By the Council for Healthy Communities and Representative Fasano

A bill to be entitled

An act relating to health care; amending s. 408.036, F.S.; exempting certain services, construction, or programs from certificate-of-need review requirements for existing health facilities under certain circumstances; specifying requirements; requiring the Agency for Health Care Administration to adopt rules and monitor programs for compliance; providing conditions for expiration of an exemption and for prohibiting another exemption for a specified period; providing application; revising the exemption from certificate-of-need requirements for a satellite hospital; amending s. 408.043, F.S.; specifying that certain hospitals in certain counties may add additional beds without agency review under certain circumstances; amending s. 408.7057, F.S.; redesignating a program title; revising definitions; including preferred provider organizations and health insurers in the claim dispute resolution program; specifying timeframes for submission of supporting documentation necessary for dispute resolution; providing consequences for failure to comply; providing an additional responsibility for the claim dispute resolution organization relating to patterns of claim disputes; providing timeframes for review by the resolution organization; directing the agency to notify

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appropriate licensure and certification entities as part of violation of final orders; creating s. 627.6131, F.S.; specifying payment of claims provisions applicable to certain health insurers; providing a definition; providing requirements and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; specifying rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect payment from an insured under certain circumstances; providing applicability; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; creating s. 627.6135, F.S., relating to treatment authorization; providing a definition; specifying circumstances for authorization timeframes; specifying content for response to authorization requests; providing for an obligation for payment, with exception;

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providing authorization procedure notice requirements; amending s. 627.651, F.S.; correcting a cross reference, to conform; amending s. 627.662, F.S.; specifying application of certain additional provisions to group, blanket, and franchise health insurance; amending s. 627.638, F.S.; revising requirements relating to direct payment of benefits to specified providers under certain circumstances; amending s. 641.234, F.S.; specifying responsibility of a health maintenance organization for certain violations under certain circumstances; amending s. 641.30, F.S.; conforming a cross reference; amending s. 641.3154, F.S.; modifying the circumstances under which a provider knows that an organization is liable for service reimbursement; amending s. 641.3155, F.S.; revising payment of claims provisions applicable to certain health maintenance organizations; providing a definition; providing requirements and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; revising rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect

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payment from a subscriber under certain circumstances; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; amending s. 641.3156, F.S., relating to treatment authorization; providing a definition; specifying circumstances for authorization timeframes; specifying content for response to authorization requests; providing for an obligation for payment, with exception; providing authorization procedure notice requirements; providing effective dates.

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

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

408.036 Projects subject to review.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

408.043 Special provisions.--

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

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

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

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

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

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

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

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

claim disputes that may be considered by the resolution organization.

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

1. Is related to interest payment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

627.6131 Payment of claims.--

(1) The contract shall include the following provision:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

627.6135 Treatment authorization; payment of claims.--

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Section 627.635, relating to excess insurance.

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

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

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

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

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

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

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

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

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

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

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

627.638 Direct payment for hospital, medical services.--

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

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

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

(c) The insured authorizes the insurer, in writing, as part of the claim to make direct payment of benefits to a recognized hospital, physician, or other licensed provider,

payments shall be made directly to the recognized hospital, physician, or other licensed provider, notwithstanding any contrary provisions in the insurance contract.

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

641.234 Administrative, provider, and management contracts.--

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

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

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

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

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

641.30 Construction and relationship to other laws.--

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

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

641.3154 Organization liability; provider billing prohibited.--

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

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

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

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

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

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

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

(Substantial rewording of section. See s. 641.3155, F.S., for present text.)

641.3155 Prompt payment of claims.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. A health maintenance organization may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or if documents submitted by the provider raise new additional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

641.3156 Treatment authorization; payment of claims.--

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

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

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

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

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

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

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

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Section 14. Except as otherwise provided herein, this act shall take effect October 1, 2002, and shall apply to claims for services rendered after such date.

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HOUSE SUMMARY

Provides additional certificate-of-need exemptions for specified health services, construction, programs, and satellite hospitals from certificate-of-need requirements. Revises claim dispute resolution program provisions. Creates payment of claims provisions applicable to health insurers and health maintenance organizations to provide requirements and procedures for paying, denying, or contesting claims, charging interest on overdue payments, electronic and nonelectronic transmission of claims, overpayment recovery, timeframes for adjudication of claims, claim payments and contents, billing review, and establishing a permissible error ratio. Creates treatment authorization provisions for health insurers and health maintenance organizations to provide requirements and procedures for authorization timeframes, content for response to authorization requests, obligation for payment, and notice. See bill for details.

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