

By the Council for Healthy Communities and Representative Fasano

1                                   A bill to be entitled  
2           An act relating to health care; amending s.  
3           408.036, F.S.; exempting certain services,  
4           construction, or programs from  
5           certificate-of-need review requirements for  
6           existing health facilities under certain  
7           circumstances; specifying requirements;  
8           requiring the Agency for Health Care  
9           Administration to adopt rules and monitor  
10          programs for compliance; providing conditions  
11          for expiration of an exemption and for  
12          prohibiting another exemption for a specified  
13          period; providing application; revising the  
14          exemption from certificate-of-need requirements  
15          for a satellite hospital; amending s. 408.043,  
16          F.S.; specifying that certain hospitals in  
17          certain counties may add additional beds  
18          without agency review under certain  
19          circumstances; amending s. 408.7057, F.S.;  
20          redesignating a program title; revising  
21          definitions; including preferred provider  
22          organizations and health insurers in the claim  
23          dispute resolution program; specifying  
24          timeframes for submission of supporting  
25          documentation necessary for dispute resolution;  
26          providing consequences for failure to comply;  
27          providing an additional responsibility for the  
28          claim dispute resolution organization relating  
29          to patterns of claim disputes; providing  
30          timeframes for review by the resolution  
31          organization; directing the agency to notify

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

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

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

18

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

20

21 Section 1. Effective upon this act becoming a law,  
22 paragraphs (t), (u), and (v) are added to subsection (3) of  
23 section 408.036, Florida Statutes, to read:

24

408.036 Projects subject to review.--

25

(3) EXEMPTIONS.--Upon request, the following projects  
26 are subject to exemption from the provisions of subsection  
27 (1):

28

(t) For the provision of health services, long-term  
29 care hospital services, new construction, or tertiary health  
30 services excluding solid organ transplant services, by an  
31 existing hospital, provided that the hospital utilizes

1 existing bed capacity and does not exceed the current licensed  
2 bed capacity for that facility. Utilizing existing bed  
3 capacity, a hospital may offer the exempted services within  
4 the hospital's respective health planning district.

5 1. In addition to any other documentation required by  
6 the agency, a request for an exemption submitted under this  
7 paragraph must certify that the applicant will meet and  
8 continuously maintain the minimum licensure requirements  
9 governing such programs adopted by the agency pursuant to  
10 subparagraph 2.

11 2. The agency shall adopt minimum licensure  
12 requirements by rule which govern the operation of health  
13 services, long-term care hospital services, and tertiary  
14 health services excluding solid organ transplant services,  
15 established pursuant to the exemption provided in this  
16 paragraph. The rules shall ensure that such programs:

17 a. Perform only services authorized by the exemption  
18 and will not provide any other services not authorized by the  
19 exemption.

20 b. Maintain sufficient appropriate equipment and  
21 health personnel to ensure quality and safety.

22 c. Maintain appropriate times of operation and  
23 protocols to ensure availability and appropriate referrals in  
24 emergencies.

25 d. Provide a minimum of 10 percent of its services to  
26 charity and Medicaid patients each year.

27 e. Establish quality outcome measures that are  
28 evidence-based. The performance of quality outcome measures  
29 for such programs must be at least at the 50th percentile of  
30 state and national outcome measures.

31

1           f. Be given an opportunity to correct any deficiencies  
2 as noted by the agency prior to the expiration of the  
3 authorized exemption.

4           3. The exemption provided by this paragraph shall not  
5 apply unless the agency determines that the program is in  
6 compliance with the requirements of subparagraph 1. and that  
7 the program will, after beginning operation, continuously  
8 comply with the rules adopted pursuant to subparagraph 2. The  
9 agency shall monitor such programs to ensure compliance with  
10 the requirements of subparagraph 2.

11           4.a. The exemption for a program shall expire  
12 immediately when the agency determines that the program fails  
13 to comply with the rules adopted pursuant to sub-subparagraphs  
14 2.a., b., and c.

15           b. Beginning 24 months after a program first begins  
16 treating patients, the exemption for the program shall expire  
17 when the program fails to comply with the rules adopted  
18 pursuant to sub-subparagraph 2.d.

19           5. If the exemption for a program expires pursuant to  
20 sub-subparagraph 4.a. or sub-subparagraph 4.b., the agency  
21 shall not grant an exemption pursuant to this paragraph for a  
22 program located at the same hospital until 2 years following  
23 the date of the determination by the agency that the program  
24 failed to comply with the rules adopted pursuant to  
25 subparagraph 2.

26           (u) For the provision of adult open heart services in  
27 a hospital. When a clear problem exists in access to needed  
28 cardiac services, consideration must be given to creating an  
29 exemption. While such needs might be addressed by the changing  
30 of the specific need criteria under the certificate-of-need  
31 law, the problem of protracted administrative appeals would

1 still remain. The exemption must be based upon objective  
2 criteria and address and solve the twin problems of geographic  
3 and temporal access. A hospital shall be exempt from the  
4 certificate-of-need review for the establishment of an open  
5 heart surgery program subject to the following conditions and  
6 criteria:

7 1. The applicant must certify it will meet and  
8 continuously maintain the minimum licensure requirements  
9 adopted by the agency governing adult open heart programs,  
10 including the most current guidelines of the American College  
11 of Cardiology and American Heart Association Guidelines for  
12 Adult Open Heart Programs.

13 2. The applicant must certify it will maintain  
14 sufficient appropriate equipment and health personnel to  
15 ensure quality and safety.

16 3. The applicant must certify it will maintain  
17 appropriate times of operation and protocols to ensure  
18 availability and appropriate referrals in the event of  
19 emergencies.

20 4. The applicant can demonstrate that it is referring  
21 300 or more cardiac patients from the hospital, including the  
22 emergency room, per year to a hospital with cardiac services,  
23 or that the average wait for transfer for 50 percent or more  
24 of the cardiac patients exceeds 4 hours.

25 5. The applicant is a general acute care hospital that  
26 is in operation for 3 years or more.

27 6. The applicant is performing more than 500  
28 diagnostic cardiac catheterization procedures per year,  
29 combined inpatient and outpatient.

30 7. The applicant has a formal agreement with an  
31 existing statutory teaching hospital or cardiac program

1 performing 750 open heart cases per year which creates at a  
2 minimum an external peer review process. The peer review shall  
3 be conducted quarterly the first year of operation and two  
4 times a year in the succeeding years until either the program  
5 reaches 350 cases per year or demonstrates consistency with  
6 state-adopted quality and outcome standards for the service.

7 8. The applicant payor-mix at a minimum reflects the  
8 community average for Medicaid, charity care, and self-pay or  
9 the applicant must certify that it will provide a minimum of 5  
10 percent of Medicaid, charity care, and self-pay to open heart  
11 surgery patients.

12 9. If the applicant fails to meet the established  
13 criteria for open heart programs or fails to reach 300  
14 surgeries per year by the end of year 3, it must show cause  
15 why its exemption should not be revoked.

16 (v) For the establishment of a satellite hospital  
17 through the relocation of 100 general acute care beds from an  
18 existing hospital located in the same district, as defined in  
19 s. 408.032(5).

20 Section 2. Subsection (5) is added to section 408.043,  
21 Florida Statutes, to read:

22 408.043 Special provisions.--

23 (5) SOLE ACUTE CARE HOSPITAL IN A HIGH GROWTH  
24 COUNTY.--Notwithstanding any other provision of law, an acute  
25 care hospital licensed under chapter 395 may add up to 180  
26 additional beds without agency review, provided such hospital  
27 is located in a county that has experienced at least a  
28 60-percent growth rate since 1990, is under construction on  
29 January 1, 2002, is the sole acute care hospital in the  
30 county, and is located such that there is no other acute care  
31 hospital within a 10-mile radius of such hospital.



1 Section 3. Section 408.7057, Florida Statutes, is  
2 amended to read:

3 408.7057 Statewide provider and health plan managed  
4 ~~care organization~~ claim dispute resolution program.--

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

6 (a) "Agency" means the Agency for Health Care  
7 Administration.

8 (b)(a) "Health plan Managed care organization" means a  
9 health maintenance organization or a prepaid health clinic  
10 certified under chapter 641, a prepaid health plan authorized  
11 under s. 409.912, ~~or~~ an exclusive provider organization  
12 certified under s. 627.6472, or a major medical expense health  
13 insurance policy, as defined in s. 627.643(2)(e), offered by a  
14 group or an individual health insurer licensed pursuant to  
15 chapter 624, including a preferred provider organization under  
16 s. 627.6471.

17 (c)(b) "Resolution organization" means a qualified  
18 independent third-party claim-dispute-resolution entity  
19 selected by and contracted with the Agency for Health Care  
20 Administration.

21 (2)(a) ~~The agency for Health Care Administration shall~~  
22 establish a program by January 1, 2001, to provide assistance  
23 to contracted and noncontracted providers and health plans  
24 ~~managed care organizations~~ for resolution of claim disputes  
25 that are not resolved by the provider and the health plan  
26 ~~managed care organization~~. The agency shall contract with a  
27 resolution organization to timely review and consider claim  
28 disputes submitted by providers and health plans ~~managed care~~  
29 ~~organizations~~ and recommend to the agency an appropriate  
30 resolution of those disputes. The agency shall establish by  
31 rule jurisdictional amounts and methods of aggregation for

1 claim disputes that may be considered by the resolution  
2 organization.

3 (b) The resolution organization shall review claim  
4 disputes filed by contracted and noncontracted providers and  
5 health plans ~~managed care organizations~~ unless the disputed  
6 claim:

7 1. Is related to interest payment;

8 2. Does not meet the jurisdictional amounts or the  
9 methods of aggregation established by agency rule, as provided  
10 in paragraph (a);

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

14 4. Is related to a health plan that is not regulated  
15 by the state;

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

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

20 7. Is subject to a binding claim-dispute-resolution  
21 process provided by contract entered into prior to October 1,  
22 2000, between the provider and the managed care organization.

23 (c) Contracts entered into or renewed on or after  
24 October 1, 2000, may require exhaustion of an internal  
25 dispute-resolution process as a prerequisite to the submission  
26 of a claim by a provider or a health plan ~~maintenance~~  
27 ~~organization~~ to the resolution organization ~~when the~~  
28 ~~dispute-resolution program becomes effective.~~

29 (d) A contracted or noncontracted provider or health  
30 plan ~~maintenance organization~~ may not file a claim dispute  
31 with the resolution organization more than 12 months after a

1 final determination has been made on a claim by a health plan  
2 or provider ~~maintenance organization~~.

3 (e) The resolution organization shall require the  
4 health plan or provider submitting the claim dispute to submit  
5 any supporting documentation to the resolution organization  
6 within 15 days after receipt by the health plan or provider of  
7 a request from the resolution organization for documentation  
8 in support of the claim dispute. The resolution organization  
9 may extend the time if appropriate. Failure to submit the  
10 supporting documentation within such time period shall result  
11 in the dismissal of the submitted claim dispute.

12 (f) The resolution organization shall require the  
13 respondent in the claim dispute to submit all documentation in  
14 support of its position within 15 days after receiving a  
15 request from the resolution organization for supporting  
16 documentation. The resolution organization may extend the time  
17 if appropriate. Failure to submit the supporting documentation  
18 within such time period shall result in a default against the  
19 health plan or provider. In the event of such a default, the  
20 resolution organization shall issue its written recommendation  
21 to the agency that a default be entered against the defaulting  
22 entity. The written recommendation shall include a  
23 recommendation to the agency that the defaulting entity shall  
24 pay the entity submitting the claim dispute the full amount of  
25 the claim dispute, plus all accrued interest, and shall be  
26 considered a nonprevailing party for the purposes of this  
27 section.

28 (g) If, on an ongoing basis, during the preceding  
29 12-month period, the resolution organization has reason to  
30 believe that a pattern exists on the part of a particular  
31 health plan or provider, the resolution organization shall

1 evaluate the information contained in these cases to determine  
2 whether the information as to the timely processing of claims  
3 evidences a pattern of violation of s. 627.6131 or s. 641.3155  
4 and report its findings, together with substantiating  
5 evidence, to the appropriate licensure or certification entity  
6 for the health plan or provider.

7 (3) The agency shall adopt rules to establish a  
8 process to be used by the resolution organization in  
9 considering claim disputes submitted by a provider or health  
10 plan managed care organization which must include the issuance  
11 by the resolution organization of a written recommendation,  
12 supported by findings of fact, to the agency within 60 days  
13 after the requested information is received by the resolution  
14 organization within the timeframes specified by the resolution  
15 organization. In no event shall the review time exceed 90 days  
16 following receipt of the initial claim dispute submission by  
17 the resolution organization ~~receipt of the claim dispute~~  
18 ~~submission.~~

19 (4) Within 30 days after receipt of the recommendation  
20 of the resolution organization, the agency shall adopt the  
21 recommendation as a final order.

22 (5) The agency shall notify within 7 days the  
23 appropriate licensure or certification entity whenever there  
24 is a violation of a final order issued by the agency pursuant  
25 to this section.

26 (6)~~(5)~~ The entity that does not prevail in the  
27 agency's order must pay a review cost to the review  
28 organization, as determined by agency rule. Such rule must  
29 provide for an apportionment of the review fee in any case in  
30 which both parties prevail in part. If the nonprevailing party  
31 fails to pay the ordered review cost within 35 days after the

1 agency's order, the nonpaying party is subject to a penalty of  
2 not more than \$500 per day until the penalty is paid.

3 ~~(7)(6)~~ The agency ~~for Health Care Administration~~ may  
4 adopt rules to administer this section.

5 Section 4. Section 627.6131, Florida Statutes, is  
6 created to read:

7 627.6131 Payment of claims.--

8 (1) The contract shall include the following  
9 provision:

10  
11 "Time of Payment of Claims: After receiving  
12 written proof of loss, the insurer will pay  
13 monthly all benefits then due for ...(type of  
14 benefit).... Benefits for any other loss  
15 covered by this policy will be paid as soon as  
16 the insurer receives proper written proof."  
17

18 (2) As used in this section, the term "claim" for a  
19 noninstitutional provider means a paper or electronic billing  
20 instrument submitted to the insurer's designated location that  
21 consists of the HCFA 1500 data set, or its successor, that has  
22 all mandatory entries for a physician licensed under chapter  
23 458, chapter 459, chapter 460, or chapter 461 or other  
24 appropriate billing instrument that has all mandatory entries  
25 for any other noninstitutional provider. For institutional  
26 providers, "claim" means a paper or electronic billing  
27 instrument submitted to the insurer's designated location that  
28 consists of the UB-92 data set or its successor that has all  
29 mandatory entries.

30 (3) All claims for payment, whether electronic or  
31 nonelectronic:

1        (a) Are considered received on the date the claim is  
2 received by the insurer at its designated claims receipt  
3 location.

4        (b) Must be mailed or electronically transferred to an  
5 insurer within 9 months after completion of the service and  
6 the provider is furnished with the correct name and address of  
7 the patient's health insurer.

8        (c) Must not duplicate a claim previously submitted  
9 unless it is determined that the original claim was not  
10 received or is otherwise lost.

11        (4) For all electronically submitted claims, a health  
12 insurer shall:

13        (a) Within 24 hours after the beginning of the next  
14 business day after receipt of the claim, provide electronic  
15 acknowledgment of the receipt of the claim to the electronic  
16 source submitting the claim.

17        (b) Within 20 days after receipt of the claim, pay the  
18 claim or notify a provider or designee if a claim is denied or  
19 contested. Notice of the insurer's action on the claim and  
20 payment of the claim is considered to be made on the date the  
21 notice or payment was mailed or electronically transferred.

22        (c)1. Notification of the health insurer's  
23 determination of a contested claim must be accompanied by an  
24 itemized list of additional information or documents the  
25 insurer can reasonably determine are necessary to process the  
26 claim.

27        2. A provider must submit the additional information  
28 or documentation, as specified on the itemized list, within 35  
29 days after receipt of the notification. Failure of a provider  
30 to submit by mail or electronically the additional information  
31

1 or documentation requested within 35 days after receipt of the  
2 notification may result in denial of the claim.

3 3. A health insurer may not make more than one request  
4 for documents under this paragraph in connection with a claim,  
5 unless the provider fails to submit all of the requested  
6 documents to process the claim or if documents submitted by  
7 the provider raise new additional issues not included in the  
8 original written itemization, in which case the health insurer  
9 may provide the provider with one additional opportunity to  
10 submit the additional documents needed to process the claim.  
11 In no case may the health insurer request duplicate documents.

12 (d) For purposes of this subsection, electronic means  
13 of transmission of claims, notices, documents, forms, and  
14 payments shall be used to the greatest extent possible by the  
15 health insurer and the provider.

16 (e) A claim must be paid or denied within 90 days  
17 after receipt of the claim. Failure to pay or deny a claim  
18 within 120 days after receipt of the claim creates an  
19 uncontestable obligation to pay the claim.

20 (5) For all nonelectronically submitted claims, a  
21 health insurer shall:

22 (a) Effective November 1, 2003, provide acknowledgment  
23 of receipt of the claim within 15 days after receipt of the  
24 claim to the provider or provide a provider within 15 days  
25 after receipt with electronic access to the status of a  
26 submitted claim.

27 (b) Within 40 days after receipt of the claim, pay the  
28 claim or notify a provider or designee if a claim is denied or  
29 contested. Notice of the insurer's action on the claim and  
30 payment of the claim is considered to be made on the date the  
31 notice or payment was mailed or electronically transferred.

1           (c)1. Notification of the health insurer's  
2 determination of a contested claim must be accompanied by an  
3 itemized list of additional information or documents the  
4 insurer can reasonably determine are necessary to process the  
5 claim.

6           2. A provider must submit the additional information  
7 or documentation, as specified on the itemized list, within 35  
8 days after receipt of the notification. Failure of a provider  
9 to submit by mail or electronically the additional information  
10 or documentation requested within 35 days after receipt of the  
11 notification may result in denial of the claim.

12           3. A health insurer may not make more than one request  
13 for documents under this paragraph in connection with a claim  
14 unless the provider fails to submit all of the requested  
15 documents to process the claim or if documents submitted by  
16 the provider raise new additional issues not included in the  
17 original written itemization, in which case the health insurer  
18 may provide the provider with one additional opportunity to  
19 submit the additional documents needed to process the claim.  
20 In no case may the health insurer request duplicate documents.

21           (d) For purposes of this subsection, electronic means  
22 of transmission of claims, notices, documents, forms, and  
23 payments shall be used to the greatest extent possible by the  
24 health insurer and the provider.

25           (e) A claim must be paid or denied within 120 days  
26 after receipt of the claim. Failure to pay or deny a claim  
27 within 140 days after receipt of the claim creates an  
28 uncontestable obligation to pay the claim.

29           (6) If a health insurer determines that it has made an  
30 overpayment to a provider for services rendered to an insured,  
31 the health insurer must make a claim for such overpayment. A



1 health insurer that makes a claim for overpayment to a  
2 provider under this section shall give the provider a written  
3 or electronic statement specifying the basis for the  
4 retroactive denial or payment adjustment. The insurer must  
5 identify the claim or claims, or overpayment claim portion  
6 thereof, for which a claim for overpayment is submitted.

7 (a) If an overpayment determination is the result of  
8 retroactive review or audit of coverage decisions or payment  
9 levels not related to fraud, a health insurer shall adhere to  
10 the following procedures:

11 1. All claims for overpayment must be submitted to a  
12 provider within 30 months after the health insurer's payment  
13 of the claim. A provider must pay, deny, or contest the health  
14 insurer's claim for overpayment within 40 days after the  
15 receipt of the claim. All contested claims for overpayment  
16 must be paid or denied within 120 days after receipt of the  
17 claim. Failure to pay or deny overpayment and claim within 140  
18 days after receipt creates an uncontestable obligation to pay  
19 the claim.

20 2. A provider that denies or contests a health  
21 insurer's claim for overpayment or any portion of a claim  
22 shall notify the health insurer, in writing, within 35 days  
23 after the provider receives the claim that the claim for  
24 overpayment is contested or denied. The notice that the claim  
25 for overpayment is denied or contested must identify the  
26 contested portion of the claim and the specific reason for  
27 contesting or denying the claim and, if contested, must  
28 include a request for additional information. If the health  
29 insurer submits additional information, the health insurer  
30 must, within 35 days after receipt of the request, mail or  
31 electronically transfer the information to the provider. The

1 provider shall pay or deny the claim for overpayment within 45  
2 days after receipt of the information. The notice is  
3 considered made on the date the notice is mailed or  
4 electronically transferred by the provider.

5 3. Failure of a health insurer to respond to a  
6 provider's contesting of claim or request for additional  
7 information regarding the claim within 35 days after receipt  
8 of such notice may result in denial of the claim.

9 4. The health insurer may not reduce payment to the  
10 provider for other services unless the provider agrees to the  
11 reduction in writing or fails to respond to the health  
12 insurer's overpayment claim as required by this paragraph.

13 5. Payment of an overpayment claim is considered made  
14 on the date the payment was mailed or electronically  
15 transferred. An overdue payment of a claim bears simple  
16 interest at the rate of 12 percent per year. Interest on an  
17 overdue payment for a claim for an overpayment begins to  
18 accrue when the claim should have been paid, denied, or  
19 contested.

20 (b) A claim for overpayment shall not be permitted  
21 beyond 30 months after the health insurer's payment of a  
22 claim, except that claims for overpayment may be sought beyond  
23 that time from providers convicted of fraud pursuant to s.  
24 817.234.

25 (7) Payment of a claim is considered made on the date  
26 the payment was mailed or electronically transferred. An  
27 overdue payment of a claim bears simple interest of 12 percent  
28 per year. Interest on an overdue payment for a claim or for  
29 any portion of a claim begins to accrue when the claim should  
30 have been paid, denied, or contested. The interest is payable  
31 with the payment of the claim.

1       (8) For all contracts entered into or renewed on or  
2 after October 1, 2002, a health insurer's internal dispute  
3 resolution process related to a denied claim not under active  
4 review by a mediator, arbitrator, or third-party dispute  
5 entity must be finalized within 60 days after the receipt of  
6 the provider's request for review or appeal.

7       (9) A provider or any representative of a provider,  
8 regardless of whether the provider is under contract with the  
9 health insurer, may not collect or attempt to collect money  
10 from, maintain any action at law against, or report to a  
11 credit agency an insured for payment of covered services for  
12 which the health insurer contested or denied the provider's  
13 claim. This prohibition applies during the pendency of any  
14 claim for payment made by the provider to the health insurer  
15 for payment of the services or internal dispute resolution  
16 process to determine whether the health insurer is liable for  
17 the services. For a claim, this pendency applies from the  
18 date the claim or a portion of the claim is denied to the date  
19 of the completion of the health insurer's internal dispute  
20 resolution process, not to exceed 60 days.

21       (10) The provisions of this section may not be waived,  
22 voided, or nullified by contract.

23       (11) A health insurer may not retroactively deny a  
24 claim because of insured ineligibility more than 1 year after  
25 the date of payment of the claim.

26       (12) A health insurer shall pay a contracted primary  
27 care or admitting physician, pursuant to such physician's  
28 contract, for providing inpatient services in a contracted  
29 hospital to an insured if such services are determined by the  
30 health insurer to be medically necessary and covered services  
31 under the health insurer's contract with the contract holder.

1       (13) Upon written notification by an insured, an  
2 insurer shall investigate any claim of improper billing by a  
3 physician, hospital, or other health care provider. The  
4 insurer shall determine if the insured was properly billed for  
5 only those procedures and services that the insured actually  
6 received. If the insurer determines that the insured has been  
7 improperly billed, the insurer shall notify the insured and  
8 the provider of its findings and shall reduce the amount of  
9 payment to the provider by the amount determined to be  
10 improperly billed. If a reduction is made due to such  
11 notification by the insured, the insurer shall pay to the  
12 insured 20 percent of the amount of the reduction up to \$500.

13       (14) A permissible error ratio of 5 percent is  
14 established for insurer's claims payment violations of s.  
15 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and  
16 (e). If the error ratio of a particular insurer does not  
17 exceed the permissible error ratio of 5 percent for an audit  
18 period, no fine shall be assessed for the noted claims  
19 violations for the audit period. The error ratio shall be  
20 determined by dividing the number of claims with violations  
21 found on a statistically valid sample of claims for the audit  
22 period by the total number of claims in the sample. If the  
23 error ratio exceeds the permissible error ratio of 5 percent,  
24 a fine may be assessed according to s. 624.4211 for those  
25 claims payment violations which exceed the error ratio.  
26 Notwithstanding the provisions of this section, the department  
27 may fine a health insurer for claims payment violations of s.  
28 627.6131(4)(e) and (5)(e) which create an uncontestable  
29 obligation to pay the claim. The department shall not fine  
30 insurers for violations which the department determines were  
31 due to circumstances beyond the insurer's control.

1       (15) This section is applicable only to a major  
2 medical expense health insurance policy as defined in s.  
3 627.643(2)(e) offered by a group or an individual health  
4 insurer licensed pursuant to chapter 624, including a  
5 preferred provider policy under s. 627.6471 and an exclusive  
6 provider organization under s. 627.6472 or a group or  
7 individual insurance contract that provides payment for  
8 enumerated dental services.

9           Section 5. Section 627.6135, Florida Statutes, is  
10 created to read:

11           627.6135 Treatment authorization; payment of claims.--

12           (1) For purposes of this section, "authorization"  
13 consists of any requirement of a provider to obtain prior  
14 approval or to provide documentation relating to the necessity  
15 of a covered medical treatment or service as a condition for  
16 reimbursement for the treatment or service prior to the  
17 treatment or service. Each authorization request from a  
18 provider must be assigned an identification number by the  
19 health insurer.

20           (2) Upon receipt of a request from a provider for  
21 authorization, the health insurer shall make a determination  
22 within a reasonable time appropriate to medical circumstance  
23 indicating whether the treatment or services are authorized.  
24 For urgent care requests for which the standard timeframe for  
25 the health insurer to make a determination would seriously  
26 jeopardize the life or health of an insured or would  
27 jeopardize the insured's ability to regain maximum function, a  
28 health insurer must notify the provider as to its  
29 determination as soon as possible taking into account medical  
30 exigencies.

31

1       (3) Each response to an authorization request must be  
2 assigned an identification number. Each authorization provided  
3 by a health insurer must include the date of request of  
4 authorization, a timeframe of the authorization, length of  
5 stay if applicable, identification number of the  
6 authorization, place of service, and type of service.

7       (4) A claim for treatment may not be denied if a  
8 provider follows the health insurer's authorization procedures  
9 and receives authorization for a covered service for an  
10 eligible insured unless the provider provided information to  
11 the health insurer with the intention to misinform the health  
12 insurer.

13       (5) A health insurer's requirements for authorization  
14 for medical treatment or services and 30-day advance notice of  
15 material change in such requirements must be provided to all  
16 contracted providers and upon request to all noncontracted  
17 providers. A health insurer that makes such requirements and  
18 advance notices accessible to providers and insureds  
19 electronically shall be deemed to be in compliance with this  
20 subsection.

21       Section 6. Subsection (4) of section 627.651, Florida  
22 Statutes, is amended to read:

23       627.651 Group contracts and plans of self-insurance  
24 must meet group requirements.--

25       (4) This section does not apply to any plan which is  
26 established or maintained by an individual employer in  
27 accordance with the Employee Retirement Income Security Act of  
28 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
29 arrangement as defined in s. 624.437(1), except that a  
30 multiple-employer welfare arrangement shall comply with ss.  
31 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,

1 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(8)~~~~(6)~~.  
2 This subsection does not allow an authorized insurer to issue  
3 a group health insurance policy or certificate which does not  
4 comply with this part.

5 Section 7. Section 627.662, Florida Statutes, is  
6 amended to read:

7 627.662 Other provisions applicable.--The following  
8 provisions apply to group health insurance, blanket health  
9 insurance, and franchise health insurance:

10 (1) Section 627.569, relating to use of dividends,  
11 refunds, rate reductions, commissions, and service fees.

12 (2) Section 627.602(1)(f) and (2), relating to  
13 identification numbers and statement of deductible provisions.

14 (3) Section 627.635, relating to excess insurance.

15 (4) Section 627.638, relating to direct payment for  
16 hospital or medical services.

17 (5) Section 627.640, relating to filing and  
18 classification of rates.

19 (6) Section 627.613, relating to timely payment of  
20 claims, or s. 627.6131, relating to payment of claims.

21 (7) Section 627.6135, relating to treatment  
22 authorizations and payment of claims.

23 ~~(8)~~~~(6)~~ Section 627.645(1), relating to denial of  
24 claims.

25 ~~(9)~~~~(7)~~ Section 627.613, relating to time of payment of  
26 claims.

27 ~~(10)~~~~(8)~~ Section 627.6471, relating to preferred  
28 provider organizations.

29 ~~(11)~~~~(9)~~ Section 627.6472, relating to exclusive  
30 provider organizations.

31

1        ~~(12)~~~~(10)~~ Section 627.6473, relating to combined  
2 preferred provider and exclusive provider policies.

3        ~~(13)~~~~(11)~~ Section 627.6474, relating to provider  
4 contracts.

5        Section 8. Subsection (2) of section 627.638, Florida  
6 Statutes, is amended to read:

7            627.638 Direct payment for hospital, medical  
8 services.--

9            (2) Whenever, in any health insurance claim form, an  
10 insured specifically authorizes payment of benefits directly  
11 to any recognized hospital or physician, the insurer shall  
12 make such payment to the designated provider of such services,  
13 unless otherwise provided in the insurance contract. However,  
14 if:

15            (a) The benefit is determined to be covered under the  
16 terms of the policy;

17            (b) The claim is limited to treatment of mental health  
18 or substance abuse, including drug and alcohol abuse; and

19            (c) The insured authorizes the insurer, in writing, as  
20 part of the claim to make direct payment of benefits to a  
21 recognized hospital, physician, or other licensed provider,  
22  
23 payments shall be made directly to the recognized hospital,  
24 physician, or other licensed provider, notwithstanding any  
25 contrary provisions in the insurance contract.

26        Section 9. Subsection (4) is added to section 641.234,  
27 Florida Statutes, to read:

28            641.234 Administrative, provider, and management  
29 contracts.--

30            (4) If a health maintenance organization, through a  
31 health care risk contract, transfers to any entity the



1 obligations to pay any provider for any claims arising from  
2 services provided to or for the benefit of any subscriber of  
3 the organization, the health maintenance organization shall  
4 remain responsible for any violations of ss. 641.3155 and  
5 641.51(4). The provisions of ss. 624.418-624.4211 and 641.52  
6 shall apply to any such violations. For purposes of this  
7 subsection:

8 (a) The term "health care risk contract" shall mean a  
9 contract under which an entity receives compensation in  
10 exchange for providing to the health maintenance organization  
11 a provider network or other services, which may include  
12 administrative services.

13 (b) The term "entity" shall not include any provider  
14 or group practice, as defined in s. 456.053, providing  
15 services under the scope of the license of the provider or the  
16 members of the group practice.

17 Section 10. Subsection (1) of section 641.30, Florida  
18 Statutes, is amended to read:

19 641.30 Construction and relationship to other laws.--

20 (1) Every health maintenance organization shall accept  
21 the ~~standard health~~ claim form prescribed pursuant to s.  
22 641.3155 ~~627.647~~.

23 Section 11. Subsection (4) of section 641.3154,  
24 Florida Statutes, is amended to read:

25 641.3154 Organization liability; provider billing  
26 prohibited.--

27 (4) A provider or any representative of a provider,  
28 regardless of whether the provider is under contract with the  
29 health maintenance organization, may not collect or attempt to  
30 collect money from, maintain any action at law against, or  
31 report to a credit agency a subscriber of an organization for

1 payment of services for which the organization is liable, if  
2 the provider in good faith knows or should know that the  
3 organization is liable. This prohibition applies during the  
4 pendency of any claim for payment made by the provider to the  
5 organization for payment of the services and any legal  
6 proceedings or dispute resolution process to determine whether  
7 the organization is liable for the services if the provider is  
8 informed that such proceedings are taking place. It is  
9 presumed that a provider does not know and should not know  
10 that an organization is liable unless:

11 (a) The provider is informed by the organization that  
12 it accepts liability;

13 (b) A court of competent jurisdiction determines that  
14 the organization is liable; ~~or~~

15 (c) The department or agency makes a final  
16 determination that the organization is required to pay for  
17 such services subsequent to a recommendation made by the  
18 Statewide Provider and Subscriber Assistance Panel pursuant to  
19 s. 408.7056; or

20 (d) The agency issues a final order that the  
21 organization is required to pay for such services subsequent  
22 to a recommendation made by a resolution organization pursuant  
23 to s. 408.7057.

24 Section 12. Section 641.3155, Florida Statutes, is  
25 amended to read:

26 (Substantial rewording of section. See  
27 s. 641.3155, F.S., for present text.)  
28 641.3155 Prompt payment of claims.--

29 (1) As used in this section, the term "claim" for a  
30 noninstitutional provider means a paper or electronic billing  
31 instrument submitted to the health maintenance organization's

1 designated location that consists of the HCFA 1500 data set,  
2 or its successor, that has all mandatory entries for a  
3 physician licensed under chapter 458, chapter 459, chapter  
4 460, or chapter 461 or other appropriate billing instrument  
5 that has all mandatory entries for any other noninstitutional  
6 provider. For institutional providers, "claim" means a paper  
7 or electronic billing instrument submitted to the health  
8 maintenance organization's designated location that consists  
9 of the UB-92 data set or its successor that has all mandatory  
10 entries.

11 (2) All claims for payment, whether electronic or  
12 nonelectronic:

13 (a) Are considered received on the date the claim is  
14 received by the organization at its designated claims receipt  
15 location.

16 (b) Must be mailed or electronically transferred to an  
17 organization within 9 months after completion of the service  
18 and the provider is furnished with the correct name and  
19 address of the patient's health insurer.

20 (c) Must not duplicate a claim previously submitted  
21 unless it is determined that the original claim was not  
22 received or is otherwise lost.

23 (3) For all electronically submitted claims, a health  
24 maintenance organization shall:

25 (a) Within 24 hours after the beginning of the next  
26 business day after receipt of the claim, provide electronic  
27 acknowledgment of the receipt of the claim to the electronic  
28 source submitting the claim.

29 (b) Within 20 days after receipt of the claim, pay the  
30 claim or notify a provider or designee if a claim is denied or  
31 contested. Notice of the organization's action on the claim

1 and payment of the claim is considered to be made on the date  
2 the notice or payment was mailed or electronically  
3 transferred.

4 (c)1. Notification of the health maintenance  
5 organization's determination of a contested claim must be  
6 accompanied by an itemized list of additional information or  
7 documents the insurer can reasonably determine are necessary  
8 to process the claim.

9 2. A provider must submit the additional information  
10 or documentation, as specified on the itemized list, within 35  
11 days after receipt of the notification. Failure of a provider  
12 to submit by mail or electronically the additional information  
13 or documentation requested within 35 days after receipt of the  
14 notification may result in denial of the claim.

15 3. A health maintenance organization may not make more  
16 than one request for documents under this paragraph in  
17 connection with a claim, unless the provider fails to submit  
18 all of the requested documents to process the claim or if  
19 documents submitted by the provider raise new additional  
20 issues not included in the original written itemization, in  
21 which case the health maintenance organization may provide the  
22 provider with one additional opportunity to submit the  
23 additional documents needed to process the claim. In no case  
24 may the health maintenance organization request duplicate  
25 documents.

26 (d) For purposes of this subsection, electronic means  
27 of transmission of claims, notices, documents, forms, and  
28 payment shall be used to the greatest extent possible by the  
29 health maintenance organization and the provider.

30 (e) A claim must be paid or denied within 90 days  
31 after receipt of the claim. Failure to pay or deny a claim

1 within 120 days after receipt of the claim creates an  
2 uncontestable obligation to pay the claim.

3 (4) For all nonelectronically submitted claims, a  
4 health maintenance organization shall:

5 (a) Effective November 1, 2003, provide  
6 acknowledgement of receipt of the claim within 15 days after  
7 receipt of the claim to the provider or designee or provide a  
8 provider or designee within 15 days after receipt with  
9 electronic access to the status of a submitted claim.

10 (b) Within 40 days after receipt of the claim, pay the  
11 claim or notify a provider or designee if a claim is denied or  
12 contested. Notice of the health maintenance organization's  
13 action on the claim and payment of the claim is considered to  
14 be made on the date the notice or payment was mailed or  
15 electronically transferred.

16 (c)1. Notification of the health maintenance  
17 organization's determination of a contested claim must be  
18 accompanied by an itemized list of additional information or  
19 documents the organization can reasonably determine are  
20 necessary to process the 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 maintenance organization may not make more  
28 than one request for documents under this paragraph in  
29 connection with a claim unless the provider fails to submit  
30 all of the requested documents to process the claim or if  
31 documents submitted by the provider raise new additional

1 issues not included in the original written itemization, in  
2 which case the health maintenance organization may provide the  
3 provider with one additional opportunity to submit the  
4 additional documents needed to process the claim. In no case  
5 may the health maintenance organization request duplicate  
6 documents.

7 (d) For purposes of this subsection, electronic means  
8 of transmission of claims, notices, documents, forms, and  
9 payments shall be used to the greatest extent possible by the  
10 health maintenance organization and the provider.

11 (e) A claim must be paid or denied within 120 days  
12 after receipt of the claim. Failure to pay or deny a claim  
13 within 140 days after receipt of the claim creates an  
14 uncontestable obligation to pay the claim.

15 (5) If a health maintenance organization determines  
16 that it has made an overpayment to a provider for services  
17 rendered to a subscriber, the health maintenance organization  
18 must make a claim for such overpayment. A health maintenance  
19 organization that makes a claim for overpayment to a provider  
20 under this section shall give the provider a written or  
21 electronic statement specifying the basis for the retroactive  
22 denial or payment adjustment. The health maintenance  
23 organization must identify the claim or claims, or overpayment  
24 claim portion thereof, for which a claim for overpayment is  
25 submitted.

26 (a) If an overpayment determination is the result of  
27 retroactive review or audit of coverage decisions or payment  
28 levels not related to fraud, a health maintenance organization  
29 shall adhere to the following procedures:

30 1. All claims for overpayment must be submitted to a  
31 provider within 30 months after the health maintenance

1 organization's payment of the claim. A provider must pay,  
2 deny, or contest the health maintenance organization's claim  
3 for overpayment within 40 days after the receipt of the claim.  
4 All contested claims for overpayment must be paid or denied  
5 within 120 days after receipt of the claim. Failure to pay or  
6 deny overpayment and claim within 140 days after receipt  
7 creates an uncontestable obligation to pay the claim.

8 2. A provider that denies or contests a health  
9 maintenance organization's claim for overpayment or any  
10 portion of a claim shall notify the organization, in writing,  
11 within 35 days after the provider receives the claim that the  
12 claim for overpayment is contested or denied. The notice that  
13 the claim for overpayment is denied or contested must identify  
14 the contested portion of the claim and the specific reason for  
15 contesting or denying the claim and, if contested, must  
16 include a request for additional information. If the  
17 organization submits additional information, the organization  
18 must, within 35 days after receipt of the request, mail or  
19 electronically transfer the information to the provider. The  
20 provider shall pay or deny the claim for overpayment within 45  
21 days after receipt of the information. The notice is  
22 considered made on the date the notice is mailed or  
23 electronically transferred by the provider.

24 3. Failure of a health maintenance organization to  
25 respond to a provider's contestment of claim or request for  
26 additional information regarding the claim within 35 days  
27 after receipt of such notice may result in denial of the  
28 claim.

29 4. The health maintenance organization may not reduce  
30 payment to the provider for other services unless the provider  
31 agrees to the reduction in writing or fails to respond to the

1 health maintenance organization's overpayment claim as  
2 required by this paragraph.

3 5. Payment of an overpayment claim is considered made  
4 on the date the payment was mailed or electronically  
5 transferred. An overdue payment of a claim bears simple  
6 interest at the rate of 12 percent per year. Interest on an  
7 overdue payment for a claim for an overpayment payment begins  
8 to accrue when the claim should have been paid, denied, or  
9 contested.

10 (b) A claim for overpayment shall not be permitted  
11 beyond 30 months after the health maintenance organization's  
12 payment of a claim, except that claims for overpayment may be  
13 sought beyond that time from providers convicted of fraud  
14 pursuant to s. 817.234.

15 (6) Payment of a claim is considered made on the date  
16 the payment was mailed or electronically transferred. An  
17 overdue payment of a claim bears simple interest of 12 percent  
18 per year. Interest on an overdue payment for a claim or for  
19 any portion of a claim begins to accrue when the claim should  
20 have been paid, denied, or contested. The interest is payable  
21 with the payment of the claim.

22 (7)(a) For all contracts entered into or renewed on or  
23 after October 1, 2002, a health maintenance organization's  
24 internal dispute resolution process related to a denied claim  
25 not under active review by a mediator, arbitrator, or  
26 third-party dispute entity must be finalized within 60 days  
27 after the receipt of the provider's request for review or  
28 appeal.

29 (b) All claims to a health maintenance organization  
30 begun after October 1, 2000, not under active review by a  
31 mediator, arbitrator, or third-party dispute entity, shall



1 result in a final decision on the claim by the health  
2 maintenance organization by January 2, 2003, for the purpose  
3 of the statewide provider and managed care organization claim  
4 dispute resolution program pursuant to s. 408.7057.

5 (8) A provider or any representative of a provider,  
6 regardless of whether the provider is under contract with the  
7 health maintenance organization, may not collect or attempt to  
8 collect money from, maintain any action at law against, or  
9 report to a credit agency a subscriber for payment of covered  
10 services for which the health maintenance organization  
11 contested or denied the provider's claim. This prohibition  
12 applies during the pendency of any claim for payment made by  
13 the provider to the health maintenance organization for  
14 payment of the services or internal dispute resolution process  
15 to determine whether the health maintenance organization is  
16 liable for the services. For a claim, this pendency applies  
17 from the date the claim or a portion of the claim is denied to  
18 the date of the completion of the health maintenance  
19 organization's internal dispute resolution process, not to  
20 exceed 60 days.

21 (9) The provisions of this section may not be waived,  
22 voided, or nullified by contract.

23 (10) A health maintenance organization may not  
24 retroactively deny a claim because of subscriber ineligibility  
25 more than 1 year after the date of payment of the claim.

26 (11) A health maintenance organization shall pay a  
27 contracted primary care or admitting physician, pursuant to  
28 such physician's contract, for providing inpatient services in  
29 a contracted hospital to a subscriber if such services are  
30 determined by the health maintenance organization to be  
31

1 medically necessary and covered services under the health  
2 maintenance organization's contract with the contract holder.

3 (12) Upon written notification by a subscriber, a  
4 health maintenance organization shall investigate any claim of  
5 improper billing by a physician, hospital, or other health  
6 care provider. The organization shall determine if the  
7 subscriber was properly billed for only those procedures and  
8 services that the subscriber actually received. If the  
9 organization determines that the subscriber has been  
10 improperly billed, the organization shall notify the  
11 subscriber and the provider of its findings and shall reduce  
12 the amount of payment to the provider by the amount determined  
13 to be improperly billed. If a reduction is made due to such  
14 notification by the insured, the insurer shall pay to the  
15 insured 20 percent of the amount of the reduction up to \$500.

16 (13) A permissible error ratio of 5 percent is  
17 established for health maintenance organizations' claims  
18 payment violations of s. 641.3155(3)(a), (b), (c), and (e) and  
19 (4)(a), (b), (c), and (e). If the error ratio of a particular  
20 insurer does not exceed the permissible error ratio of 5  
21 percent for an audit period, no fine shall be assessed for the  
22 noted claims violations for the audit period. The error ratio  
23 shall be determined by dividing the number of claims with  
24 violations found on a statistically valid sample of claims for  
25 the audit period by the total number of claims in the sample.  
26 If the error ratio exceeds the permissible error ratio of 5  
27 percent, a fine may be assessed according to s. 624.4211 for  
28 those claims payment violations which exceed the error ratio.  
29 Notwithstanding the provisions of this section, the department  
30 may fine a health maintenance organization for claims payment  
31 violations of s. 641.3155(3)(e) and (4)(e) which create an

1 uncontestable obligation to pay the claim. The department  
2 shall not fine organizations for violations which the  
3 department determines were due to circumstances beyond the  
4 organization's control.

5 Section 13. Section 641.3156, Florida Statutes, is  
6 amended to read:

7 641.3156 Treatment authorization; payment of claims.--

8 (1) For purposes of this section, "authorization"  
9 consists of any requirement of a provider to obtain prior  
10 approval or to provide documentation relating to the necessity  
11 of a covered medical treatment or service as a condition for  
12 reimbursement for the treatment or service prior to the  
13 treatment or service. Each authorization request from a  
14 provider must be assigned an identification number by the  
15 health maintenance organization ~~A health maintenance~~  
16 ~~organization must pay any hospital service or referral service~~  
17 ~~claim for treatment for an eligible subscriber which was~~  
18 ~~authorized by a provider empowered by contract with the health~~  
19 ~~maintenance organization to authorize or direct the patient's~~  
20 ~~utilization of health care services and which was also~~  
21 ~~authorized in accordance with the health maintenance~~  
22 ~~organization's current and communicated procedures, unless the~~  
23 ~~provider provided information to the health maintenance~~  
24 ~~organization with the willful intention to misinform the~~  
25 ~~health maintenance organization.~~

26 (2) A claim for treatment may not be denied if a  
27 provider follows the health maintenance organization's  
28 authorization procedures and receives authorization for a  
29 covered service for an eligible subscriber, unless the  
30 provider provided information to the health maintenance  
31

1 organization with the ~~willful~~ intention to misinform the  
2 health maintenance organization.

3 (3) Upon receipt of a request from a provider for  
4 authorization, the health maintenance organization shall make  
5 a determination within a reasonable time appropriate to  
6 medical circumstance indicating whether the treatment or  
7 services are authorized. For urgent care requests for which  
8 the standard timeframe for the health maintenance organization  
9 to make a determination would seriously jeopardize the life or  
10 health of a subscriber or would jeopardize the subscriber's  
11 ability to regain maximum function, a health maintenance  
12 organization must notify the provider as to its determination  
13 as soon as possible taking into account medical exigencies.

14 (4) Each response to an authorization request must be  
15 assigned an identification number. Each authorization provided  
16 by a health maintenance organization must include the date of  
17 request of authorization, timeframe of the authorization,  
18 length of stay if applicable, identification number of the  
19 authorization, place of service, and type of service.

20 (5) A health maintenance organization's requirements  
21 for authorization for medical treatment or services and 30-day  
22 advance notice of material change in such requirements must be  
23 provided to all contracted providers and upon request to all  
24 noncontracted providers. A health maintenance organization  
25 that makes such requirements and advance notices accessible to  
26 providers and subscribers electronically shall be deemed to be  
27 in compliance with this paragraph.

28 (6)~~(3)~~ Emergency services are subject to the  
29 provisions of s. 641.513 and are not subject to the provisions  
30 of this section.

31

