Amendment No. ___ (for drafter's use only)

CHAMBER ACTION

Senate		House
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5 ORIGINAL STAMP BELOW
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11 Representative(s) Bucher offered the following:

12

13 **Amendment (with title amendment)**

14 Remove everything after the enacting clause

15

16 and insert:

17 Section 1. Section 408.7057, Florida Statutes, is

18 amended to read:

19 408.7057 Statewide provider and health plan ~~managed~~

20 ~~care organization~~ claim dispute resolution program.--

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

22 (a) "Agency" means the Agency for Health Care

23 Administration.

24 (b)~~(a)~~ "Health plan ~~Managed care organization~~" means a

25 health maintenance organization or a prepaid health clinic

26 certified under chapter 641, a prepaid health plan authorized

27 under s. 409.912, ~~or~~ an exclusive provider organization

28 certified under s. 627.6472, or a major medical expense health

29 insurance policy, as defined in s. 627.643(2)(e), offered by a

30 group or an individual health insurer licensed pursuant to

31 chapter 624, including a preferred provider

organization under

1 s. 627.6471.

2 (c)~~(b)~~ "Resolution organization" means a qualified

3 independent third-party claim-dispute-resolution entity

4 selected by and contracted with the Agency for Health Care

5 Administration.

6 (2)(a) The agency ~~for Health Care Administration~~ shall

7 establish a program by January 1, 2001, to provide assistance

8 to contracted and noncontracted providers and health plans

9 ~~managed care organizations~~ for resolution of claim disputes

10 that are not resolved by the provider and the health plan

11 ~~managed care organization~~. The agency shall contract with a

12 resolution organization to timely review and consider claim

13 disputes submitted by providers and health plans ~~managed care~~

14 ~~organizations~~ and recommend to the agency an appropriate

15 resolution of those disputes. The agency shall establish by

16 rule jurisdictional amounts and methods of aggregation for

17 claim disputes that may be considered by the resolution

18 organization.

19 (b) The resolution organization shall review claim

20 disputes filed by contracted and noncontracted providers and

21 health plans ~~managed care organizations~~ unless the disputed

22 claim:

23 1. Is related to interest payment;

24 2. Does not meet the jurisdictional amounts or the

25 methods of aggregation established by agency rule, as provided

26 in paragraph (a);

27 3. Is part of an internal grievance in a Medicare

28 managed care organization or a reconsideration appeal through

29 the Medicare appeals process;

30 4. Is related to a health plan that is not regulated

31 by the state;

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1 5. Is part of a Medicaid fair hearing pursued under 42
2 C.F.R. ss. 431.220 et seq.;
3 6. Is the basis for an action pending in state or
4 federal court; or
5 7. Is subject to a binding claim-dispute-resolution
6 process provided by contract entered into prior to October 1,
7 2000, between the provider and the managed care organization.
8 (c) Contracts entered into or renewed on or after
9 October 1, 2000, may require exhaustion of an internal
10 dispute-resolution process as a prerequisite to the submission
11 of a claim by a provider or a health plan ~~maintenance~~
12 ~~organization~~ to the resolution organization ~~when the~~
13 ~~dispute-resolution program becomes effective~~.
14 (d) A contracted or noncontracted provider or health
15 plan ~~maintenance organization~~ may not file a claim dispute
16 with the resolution organization more than 12 months after a
17 final determination has been made on a claim by a health plan
18 or provider ~~maintenance organization~~.
19 (e) The resolution organization shall require the
20 health plan or provider submitting the claim dispute to submit
21 any supporting documentation to the resolution organization
22 within 15 days after receipt by the health plan or provider of
23 a request from the resolution organization for documentation
24 in support of the claim dispute. The resolution organization
25 may extend the time if appropriate. Failure to submit the
26 supporting documentation within such time period shall result
27 in the dismissal of the submitted claim dispute.
28 (f) The resolution organization shall require the

29 respondent in the claim dispute to submit all documentation in

30 support of its position within 15 days after receiving a

31 request from the resolution organization for supporting

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1 documentation. The resolution organization may extend the time
2 if appropriate. Failure to submit the supporting documentation
3 within such time period shall result in a default against the
4 health plan or provider. In the event of such a default, the
5 resolution organization shall issue its written recommendation
6 to the agency that a default be entered against the defaulting
7 entity. The written recommendation shall include a
8 recommendation to the agency that the defaulting entity shall
9 pay the entity submitting the claim dispute the full amount of
10 the claim dispute, plus all accrued interest, and shall be
11 considered a nonprevailing party for the purposes of this
12 section.
13 (g) If, on an ongoing basis, during the preceding
14 12-month period, the resolution organization has reason to
15 believe that a pattern exists on the part of a particular
16 health plan or provider, the resolution organization shall
17 evaluate the information contained in these cases to determine
18 whether the information as to the timely processing of claims
19 evidences a pattern of violation of s. 627.6131 or s. 641.3155
20 and report its findings, together with substantiating
21 evidence, to the appropriate licensure or certification entity
22 for the health plan or provider.
23 (3) The agency shall adopt rules to establish a
24 process to be used by the resolution organization in
25 considering claim disputes submitted by a provider or health
26 plan ~~managed care organization~~ which

must include the issuance

27 by the resolution organization of a written recommendation,

28 supported by findings of fact, to the agency within 60 days

29 after the requested information is received by the resolution

30 organization within the timeframes specified by the resolution

31 organization. In no event shall the review time exceed 90 days

1 following receipt of the initial claim dispute submission by
2 the resolution organization ~~receipt of the claim dispute~~
3 ~~submission~~.
4 (4) Within 30 days after receipt of the recommendation
5 of the resolution organization, the agency shall adopt the
6 recommendation as a final order.
7 (5) The agency shall notify within 7 days the
8 appropriate licensure or certification entity whenever there
9 is a violation of a final order issued by the agency pursuant
10 to this section.
11 (6)~~(5)~~ The entity that does not prevail in the
12 agency's order must pay a review cost to the review
13 organization, as determined by agency rule. Such rule must
14 provide for an apportionment of the review fee in any case in
15 which both parties prevail in part. If the nonprevailing party
16 fails to pay the ordered review cost within 35 days after the
17 agency's order, the nonpaying party is subject to a penalty of
18 not more than $500 per day until the penalty is paid.
19 (7)~~(6)~~ The agency ~~for Health Care Administration~~ may
20 adopt rules to administer this section.
21 Section 2. Section 627.6131, Florida Statutes, is
22 created to read:
23 627.6131 Payment of claims.--
24 (1) The contract shall include the following
25 provision:
26
27 "Time of Payment of Claims: After receiving
28 written proof of loss, the insurer will pay
29 monthly all benefits then due for ...(type of
30 benefit).... Benefits for any other loss
31 covered by this policy will be paid as soon as

1 the insurer receives proper written proof."

2

3 (2) As used in this section, the term "claim" for a

4 noninstitutional provider means a paper or electronic billing

5 instrument submitted to the insurer's designated location that

6 consists of the HCFA 1500 data set, or its successor, that has

7 all mandatory entries for a physician licensed under chapter

8 458, chapter 459, chapter 460, or chapter 461 or other

9 appropriate billing instrument that has all mandatory entries

10 for any other noninstitutional provider. For institutional

11 providers, "claim" means a paper or electronic billing

12 instrument submitted to the insurer's designated location that

13 consists of the UB-92 data set or its successor that has all

14 mandatory entries.

15 (3) All claims for payment, whether electronic or

16 nonelectronic:

17 (a) Are considered received on the date the claim is

18 received by the insurer at its designated claims receipt

19 location.

20 (b) Must be mailed or electronically transferred to an

21 insurer within 9 months after completion of the service and

22 the provider is furnished with the correct name and address of

23 the patient's health insurer.

24 (c) Must not duplicate a claim previously submitted

25 unless it is determined that the original claim was not

26 received or is otherwise lost.

27 (4) For all electronically submitted claims, a health
28 insurer shall:
29 (a) Within 24 hours after the beginning of the next
30 business day after receipt of the claim, provide electronic
31 acknowledgment of the receipt of the claim to the electronic

1 source submitting the claim.
2 (b) Within 20 days after receipt of the claim, pay the
3 claim or notify a provider or designee if a claim is denied or
4 contested. Notice of the insurer's action on the claim and
5 payment of the claim is considered to be made on the date the
6 notice or payment was mailed or electronically transferred.
7 (c)1. Notification of the health insurer's
8 determination of a contested claim must be accompanied by an
9 itemized list of additional information or documents the
10 insurer can reasonably determine are necessary to process the
11 claim.
12 2. A provider must submit the additional information
13 or documentation, as specified on the itemized list, within 35
14 days after receipt of the notification. Failure of a provider
15 to submit by mail or electronically the additional information
16 or documentation requested within 35 days after receipt of the
17 notification may result in denial of the claim.
18 3. A health insurer may not make more than one request
19 for documents under this paragraph in connection with a claim,
20 unless the provider fails to submit all of the requested
21 documents to process the claim or if documents submitted by
22 the provider raise new additional issues not included in the
23 original written itemization, in which case the health insurer
24 may provide the provider with one additional opportunity to
25 submit the additional documents needed to process the claim.

26 In no case may the health insurer request duplicate documents.

27 (d) For purposes of this subsection, electronic means

28 of transmission of claims, notices, documents, forms, and

29 payments shall be used to the greatest extent possible by the

30 health insurer and the provider.

31 (e) A claim must be paid or denied within 90 days

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1 after receipt of the claim. Failure to pay or deny a claim
2 within 120 days after receipt of the claim creates an
3 uncontestable obligation to pay the claim.
4 (5) For all nonelectronically submitted claims, a
5 health insurer shall:
6 (a) Effective November 1, 2003, provide acknowledgment
7 of receipt of the claim within 15 days after receipt of the
8 claim to the provider or provide a provider within 15 days
9 after receipt with electronic access to the status of a
10 submitted claim.
11 (b) Within 40 days after receipt of the claim, pay the
12 claim or notify a provider or designee if a claim is denied or
13 contested. Notice of the insurer's action on the claim and
14 payment of the claim is considered to be made on the date the
15 notice or payment was mailed or electronically transferred.
16 (c)1. Notification of the health insurer's
17 determination of a contested claim must be accompanied by an
18 itemized list of additional information or documents the
19 insurer can reasonably determine are necessary to process the
20 claim.
21 2. A provider must submit the additional information
22 or documentation, as specified on the itemized list, within 35
23 days after receipt of the notification. Failure of a provider
24 to submit by mail or electronically the additional information
25 or documentation requested within 35 days after receipt of the
26 notification may result in denial of the claim.

27 3. A health insurer may not make more than one request

28 for documents under this paragraph in connection with a claim

29 unless the provider fails to submit all of the requested

30 documents to process the claim or if documents submitted by

31 the provider raise new additional issues not included in the

1 original written itemization, in which case the health insurer
2 may provide the provider with one additional opportunity to
3 submit the additional documents needed to process the claim.
4 In no case may the health insurer request duplicate documents.
5 (d) For purposes of this subsection, electronic means
6 of transmission of claims, notices, documents, forms, and
7 payments shall be used to the greatest extent possible by the
8 health insurer and the provider.
9 (e) A claim must be paid or denied within 120 days
10 after receipt of the claim. Failure to pay or deny a claim
11 within 140 days after receipt of the claim creates an
12 uncontestable obligation to pay the claim.
13 (6) If a health insurer determines that it has made an
14 overpayment to a provider for services rendered to an insured,
15 the health insurer must make a claim for such overpayment. A
16 health insurer that makes a claim for overpayment to a
17 provider under this section shall give the provider a written
18 or electronic statement specifying the basis for the
19 retroactive denial or payment adjustment. The insurer must
20 identify the claim or claims, or overpayment claim portion
21 thereof, for which a claim for overpayment is submitted.
22 (a) If an overpayment determination is the result of
23 retroactive review or audit of coverage decisions or payment
24 levels not related to fraud, a health insurer shall adhere to
25 the following procedures:

26 1. All claims for overpayment must be submitted to a
27 provider within 30 months after the health insurer's payment
28 of the claim. A provider must pay, deny, or contest the health
29 insurer's claim for overpayment within 40 days after the
30 receipt of the claim. All contested claims for overpayment
31 must be paid or denied within 120 days after receipt of the

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1 claim. Failure to pay or deny overpayment and claim within 140
2 days after receipt creates an uncontestable obligation to pay
3 the claim.
4 2. A provider that denies or contests a health
5 insurer's claim for overpayment or any portion of a claim
6 shall notify the health insurer, in writing, within 35 days
7 after the provider receives the claim that the claim for
8 overpayment is contested or denied. The notice that the claim
9 for overpayment is denied or contested must identify the
10 contested portion of the claim and the specific reason for
11 contesting or denying the claim and, if contested, must
12 include a request for additional information. If the health
13 insurer submits additional information, the health insurer
14 must, within 35 days after receipt of the request, mail or
15 electronically transfer the information to the provider. The
16 provider shall pay or deny the claim for overpayment within 45
17 days after receipt of the information. The notice is
18 considered made on the date the notice is mailed or
19 electronically transferred by the provider.
20 3. Failure of a health insurer to respond to a
21 provider's contesting of claim or request for additional
22 information regarding the claim within 35 days after receipt
23 of such notice may result in denial of the claim.
24 4. The health insurer may not reduce payment to the
25 provider for other services unless the provider agrees to the

26 reduction in writing or fails to respond to the health

27 insurer's overpayment claim as required by this paragraph.

28 5. Payment of an overpayment claim is considered made

29 on the date the payment was mailed or electronically

30 transferred. An overdue payment of a claim bears simple

31 interest at the rate of 12 percent per year. Interest on an

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1 overdue payment for a claim for an overpayment begins to
2 accrue when the claim should have been paid, denied, or
3 contested.
4 (b) A claim for overpayment shall not be permitted
5 beyond 30 months after the health insurer's payment of a
6 claim, except that claims for overpayment may be sought beyond
7 that time from providers convicted of fraud pursuant to s.
8 817.234.
9 (7) Payment of a claim is considered made on the date
10 the payment was mailed or electronically transferred. An
11 overdue payment of a claim bears simple interest of 12 percent
12 per year. Interest on an overdue payment for a claim or for
13 any portion of a claim begins to accrue when the claim should
14 have been paid, denied, or contested. The interest is payable
15 with the payment of the claim.
16 (8) For all contracts entered into or renewed on or
17 after October 1, 2002, a health insurer's internal dispute
18 resolution process related to a denied claim not under active
19 review by a mediator, arbitrator, or third-party dispute
20 entity must be finalized within 60 days after the receipt of
21 the provider's request for review or appeal.
22 (9) A provider or any representative of a provider,
23 regardless of whether the provider is under contract with the
24 health insurer, may not collect or attempt to collect money
25 from, maintain any action at law against, or report to a

26 credit agency an insured for payment of covered services for

27 which the health insurer contested or denied the provider's

28 claim. This prohibition applies during the pendency of any

29 claim for payment made by the provider to the health insurer

30 for payment of the services or internal dispute resolution

31 process to determine whether the health insurer is liable for

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1 the services. For a claim, this pendency applies from the
2 date the claim or a portion of the claim is denied to the date
3 of the completion of the health insurer's internal dispute
4 resolution process, not to exceed 60 days.
5 (10) The provisions of this section may not be waived,
6 voided, or nullified by contract.
7 (11) A health insurer may not retroactively deny a
8 claim because of insured ineligibility more than 1 year after
9 the date of payment of the claim.
10 (12) A health insurer shall pay a contracted primary
11 care or admitting physician, pursuant to such physician's
12 contract, for providing inpatient services in a contracted
13 hospital to an insured if such services are determined by the
14 health insurer to be medically necessary and covered services
15 under the health insurer's contract with the contract holder.
16 (13) Upon written notification by an insured, an
17 insurer shall investigate any claim of improper billing by a
18 physician, hospital, or other health care provider. The
19 insurer shall determine if the insured was properly billed for
20 only those procedures and services that the insured actually
21 received. If the insurer determines that the insured has been
22 improperly billed, the insurer shall notify the insured and
23 the provider of its findings and shall reduce the amount of
24 payment to the provider by the amount determined to be
25 improperly billed. If a reduction is made due to such

26 notification by the insured, the insurer shall pay to the
27 insured 20 percent of the amount of the reduction up to $500.
28 (14) A permissible error ratio of 5 percent is
29 established for insurer's claims payment violations of s.
30 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and
31 (e). If the error ratio of a particular insurer does not

1 exceed the permissible error ratio of 5 percent for an audit
2 period, no fine shall be assessed for the noted claims
3 violations for the audit period. The error ratio shall be
4 determined by dividing the number of claims with violations
5 found on a statistically valid sample of claims for the audit
6 period by the total number of claims in the sample. If the
7 error ratio exceeds the permissible error ratio of 5 percent,
8 a fine may be assessed according to s. 624.4211 for those
9 claims payment violations which exceed the error ratio.
10 Notwithstanding the provisions of this section, the department
11 may fine a health insurer for claims payment violations of s.
12 627.6131(4)(e) and (5)(e) which create an uncontestable
13 obligation to pay the claim. The department shall not fine
14 insurers for violations which the department determines were
15 due to circumstances beyond the insurer's control.
16 (15) This section is applicable only to a major
17 medical expense health insurance policy as defined in s.
18 627.643(2)(e) offered by a group or an individual health
19 insurer licensed pursuant to chapter 624, including a
20 preferred provider policy under s. 627.6471 and an exclusive
21 provider organization under s. 627.6472 or a group or
22 individual insurance contract that provides payment for
23 enumerated dental services.
24 Section 3. Section 627.6135, Florida Statutes, is
25 created to read:

26 627.6135 Treatment authorization; payment of claims.--

27 (1) For purposes of this section, "authorization"

28 consists of any requirement of a provider to obtain prior

29 approval or to provide documentation relating to the necessity

30 of a covered medical treatment or service as a condition for

31 reimbursement for the treatment or service prior to the

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1 treatment or service. Each authorization request from a
2 provider must be assigned an identification number by the
3 health insurer.
4 (2) Upon receipt of a request from a provider for
5 authorization, the health insurer shall make a determination
6 within a reasonable time appropriate to medical circumstance
7 indicating whether the treatment or services are authorized.
8 For urgent care requests for which the standard timeframe for
9 the health insurer to make a determination would seriously
10 jeopardize the life or health of an insured or would
11 jeopardize the insured's ability to regain maximum function, a
12 health insurer must notify the provider as to its
13 determination as soon as possible taking into account medical
14 exigencies.
15 (3) Each response to an authorization request must be
16 assigned an identification number. Each authorization provided
17 by a health insurer must include the date of request of
18 authorization, a timeframe of the authorization, length of
19 stay if applicable, identification number of the
20 authorization, place of service, and type of service.
21 (4) A claim for treatment may not be denied if a
22 provider follows the health insurer's authorization procedures
23 and receives authorization for a covered service for an
24 eligible insured unless the provider provided information to
25 the health insurer with the intention to misinform the health

26 insurer.

27 (5) A health insurer's requirements for authorization

28 for medical treatment or services and 30-day advance notice of

29 material change in such requirements must be provided to all

30 contracted providers and upon request to all noncontracted

31 providers. A health insurer that makes such requirements and

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1 advance notices accessible to providers and insureds
2 electronically shall be deemed to be in compliance with this
3 subsection.
4 Section 4. Subsection (4) of section 627.651, Florida
5 Statutes, is amended to read:
6 627.651 Group contracts and plans of self-insurance
7 must meet group requirements.--
8 (4) This section does not apply to any plan which is
9 established or maintained by an individual employer in
10 accordance with the Employee Retirement Income Security Act of
11 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
12 arrangement as defined in s. 624.437(1), except that a
13 multiple-employer welfare arrangement shall comply with ss.
14 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
15 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~.
16 This subsection does not allow an authorized insurer to issue
17 a group health insurance policy or certificate which does not
18 comply with this part.
19 Section 5. Section 627.662, Florida Statutes, is
20 amended to read:
21 627.662 Other provisions applicable.--The following
22 provisions apply to group health insurance, blanket health
23 insurance, and franchise health insurance:
24 (1) Section 627.569, relating to use of dividends,
25 refunds, rate reductions, commissions, and service fees.
26 (2) Section 627.602(1)(f) and (2), relating to
27 identification numbers and statement of deductible provisions.
28 (3) Section 627.635, relating to excess insurance.
29 (4) Section 627.638, relating to direct payment for
30 hospital or medical services.
31 (5) Section 627.640, relating to filing and

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1 classification of rates.
2 (6) Section 627.613, relating to timely payment of
3 claims, or s. 627.6131, relating to payment of claims.
4 (7) Section 627.6135, relating to treatment
5 authorizations and payment of claims.
6 (8)~~(6)~~ Section 627.645(1), relating to denial of
7 claims.
8 (9)~~(7)~~ Section 627.613, relating to time of payment of
9 claims.
10 (10)~~(8)~~ Section 627.6471, relating to preferred
11 provider organizations.
12 (11)~~(9)~~ Section 627.6472, relating to exclusive
13 provider organizations.
14 (12)~~(10)~~ Section 627.6473, relating to combined
15 preferred provider and exclusive provider policies.
16 (13)~~(11)~~ Section 627.6474, relating to provider
17 contracts.
18 Section 6. Subsection (2) of section 627.638, Florida
19 Statutes, is amended to read:
20 627.638 Direct payment for hospital, medical
21 services.--
22 (2) Whenever, in any health insurance claim form, an
23 insured specifically authorizes payment of benefits directly
24 to any recognized hospital or physician, the insurer shall
25 make such payment to the designated provider of such services,
26 unless otherwise provided in the insurance contract. However,
27 if:
28 (a) The benefit is determined to be covered under the
29 terms of the policy;
30 (b) The claim is limited to treatment of mental health

31 or substance abuse, including drug and alcohol abuse; and

1 (c) The insured authorizes the insurer, in writing, as
2 part of the claim to make direct payment of benefits to a
3 recognized hospital, physician, or other licensed provider,
4
5 payments shall be made directly to the recognized hospital,
6 physician, or other licensed provider, notwithstanding any
7 contrary provisions in the insurance contract.
8 Section 7. Subsection (4) is added to section 641.234,
9 Florida Statutes, to read:
10 641.234 Administrative, provider, and management
11 contracts.--
12 (4) If a health maintenance organization, through a
13 health care risk contract, transfers to any entity the
14 obligations to pay any provider for any claims arising from
15 services provided to or for the benefit of any subscriber of
16 the organization, the health maintenance organization shall
17 remain responsible for any violations of ss. 641.3155 and
18 641.51(4). The provisions of ss. 624.418-624.4211 and 641.52
19 shall apply to any such violations. For purposes of this
20 subsection:
21 (a) The term "health care risk contract" shall mean a
22 contract under which an entity receives compensation in
23 exchange for providing to the health maintenance organization
24 a provider network or other services, which may include
25 administrative services.
26 (b) The term "entity" shall not include any provider
27 or group practice, as defined in s. 456.053,

providing

28 services under the scope of the license of the provider or the

29 members of the group practice.

30   Section 8. Subsection (1) of section 641.30, Florida

31 Statutes, is amended to read:

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1 641.30 Construction and relationship to other laws.--
2 (1) Every health maintenance organization shall accept
3 the ~~standard health~~ claim form prescribed pursuant to s.
4 641.3155 ~~627.647~~.
5 Section 9. Subsection (4) of section 641.3154, Florida
6 Statutes, is amended to read:
7 641.3154 Organization liability; provider billing
8 prohibited.--
9 (4) A provider or any representative of a provider,
10 regardless of whether the provider is under contract with the
11 health maintenance organization, may not collect or attempt to
12 collect money from, maintain any action at law against, or
13 report to a credit agency a subscriber of an organization for
14 payment of services for which the organization is liable, if
15 the provider in good faith knows or should know that the
16 organization is liable. This prohibition applies during the
17 pendency of any claim for payment made by the provider to the
18 organization for payment of the services and any legal
19 proceedings or dispute resolution process to determine whether
20 the organization is liable for the services if the provider is
21 informed that such proceedings are taking place. It is
22 presumed that a provider does not know and should not know
23 that an organization is liable unless:
24 (a) The provider is informed by the organization that
25 it accepts liability;
26 (b) A court of competent jurisdiction determines that
27 the organization is liable; ~~or~~
28 (c) The department or agency makes a final
29 determination that the organization is required to pay for
30 such services subsequent to a recommendation made by the
31 Statewide Provider and Subscriber Assistance Panel pursuant to

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1 s. 408.7056; or
2 (d) The agency issues a final order that the
3 organization is required to pay for such services subsequent
4 to a recommendation made by a resolution organization pursuant
5 to s. 408.7057.
6 Section 10. Section 641.3155, Florida Statutes, is
7 amended to read:
8 (Substantial rewording of section. See
9 s. 641.3155, F.S., for present text.)
10 641.3155 Prompt payment of claims.--
11 (1) As used in this section, the term "claim" for a
12 noninstitutional provider means a paper or electronic billing
13 instrument submitted to the health maintenance organization's
14 designated location that consists of the HCFA 1500 data set,
15 or its successor, that has all mandatory entries for a
16 physician licensed under chapter 458, chapter 459, chapter
17 460, or chapter 461 or other appropriate billing instrument
18 that has all mandatory entries for any other noninstitutional
19 provider. For institutional providers, "claim" means a paper
20 or electronic billing instrument submitted to the health
21 maintenance organization's designated location that consists
22 of the UB-92 data set or its successor that has all mandatory
23 entries.
24 (2) All claims for payment, whether electronic or
25 nonelectronic:
26 (a) Are considered received on the date the claim is
27 received by the organization at its designated claims receipt

28 location.

29 (b) Must be mailed or electronically transferred to an

30 organization within 9 months after completion of the service

31 and the provider is furnished with the correct name and

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1 address of the patient's health insurer.
2 (c) Must not duplicate a claim previously submitted
3 unless it is determined that the original claim was not
4 received or is otherwise lost.
5 (3) For all electronically submitted claims, a health
6 maintenance organization shall:
7 (a) Within 24 hours after the beginning of the next
8 business day after receipt of the claim, provide electronic
9 acknowledgment of the receipt of the claim to the electronic
10 source submitting the claim.
11 (b) Within 20 days after receipt of the claim, pay the
12 claim or notify a provider or designee if a claim is denied or
13 contested. Notice of the organization's action on the claim
14 and payment of the claim is considered to be made on the date
15 the notice or payment was mailed or electronically
16 transferred.
17 (c)1. Notification of the health maintenance
18 organization's determination of a contested claim must be
19 accompanied by an itemized list of additional information or
20 documents the insurer can reasonably determine are necessary
21 to process the claim.
22 2. A provider must submit the additional information
23 or documentation, as specified on the itemized list, within 35
24 days after receipt of the notification. Failure of a provider
25 to submit by mail or electronically the additional information
26 or documentation requested within 35 days after receipt of the

27 notification may result in denial of the claim.

28 3. A health maintenance organization may not make more

29 than one request for documents under this paragraph in

30 connection with a claim, unless the provider fails to submit

31 all of the requested documents to process the claim or if

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1 documents submitted by the provider raise new additional
2 issues not included in the original written itemization, in
3 which case the health maintenance organization may provide the
4 provider with one additional opportunity to submit the
5 additional documents needed to process the claim. In no case
6 may the health maintenance organization request duplicate
7 documents.
8 (d) For purposes of this subsection, electronic means
9 of transmission of claims, notices, documents, forms, and
10 payment shall be used to the greatest extent possible by the
11 health maintenance organization and the provider.
12 (e) A claim must be paid or denied within 90 days
13 after receipt of the claim. Failure to pay or deny a claim
14 within 120 days after receipt of the claim creates an
15 uncontestable obligation to pay the claim.
16 (4) For all nonelectronically submitted claims, a
17 health maintenance organization shall:
18 (a) Effective November 1, 2003, provide
19 acknowledgement of receipt of the claim within 15 days after
20 receipt of the claim to the provider or designee or provide a
21 provider or designee within 15 days after receipt with
22 electronic access to the status of a submitted claim.
23 (b) Within 40 days after receipt of the claim, pay the
24 claim or notify a provider or designee if a claim is denied or
25 contested. Notice of the health maintenance organization's

26 action on the claim and payment of the claim is considered to

27 be made on the date the notice or payment was mailed or

28 electronically transferred.

29 (c)1. Notification of the health maintenance

30 organization's determination of a contested claim must be

31 accompanied by an itemized list of additional information or

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1 documents the organization can reasonably determine are
2 necessary to process the claim.
3 2. A provider must submit the additional information
4 or documentation, as specified on the itemized list, within 35
5 days after receipt of the notification. Failure of a provider
6 to submit by mail or electronically the additional information
7 or documentation requested within 35 days after receipt of the
8 notification may result in denial of the claim.
9 3. A health maintenance organization may not make more
10 than one request for documents under this paragraph in
11 connection with a claim unless the provider fails to submit
12 all of the requested documents to process the claim or if
13 documents submitted by the provider raise new additional
14 issues not included in the original written itemization, in
15 which case the health maintenance organization may provide the
16 provider with one additional opportunity to submit the
17 additional documents needed to process the claim. In no case
18 may the health maintenance organization request duplicate
19 documents.
20 (d) For purposes of this subsection, electronic means
21 of transmission of claims, notices, documents, forms, and
22 payments shall be used to the greatest extent possible by the
23 health maintenance organization and the provider.
24 (e) A claim must be paid or denied within 120 days
25 after receipt of the claim. Failure to pay or deny a claim

26 within 140 days after receipt of the claim creates an

27 uncontestable obligation to pay the claim.

28 (5) If a health maintenance organization determines

29 that it has made an overpayment to a provider for services

30 rendered to a subscriber, the health maintenance organization

31 must make a claim for such overpayment. A health maintenance

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1 organization that makes a claim for overpayment to a provider
2 under this section shall give the provider a written or
3 electronic statement specifying the basis for the retroactive
4 denial or payment adjustment. The health maintenance
5 organization must identify the claim or claims, or overpayment
6 claim portion thereof, for which a claim for overpayment is
7 submitted.
8 (a) If an overpayment determination is the result of
9 retroactive review or audit of coverage decisions or payment
10 levels not related to fraud, a health maintenance organization
11 shall adhere to the following procedures:
12 1. All claims for overpayment must be submitted to a
13 provider within 30 months after the health maintenance
14 organization's payment of the claim. A provider must pay,
15 deny, or contest the health maintenance organization's claim
16 for overpayment within 40 days after the receipt of the claim.
17 All contested claims for overpayment must be paid or denied
18 within 120 days after receipt of the claim. Failure to pay or
19 deny overpayment and claim within 140 days after receipt
20 creates an uncontestable obligation to pay the claim.
21 2. A provider that denies or contests a health
22 maintenance organization's claim for overpayment or any
23 portion of a claim shall notify the organization, in writing,
24 within 35 days after the provider receives the claim that the
25 claim for overpayment is contested or denied. The

notice that

26 the claim for overpayment is denied or contested must identify

27 the contested portion of the claim and the specific reason for

28 contesting or denying the claim and, if contested, must

29 include a request for additional information. If the

30 organization submits additional information, the organization

31 must, within 35 days after receipt of the request, mail or

1 electronically transfer the information to the provider. The
2 provider shall pay or deny the claim for overpayment within 45
3 days after receipt of the information. The notice is
4 considered made on the date the notice is mailed or
5 electronically transferred by the provider.
6 3. Failure of a health maintenance organization to
7 respond to a provider's contestment of claim or request for
8 additional information regarding the claim within 35 days
9 after receipt of such notice may result in denial of the
10 claim.
11 4. The health maintenance organization may not reduce
12 payment to the provider for other services unless the provider
13 agrees to the reduction in writing or fails to respond to the
14 health maintenance organization's overpayment claim as
15 required by this paragraph.
16 5. Payment of an overpayment claim is considered made
17 on the date the payment was mailed or electronically
18 transferred. An overdue payment of a claim bears simple
19 interest at the rate of 12 percent per year. Interest on an
20 overdue payment for a claim for an overpayment payment begins
21 to accrue when the claim should have been paid, denied, or
22 contested.
23 (b) A claim for overpayment shall not be permitted
24 beyond 30 months after the health maintenance organization's
25 payment of a claim, except that claims for overpayment may be

26 sought beyond that time from providers convicted of fraud

27 pursuant to s. 817.234.

28 (6) Payment of a claim is considered made on the date

29 the payment was mailed or electronically transferred. An

30 overdue payment of a claim bears simple interest of 12 percent

31 per year. Interest on an overdue payment for a claim or for

1 any portion of a claim begins to accrue when the claim should
2 have been paid, denied, or contested. The interest is payable
3 with the payment of the claim.
4 (7)(a) For all contracts entered into or renewed on or
5 after October 1, 2002, a health maintenance organization's
6 internal dispute resolution process related to a denied claim
7 not under active review by a mediator, arbitrator, or
8 third-party dispute entity must be finalized within 60 days
9 after the receipt of the provider's request for review or
10 appeal.
11 (b) All claims to a health maintenance organization
12 begun after October 1, 2000, not under active review by a
13 mediator, arbitrator, or third-party dispute entity, shall
14 result in a final decision on the claim by the health
15 maintenance organization by January 2, 2003, for the purpose
16 of the statewide provider and managed care organization claim
17 dispute resolution program pursuant to s. 408.7057.
18 (8) A provider or any representative of a provider,
19 regardless of whether the provider is under contract with the
20 health maintenance organization, may not collect or attempt to
21 collect money from, maintain any action at law against, or
22 report to a credit agency a subscriber for payment of covered
23 services for which the health maintenance organization
24 contested or denied the provider's claim. This prohibition
25 applies during the pendency of any claim for payment

made by

26 the provider to the health maintenance organization for

27 payment of the services or internal dispute resolution process

28 to determine whether the health maintenance organization is

29 liable for the services. For a claim, this pendency applies

30 from the date the claim or a portion of the claim is denied to

31 the date of the completion of the health maintenance

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1 organization's internal dispute resolution process, not to
2 exceed 60 days.
3 (9) The provisions of this section may not be waived,
4 voided, or nullified by contract.
5 (10) A health maintenance organization may not
6 retroactively deny a claim because of subscriber ineligibility
7 more than 1 year after the date of payment of the claim.
8 (11) A health maintenance organization shall pay a
9 contracted primary care or admitting physician, pursuant to
10 such physician's contract, for providing inpatient services in
11 a contracted hospital to a subscriber if such services are
12 determined by the health maintenance organization to be
13 medically necessary and covered services under the health
14 maintenance organization's contract with the contract holder.
15 (12) Upon written notification by a subscriber, a
16 health maintenance organization shall investigate any claim of
17 improper billing by a physician, hospital, or other health
18 care provider. The organization shall determine if the
19 subscriber was properly billed for only those procedures and
20 services that the subscriber actually received. If the
21 organization determines that the subscriber has been
22 improperly billed, the organization shall notify the
23 subscriber and the provider of its findings and shall reduce
24 the amount of payment to the provider by the amount determined
25 to be improperly billed. If a reduction is made due to

such

26 notification by the insured, the insurer shall pay to the

27 insured 20 percent of the amount of the reduction up to $500.

28 (13) A permissible error ratio of 5 percent is

29 established for health maintenance organizations' claims

30 payment violations of s. 641.3155(3)(a), (b), (c), and (e) and

31 (4)(a), (b), (c), and (e). If the error ratio of a particular

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1 insurer does not exceed the permissible error ratio of 5
2 percent for an audit period, no fine shall be assessed for the
3 noted claims violations for the audit period. The error ratio
4 shall be determined by dividing the number of claims with
5 violations found on a statistically valid sample of claims for
6 the audit period by the total number of claims in the sample.
7 If the error ratio exceeds the permissible error ratio of 5
8 percent, a fine may be assessed according to s. 624.4211 for
9 those claims payment violations which exceed the error ratio.
10 Notwithstanding the provisions of this section, the department
11 may fine a health maintenance organization for claims payment
12 violations of s. 641.3155(3)(e) and (4)(e) which create an
13 uncontestable obligation to pay the claim. The department
14 shall not fine organizations for violations which the
15 department determines were due to circumstances beyond the
16 organization's control.
17 Section 11. Section 641.3156, Florida Statutes, is
18 amended to read:
19 641.3156 Treatment authorization; payment of claims.--
20 (1) For purposes of this section, "authorization"
21 consists of any requirement of a provider to obtain prior
22 approval or to provide documentation relating to the necessity
23 of a covered medical treatment or service as a condition for
24 reimbursement for the treatment or service prior to the
25 treatment or service. Each authorization request from a

26 provider must be assigned an identification number by the

27 health maintenance organization ~~A health maintenance~~

28 ~~organization must pay any hospital-service or referral-service~~

29 ~~claim for treatment for an eligible subscriber which was~~

30 ~~authorized by a provider empowered by contract with the health~~

31 ~~maintenance organization to authorize or direct the patient's~~

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1 ~~utilization of health care services and which was also~~

2 ~~authorized in accordance with the health maintenance~~

3 ~~organization's current and communicated procedures, unless the~~

4 ~~provider provided information to the health maintenance~~

5 ~~organization with the willful intention to misinform the~~

6 ~~health maintenance organization~~.

7 (2) A claim for treatment may not be denied if a

8 provider follows the health maintenance organization's

9 authorization procedures and receives authorization for a

10 covered service for an eligible subscriber, unless the

11 provider provided information to the health maintenance

12 organization with the ~~willful~~ intention to misinform the

13 health maintenance organization.

14 (3) Upon receipt of a request from a provider for

15 authorization, the health maintenance organization shall make

16 a determination within a reasonable time appropriate to

17 medical circumstance indicating whether the treatment or

18 services are authorized. For urgent care requests for which

19 the standard timeframe for the health maintenance organization

20 to make a determination would seriously jeopardize the life or

21 health of a subscriber or would jeopardize the subscriber's

22 ability to regain maximum function, a health maintenance

23 organization must notify the provider as to its determination

24 as soon as possible taking into account medical exigencies.

25 (4) Each response to an authorization request must be

26 assigned an identification number. Each authorization provided

27 by a health maintenance organization must include the date of
28 request of authorization, timeframe of the authorization,
29 length of stay if applicable, identification number of the
30 authorization, place of service, and type of service.
31 (5) A health maintenance organization's requirements

1 for authorization for medical treatment or services and 30-day
2 advance notice of material change in such requirements must be
3 provided to all contracted providers and upon request to all
4 noncontracted providers. A health maintenance organization
5 that makes such requirements and advance notices accessible to
6 providers and subscribers electronically shall be deemed to be
7 in compliance with this paragraph.
8 (6)~~(3)~~ Emergency services are subject to the
9 provisions of s. 641.513 and are not subject to the provisions
10 of this section.
11 Section 12. Except as otherwise provided herein, this
12 act shall take effect October 1, 2002, and shall apply to
13 claims for services rendered after such date.
14
15
16 =============== T I T L E   A M E N D M E N T ===============
17 And the title is amended as follows:
18 A bill to be entitled
19
20 An act relating to health care; amending s.
21 408.7057, F.S.; redesignating a program title;
22 revising definitions; including preferred
23 provider organizations and health insurers in
24 the claim dispute resolution program;
25 specifying timeframes for submission of
26 supporting documentation necessary for dispute
27 resolution; providing consequences for failure
28 to comply; providing an additional
29 responsibility for the claim dispute resolution
30 organization relating to patterns of claim
31 disputes; providing timeframes for review by

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1 the resolution organization; directing the
2 agency to notify appropriate licensure and
3 certification entities as part of violation of
4 final orders; creating s. 627.6131, F.S.;
5 specifying payment of claims provisions
6 applicable to certain health insurers;
7 providing a definition; providing requirements
8 and procedures for paying, denying, or
9 contesting claims; providing criteria and
10 limitations; requiring payment within specified
11 periods; specifying rate of interest charged on
12 overdue payments; providing for electronic and
13 nonelectronic transmission of claims; providing
14 procedures for overpayment recovery; specifying
15 timeframes for adjudication of claims,
16 internally and externally; prohibiting action
17 to collect payment from an insured under
18 certain circumstances; providing applicability;
19 prohibiting contractual modification of
20 provisions of law; specifying circumstances for
21 retroactive claim denial; specifying claim
22 payment requirements; providing for billing
23 review procedures; specifying claim content
24 requirements; establishing a permissible error
25 ratio, specifying its applicability, and
26 providing for fines; creating s. 627.6135,
27 F.S., relating to treatment authorization;
28 providing a definition; specifying
29 circumstances for authorization timeframes;
30 specifying content for response to
31 authorization requests; providing for an

1 obligation for payment, with exception;
2 providing authorization procedure notice
3 requirements; amending s. 627.651, F.S.;
4 correcting a cross reference, to conform;
5 amending s. 627.662, F.S.; specifying
6 application of certain additional provisions to
7 group, blanket, and franchise health insurance;
8 amending s. 627.638, F.S.; revising
9 requirements relating to direct payment of
10 benefits to specified providers under certain
11 circumstances; amending s. 641.234, F.S.;
12 specifying responsibility of a health
13 maintenance organization for certain violations
14 under certain circumstances; amending s.
15 641.30, F.S.; conforming a cross reference;
16 amending s. 641.3154, F.S.; modifying the
17 circumstances under which a provider knows that
18 an organization is liable for service
19 reimbursement; amending s. 641.3155, F.S.;
20 revising payment of claims provisions
21 applicable to certain health maintenance
22 organizations; providing a definition;
23 providing requirements and procedures for
24 paying, denying, or contesting claims;
25 providing criteria and limitations; requiring
26 payment within specified periods; revising rate
27 of interest charged on overdue payments;
28 providing for electronic and nonelectronic
29 transmission of claims; providing procedures
30 for overpayment recovery; specifying timeframes
31 for adjudication of claims, internally and

1 externally; prohibiting action to collect
2 payment from a subscriber under certain
3 circumstances; prohibiting contractual
4 modification of provisions of law; specifying
5 circumstances for retroactive claim denial;
6 specifying claim payment requirements;
7 providing for billing review procedures;
8 specifying claim content requirements;
9 establishing a permissible error ratio,
10 specifying its applicability, and providing for
11 fines; amending s. 641.3156, F.S., relating to
12 treatment authorization; providing a
13 definition; specifying circumstances for
14 authorization timeframes; specifying content
15 for response to authorization requests;
16 providing for an obligation for payment, with
17 exception; providing authorization procedure
18 notice requirements; providing effective dates.
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