

Amendment No. \_\_\_\_ (for drafter's use only)

	<u>Senate</u>	CHAMBER ACTION	<u>House</u>
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The Committee on Judicial Oversight offered the following:

**Substitute Amendment for Amendment (864531) (with title amendment)**

On page 3, line 9, through page 34, line 2,  
remove: all of said lines

and insert:

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

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

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

(a) "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, a preferred provider organization under s. 627.6471, or a health insurer licensed pursuant to chapter 627 transacting group or individual hospital and medical expense incurred health insurance business in this state. This

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1 section shall not apply to Medicare supplement, long-term  
2 care, disability, limited-benefit, accident-only,  
3 hospital-indemnity, specified disease, dental, vision, or  
4 other supplemental policies unless said policies provide  
5 payment directly to the provider.

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

10 (c) "Agency" means the Agency for Health Care  
11 Administration.

12 (2)(a) ~~The agency for Health Care Administration~~ shall  
13 establish a program by January 1, 2001, to provide assistance  
14 to contracted and noncontracted providers and managed care  
15 organizations for resolution of claim disputes that are not  
16 resolved by the provider and the managed care organization.  
17 The agency shall contract with a resolution organization to  
18 timely review and consider claim disputes submitted by  
19 providers and managed care organizations and recommend to the  
20 agency an appropriate resolution of those disputes. The agency  
21 shall establish by rule jurisdictional amounts and methods of  
22 aggregation for claim disputes that may be considered by the  
23 resolution organization.

24 (b) The resolution organization shall review claim  
25 disputes filed by contracted and noncontracted providers and  
26 managed care organizations unless the disputed claim:

27 1. Is related to interest payment;  
28 2. Does not meet the jurisdictional amounts or the  
29 methods of aggregation established by agency rule, as provided  
30 in paragraph (a);

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

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1 managed care organization or a reconsideration appeal through  
2 the Medicare appeals process;

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

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

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

9 7. Is subject to a binding claim-dispute-resolution  
10 process provided by contract entered into prior to October 1,  
11 2000, between the provider and the managed care organization.

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

18 (d) A contracted or noncontracted provider or managed  
19 care ~~health maintenance~~ organization may not file a claim  
20 dispute with the resolution organization more than 12 months  
21 after a final determination has been made on a claim by a  
22 managed care ~~health maintenance~~ organization or provider.

23 (e) The resolution organization shall require the  
24 managed care organization or provider submitting the claim  
25 dispute to submit any supporting documentation to the  
26 resolution organization within 15 days after receipt by the  
27 managed care organization or provider of a request from the  
28 resolution organization for documentation in support of the  
29 claim dispute. The resolution organization may extend the time  
30 if appropriate. Failure to submit the supporting documentation  
31 within such time period shall result in the dismissal of the

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1 submitted claim dispute.

2 (f) The resolution organization shall require the  
3 respondent in the claim dispute to submit all documentation in  
4 support of its position within 15 days after receiving a  
5 request from the resolution organization for supporting  
6 documentation. The resolution organization may extend the time  
7 if appropriate. Failure to submit the supporting documentation  
8 within such time period shall result in a default against the  
9 managed care organization or provider. In the event of such a  
10 default, the resolution organization shall issue its written  
11 recommendation to the agency that a default be entered against  
12 the defaulting entity. The written recommendation shall  
13 include a recommendation to the agency that the defaulting  
14 entity shall pay the entity submitting the claim dispute the  
15 full amount of the claim dispute, plus all accrued interest,  
16 and shall be considered a nonprevailing party for the purposes  
17 of this section.

18 (3) The agency shall adopt rules to establish a  
19 process to be used by the resolution organization in  
20 considering claim disputes submitted by a provider or managed  
21 care organization which must include the issuance by the  
22 resolution organization of a written recommendation, supported  
23 by findings of fact, to the agency within 60 days after  
24 receipt of the claim dispute submission.

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

28 (5) The agency shall provide written notification  
29 within 7 days to the appropriate licensure or certification  
30 entity whenever the agency issues a final order pursuant to  
31 this section.

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1           ~~(6)(5)~~ The entity that does not prevail in the  
2 agency's order must pay a review cost to the review  
3 organization, as determined by agency rule. Such rule must  
4 provide for an apportionment of the review fee in any case in  
5 which both parties prevail in part. If the nonprevailing party  
6 fails to pay the ordered review cost within 35 days after the  
7 agency's order, the nonpaying party is subject to a penalty of  
8 not more than \$500 per day until the penalty is paid.

9           ~~(7)(6)~~ The agency for ~~Health Care Administration~~ may  
10 adopt rules to administer this section.

11           Section 2. Section 627.613, Florida Statutes, is  
12 amended to read:

13           (Substantial rewording of section. See

14           s. 627.613, F.S., for present text.)

15           627.613 Payment of claims.--

16           (1) The contract shall include the following  
17 provision:

18  
19           "Time of Payment of Claims: After receiving written  
20 proof of loss, the insurer will pay monthly all benefits then  
21 due for ...(type of benefit)... Benefits for any other loss  
22 covered by this policy will be paid as soon as the insurer  
23 receives proper written proof."

24  
25           (2)(a) As used in this section, the term "clean claim"  
26 for a noninstitutional provider means an electronic or  
27 nonelectronic claim submitted on a HCFA 1500 form which has no  
28 defect or impropriety, including lack of required  
29 substantiating documentation for noncontracted providers and  
30 suppliers, or particular circumstances requiring special  
31 treatment which prevent timely payment from being made on the

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1 claim. A claim may not be excluded from meeting this  
2 definition solely because a health insurer refers the claim to  
3 a medical specialist for examination. If additional  
4 substantiating documentation, such as the medical record or  
5 encounter data, is required, the claim shall not be considered  
6 a clean claim.

7 (b) Absent a written definition that is agreed upon  
8 through contract, the term "clean claim" for an institutional  
9 claim is a properly and accurately completed paper or  
10 electronic billing instrument that consists of the UB-92 data  
11 set with entries stated as mandatory by the National Uniform  
12 Billing Committee.

13 (c) The department shall adopt rules to establish  
14 claim forms consistent with applicable federal claim-filing  
15 standards. The department may adopt rules relating to coding  
16 standards consistent with Medicare coding standards of the  
17 federal Centers for Medicare and Medicaid Services in  
18 existence on February 1, 2002.

19 (3) All claims for payment, notices, and requests for  
20 more information or review, whether electronic or  
21 nonelectronic, are considered received on the date the claim,  
22 notice, or request is received.

23 (4) For an electronically submitted claim, a health  
24 insurer shall:

25 (a) Provide electronic acknowledgment of the receipt  
26 of the claim within 24 hours of receipt of the claim to the  
27 provider, or the provider's designee.

28 (b)1. Notify a provider if a claim is "not clean"  
29 within 10 days of receipt of the claim.

30 2. A claim determined to be clean during the initial  
31 10 days after the health insurer's receipt of the claim must

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1 be paid, denied, or contested within 20 days of the receipt of  
2 the claim.

3 (c)1. Notification of the health insurer's  
4 determination of a "not clean" claim must be accompanied by a  
5 complete itemized list of additional information or documents  
6 needed to process the claim as a "clean claim." Failure to  
7 notify a provider within 20 days of receipt of the claim  
8 creates an uncontestable obligation to pay the claim.

9 2. A provider must submit the additional information  
10 or documentation, as specified on the complete itemized list,  
11 within 15 days of receipt of the notification. Failure of a  
12 provider to submit the additional information or documentation  
13 requested within 15 days of receipt of the notification may  
14 result in denial of the claim.

15 3. Upon receipt of the requested additional  
16 information by the health insurer, the health insurer must  
17 determine if the claim is clean or not clean. A clean claim  
18 must be paid, denied, or contested within 10 days of receipt  
19 of the additional information.

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

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

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

31 (a) Provide acknowledgement of receipt of the claim

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1 within 15 days of receipt of the claim to the provider, or the  
2 provider's designee.

3 (b)1. Notify a provider if a claim is "not clean"  
4 within 20 days of receipt.

5 2. A claim determined to be clean during the initial  
6 20 days after the health insurer's receipt of the claim must  
7 be paid, denied, or contested within 55 days of the receipt of  
8 the claim.

9 (c)1. Notification of the health insurer's  
10 determination of a "not clean" claim must be accompanied by a  
11 complete itemized list of additional information or documents  
12 needed to process the claim as a "clean claim." Failure to  
13 notify a provider or a provider's designee within 40 days of  
14 receipt of the claim that the claim is not clean or to provide  
15 a complete itemized list of additional information or  
16 documents needed to process the claim creates an uncontestable  
17 obligation to pay the claim.

18 2. A provider must submit the additional information  
19 or documentation, as specified on the complete itemized list,  
20 within 15 days of receipt of the notification. Failure of a  
21 provider to submit the additional information or documentation  
22 requested within 15 days of receipt of the notification may  
23 result in the denial of the claim.

24 3. Upon receipt of the requested additional  
25 information by the health insurer, the health insurer must  
26 determine if the claim is clean or not clean. A clean claim  
27 must be paid, denied, or contested within 20 days of receipt  
28 of the additional information.

29 (d) A claim determined to be clean but contested must  
30 be paid or denied within 150 days of receipt of the claim.  
31 Failure to pay or deny a claim within 150 days of receipt of



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1 the claim creates an uncontestable obligation to pay the  
2 claim.

3 (6) Payment of a claim is considered made on the date  
4 the payment was received or electronically transferred. An  
5 overdue payment of a claim bears simple interest of 12 percent  
6 per year. Interest on an overdue payment for a clean claim or  
7 for any portion of a clean claim begins to accrue on the 36th  
8 day after the receipt of a clean electronic claim and on the  
9 56th day after receipt of a clean nonelectronic claim. The  
10 interest is payable with the payment of the claim.

11 (7) If a health insurer determines that it has made an  
12 overpayment to a provider for services rendered to an insured,  
13 the health insurer must make a claim for such overpayment. A  
14 health insurer that makes a claim for overpayment to a  
15 provider under this section shall give the provider a written  
16 or electronic statement specifying the basis for the  
17 retroactive denial and identifying the claim or claims, or  
18 portion thereof, which are being retroactively denied.

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

23 1. All claims for overpayment must be submitted to a  
24 provider within 30 months after the health insurer's payment  
25 of the claim. A provider must pay, deny, or contest the health  
26 insurer's claim for overpayment. All claims for overpayment  
27 which are not contested must be paid or denied within 45 days  
28 of the receipt of the claim. All contested claims for  
29 overpayment must be paid or denied within 120 days of receipt  
30 of the claim.

31 2. A provider must notify a health insurer that it

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1 will pay, deny, or contest a claim for overpayment within 20  
2 days of receipt of the overpayment claim. The provider's  
3 notice of contestment must contain a complete itemized list of  
4 requested information and documents. Failure of a provider to  
5 pay, deny, or contest a claim within the 20 days creates an  
6 uncontestable obligation of the provider to pay the  
7 overpayment claim.

8 3. A health insurer must respond to a provider's  
9 contestment of a claim or request for additional information  
10 regarding the claim within 15 days. Failure of a health  
11 insurer to respond to a provider's contestment of claim or  
12 request for additional information regarding the claim within  
13 15 days after receipt of such notice creates an uncontestable  
14 denial of the claim.

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

19 5. Payment of an overpayment claim is considered made  
20 on the date the payment was received or electronically  
21 transferred. An overdue payment of a claim bears simple  
22 interest at the rate of 12 percent per year. Interest on an  
23 overdue payment for a noncontested overpayment payment of a  
24 claim begins on the 36th day after receipt of a claim of  
25 overpayment. Interest on an overdue payment of a contested  
26 overpayment of a claim begins on the 120th day after receipt  
27 of a claim for overpayment.

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

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1           (8)(a) 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 within 60 days, must be finalized within 60 days of the  
6 receipt of the provider's request for review or appeal.

7           (b) All claims to a health insurer begun after October  
8 1, 2000, not under active review by a mediator, arbitrator, or  
9 third-party dispute entity, shall result in a final decision  
10 on the claim by the health insurer by January 2, 2003, for the  
11 purpose of the statewide provider and managed care  
12 organization claim dispute resolution program pursuant to s.  
13 408.7057.

14           (9) A provider or any representative of a provider,  
15 regardless of whether the provider is under contract with the  
16 health insurer, may not collect or attempt to collect money  
17 from, maintain any action at law against, or report to a  
18 credit agency an insured for payment of covered services for  
19 which the health insurer contested or denied the provider's  
20 claim for not being a clean claim. The prohibition applies  
21 during the pendency of any claim for payment made by the  
22 provider to the health insurer for payment of the services or  
23 internal dispute resolution process to determine whether the  
24 claim is a clean claim and the health insurer is liable for  
25 the services. For an electronic claim, this pendency applies  
26 from the date the claim is determined to be "not clean" or  
27 denied, to the date of the completion of the health insurer's  
28 internal dispute resolution process, not to exceed 180 days.  
29 For a nonelectronic claim, this pendency applies from the date  
30 the claim is determined to be "not clean" or denied, to the  
31 date of the completion of the health insurer's internal

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1 dispute resolution process, not to exceed 210 days.

2 (10) Any entity which contracts with a health insurer  
3 or its designee to furnish provider services to an insured  
4 shall comply with the provisions of this section. For the  
5 purposes of regulation by the Department of Insurance, a  
6 health insurer shall be liable for those entities' compliance,  
7 except for those providers or provider-owned or  
8 provider-formed entities under contract with a health insurer.

9 (11) This section does not preclude the health insurer  
10 and provider from agreeing to other methods of submission and  
11 receipt of claims; however, time frames specified herein shall  
12 not be extended.

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

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

22 (14) Upon written notification by an insured, an  
23 insurer shall investigate any claim of improper billing by a  
24 physician, hospital, or other health care provider. The  
25 insurer shall determine if the insured was properly billed for  
26 only those procedures and services that the insured actually  
27 received. If the insurer determines that the insured has been  
28 improperly billed, the insurer shall notify the insured and  
29 the provider of its findings and shall reduce the amount of  
30 payment to the provider by the amount determined to be  
31 improperly billed. If a reduction is made due to such

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1 notification by the insured, the insurer shall pay to the  
2 insured 20 percent of the amount of the reduction up to \$500.

3 (15)(a) Without regard to any other remedy or relief  
4 to which a person is entitled, or obligated to under contract,  
5 anyone aggrieved by a violation of this section may bring an  
6 action to obtain a declaratory judgment that an act or  
7 practice violates this section and to enjoin a person who has  
8 violated, is violating, or is otherwise likely to violate this  
9 section.

10 (b) Except as provided in paragraph (d), in any action  
11 brought by a person who has suffered a loss as a result of a  
12 violation of this section, such person may recover any amounts  
13 due the person under this section, including accrued interest,  
14 plus attorney's fees and court costs as provided in paragraph  
15 (c).

16 (c) In any civil litigation resulting from either an  
17 insured, or the insured's assignee, or health insurer not  
18 receiving a payment or repayment of monies due under this  
19 section where the losing party is found not to have paid the  
20 prevailing party in accordance with this section, the  
21 prevailing party, after judgment in the trial court and after  
22 exhausting all appeals, if any, shall receive his or her  
23 attorney's fees and costs from the losing party; provided,  
24 however, that such fees shall not exceed two times the amount  
25 in controversy or \$5,000, whichever is greater.

26 (d) In any civil litigation brought by a person who  
27 has suffered a loss as a result of a violation of this  
28 section, if the prevailing party can demonstrate that:

29 1. The acts giving rise to a violation of this section  
30 occur with such frequency as to indicate a general business  
31 practice; and

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1           2. The losing party has failed to exercise good faith  
2 in complying with this section, when, under the circumstances,  
3 it could and should have done so, had it acted fairly and  
4 honestly toward the prevailing party;

5  
6 the prevailing party, after judgment in trial court and after  
7 exhausting all appeals, if any, shall be entitled to recover  
8 up to two times the amount due the person under this section  
9 and his or her attorney's fees from the losing party.

10           (e) The attorney for the prevailing party shall submit  
11 a sworn affidavit of his or her time spent on the case and his  
12 or her costs incurred for all the motions, hearings, and  
13 appeals to the trial court.

14           (f) Any award of attorney's fees or costs shall become  
15 a part of the judgment and subject to execution as the law  
16 allows.

17           (16)(a) The provisions of this section shall also  
18 apply to ss. 627.6471 and 627.6472.

19           (b) An insured's assignee who has a contract pursuant  
20 to s. 627.6471 or s. 627.6472 with the insurer must include on  
21 the claim form the amount due according to the terms of the  
22 contract.

23           (17) This section shall only apply to policies and  
24 certificates issued or renewed on or after the effective date  
25 of this act for group or individual hospital and medical  
26 expense-incurred health insurance business in this state.  
27 This section shall not apply to Medicare supplement, long-term  
28 care, disability, limited-benefit, accident-only, hospital  
29 indemnity, special disease, dental, vision, or other  
30 supplemental policies unless said policies provide payment  
31 directly to the provider.

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1           Section 3. Section 627.6135, Florida Statutes, is  
2 created to read:

3           627.6135 Treatment authorization; payment of claims.--

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

19           (2) Upon receipt of a request from a provider for  
20 authorization, the health insurer shall make a determination  
21 within a reasonable time appropriate to medical circumstance  
22 indicating whether the treatment or services are authorized.  
23 For urgent care requests for which the standard time frame for  
24 the health insurer to make a determination would seriously  
25 jeopardize the life or health of an insured or would  
26 jeopardize the insured's ability to regain maximum function, a  
27 health insurer must notify the provider as to its  
28 determination as soon as possible taking into account medical  
29 exigencies but not later than 72 hours after receiving the  
30 request for authorization.

31           (3) Each response to an authorization request must be

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1 assigned an identification number. Each authorization provided  
2 by a health insurer must include the date of request of  
3 authorization, the time frame of the authorization, the  
4 identification number of the authorization, place of service,  
5 type of service, and patient status.

6 (4) Failure of a health insurer to respond to a  
7 request for authorization within the specified time frames  
8 creates an uncontestable obligation to provide reimbursement  
9 for the requested treatment or service.

10 (5) A claim for treatment may not be denied if a  
11 provider follows the health insurer's authorization procedures  
12 and receives authorization for a covered service for an  
13 eligible insured, unless the provider provided information to  
14 the health insurer with the willful intention to misinform the  
15 health insurer.

16 (6) A health insurer's material change in  
17 authorization procedures or requirements for authorization for  
18 medical treatment or services must be provided, at least 30  
19 days in advance of the change, to all contracted providers and  
20 to all noncontracted providers upon request. A health insurer  
21 that makes such procedures accessible to providers and  
22 insureds electronically, at least 30 days in advance of the  
23 change, shall be deemed to be in compliance with this section.  
24 An organization shall send notice to a contracted provider  
25 providing notice and an effective date of the material  
26 changes.

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

29 627.651 Group contracts and plans of self-insurance  
30 must meet group requirements.--

31 (4) This section does not apply to any plan which is



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1 established or maintained by an individual employer in  
2 accordance with the Employee Retirement Income Security Act of  
3 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
4 arrangement as defined in s. 624.437(1), except that a  
5 multiple-employer welfare arrangement shall comply with ss.  
6 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,  
7 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~.  
8 This subsection does not allow an authorized insurer to issue  
9 a group health insurance policy or certificate which does not  
10 comply with this part.

11 Section 5. Section 627.662, Florida Statutes, is  
12 amended to read:

13 627.662 Other provisions applicable.--The following  
14 provisions apply to group health insurance, blanket health  
15 insurance, and franchise health insurance:

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

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

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

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

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

25 (6) Section 627.613, relating to payment of claims.

26 (7) Section 627.6135, relating to treatment  
27 authorizations; payment of claims.

28 ~~(8)(6)~~ Section 627.645(1), relating to denial of  
29 claims.

30 ~~(9)(7)~~ Section 627.613, relating to time of payment of  
31 claims.

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1           ~~(10)~~~~(8)~~ Section 627.6471, relating to preferred  
2 provider organizations.

3           ~~(11)~~~~(9)~~ Section 627.6472, relating to exclusive  
4 provider organizations.

5           ~~(12)~~~~(10)~~ Section 627.6473, relating to combined  
6 preferred provider and exclusive provider policies.

7           ~~(13)~~~~(11)~~ Section 627.6474, relating to provider  
8 contracts.

9           Section 6. Section 641.234, Florida Statutes, is  
10 amended to read:

11           641.234 Administrative, provider, and management  
12 contracts.--

13           (1) The department may require a health maintenance  
14 organization to submit any contract for administrative  
15 services, contract with a provider other than an individual  
16 physician, contract for management services, and contract with  
17 an affiliated entity to the department.

18           (2) After review of a contract the department may  
19 order the health maintenance organization to cancel the  
20 contract in accordance with the terms of the contract and  
21 applicable law if it determines:

22           (a) That the fees to be paid by the health maintenance  
23 organization under the contract are so unreasonably high as  
24 compared with similar contracts entered into by the health  
25 maintenance organization or as compared with similar contracts  
26 entered into by other health maintenance organizations in  
27 similar circumstances that the contract is detrimental to the  
28 subscribers, stockholders, investors, or creditors of the  
29 health maintenance organization; or

30           (b) That the contract is with an entity that is not  
31 licensed under state statutes, if such license is required, or

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1 is not in good standing with the applicable regulatory agency.

2 (3) No contract for administrative services,  
3 management services, and provider services entered into or  
4 renewed by a health maintenance organization may transfer or  
5 assign any of the primary risk-taker duties and  
6 responsibilities to any other entity, including payment of  
7 claims pursuant to s. 641.3155 and quality assurance  
8 requirements pursuant to s. 641.51.

9 (4)(3) All contracts for administrative services,  
10 management services, provider services other than individual  
11 physician contracts, and with affiliated entities entered into  
12 or renewed by a health maintenance organization on or after  
13 October 1, 1988, shall contain a provision that the contract  
14 shall be canceled upon issuance of an order by the department  
15 pursuant to this section.

16 Section 7. Subsection (1) of section 641.30, Florida  
17 Statutes, is amended to read:

18 641.30 Construction and relationship to other laws.--

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

22 Section 8. Subsection (4) of section 641.3154, Florida  
23 Statutes, is amended to read:

24 641.3154 Organization liability; provider billing  
25 prohibited.--

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

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

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

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

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

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

23 Section 9. Section 641.3155, Florida Statutes, is  
24 amended to read:

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

27 641.3155 Prompt payment of claims.--

28 (1)(a) As used in this section, the term "clean claim"  
29 for a noninstitutional provider means an electronic or  
30 nonelectronic claim submitted on a HCFA 1500 form which has no  
31 defect or impropriety, including lack of required

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1 substantiating documentation for noncontracted providers and  
2 suppliers, or particular circumstances requiring special  
3 treatment which prevent timely payment from being made on the  
4 claim. A claim may not be excluded from meeting this  
5 definition solely because a health maintenance organization  
6 refers the claim to a medical specialist within the health  
7 maintenance organization for examination. If additional  
8 substantiating documentation, such as the medical record or  
9 encounter data, is required from a source outside the health  
10 maintenance organization, the claim shall not be considered a  
11 clean claim. This definition of "clean claim" is repealed on  
12 the effective date of rules adopted by the department which  
13 define the term "clean claim".

14 (b) Absent a written definition that is agreed upon  
15 through contract, the term "clean claim" for an institutional  
16 claim is a properly and accurately completed paper or  
17 electronic billing instrument that consists of the UB-92 data  
18 set or its successor with entries stated as mandatory by the  
19 National Uniform Billing Committee.

20 (c) The department shall adopt rules to establish  
21 claim forms consistent with federal claim-filing standards for  
22 health maintenance organizations required by the federal  
23 Centers for Medicare and Medicaid Services. The department may  
24 adopt rules relating to coding standards consistent with  
25 Medicare coding standards adopted by the federal Centers for  
26 Medicare and Medicaid Services.

27 (2) All claims for payment, notices, and requests for  
28 more information or review, whether electronic or  
29 nonelectronic, are considered received on the date the claim,  
30 notice, or request is received.

31 (3) For an electronically submitted claim, a health

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1 maintenance organization shall:

2 (a) Provide electronic acknowledgment of the receipt  
3 of the claim within 24 hours of receipt of the claim to the  
4 provider, or the provider's designee.

5 (b)1. Notify a provider if a claim is "not clean"  
6 within 10 days of receipt of the claim.

7 2. A claim determined to be clean during the initial  
8 10 days after the organization's receipt of the claim must be  
9 paid, denied, or contested within 20 days of the receipt of  
10 the claim.

11 (c)1. Notification of the organization's determination  
12 of a "not clean" claim must be accompanied by a complete  
13 itemized list of additional information or documents needed to  
14 process the claim as a "clean claim." Failure to notify a  
15 provider within 20 days of receipt of the claim creates an  
16 uncontestable obligation to pay the claim.

17 2. A provider must submit the additional information  
18 or documentation, as specified on the complete itemized list,  
19 within 15 days of receipt of the notification. Failure of a  
20 provider to submit the additional information or documentation  
21 requested within 15 days of receipt of the notification may  
22 result in denial of the claim.

23 3. Upon receipt of the requested additional  
24 information by the organization, the organization must  
25 determine if the claim is clean or not clean. A clean claim  
26 must be paid, denied, or contested within 10 days of receipt  
27 of the additional information.

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

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1           (e) A claim determined to be clean but contested must  
2 be paid or denied within 120 days of receipt of the claim.  
3 Failure to pay or deny a claim within 120 days of receipt of  
4 the claim creates an uncontestable obligation to pay the  
5 claim.

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

8           (a) Provide acknowledgement of receipt of the claim  
9 within 15 days of receipt of the claim to the provider, or the  
10 provider's designee.

11           (b)1. Notify a provider if a claim is "not clean"  
12 within 20 days of receipt.

13           2. A claim determined to be clean during the initial  
14 20 days after the organization's receipt of the claim must be  
15 paid, denied, or contested within 55 days of the receipt of  
16 the claim.

17           (c)1. Notification of the organization's determination  
18 of a "not clean" claim must be accompanied by a complete  
19 itemized list of additional information or documents needed to  
20 process the claim as a "clean claim." Failure to notify a  
21 provider or a provider's designee within 40 days of receipt of  
22 the claim that the claim is not clean or to provide a complete  
23 itemized list of additional information or documents needed to  
24 process the claim creates an uncontestable obligation to pay  
25 the claim.

26           2. A provider must submit the additional information  
27 or documentation, as specified on the complete itemized list,  
28 within 15 days of receipt of the notification. Failure of a  
29 provider to submit the additional information or documentation  
30 requested within 15 days of receipt of the notification may  
31 result in the denial of the claim.

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1           3. Upon receipt of the requested additional  
2 information by the organization, the organization must  
3 determine if the claim is clean or not clean. A clean claim  
4 must be paid, denied, or contested within 20 days of receipt  
5 of the additional information.

6           (d) A claim determined to be clean but contested must  
7 be paid or denied within 150 days of receipt of the claim.  
8 Failure to pay or deny a claim within 150 days of receipt of  
9 the claim creates an uncontestable obligation to pay the  
10 claim.

11           (5) Payment of a claim is considered made on the date  
12 the payment was received or electronically transferred. An  
13 overdue payment of a claim bears simple interest of 12 percent  
14 per year. Interest on an overdue payment for a clean claim or  
15 for any portion of a clean claim begins to accrue on the 36th  
16 day after the receipt of a clean electronic claim and on the  
17 56th day after receipt of a clean nonelectronic claim. The  
18 interest is payable with the payment of the claim.

19           (6) If a health maintenance organization determines  
20 that it has made an overpayment to a provider for services  
21 rendered to a subscriber, the organization must make a claim  
22 for such overpayment. A health maintenance organization that  
23 makes a claim for overpayment to a provider under this section  
24 shall give the provider a written or electronic statement  
25 specifying the basis for the retroactive denial and  
26 identifying the claim or claims, or portion thereof, which are  
27 being retroactively denied.

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



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1           1. All claims for overpayment must be submitted to a  
2 provider within 30 months after the organization's payment of  
3 the claim. A provider must pay, deny, or contest the health  
4 maintenance organization's claim for overpayment. All claims  
5 for overpayment which are not contested must be paid or denied  
6 within 45 days of the receipt of the claim. All contested  
7 claims for overpayment must be paid or denied within 120 days  
8 of receipt of the claim.

9           2. A provider must notify a health maintenance  
10 organization that it will pay, deny, or contest a claim for  
11 overpayment within 20 days of receipt of the overpayment  
12 claim. The provider's notice of contestment must contain a  
13 complete itemized list of requested information and documents.  
14 Failure of a provider to pay, deny, or contest a claim within  
15 the 20 days creates an uncontestable obligation of the  
16 provider to pay the overpayment claim.

17           3. A health maintenance organization must respond to a  
18 provider's contestment of a claim or request for additional  
19 information regarding the claim within 15 days. Failure of a  
20 health maintenance organization to respond to a provider's  
21 contestment of claim or request for additional information  
22 regarding the claim within 15 days after receipt of such  
23 notice creates an uncontestable denial of the claim.

24           4. The health maintenance organization may not reduce  
25 payment to the provider for other services unless the provider  
26 agrees to the reduction in writing or fails to respond to the  
27 health maintenance organization's claim as required by this  
28 paragraph.

29           5. Payment of an overpayment claim is considered made  
30 on the date the payment was received or electronically  
31 transferred. An overdue payment of a claim bears simple

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1 interest at the rate of 12 percent per year. Interest on an  
2 overdue payment for a noncontested overpayment payment of a  
3 claim begins on the 36th day after receipt of a claim of  
4 overpayment. Interest on an overdue payment of a contested  
5 overpayment of a claim begins on the 120th day after receipt  
6 of a claim for overpayment.

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

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

17 (b) All claims to a health maintenance organization  
18 begun after October 1, 2000, not under active review by a  
19 mediator, arbitrator, or third-party dispute entity, shall  
20 result in a final decision on the claim by the organization by  
21 January 2, 2003, for the purpose of the statewide provider and  
22 managed care organization claim dispute resolution program  
23 pursuant to s. 408.7057.

24 (8) A provider or any representative of a provider,  
25 regardless of whether the provider is under contract with the  
26 health maintenance organization, may not collect or attempt to  
27 collect money from, maintain any action at law against, or  
28 report to a credit agency a subscriber of an organization for  
29 payment of covered services for which the organization  
30 contested or denied the provider's claim for not being a clean  
31 claim. The prohibition applies during the pendency of any

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1 claim for payment made by the provider to the organization for  
2 payment of the services or internal dispute resolution process  
3 to determine whether the claim is a clean claim and the  
4 organization is liable for the services. For an electronic  
5 claim, this pendency applies from the date the claim is  
6 determined to be "not clean" or denied, to the date of the  
7 completion of the organization's internal dispute resolution  
8 process, not to exceed 180 days. For a nonelectronic claim,  
9 this pendency applies from the date the claim is determined to  
10 be "not clean" or denied, to the date of the completion of the  
11 organization's internal dispute resolution process, not to  
12 exceed 210 days.

13 (9) Any entity which contracts with a health  
14 maintenance organization or its designee to furnish provider  
15 services to a health maintenance organization's subscribers  
16 shall comply with the provisions of this section. For the  
17 purposes of regulation by the Department of Insurance, a  
18 health maintenance organization shall be liable for those  
19 entities' compliance, except for those providers or  
20 provider-owned or provider-formed entities under contract with  
21 an organization pursuant to s. 641.315.

22 (10) This section does not preclude the health  
23 maintenance organization and provider from agreeing to other  
24 methods of submission and receipt of claims; however, time  
25 frames specified herein shall not be extended.

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

29 (12) A health maintenance organization shall pay a  
30 contracted primary care or admitting physician, pursuant to  
31 such physician's contract, for providing inpatient services in

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1 a contracted hospital to a subscriber, if such services are  
2 determined by the organization to be medically necessary and  
3 covered services under the organization's contract with the  
4 contract holder.

5 (13) A provider who has a provider contract with the  
6 health maintenance organization must include on the claim form  
7 the amount due according to the terms of the contract.

8 (14)(a) Without regard to any other remedy or relief  
9 to which a person is entitled, or obligated to under contract,  
10 anyone aggrieved by a violation of this section may bring an  
11 action to obtain a declaratory judgment that an act or  
12 practice violates this section and to enjoin a person who has  
13 violated, is violating, or is otherwise likely to violate this  
14 section.

15 (b) Except as provided in paragraph (d), in any action  
16 brought by a person who has suffered a loss as a result of a  
17 violation of this section, such person may recover any amounts  
18 due the person under this section, including accrued interest,  
19 plus attorney's fees and court costs as provided in paragraph  
20 (c).

21 (c) In any civil litigation resulting from either a  
22 provider, or a health maintenance organization not receiving a  
23 payment or repayment of monies due under this section where  
24 the losing party is found not to have paid the prevailing  
25 party in accordance with this section, the prevailing party,  
26 after judgment in the trial court and after exhausting all  
27 appeals, if any, shall receive his or her attorney's fees and  
28 costs from the losing party; provided, however, that such fees  
29 shall not exceed two times the amount in controversy or  
30 \$5,000, whichever is greater.

31 (d) In any civil litigation brought by a person who

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1 has suffered a loss as a result of a violation of this  
2 section, if the prevailing party can demonstrate that:  
3 1. The acts giving rise to a violation of this section  
4 occur with such frequency as to indicate a general business  
5 practice; and  
6 2. The losing party has failed to exercise good faith  
7 in complying with this section, when, under the circumstances,  
8 it could and should have done so, had it acted fairly and  
9 honestly toward the prevailing party;  
10  
11 the prevailing party, after judgment in trial court and after  
12 exhausting all appeals, if any, shall be entitled to recover  
13 up to two times the amount due the person under this section  
14 and his or her attorney's fees from the losing party.  
15 (e) The attorney for the prevailing party shall submit  
16 a sworn affidavit of his or her time spent on the case and his  
17 or her costs incurred for all the motions, hearings, and  
18 appeals to the trial court.  
19 (f) Any award of attorney's fees or costs shall become  
20 a part of the judgment and subject to execution as the law  
21 allows.  
22 Section 10. Section 641.3156, Florida Statutes, is  
23 amended to read:  
24 641.3156 Treatment authorization; payment of claims.--  
25 (1) A health maintenance organization must pay any  
26 hospital-service or referral-service claim for treatment for  
27 an eligible subscriber which was authorized by a provider  
28 empowered by contract with the health maintenance organization  
29 to authorize or direct the patient's utilization of health  
30 care services and which was also authorized in accordance with  
31 the health maintenance organization's current and communicated

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1 procedures, unless the provider provided information to the  
2 health maintenance organization with the willful intention to  
3 misinform the health maintenance organization. For purposes of  
4 this section, "authorization" consists of any requirement of a  
5 provider to obtain prior approval or to provide documentation  
6 relating to the necessity of a covered medical treatment or  
7 service as a condition for reimbursement for the treatment or  
8 service prior to the treatment or service. Each authorization  
9 request from a provider must be assigned an identification  
10 number by the health maintenance organization.

11 (2) Upon receipt of a request from a provider for  
12 authorization, the health maintenance organization shall make  
13 a determination within a reasonable time appropriate to  
14 medical circumstance indicating whether the treatment or  
15 services are authorized. For urgent care requests for which  
16 the standard time frame for the health maintenance  
17 organization to make a determination would seriously  
18 jeopardize the life or health of a subscriber or would  
19 jeopardize the subscriber's ability to regain maximum  
20 function, a health maintenance organization must notify the  
21 provider as to its determination as soon as possible taking  
22 into account medical exigencies but not later than 72 hours  
23 after receiving the request for authorization.

24 (3) Each response to an authorization request must be  
25 assigned an identification number. Each authorization provided  
26 by a health maintenance organization must include the date of  
27 request of authorization, the time frame of the authorization,  
28 the identification number of the authorization, place of  
29 service, type of service, and patient status.

30 (4) Failure of an organization to respond to a request  
31 for authorization within the specified time frames creates an

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1 uncontestable obligation to provide reimbursement for the  
2 requested treatment or service.

3 (5)(2) A claim for treatment may not be denied if a  
4 provider follows the health maintenance organization's  
5 authorization procedures and receives authorization for a  
6 covered service for an eligible subscriber, unless the  
7 provider provided information to the health maintenance  
8 organization with the willful intention to misinform the  
9 health maintenance organization.

10 (6) A health maintenance organization's material  
11 change in authorization procedures or requirements for  
12 authorization for medical treatment or services must be  
13 provided, at least 30 days in advance of the change, to all  
14 contracted providers and to all noncontracted providers upon  
15 request. A health maintenance organization that makes such  
16 procedures accessible to providers and subscribers  
17 electronically, at least 30 days in advance of the change,  
18 shall be deemed to be in compliance with this section. An  
19 organization shall send notice to a contracted provider  
20 providing notice and an effective date of the material  
21 changes.

22 (7)(3) Emergency services are subject to the  
23 provisions of s. 641.513 and are not subject to the provisions  
24 of this section.

25 Section 11. This act shall take effect october 1,  
26 2002.

27  
28

29 ===== T I T L E A M E N D M E N T =====

30 And the title is amended as follows:

31 On page 23, line 6, through page 25, line 3,

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1 remove: all of said lines

2

3 and insert:

4

A bill to be entitled

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An act relating to health insurance; amending

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s. 408.7057, F.S.; redefining "managed care

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organization"; including preferred provider

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organizations and health insurers in the claim

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dispute resolution program; specifying

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timeframes for submission of supporting

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documentation necessary for dispute resolution;

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providing consequences for failure to comply;

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directing the agency to notify appropriate

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licensure and certification entities as part of

15

final orders; amending s. 627.613, F.S.;

16

revising time of payment of claims provisions

17

applicable to health insurers; providing

18

definitions; providing requirements and

19

procedures for payment, denial, or contestment

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of claims; providing criteria and limitations;

21

requiring payment within specified periods;

22

revising rate of interest charged on overdue

23

payments; providing for electronic and

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nonelectronic transmission of claims; providing

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procedures for overpayment recovery; specifying

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timeframes for adjudication of claims,

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internally and externally; prohibiting action

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to collect payment from an insured under

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certain circumstances; providing applicability;

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authorizing contractual modification of

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provisions of law, with exception; specifying



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1           circumstances for retroactive claim denial;  
2           specifying claim payment requirements;  
3           providing for billing review procedures;  
4           specifying claim content; providing civil  
5           causes of action; providing for award of  
6           attorney's fees; creating s. 627.6135, F.S.;  
7           providing procedural requirements for  
8           determination and issuance of authorizations of  
9           services; providing a definition; specifying  
10          circumstances for authorization timeframes;  
11          specifying content for response to  
12          authorization requests; providing for an  
13          obligation for payment, with exception;  
14          providing authorization procedure notice  
15          requirements; amending s. 627.651, F.S.;  
16          correcting a cross reference, to conform;  
17          amending s. 627.662, F.S.; specifying  
18          application of certain additional provisions to  
19          group, blanket, and franchise health insurance;  
20          amending s. 641.234, F.S., relating to  
21          administrative, provider and management  
22          contracts; prohibits health maintenance  
23          organization from transferring or assigning any  
24          primary risk-taker duties and responsibilities  
25          to any other entity; amending s. 641.30, F.S.;  
26          conforming a cross reference; amending s.  
27          641.3154, F.S.; modifying the circumstances  
28          under which a provider knows that an  
29          organization is liable for service  
30          reimbursement; amending s. 641.3155, F.S.;  
31          revising payment of claims provisions

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1 applicable to health maintenance organizations;  
2 providing definitions; requiring the Department  
3 of Insurance to adopt rules consistent with  
4 federal claim-filing standards; providing  
5 requirements and procedures for payment,  
6 denial, or contestment of claims; providing  
7 criteria and limitations; requiring payment  
8 within specified periods; revising rate of  
9 interest charged on overdue payments; providing  
10 for electronic and nonelectronic transmission  
11 of claims; providing procedures for overpayment  
12 recovery; specifying timeframes for  
13 adjudication of claims internally and  
14 externally; prohibiting action to collect  
15 payment from an insured under certain  
16 circumstances; authorizing contractual  
17 modification of provisions of law, with  
18 exceptions; specifying circumstances for  
19 retroactive claim denial; specifying claim  
20 payment requirements; authorizing contractual  
21 modification of provisions of law, with  
22 exception; specifying circumstances for  
23 retroactive claim denial; specifying claim  
24 payment requirements; specifying claim content;  
25 providing payment requirements; providing civil  
26 causes of action; providing for award of  
27 attorney's fees; amending s. 641.3156, F.S.;  
28 providing procedural requirements for  
29 determination and issuance of authorizations of  
30 services; providing a definition; specifying  
31 circumstances for authorization timeframes;

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specifying content for response to  
authorization requests; providing for an  
obligation for payment, with exception;  
providing authorization procedure notice  
requirements; providing an effective date.