STORAGE NAME: h2427.hcs
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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 2427 (PCB HCS 00-09)

RELATING TO: Managed Care

SPONSOR(S): Committee on Health Care Services, Reps. Peaden and Casey

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 13 NAYS 1
(2)
(3)

I. SUMMARY:

HB 2427 addresses a variety of issues relating to managed care and prompt payment of provider claims. The bill:

- Deletes provisions relating to provider billings and revises provisions relating to provider contracts;
- Provides for certain disclosures and notice;
- Requires procedures for requesting and granting authorization for utilization of services;
- Provides for HMO liability for payment for services rendered to subscribers;
- Prohibits provider billing of subscribers under specified circumstances;
- Defines the term “clean claim” in the institutional and non-institutional setting;
- Specifies the basis for determining when a claim is to be considered clean or not clean;
- Requires the Department of Insurance to adopt rules to establish a claim form and provides requirements for the form;
- Provides the Department of Insurance with discretionary rulemaking authority for coding standards and provides requirements;
- Provides for payment of clean claims and requirements for denying or contesting all or a portion of a claim;
- Provides for interest accrual and payment of interest;
- Provides an uncontestable obligation to pay a claim;
- Requires an HMO to make a claim for overpayment, and provides exceptions;
- Requires a provider to pay a claim for overpayment within a specified timeframe and provides a procedure and timeframes for a provider to notify an HMO that it is denying or contesting a claim for overpayment;
- Specifies when a provider payment of a claim for overpayment is to be considered made;
- Provides for assessment of simple interest against overdue payment of a claim and specifies when interest on overdue claims for overpayment begins to accrue;
- Specifies a timeframe for a provider to deny or contest a claim for overpayment and provides an uncontestable obligation to pay a claim for overpayment;
- Specifies when a provider claim and an HMO claim for overpayment is considered received;
- Mandates acknowledgment of receipts for submitted provider claims;
- Prescribes a timeframe for an HMO to retroactively deny a claim for services provided to an ineligible subscriber;
- Provides for treatment authorization and payment of claims by an HMO;
- Clarifies that treatment authorization and payment of a claim for emergency services is subject to another provision of law;
- Provides that certain actions by an HMO are unfair methods of competition and unfair or deceptive acts or practices;
- Authorizes the Department of Insurance to issue a cease and desist order for violations relating to the payment of claims;
- Revises provisions relating to treatment-authorization capabilities;
- Requires contractual agreement for pending authorizations and tracking numbers as a precondition to such authorizations;
- Provides for the establishment of a statewide provider and managed care organization claim dispute resolution program by the Agency for Heath Care Administration;
- Provides rulemaking authority to the agency;
- Imposes certain administrative sanctions and penalties for specified actions; and
- Expands prohibition of fraud against hospitals to apply to all health care providers.

Provides, except as otherwise provided, an effective date of October 1, 2000, to apply to claims for services rendered after such date and to all requests for claim-dispute resolution submitted by a provider or a managed care organization 60 days after the effective date of the contract between the resolution organization and the Agency for Health Care Administration.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

Department of Insurance: The bill requires the Department of Insurance (department) to do the following: adopt rules which define “clean claim” and adopt rules to establish claim forms consistent with specified federal claim-filing standards. The bill authorizes the department to adopt rules relating to coding standards consistent with certain Medicare coding standards. The bill adds “systematic downcoding” with the intent to deny reimbursement otherwise not due as an unfair claim settlement practice subject to action by the department. The bill adds violation of s. 641.3155, F.S., relating to payment of claims, as subject to a cease and desist and penalty order issued by the department. The bill adds “systematic upcoding” with intent to obtain reimbursement otherwise not due as a false and fraudulent insurance claim. The bill expands language defining fraudulently obtaining goods and services to include health care providers.

Agency for Health Care Administration: The bill requires the Agency for Health Care Administration (agency) to do the following: establish a statewide provider and managed care organization claim dispute resolution program; establish, by rule, jurisdictional amounts and methods of aggregation of claim disputes; adopt rules to establish a process of consideration by resolution organizations; issue final orders based on resolution organization recommendations; adopt rules regulating resolution organization review fees and apportionment of review fees; and imposition of administrative fines for nonpayment of resolution organization review fees.

B. PRESENT SITUATION:

HMO “Prompt Payment” Statute (s. 641.3155, F.S.)

In 1998, the Legislature adopted ch. 98-79, L.O.F., CS/SB 1584, enacting s. 641.3155, F.S., requiring health maintenance organizations (HMOs) to pay claims within certain time frames. This statute (referred to as the “prompt payment” law), requires an HMO to reimburse any claim or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim. If the claim is contested by the HMO, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, and identify the contested portion of the claim and the specific reason for contesting or denying the claim. This notice may also include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Within 45 days after receipt of the information

requested, the HMO must pay or deny the contested claim or portion of the contested claim. In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

In 1999, the Legislature amended s. 641.3155(4), F.S., to address the issue of HMOs deducting past overpayments from a provider's claim, commonly referred to as "take backs." As amended, this subsection requires any retroactive reduction of payments or demands for refund of previous overpayments to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. This also applies to providers who make retroactive demands for payment due to underpayments or nonpayment. The look-back period may be specified by the terms of the contract.

Balanced Billing Prohibition (s. 641.315, F.S.)

In 1988, the Legislature amended s. 641.315, F.S., which provides that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. This law also prohibits a provider of services from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO. This statute is interpreted by the Department of Insurance (department), and the Agency for Health Care Administration (agency), as applying to both contract and non-contract providers in those cases where services are covered by the HMO. For example, if a subscriber obtains a covered service at a contract hospital from a non-contract physician, the HMO is liable and the physician may not bill the subscriber. However, some providers argue that the statute is limited to balanced billing by contract providers, due to the directory language of the section that reads, "Provider contracts." There are no appellate court decisions on this point.

The Statewide Provider and Subscriber Assistance Program

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., and is administered by the agency. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to panels that hold hearings on the grievance and issue recommendations to the agency or to the department for a final order. The program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. The program does not provide assistance for a grievance for "unpaid balances." The program does not typically provide assistance for grievances related to provider disputes for late payments or underpayments.

HMO Claims for Emergency Care and Treatment

HMOs are required to provide coverage for emergency services and care without prior authorization or referral pursuant to ss. 641.31(12), 641.47(7) and (8), and 641.513, F.S. This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers. "Emergency medical condition" is defined in s. 641.19(7), F.S., as a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medial attention could reasonably be expected to result in serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

When a subscriber seeks emergency services at a hospital, a determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination. Compensation must be made even if the provider determines that an emergency medical condition does not exist. If the provider determines that an emergency medical condition does exist, the HMO must also compensate the provider for emergency services and care. Emergency services and care include the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition and within the service capability of a hospital.

The hospital must make a reasonable attempt to notify the subscriber's primary care physician or HMO, if known, within a prescribed amount of time; however, an HMO may not deny payment for emergency services and care simply based on a hospital's failure to comply with the notice requirements. A subscriber may be charged a reasonable copayment, up to $100, for the use of an emergency room. Net of this copayment, an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; or the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

Department of Insurance Bulletin 99-901

On September 3, 1999, the Florida Department of Insurance issued Bulletin 99-901, relating to all health maintenance organizations and payments of claims of contract providers. The purpose of the bulletin was to remind all HMOs of the requirements of ss. 641.3155 and 641.3903(5), F.S., which govern the payment of claims filed with HMOs by contract medical providers. In the bulletin, the department reminded the HMOs that they are required by law to pay, contest, or deny a claim within 35 days after receipt of the claim from a contracted medical provider under the terms of the contract between the provider and the HMO; and that evidence of the date of receipt of the claim by the HMO is the starting point of the 35-day period.

According to the bulletin, the department has received complaints regarding a variety of claim payment practices by HMOs which had resulted in systematic, automatic denials of claims, such as emergency room claims and others that fall into particular categories. In addition, the department had evidence that some HMOs would automatically "pend" or deny particular types of claims or employ the practice of "downcoding" or "rightcoding" without investigation, changing the billing, and reducing the amount due on claims without discussion.

Federal HIPAA Requirements for "Clean Claims" and Electronic Billing

The federal Health Insurance Portability and Accountability Act (HIPAA), requires the Health Care Financing Administration (HCFA), to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility, and payment. However, there have been problems and delays with the implementation of HIPAA. The National Uniform Billing Committee (NUBC), an industry group working on the implementation, recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC), is expected to agree on an equivalent definition of a practitioner clean claim. Both of these committee recommendations, and other administrative simplification recommendations, will be

submitted to the federal Secretary of Health and Human Services for adoption and implementation. The U.S. Department of Health and Human Services (DHHS) is planning to begin issuing HIPAA regulations on administrative simplification requirements in June 2000. This will be an on-going matter addressing a variety of topics over time.

The Agency for Health Care Administration and the Department of Insurance HMOs Review

The agency conducted a focused claims review of emergency room services of Medicaid and commercial health maintenance organizations (HMOs). The purposes of the reviews were: to determine compliance related to statutory and contractual requirements, address concerns of the provider community, and substantiate or refute anecdotal information. On-site surveys began in March and were completed in November, 1999. A random sample of 75 Medicaid claims and 75 commercial claims was pulled from each HMO for each of the reviews. These claims covered dates of service from April 1, 1998, through June 30, 1998. Each claim included a hospital emergency room claim, and all related claims (physician, laboratory, x-ray, etc.) for that date of service. Medicaid claims were reviewed for compliance related to timeliness of payment, appropriateness of payment amount, and evidence of inappropriately denied claims. Commercial claims were reviewed for compliance related to appropriateness of payment amount and evidence of inappropriately denied claims.

Fourteen Medicaid HMOs were reviewed. The agency found that 4 plans were found in full compliance for payment amount, and one for timely payment. A total of 2,819 claims were reviewed, of which 687, or 25 percent, exceeded 35 days to pay without an acceptable explanation. Of the total claims, 234, or 8 percent, were paid at inappropriate amounts. Thirteen Medicaid HMOs were fined a combined total of $211,000 (subject to change based on appeals); 13 HMOs were required to submit corrective action plans; and 6 were required to reprocess all emergency room claims from July 1997 to present.

Twenty-six commercial HMOs were reviewed. A total of 4,924 claims were reviewed (an average of 190 claims per HMO). Fourteen, or 54 percent, of HMOs were found in compliance, and 32, or 0.65 percent of claims were denied or paid improperly. Twelve HMOs were fined a combined total of $16,000; 12 HMOs were required to submit corrective action plans; and one HMO was required to reprocess all emergency room claims from July 1997 to present.

Since HMOs are dually regulated by the agency and the department and timeliness of payment for commercial claims falls within the jurisdiction of the department, the agency documented commercial timeliness deficiencies and forwarded the information to the department for review. The department accompanied the agency on eight joint audits and then decided to perform its own in-depth analysis of the HMO claims payment systems.

On March 30, 2000, the department issued a Notice and Order to Show Cause (“Order”) to each of two HMOs, resulting from a targeted examination of their claims payment practices. Each of the Orders finds that the HMO failed to pay, contest, or deny claims within the 35 days, as required by s. 641.3155, F.S., and failed to pay the 10 percent penalty for late payments as required under that section, among other allegations. The Orders include notice that the department intends to impose administrative penalties of $100,000 against one HMO and $75,000 against the other HMO. This is a preliminary agency order, and is subject to challenge or denial by the HMOs.

Advisory Group on the Submission and Payment of Health Claims

The health care provider community has voiced concerns about delays in payment of HMO claims, underpayment of claims, and difficulty in obtaining authorization for treatment from HMOs. Providers assert that the current prompt payment law is not being observed. Estimates generated by the Florida Hospital Association show that as of May 1999, 16.1 percent of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital and Healthcare Association found that the average age of HMO receivables in the hospitals in question were over 70 days old, with about 30 percent of the receivables being over 60 days old.

The managed care community disputes the magnitude of this problem and maintains that most delays in payment are caused by providers' failure to include essential and accurate information with their claims. In response to these concerns and divided opinions, the Florida Legislature in 1999 authorized the Director of the agency, pursuant to ch. 99-393, L.O.F.; CS/HBs 1927 and 961, to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The advisory group issued its report and recommendations on February 1, 2000 ("Advisory Group Report").

The following is a committee staff summary of the recommendations of the Advisory Group Report, with the page number of the report where the recommendation is contained. The staff summary uses the term "HMO," rather than "MCOs" or managed care organizations, as used in the report, which are, for current purposes, synonymous terms (as stated on page 1 of the report).

Issues and Recommendations: Non-Emergent Treatments

A) Authorization to Treat

1. 24-Hour Service -- HMOs should have the capability to provide authorization 24 hours a day, 7 days a week for all services for which pre-authorization is required. (p. 16)

2. Binding Authorization of Services -- If a provider follows authorization procedures and applicable laws, and receives authorization for a covered service for an eligible employee (subscriber), then the plan is bound by its authorization to pay and the service is deemed medically necessary. (p. 16)

3. Pend Numbers -- It is inappropriate for HMOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number. (p.16)

B) Electronic Billing and Clean Claims

1. Definition of Clean Claim -- Recommend adoption of the recently adopted National Uniform Billing Committee (NUBC) definition of institutional clean claim. However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them. (p. 17)

2. HIPAA Standards (Federal Health Insurance Portability and Accountability Act) -- The federal HIPAA law includes requirements for electronic filing of claims, but these provisions have not yet been implemented. It is believed that implementation will take place within the next 3 years. Recommendation that Florida adopt the expected federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be

applied to all HMOs and providers. Agency staff estimate the costs of HIPAA implementation in Florida to average between $24,000 and $30,000 per office practice. (p. 17)

C) Late Payments

1. Interest Payments -- Section 641.3155, F.S., should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, that is, 35 days after the receipt of a clean claim. The statute should also clarify that the accrued interest must automatically be included with any late payment of a claim. This revised statute should apply equally to payment to contracted and non-contracted providers. (p. 18)

2. Venue for Complaints and Dispute Resolution -- Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. The scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmerited appeals. (p. 18)

3. Sub-Contractor Processing and Payment of Claims -- In instances where an HMO delegates authority for issuing authorization or processing or paying claims to a third-party subcontractor, the current policy of the department is to hold the licensed HMO financially and legally responsible for all actions or failures to act of the third-party subcontractor. The Advisory Group and the agency support this policy. (p. 19)

D) Claims Review

1. Eligibility Determination -- Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days. (p. 19)

2. Receipts -- Providers who submit claims electronically should be entitled to electronic acknowledgment of receipts of claims. Providers who receive acknowledgment of receipts of claims should be prohibited from sending a duplicate bill for 45 days. (p. 19)

3. Take Backs -- Take backs should be treated as claims made by an HMO to a provider. Insurers should provide written notice to providers of all over-payments, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments. (p. 19)

E) Balance and Duplicate Billing

1. Enforcement of Balance Billing Prohibition -- The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. The agency, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards. Balance billing by facilities shall be referred to the agency in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered services. Providers may not balance bill patients while billing disputes are going through any future state supervised dispute resolution process. (p. 20)

2. Medical Necessity -- Except in emergency situations, if an HMO denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not

covered by the HMO, and the provider is entitled to bill the patient for the service. It is important to educate the subscriber that he or she will be responsible for payment of services under these conditions. (p. 20)

3. Non-Covered Services -- Providers have a right to bill patients for non-covered services. (p. 20)

4. Non-Participating Providers -- Current s. 641.315, F.S., is ambiguous because the heading refers to provider contracts, but the language says no provider is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing the heading of the statute. Non-participating providers should not bill patients (beyond HMO copayments) if they are billing the HMO, going through a dispute resolution process to secure payment from an HMO or have accepted HMO payment for this specific service. (p. 20)

5. Restriction on Referral to Credit Agencies -- It is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations.

F) Non-Participating Providers

Recommends that when a physician empowered by an HMO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the HMO is obligated to reimburse that other provider for the authorized services. (p. 21)

G) Fraud and Abuse

1. Automated Recoding of Claims -- Systematic downcoding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The department has already issued a statement to that effect. (p. 22)

2. Incentives for Billing Agent to Submit Fraudulent Claims -- Florida should follow the same policies as Medicare. Under current Medicare regulations, billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised, or enforced more stringently by the Health Care Financing Administration in the near future. Similarly, if Medicare implements a policy against percentage incentives for HMO audit or credit collection firms, the Advisory Group recommends that Florida do likewise. (p. 22)

3. Reporting Liability of Additional Payors -- The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial HMOs. (p. 22)

4. Auditing of Claims -- Providers should not charge HMOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the HMO, but still should not add an extra charge for HMO staff reviewing provider records. (p. 22)

5. Civil Liability of Whistleblowers -- Requested the department to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud. (p. 22)

Issues and Recommendations: Emergency Treatments

1. Hospital Code System -- The Advisory Group acknowledges the agency's review of Medicaid standards concerning the coding of hospital emergency department treatments. The group recommends that the agency look into redoing the Florida Medical Quality Assurance Inc. (FMQAI) study of hospital emergency room coding in light of the objections to that study that have been presented to the group. (p. 26)

2. Availability of Specialized Physicians for Emergency Treatment -- In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific HMO, the hospital should notify the HMO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the agency's Bureau of Managed Care, which assesses HMO network adequacy. Access to emergency care is addressed in s. 395.1041, F.S. This law gives the agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need. (p. 26)

In addition to the above, the Advisory Group heard testimony on the reimbursement/prompt payment for emergency room claims. Currently, subsection (5) of s. 641.513, F.S., calls for the "lesser of:

(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided; or
(c) The charge mutually agreed to by the HMO and the provider within 60 days of the submittal of the claim."

Fraudulently Obtaining Goods, Services, etc. from Hospitals

Subsection (1) of s. 817.50, F.S., provides that any person who, willfully and with intent to defraud, obtains or attempts to obtain goods, products, merchandise, or services from any hospital is guilty of a second degree misdemeanor.

Subsection (2) of s. 817.50, F.S., provides that giving a hospital a false or fictitious name or a false or fictitious address or assigns to any hospital the proceeds of any insurance contract knowing that such contract is no longer in force, invalid, or void for any reason, is prima facie (a fact presumed to be true unless disproved by some evidence to the contrary) evidence of the intent of such person to defraud the hospital.

C. EFFECT OF PROPOSED CHANGES:

HB 2427:

- Revises requirements relating to provider contracts, as follows: requires written contracts between HMOs and providers, with provisions relating to HMO and subscriber liability for payment for services; requires certain disclosures by the HMO to providers; requires written procedures for request and authorization for health care services; and mandates certain notice requirements for changes to the request and authorization procedures for health care services procedures.

- Creates provisions related to HMO liability and prohibiting provider billing, as follows: specifies HMO liability for services rendered to a subscriber; clarifies that the

subscriber is not liable for payment of fees to the provider; specifies HMO liability for services rendered to a subscriber by a provider if the provider follows the HMO's authorization procedures and receives authorization; creates an exemption for information provided to the HMO with willful intent to misinform; prohibits collection attempts by providers from subscribers; provides a presumption regarding provider knowledge and specific exemptions; and mandates reporting of violations to the appropriate regulatory authority.

- Amends provisions relating to provider contracts and payment of claims, as follows: defines "clean claim" for non-institutional providers; prohibits classification of claim as not clean solely on the basis of HMO referral to medical specialist for review; provides for repeal of definition upon effective date of department's rule defining clean claim; defines "clean claim" for institutions absent a contract definition; requires the Department of Insurance to adopt rules to establish claim forms subject to specified requirements; and authorizes the department to adopt rules for coding standards consistent with Medicare standards.

- Expands requirements for payment of claims to include clean claims and portions of clean claims and to include those claims made by noncontract providers; expands requirements relating to denial or contest of claims to require request for additional information within specified timeframes; clarifies the date interest begins to accrue on overdue payments of clean claims and uncontested portions of clean claims; specifies when payment is due; and creates uncontestable obligation to pay a claim for claims not paid or denied within 120 days.

- Requires an HMO to make a claim for overpayments; prohibits reduction of payments for other services to cover claim for overpayment, subject to certain exceptions; requires providers to pay nondenied and noncontested claims for overpayment within 35 days of receipt; provides interest rate for overdue claim for overpayment; specifies when payment for overdue claim for overpayment accrues interest; and creates uncontestable obligation to pay claim for overpayment for claims not paid or denied within 120 days.

- Provides timeframes for payment of claim to be considered received and prohibits submission of duplicate claims within 45 days of initial claim receipt; provides timeframes for payments of claim for overpayment to be considered received and prohibits submission of duplicate claim for overpayment within 45 days of initial claim for overpayment receipt; provides that nothing in the section precludes an HMO and provider from agreeing to other methods of transmission and receipt of claims.

- Provides that a provider or his or her designee, who bills electronically is entitled to electronic acknowledgment of receipt within 72 hours; and prohibits retroactively denying a claim of more than 1 year after date of service due to subscriber ineligibility.

- Creates requirements for treatment authorization and payment of claims; provides exceptions for willful intention to misinform; and excludes provision of emergency services from the provisions of s. 641.3156, F.S.

- Expands unfair claim settlement practices to include systematic downcoding with intent to deny reimbursement.

- Authorizes the Department of Insurance to issue specified cease and desist and penalty orders relating to payment of claims submitted by providers.

- Requires HMOs to provide treatment authorization 24-hours a day, 7-days-a-week; and provides that requests for treatment authorization may not be pended, except as contractually agreed.

- Creates a statewide provider and managed care organization claim dispute resolution program established by the Agency for Health Care Administration; defines terms; requires the agency to contract with organizations to conduct timely review and consider claim disputes; grants the agency rulemaking authority to establish jurisdictional amounts, methods of aggregation for claims; provides exclusions of specified claims from resolution organization claim dispute resolution program; and provides that claims subject to certain contract requirements may be required to exhaust an internal resolution dispute process as a prerequisite to submitting the claim to the dispute resolution organization.

- Requires the agency to adopt rules to establish a process of consideration to be used by the resolution organization, including a requirement that the resolution organization issue a written recommendation, supported by findings of fact to the agency within 60 days after the receipt of the claims dispute submission; and requires the agency to adopt the recommendation as a final order within 30 days after receipt.

- Requires nonprevailing entity in a resolution organization claim dispute process to pay a review fee; requires the agency to adopt a rule for determining review fees; requires the agency to include determination of apportionment of review fee in rule; provides for penalty of nonprevailing party failing to pay review fee within 35 days after the agency's adoption of the final order; limits the penalty to no more than $500 per day until penalty is paid; and authorizes the agency to adopt rules necessary to implement the claim dispute resolution program.

- Amends statute relating to administrative penalties to update statutory language; and to authorize the agency, under specified circumstances, to impose an administrative fine for violation of the requirements relating to HMO liability and prohibiting provider billing, provider contracts and payment of claims, in amounts authorized for administrative fines, excluding reporting requirements relating to specified licensed physicians.

- Provides that systematic upcoding by a provider with intent to obtain reimbursement not otherwise due is a false and fraudulent insurance claim subject to specified administrative fines.

- Updates statutory language replacing “hospital” with “health care provider”, “hospital” with “provider” and adding “health maintenance contract” to s. 817.50, F.S., relating to fraudulently obtaining goods, services, etc. from a hospital.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 641.315, F.S., relating to provider contracts.

Subsections (1), (2), and (3), relating to provider contracts, are deleted.

Subsection (4) is renumbered as subsection (1) and is amended to require that each contract between an HMO and a provider of health care services must be in writing and contain a provision that the subscriber is not liable to the provider for services for which

the HMO is liable, as specified in s. 641.3154, F.S., relating to HMO liability for payment for services rendered to subscribers.

Subsection (5), relating to deductibles and co-payments, is deleted.

Subsection (6), paragraph (a), relating to provider contracts executed after October 1, 1991, is renumbered as subsection (2), paragraph (a), and is amended as follows:

Subparagraph 1. is amended to clarify that contracts must require the provider to give 60 days prior written notice to the HMO and the Department of Insurance (department) before canceling the contract with the HMO for any reason; and

Subparagraph 2. is amended to clarify that nonpayment for goods and services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day requirement.

Subsection (7) is renumbered as subsection (3).

A new subsection (4) is created to require that whenever a contract exists between an HMO and a provider, the HMO must disclose to the provider the following:

- The mailing address or electronic address where claims should be sent for processing;
- The telephone number a provider may call to have questions and concerns addressed regarding claims; and
- The address of any separate claims processing centers for specific types of services.

Provides that an HMO must provide, in no less than 30 calendar days, prior written notice of any changes in this required information to contract providers

Subsections (8) and (9) are renumbered as subsections (5) and (6).

Subsection (10) is renumbered as subsection (7), and grammatical changes are incorporated.

A new subsection (8) is created to require that the contract between an HMO and a provider must establish written procedures for the provider to request and the HMO to provide authorization for utilization of health care services. Requires the HMO to give written notice to the provider prior to making any changes in these procedures.

Section 2. Creates s. 641.3154, F.S., relating to HMO liability and prohibiting provider billing.

Subsection (1) provides that if the HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the HMO and the provider, the HMO is liable for the payment of fees to the provider, and the subscriber is not liable for the payment of fees to the provider.

Subsection (2) provides that, for the purposes of this section, an HMO is liable for services rendered to an eligible subscriber by a provider if the provider follows the HMO's authorization procedures and receives authorization for covered service for an

eligible subscriber, unless the provider provided information to the HMO with willful intent to misinform.

Subsection (3) provides that the liability of an HMO for payment of fees for services is not affected by any contract the HMO has with a third party for the functions of authorizing, processing, or paying claims.

Subsection (4) specifies that a provider, regardless of whether under contract with the HMO or not, or any representative of the provider, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency, a subscriber of an HMO for payment of services for which the HMO is liable, if the provider, in good faith knows or should know, that the HMO is liable. Provides that this prohibition applies during the pendency of any claim for payment made by the provider to the HMO for payment of services and any legal proceedings or dispute resolution process to determine whether the HMO is liable for services if the provider is informed that such proceedings are taking place. Provides a presumption that a provider does not know and should not know the HMO is liable unless:

- The provider is informed by the HMO that it accepts liability;
- A court of competent jurisdiction determines that the organization is liable; or
- The department or the agency makes a final determination that the organization is required to pay for such service in accordance with a recommendation by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056, F.S.

Subsection (5) requires an HMO and the department to report any suspected violation of this section by a health care practitioner to the Department of Health and by a facility to the agency which must take such actions as authorized by law.

Section 3. Amends s. 641.3155, F.S., relating to provider contracts and payment of claims. The section is retitled “payment of claims.”

A new subsection (1) is created as follows:

Paragraph (a) defines “clean claim” for a non-institutional provider as a claim submitted on a HCFA 1500 form that has no defect or impropriety. Such clean claim must also have the required substantiating documentation for noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. Provides that a claim may not be considered *not clean* solely because an HMO refers the claim to a medical specialist within the HMO for examination. Provides that if additional substantiating documentation is required from a source outside the HMO, the claim is considered *not clean*. Provides for repeal for this definition of “clean claim” upon the effective date of rules adopted by the department which define “clean claim.”

Paragraph (b) provides that absent a contractually agreed upon written definition of “clean claim,” the term “clean claim” for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

Paragraph (c) requires the department to adopt rules to establish claim forms consistent with federal claim-filing standards for HMOs required by the federal Health Care Financing Administration (HCFA). Permits the department to adopt

rules relating to coding standards consistent with Medicare coding standards adopted by HCFA.

Existing subsection (1) is renumbered as subsection (2).

Paragraph (a) is amended to include as a requirement for claim payment that such requirements are applicable to a *clean* claim or portion of a *clean* claim made by a contracted or *noncontracted* provider which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO which was mailed or electronically transferred by the provider.

Paragraph (b) is amended to make grammatical corrections and to provide that an HMO which denies or contests a provider's claim or any portion of a claim must provide written notice to the provider within 35 days after the receipt of the claim by the HMO of the contesting or denying of the claim. Provides that if the claim is contested, the notice must include a request for additional information. Provides that if the provider submits additional information, the provider must, within 35 days after the receipt of the request, mail or electronically transmit the information to the HMO.

Subsection (2) is renumbered as subsection (3) and amended to provide that 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. Provides that the interest is payable with the payment of the claim.

Subsection (3) is renumbered as subsection (4) and amended to provide that an HMO which fails to pay or deny a claim later than 120 days after receiving the claim creates an uncontestable obligation for the HMO to pay the claim to the provider.

Creates subsection (5), relating to HMO overpayments.

Creates paragraph (a) to provide that if, as a result of retroactive review of coverage decisions or payment levels, an HMO determines that it has made an overpayment to a provider for services rendered to a subscriber, the HMO must make a claim for such overpayment. Prohibits an HMO from reducing payment to that provider for other services, unless the provider agrees to the reduction or fails to respond to the HMO's claim, as required in this subsection.

Creates paragraph (b) to require a provider to pay a claim for an HMO overpayment, which is not contested or denied by the provider, within 35 days after the receipt of a claim which is mailed or electronically transferred to the provider.

Creates paragraph (c) to require a provider that denies or contests an HMO's claim for overpayment or any portion of the claim for overpayment, to notify the HMO in writing, within 35 days after receiving the claim. Provides that the written notice of denial or contest must identify the contested portion of the claim and the specific reason for the denial or contest and, if contested, must include a request for additional information. Provides that if the HMO submits additional information, the HMO must, within 35 days after the receipt of the request, mail or electronically transmit the information to the provider. Requires the provider to pay or deny the claim for overpayment within 45 days after the receipt of the information.

Creates paragraph (d) to provide that payment of a claim for overpayment is considered made on the date the payment was received or electronically transmitted or otherwise delivered to the HMO, or the date that the provider receives a payment from the HMO that reduces or deducts the overpayment. Provides that an overdue payment of a claim bears simple interest at the rate of 10 percent per year. Provides that the interest on any overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

Creates paragraph (e) to require a provider to pay or deny any claim for overpayment no later than 120 days after receiving the claim. Provides that failure to pay a claim for overpayment within 120 days creates an uncontestable obligation for the provider to pay the claim to the organization.

Subsection (4) is renumbered as subsection (6).

Creates subsection (7) relating to a provider's claim for payment.

Creates paragraph (a) to provide that a provider claim for payment is considered received by the HMO, if the claim has been electronically transmitted to the HMO, when the receipt is verified electronically or, if the claim was mailed to the address disclosed by the HMO, on the date indicated on the return receipt. Requires a provider to wait 45 days from receipt of a claim before submitting a duplicate claim.

Creates paragraph (b) to provide that an HMO claim for overpayment is considered received by a provider, if the claim has been electronically transmitted to the provider, when the receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization, on the date indicated on the return receipt. Requires an HMO to wait 45 days from the provider's receipt of claim for overpayment before submitting a duplicate claim.

Creates paragraph (c) to provide that nothing in this section precludes an HMO and provider from agreeing to other methods of transmission and receipt of claims.

Creates subsection (8) to specify that a provider, or the provider's designee, who bills electronically, is entitled to an electronic acknowledgment of the receipt of a claim within 72 hours.

Creates subsection (9) to prohibit an HMO from retroactively denying a claim more than 1 year after the date of the service because of subscriber ineligibility.

Section 4. Creates s. 641.3156, F.S., relating to treatment authorization and payment of claims.

Creates subsection (1) to require an HMO to pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a provider that is authorized by contract with the HMO to authorize or direct the patient's utilization of health care services and which was also authorized in accordance with the HMO's current and communicated procedures, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Creates subsection (2) to prohibit the denial of a claim if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an

eligible subscriber, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Creates subsection (3) to provide that emergency services are subject to the provisions of s. 641.513, F.S., relating to requirements for providing emergency services and care, and are not subject to the provisions of this section.

Section 5. Creates subparagraph 9. of paragraph (c) of subsection (5) of s. 641.3903, F.S., relating to unfair claim settlement practices, to include systematic downcoding with the intent to deny reimbursement otherwise due.

Section 6. Amends s. 641.3909, F.S., relating to cease and desist and penalty orders, to include violation of s. 641.3155, F.S., relating to payment of claims, authorizing the department to order specified cease and desist and penalty orders.

Section 7. Amends subsection (4) of s. 641.495, F.S., relating to requirements for issuance and maintenance of HMO certificates, to require the HMO to provide treatment authorization 24 hours a day, 7-days-per-week. Provides that requests for treatment authorization may not be pended, unless the requesting provider contractually agrees to take a pending or tracking number.

Section 8. Creates s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program, effective January 1, 2001.

Subsection (1) provides definitions for the following terms:

- "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under ch. 641, F.S., a prepaid health plan authorized under s. 409.912, F.S., or an exclusive provider organization certified under s. 627.6472, F.S.; and
- "Resolution organization" means a qualified independent third-party claims dispute resolution entity selected by and contracted with the Agency for Health Care Administration.

Creates subsection (2), relating to the organization claim dispute resolution program.

Creates paragraph (a) to direct the agency to establish a program to provide assistance to contracted and noncontracted providers and managed care entities for claim disputes that are not resolved by the provider and the managed care organization. Requires the agency to contract with a resolution organization to timely review and consider claims disputes submitted by providers and managed care organizations and to recommend to the agency an appropriate resolution of those disputes. Requires the agency to establish by rule jurisdictional amounts and methods of aggregation for claims disputes that may be considered by the resolution organization.

Creates paragraph (b) to specify that the resolution organization must review claim disputes filed by contracted and noncontracted providers and managed care organizations unless the disputed claim:

- Is related to interest payment;
- Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule;

- Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;
- Is related to a health plan not regulated by the state;
- Is part of a Medicaid fair hearing pursued under 42. C.F.R. ss. 431.220 et seq.;
- Is the basis for an action pending in state or federal court; or
- Is subject to a binding claim dispute resolution process provided by contract entered into prior to July 1, 2000, between the provider and the managed care organization.

Creates paragraph (c) to provide that contracts entered into or renewed on or after July 1, 2000, may require exhaustion of an internal resolution dispute process as a prerequisite to submitting a claim by a provider or HMO to the dispute resolution organization.

Creates paragraph (d) to specify that a contracted or noncontracted provider or health maintenance organization may not file a claim dispute with the resolution organization more than 12 months after a final determination on a claim by an HMO has occurred.

Creates subsection (3) to require the agency to adopt rules to establish a process for the consideration by the resolution organization of claims disputes submitted by either a provider or managed care organization which must include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after the receipt of the claims dispute submission.

Creates subsection (4) to require the agency to adopt the recommendation as a final order within 30 days after the receipt of the recommendation of the resolution organization.

Creates subsection (5) to provide that the entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. Requires the agency rule to include an apportionment of the review fee in those cases where both parties may prevail in part. Provides that the failure of the nonprevailing party to pay the ordered review cost within 35 days after the agency's order will subject the nonpaying party to a penalty of no more than $500 per day until the penalty is paid.

Creates subsection (6) to authorize the agency to adopt rules necessary to implement this section.

Section 9. Amends paragraph (a) of subsection (2) of s. 395.1065, F.S., relating to criminal and administrative penalties.

Amends paragraph (a) to update statutory language.

Creates paragraph (b) to provide that if sufficient claims due to a provider from an HMO do not exist to enable the takeback of an overpayment as provided under s. 641.3155, F.S., relating to payment of claims, the agency may impose an administrative fine for the violation of s. 641.3154, F.S., (HMO liability and prohibiting provider billing) or s. 641.3155, F.S., (payment of claims) in amounts specified in s. 641.52, F.S., (administrative fine) and the provisions of paragraph (a) do not apply.

Section 10. Amends subsection (2) of s. 817.234, F.S., relating to false and fraudulent insurance claims, and republishes subsection (11).

Renumbers subsection (2) as paragraph (a) of subsection (2).

Creates paragraph (b) to provide that in addition to any other provision of law, systematic upcoding by a provider, as defined in s. 641.19(15), F.S., relating to definitions, with the intent to obtain reimbursement which was otherwise not due from an insurer is punishable as provided in s. 641.52(5), F.S., relating to administrative fines.

Section 11. Amends s. 817.50, F.S., relating to fraudulently obtaining goods, services, etc., to replace "hospital" with "health care provider."

Subsection (1) is amended to replace "hospital" with "health care provider," as provider is defined in s. 641.19, F.S., relating to definitions, providing for a criminal penalty for fraudulently obtaining of goods, services, etc. from a health care provider.

Subsection (2) is amended to provide prima facie evidence of intent to defraud a provider when a person provides a false or fictitious name, address, or the assignment of health maintenance contract proceeds when knowing that such a contract is no longer in force.

Section 12. Amends s. 395.0193(6), F.S., relating to hospital incident reporting, to incorporate a conforming cross-reference.

Section 13. Amends s. 395.0197(12), F.S., relating to hospital internal risk management program requirements, to incorporate a conforming cross-reference.

Section 14. Provides that except as otherwise provided, this act will take effect on October 1, 2000, and shall apply to all claims for services rendered after that date, and apply to all requests for claim dispute resolution which are submitted by a provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   N/A

2. Expenditures:

   N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   N/A

2. Expenditures:

   N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

HMOs would be expected to incur additional expenses due to the following provisions of the bill:

- Prohibition of retroactive denial of a claim more than 1 year after the date of service because of subscriber ineligibility;
- Requirement for requesting additional information prior to denying or contesting a claim;
- Requirement to provide treatment authorization 24 hours per day, 7 days per week; and
- Limitation of pending requests for treatment authorization.

Such additional costs to HMOs would be expected to be passed on in higher premiums to subscribers, or reduce profits to shareholders and administrators.

HMOs would be expected to benefit due the following provisions of the bill:

- Overpayment claims payment deadlines;
- Timely determination of claim disputes by resolution organization and issuance of final agency order; and
- Prohibition of systematic upcoding by providers.

Providers would be expected to incur additional expenses due to the requirement of timely review and payment of HMO overpayment claims.

Providers would be expected to benefit due to the following provisions of the bill:

- Requirement of notice of HMO billing mailing address, billing electronic address, telephone number for questions and concerns regarding claims, and address of any separate claims processing centers for specific types of services;
- Requirement of HMOs to provide written procedures for requesting and obtaining authorization of health care services;
- Timely determination of claims disputes by the resolution organization and issuance of final agency order; and
- Prohibition of systematic downcoding by HMOs.

The bill may also benefit subscribers by expediting the payment of claims and ensuring prompt treatment authorization, and by clarifying balance billing situations. Subscribers should no longer be balanced billed nor sued by non-contract providers when providers have performed HMO authorized and covered services.

D. FISCAL COMMENTS:

Information is not available at this time on the costs associated with the claim dispute resolution organization process.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The bill grants rulemaking authority to the Department of Insurance, as follows: to adopt rules which define “clean claim” for non-institutional providers; to adopt rules to establish claim forms consistent with specified federal claim-filing standards; and to adopt rules relating to coding standards consistent with certain Medicare coding standards.

The bill grants rulemaking authority to the Agency for Health Care Administration, as follows: to adopt rules determining jurisdictional amounts and methods of aggregation of claim disputes for the statewide provider and managed care organization claim dispute resolution program; to adopt rules to establish a process of consideration by resolution organizations; to adopt rules regulating resolution organization review fees; and to adopt rules relating to apportionment of review fees.

C. OTHER COMMENTS:

Section 8 of the bill requires the Agency for Health Care Administration to establish a statewide provider and managed care organization claim dispute resolution program. The agency is required to contract with resolution organizations to timely review and consider claim disputes submitted by providers and managed care organizations. The bill provides that the nonprevailing entity (either a provider or managed care organization) will be responsible for the reviewing fee as determined by agency rule but charged by the resolution organization. After receiving a recommended order, supported by a finding of fact, the agency has 30 days to adopt the recommendation as a final order. The bill is silent on whether the agency can issue a final order which differs from the recommended order. Failure of an entity to pay the fee within the prescribed time period results in the agency imposing a penalty of up to $500 per day until the reviewing fee is paid. This process raises several concerns:

1. Because the resolution organization has a contract with the agency, failure of an entity to pay a reviewing fee could result in the resolution organization seeking reimbursement from the agency.

2. Because the agency has to issue the final order resolving the dispute, if appealed by the nonprevailing entity, the agency is obligated to defend its final order. Therefore, the agency would be defending an order which involved no agency action but was a dispute between private entities, where the agency had no role in creating the record which is now being appealed. Should the order be overturned by the court, the agency could be subjected to additional litigation from the previously prevailing party.

3. The bill is silent regarding the penalty. It is unclear whether this penalty is to be provided to the resolution organization or kept by the agency, and if by the agency, for what purpose the money is to be used.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
______________________	______________________
Tonya Sue Chavis, Esq.	Phil E. Williams