date.

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

Section 1. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider ~~contracts~~.--

(1) If ~~Whenever~~ a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization

is ~~shall be~~ liable for such ~~fee or~~ fees rather than the subscriber; and the contract must ~~shall~~ so state.

(2) A ~~No~~ subscriber of an HMO is not ~~shall be~~ liable to any provider of health care services for any services covered by the HMO.

(3) A ~~No~~ provider of services or any representative of such provider may not ~~shall~~ collect or attempt to collect from an HMO subscriber any money for services covered by an HMO, and a ~~no~~ provider or representative of the ~~such~~ provider may not maintain any action at law against a subscriber of an HMO to collect money owed to the ~~such~~ provider by an HMO. The provider may not bill the subscriber during any ongoing dispute-resolution process. The responsibility for claims payment to providers rests with the HMO/MCO and not with any party to which the HMO/MCO has delegated the functions of claims or management claims processing, or both. A provider of services or a representative of the provider may not report a subscriber to a credit agency for unpaid claims due from an HMO/MCO for covered HMO services. A violation of this subsection by an individual physician or a physician practice must be referred to the agency for investigation and to the Board of Medicine for final disciplinary action as part of the current Medical Quality Assurance Program. A violation by a facility must be referred to the agency. A violation of this subsection by an institutional provider must be referred to the agency for investigation as part of the agency's current Consumer Assistance Program.

(4) Each ~~Every~~ contract between an HMO and a provider of health care services must ~~shall~~ be in writing and ~~shall~~ contain a provision that the subscriber is ~~shall~~ not ~~be~~ liable

to the provider for any services covered by the subscriber's contract with the HMO.

(5) ~~The provisions of~~ This section does ~~shall~~ not ~~be construed to~~ apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.

(6)(a) For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:

1. The contracts must require ~~provide that~~ the provider to ~~shall~~ provide 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason; and

2. The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is ~~shall~~ not ~~be~~ a valid reason for avoiding the 60-day advance notice of cancellation.

(b) For all provider contracts executed after October 1, 1996, and within 180 days after October 1, 1996, for contracts in existence as of October 1, 1996, the contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(7) Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health

maintenance organization is not financially impaired or insolvent.

(8) A contract between a health maintenance organization and a provider of health care services may ~~shall~~ not restrict ~~contain any provision restricting~~ the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(9) A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(10) A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required by ~~in~~ this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician

licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466.

Section 2. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Provider contracts; payment of claims.--

(1)(a) As used in this section, the term "clean claim" means either:

1. An institutional claim that is a properly completed billing instrument (paper or electronic), consisting of the UB-92 data set or its successor, and submitted on the designated paper or electronic format adopted by the National Uniform Billing Committee (NUBC) with entries designated as mandatory by the NUBC, together with any data required by the state uniform billing committee and included in the UB-92 manual that is in effect at the time of service; or

2. The definition established within an executed and current provider contract.

(b) The term "clean claim" as used in this section does not involve coordination of benefits (COB) for third-party liability or subrogation as evidenced by the information provided on the claim related to COB.

(c) The definition prescribed in paragraph (a) is inapplicable to claims against a physician's practice. With respect to a physician's practice, the definition of the term "clean claim" must be agreed upon by contract.

(2)~~(1)~~(a) A health maintenance organization shall pay any clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with the health maintenance organization which the organization does not contest or deny within 35 days after

receipt of the claim by the health maintenance organization which is mailed or electronically transferred by the provider.

(b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall notify the contract provider, in writing, within 35 days after ~~receipt of the claim by~~ the health maintenance organization receives the claim that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and must ~~may~~ include a request for additional information. If the provider submits ~~health maintenance organization requests~~ additional information, the provider must ~~shall~~, within 35 days after receipt of the ~~such~~ request, mail or electronically transfer the information to the health maintenance organization. The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(3)~~(2)~~ Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year. Interest on an overdue payment for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received. The interest is payable with the payment of the claim. Interest on overpayments made to providers begins to accrue on the 36th day after the provider receives notice of overpayment. Upon the 36th day, plans must be allowed to offset any interest payment due against future claims.

(4)~~(3)~~ A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim.

(5)~~(4)~~ Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

(6) Providers must implement electronic billing in accordance with the implementation schedule established by the National Uniform Billing Committee. The department may grant special consideration and variance to the implementation schedule to rural hospitals and physician's practices.

(7) Providers who bill electronically are entitled to electronic acknowledgement of receipts of claims within 48 hours. Providers must wait 45 days before submitting duplicate bills if confirmation of receipt was received from the plan.

(8) The time limit for recouping or collecting outstanding claims may not exceed 1 year for either a contracted or a noncontracted provider.

Section 3. Section 641.3156, Florida Statutes, is created to read:

641.3156 Treatment authorization; payment of claims.--

(1) A health maintenance organization must pay any hospital-service or referral-service claim for treatment that was authorized by a physician empowered by the HMO/MCO to

authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO/MCO's current and communicated procedures.

(2) A claim for treatment that was authorized in accordance with this section may not be denied retroactively by the HMO/MCO unless:

(a) The service is not covered;

(b) The subscriber was ineligible at the time the services were rendered; or

(c) The physician provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

Section 4. Subsection (4) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(4) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(13)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs. The health maintenance organization must be able to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.

Section 5. Section 408.7057, Florida Statutes, is created to read:

408.7057 Statewide provider and managed care organization claim dispute mediation panel.--

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

(a) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(b) "Panel" means a statewide provider and managed care claim dispute mediation panel selected as provided in subsection (7).

(2)(a) The Agency for Health Care Administration shall establish a program to provide assistance to contracting and noncontracting providers and managed care organizations for those claim disputes that are in violation of s. 641.3155 and are not resolved by the provider and the managed care entity. The program must consist of one or more panels that meet as often as necessary to timely review, consider, and hear claim disputes and to recommend to the agency any actions that should be taken concerning individual cases heard by the panel.

(b) The panel shall hear claim disputes filed by participating and nonparticipating providers and managed care organizations unless the disputed claim:

1. Is related to interest payment;

2. Is for an amount of $5,000 or less for a claim against an institution or $1,000 or less for a claim against an individual physician;

3. Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process;

4. Is related to a health plan that is not regulated by the state, such as an administrative services organization, a third-party administrator, or a federal employee health benefit program;

5. Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

6. Is the basis for an action pending in state or federal court; or

7. Was filed before the provider or the managed care organization made a good-faith effort to resolve the dispute.

(c) Failure of the provider or the managed care entity that is filing for claim dispute resolution to attend the hearing constitutes a withdrawal of the request.

(3) Within 30 days after receiving a request for claim dispute resolution, the agency shall review the request and determine whether the grievance will be heard. Once the agency notifies the panel, the provider, and the managed care entity that the panel will hear the request for claim-dispute resolution, the panel must hear the claim dispute, in the network area or by teleconference, no later than 60 days after the agency has determined that the dispute will be heard. The deadline may be waived if both the provider and the managed care organization consent. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. Within 30 working days after hearing the claim dispute, the panel shall issue a written recommendation, supported by findings of fact, to the provider

and managed care entity. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the requested information or documentation has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization together with a properly filed grievance, the agency requests medical records, billing information, or claim records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records must provide the records to the agency within 10 days. Failure to provide requested medical records may result in the imposition of a fine in an amount of no more than $500. Each day that records are not produced constitutes a separate violation.

(5) After hearing the claim dispute, the panel shall make its recommendation to the agency, which may require payment of the unpaid portion of any claim not paid by the managed care entity. Interest payment in the amount of 10 percent per year accrues from the date the provider files the request for a hearing under this section.

(6) Within 30 days after the issuance of the panel's recommendation, the agency may adopt the panel's recommendation or findings of fact in a final order. The agency may reject all or part of the panel's recommendation.

(7) The panel shall consist of five members, one of whom is employed by the agency and one of whom is employed by the department, chosen by their respective agencies; a medical director of a managed care entity that holds a current certificate of authority to operate in this state; a physician who represents a hospital; and a physician licensed under

chapter 458 or chapter 459. Each member of the panel must be proficient in coding methodology.

(8) The entity that does not prevail at the hearing must pay the reasonable costs and attorney's fees of the agency or the department which were incurred in that proceeding.

Section 6. The Agency for Health Care Administration has the authority to adopt rules necessary for administering this act.

Section 7. This act shall take effect October 1, 2000, and shall apply to all requests for claim-dispute resolution which are submitted by a provider or managed care entity after September 30, 2000.

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SENATE SUMMARY

Relates to health maintenance organizations. Revises provisions relating to provider billing. Defines the term "clean claim." Provides timeframes for interest payment on late and overdue claim payments. Provides a schedule for electronic billing. Mandates acknowledgment of receipts for electronically submitted claims. Specifies timeframes for duplicate billing. Provides for treatment authorization and payment of claims. Revises provisions relating to treatment authorization capabilities. Provides for the establishment of a statewide provider and managed care organization claim-dispute mediation panel. Grants rulemaking authority to the Agency for Health Care Administration.