By the Committee on Banking and Insurance; and Senator Brown-Waite

311-1933-00

1 A bill to be entitled
2 An act relating to health maintenance
3 organizations; amending s. 641.315, F.S.;
4 revising provisions relating to provider
5 billing; amending s. 641.3155, F.S.; defining
6 the term "clean claim"; providing timeframes
7 for interest payment on late and overdue claim
8 payments; providing a schedule for electronic
9 billing; mandating acknowledgment of receipts
10 for electronically submitted claims; specifying
11 timeframes for duplicate billing; creating s.
12 641.3156, F.S.; providing for treatment
13 authorization and payment of claims; amending
14 s. 641.495, F.S.; revising provisions relating
15 to treatment authorization capabilities;
16 creating s. 408.7057, F.S.; providing for the
17 establishment of a statewide provider and
18 managed-care-organization claim-dispute
19 mediation panel; granting rulemaking authority
20 to the Agency for Health Care Administration;
21 providing an effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Section 641.315, Florida Statutes, is
26 amended to read:
27 641.315 Provider billing ~~contracts~~.--
28 (1) If ~~Whenever~~ a contract exists between a health
29 maintenance organization and a provider and the organization
30 fails to meet its obligations to pay fees for services already
31 rendered to a subscriber, the health maintenance organization

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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, whether contracted or noncontracted, 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

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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 give ~~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

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1 licensed under chapter 458, chapter 459, chapter 460, or
2 chapter 461, or a dentist licensed under chapter 466.
3 Section 2. Section 641.3155, Florida Statutes, is
4 amended to read:
5 641.3155 Provider contracts; payment of claims.--
6 (1) As used in this section, the term "clean claim"
7 means a completed claim submitted by institutional providers
8 on a UB-92 claim form or other providers on a HCFA 1500 claim
9 form for medical care or health care services under a health
10 care plan. The department may adopt rules revising and
11 updating the definition of clean claim, to be consistent with
12 federal claim filing standards for health care plans as
13 required by the Health Care Financing Administration.
14 (2)~~(1)~~(a) A health maintenance organization shall pay
15 any clean claim or any portion of a clean claim made by a
16 contract provider for services or goods provided under a
17 contract with the health maintenance organization which the
18 organization does not contest or deny within 35 days after
19 receipt of the claim by the health maintenance organization
20 which is mailed or electronically transferred by the provider.
21 (b) A health maintenance organization that denies or
22 contests a provider's claim or any portion of a claim shall
23 notify the contract provider, in writing, within 35 days after
24 ~~receipt of the claim by~~ the health maintenance organization
25 receives the claim that the claim is contested or denied. The
26 notice that the claim is denied or contested must identify the
27 contested portion of the claim and the specific reason for
28 contesting or denying the claim, and must ~~may~~ include a
29 request for additional information. If the provider submits
30 ~~health maintenance organization requests~~ additional
31 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.

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1 (6) Providers must implement electronic billing in
2 accordance with the implementation schedule established by the
3 federal Health Insurance Portability and Accountability Act.
4 The department may grant special consideration and variance to
5 the implementation schedule to rural hospitals and physician's
6 practices.
7 (7) Providers who bill electronically are entitled to
8 electronic acknowledgement of receipts of claims within 48
9 hours. Providers must wait 45 days before submitting duplicate
10 bills if confirmation of receipt was received from the plan.
11 (8) The time limit for recouping or collecting
12 outstanding claims may not exceed 1 year for either a
13 contracted or a noncontracted provider.
14 Section 3. Section 641.3156, Florida Statutes, is
15 created to read:
16 641.3156 Treatment authorization; payment of claims.--
17 (1) A health maintenance organization must pay any
18 hospital-service or referral-service claim for treatment that
19 was authorized by a physician empowered by the HMO/MCO to
20 authorize or direct the patient's utilization of health care
21 services and that was also authorized in accordance with the
22 HMO/MCO's current and communicated procedures.
23 (2) A claim for treatment that was authorized in
24 accordance with this section may not be denied retroactively
25 by the HMO/MCO unless:
26 (a) The service is not covered;
27 (b) The subscriber was ineligible at the time the
28 services were rendered; or
29 (c) The physician provided information to the health
30 maintenance organization with the willful intention to
31 misinform the health maintenance organization.

1 Section 4. Subsection (4) of section 641.495, Florida
2 Statutes, is amended to read:
3 641.495 Requirements for issuance and maintenance of
4 certificate.--
5 (4) The organization shall ensure that the health care
6 services it provides to subscribers, including physician
7 services as required by s. 641.19(13)(d) and (e), are
8 accessible to the subscribers, with reasonable promptness,
9 with respect to geographic location, hours of operation,
10 provision of after-hours service, and staffing patterns within
11 generally accepted industry norms for meeting the projected
12 subscriber needs. The health maintenance organization must
13 have the capability to provide treatment authorization 24
14 hours a day, 7 days a week. Requests for treatment
15 authorization may not be held pending unless the requesting
16 provider contractually agrees to take a pending or tracking
17 number.
18 Section 5. Section 408.7057, Florida Statutes, is
19 created to read:
20 408.7057 Statewide provider and managed care
21 organization claim dispute mediation panel.--
22 (1) As used in this section, the term:
23 (a) "Managed care entity" means a health maintenance
24 organization or a prepaid health clinic certified under
25 chapter 641, a prepaid health plan authorized under s.
26 409.912, or an exclusive provider organization certified under
27 s. 627.6472.
28 (b) "Resolution organization" means a qualified
29 independent third-party claims dispute resolution entity
30 selected by and contracted with the Agency for Health Care
31 Administration.

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1 (2)(a) The Agency for Health Care Administration shall
2 establish a program to provide assistance to contracting and
3 noncontracting providers and managed care organizations for
4 those claim disputes that are in violation of s. 641.3155 and
5 are not resolved by the provider and the managed care entity.
6 The program must include the agency contracting with a
7 resolution organization to timely review and consider claims
8 disputes submitted by providers and managed care organizations
9 and to recommend to the agency an appropriate resolution of
10 those disputes.
11 (b) The resolution organization shall review claim
12 disputes filed by participating and nonparticipating providers
13 and managed care organizations unless the disputed claim:
14 1. Is related to interest payment;
15 2. Is for an amount of $5,000 or less for a claim
16 against an institution or $1,000 or less for a claim against
17 an individual physician;
18 3. Is part of an internal grievance in a Medicare
19 managed care entity or a reconsideration appeal through the
20 Medicare appeals process;
21 4. Is related to a health plan that is not regulated
22 by the state, such as an administrative services organization,
23 a third-party administrator, or a federal employee health
24 benefit program;
25 5. Is part of a Medicaid fair hearing pursued under 42
26 C.F.R. ss. 431.220 et seq.;
27 6. Is the basis for an action pending in state or
28 federal court; or
29 7. Is subject to a binding claims dispute resolution
30 process provided by contract between the provider and the
31 managed care organization.

1 (3) The agency shall adopt rules to establish a
2 process for the consideration by the resolution organization
3 of claims disputes submitted by either a provider or managed
4 care entity which shall include the issuance by the resolution
5 organization of a written recommendation, supported by
6 findings of fact, to the agency within 60 days after receipt
7 of the claims dispute submission.
8 (4) Within 30 days after receipt of the recommendation
9 of the resolution organization the agency shall issue a final
10 order subject to the provisions of chapter 120.
11 (5) The entity that does not prevail in the agency's
12 order must pay a review cost to the review organization as
13 determined by agency rule which shall include an apportionment
14 of the review fee in those cases where both parties may
15 prevail in part. The failure of the nonprevailing party to pay
16 the ordered review cost within 35 days of the agency's order
17 will subject the nonpaying party to a penalty of no more than
18 $500 per day until the penalty is paid.
19 Section 6. The Agency for Health Care Administration
20 may adopt rules necessary to administer this act.
21 Section 7. This act shall take effect October 1, 2000,
22 and shall apply to all requests for claim-dispute resolution
23 which are submitted by a provider or managed care entity 60
24 days after the effective date of the contract between the
25 resolution organization and the agency.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 1508

Specifies that the balanced billing prohibitions of s. 641.315, F.S., apply to either a contracted or non-contracted provider who provides covered services to an HMO subscriber.

Deletes the state agency panel that the bill requires the Agency for Health Care Administration to establish to help resolve claims disputes between providers and managed care entities and, instead, requires the agency to contract with independent resolution organizations to recommend to the agency an appropriate resolution of those disputes, subject to a final order by the agency pursuant to chapter 120. This process would not apply to a claim that is subject to a binding claims dispute resolution process provided by the managed care entity's provider contract.

Revises the definition of "clean claim" to refer to specific forms and authorizes the Department of Insurance to adopt rules revising and updating the definition of clean claim to be consistent with federal clean claim standards approved by the Health Care Financing Administration.

Changes the cross-reference from the "National Uniform Billing Committee" to the "federal Health Insurance Portability and Accountability Act" that establishes the schedule for providers to implement electronic billing.

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