HOUSE AMENDMENT

Bill No. HB 293

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

CHAMBER ACTION

Senate | House

ORIGINAL STAMP BELOW

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

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

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

(c) "Agency" means 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 managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. The agency shall contract with a resolution organization to timely review and consider claim disputes submitted by providers and 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 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 managed care ~~health maintenance~~ organization to the resolution organization ~~when the dispute-resolution program becomes effective~~.

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

(e) The resolution organization shall require the managed care organization or provider submitting the claim dispute to submit any supporting documentation to the resolution organization within 15 days after receipt by the managed care organization 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 managed care organization 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.

(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 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 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 provide written notification within 7 days to the appropriate licensure or certification entity whenever the agency issues a final order 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 2. Section 627.613, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 627.613, F.S., for present text.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Provide acknowledgement of receipt of the claim

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

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

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

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

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

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

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

the claim creates an uncontestable obligation to pay the claim.

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

(7) 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 and identifying the claim or claims, or portion thereof, which are being retroactively denied.

(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. All claims for overpayment which are not contested must be paid or denied within 45 days of the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days of receipt of the claim.

2. A provider must notify a health insurer that it

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

3. A health insurer must respond to a provider's contestment of a claim or request for additional information regarding the claim within 15 days. Failure of a health insurer to respond to a provider's contestment of claim or request for additional information regarding the claim within 15 days after receipt of such notice creates an uncontestable 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 claim as required by this paragraph.

5. Payment of an overpayment claim is considered made on the date the payment was received 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 noncontested overpayment payment of a claim begins on the 36th day after receipt of a claim of overpayment. Interest on an overdue payment of a contested overpayment of a claim begins on the 120th day after receipt of a claim for overpayment.

(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.

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

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

(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 for not being a clean claim. The 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 claim is a clean claim and the health insurer is liable for the services. For an electronic claim, this pendency applies from the date the claim is determined to be "not clean" or denied, to the date of the completion of the health insurer's internal dispute resolution process, not to exceed 180 days. For a nonelectronic claim, this pendency applies from the date the claim is determined to be "not clean" or denied, to the date of the completion of the health insurer's internal

dispute resolution process, not to exceed 210 days.

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

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

(12) 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.

(13) 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.

(14) 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

627.6135 Treatment authorization; payment of claims.--

(1) A health insurer must pay any hospital-service or referral-service claim for treatment for an eligible insured which was authorized by a provider empowered by contract to authorize or direct the insured's utilization of health care services and which was also authorized in accordance with the health insured's current and communicated procedures, unless the provider provided information to the health insurer with the willful intention to misinform the health insurer. 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 time frame 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 but not later than 72 hours after receiving the request for authorization.

(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, the time frame of the authorization, the identification number of the authorization, place of service, type of service, and patient status.

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

(5) 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 willful intention to misinform the health insurer.

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

Section 4. 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 5. 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 payment of claims.

(7) Section 627.6135, relating to treatment authorizations; 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.

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

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

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

641.234 Administrative, provider, and management contracts.--

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

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

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

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

is not in good standing with the applicable regulatory agency.

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

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

Section 7. 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 ~~s. 627.647~~.

Section 8. 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.

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

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

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

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

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

(3) For an electronically submitted claim, a health

maintenance organization shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the 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 and identifying the claim or claims, or portion thereof, which are being retroactively denied.

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

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

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

3. A health maintenance organization must respond to a provider's contestment of a claim or request for additional information regarding the claim within 15 days. Failure of a health maintenance organization to respond to a provider's contestment of claim or request for additional information regarding the claim within 15 days after receipt of such notice creates an uncontestable 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 health maintenance organization's claim as required by this paragraph.

5. Payment of an overpayment claim is considered made on the date the payment was received 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 noncontested overpayment payment of a claim begins on the 36th day after receipt of a claim of overpayment. Interest on an overdue payment of a contested overpayment of a claim begins on the 120th day after receipt of a claim for overpayment.

(b) A claim for overpayment shall not be permitted beyond 30 months after the 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.

(7)(a) For all contracts entered into or renewed on or after October 1, 2002, an organization's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity within 60 days, must be finalized within 60 days of 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 result in a final decision on the claim by the 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 of an organization for payment of covered services for which the organization contested or denied the provider's claim for not being a clean claim. The prohibition applies during the pendency of any

claim for payment made by the provider to the organization for payment of the services or internal dispute resolution process to determine whether the claim is a clean claim and the organization is liable for the services. For an electronic claim, this pendency applies from the date the claim is determined to be "not clean" or denied, to the date of the completion of the organization's internal dispute resolution process, not to exceed 180 days. For a nonelectronic claim, this pendency applies from the date the claim is determined to be "not clean" or denied, to the date of the completion of the organization's internal dispute resolution process, not to exceed 210 days.

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

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

(11) 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.

(12) 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 organization to be medically necessary and covered services under the organization's contract with the contract holder.

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

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

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

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

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

has suffered a loss as a result of a violation of this section, if the prevailing party can demonstrate that:

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

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

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

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

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

Section 10. Section 641.3156, Florida Statutes, is amended to read:

641.3156 Treatment authorization; payment of claims.--

(1) 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. 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.

(2) 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 time frame 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 but not later than 72 hours after receiving the request for authorization.

(3) 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, the time frame of the authorization, the identification number of the authorization, place of service, type of service, and patient status.

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

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

(5)~~(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 organization with the willful intention to misinform the health maintenance organization.

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

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

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

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

And the title is amended as follows:

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

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

remove: all of said lines

and insert:

A bill to be entitled

An act relating to health insurance; amending s. 408.7057, F.S.; redefining "managed care organization"; 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; directing the agency to notify appropriate licensure and certification entities as part of final orders; amending s. 627.613, F.S.; revising time of payment of claims provisions applicable to health insurers; providing definitions; providing requirements and procedures for payment, denial, or contestment of 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 payment from an insured under certain circumstances; providing applicability; authorizing contractual modification of provisions of law, with exception; specifying

circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content; providing civil causes of action; providing for award of attorney's fees; creating s. 627.6135, F.S.; providing procedural requirements for determination and issuance of authorizations of services; 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; 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. 641.234, F.S., relating to administrative, provider and management contracts; prohibits health maintenance organization from transferring or assigning any primary risk-taker duties and responsibilities to any other entity; 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 health maintenance organizations; providing definitions; requiring the Department of Insurance to adopt rules consistent with federal claim-filing standards; providing requirements and procedures for payment, denial, or contestment of 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 payment from an insured under certain circumstances; authorizing contractual modification of provisions of law, with exceptions; specifying circumstances for retroactive claim denial; specifying claim payment requirements; authorizing contractual modification of provisions of law, with exception; specifying circumstances for retroactive claim denial; specifying claim payment requirements; specifying claim content; providing payment requirements; providing civil causes of action; providing for award of attorney's fees; amending s. 641.3156, F.S.; providing procedural requirements for determination and issuance of authorizations of services; providing a definition; specifying circumstances for authorization timeframes;

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

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