CHAMBER ACTION

Senate		House
	.	

ORIGINAL STAMP BELOW

The Committee on Health Promotion offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause

and insert:

Section 1. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsection (4) of section 408.7057, Florida Statutes, are amended, and paragraphs (e) and (f) are added to subsection (2) of said section, 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.

(2)

(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~~ health maintenance organization, or health insurer to the resolution organization ~~when the dispute-resolution program becomes effective~~.

(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. 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. 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.

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

order imposing fines or sanctions, including those contained in s. 641.52. All fines collected under this subsection shall be deposited into the Health Care Trust Fund.

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

627.613 Time of 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) Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 35 ~~45~~ days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within 35 ~~45~~ days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim, ~~and~~ the specific reasons for contesting the claim, and written itemization of any additional information or additional documents needed to process the claim or the contested portion of the claim. A health insurer may not make more than one request under this subsection in connection with a claim unless the provider fails to submit all of the requested information to process

the claim or if information submitted by the provider raises new, additional issues not included in the original written itemization, in which case the health insurer may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim. In no case may the health insurer request duplicate information.

(3) A health insurer, upon receipt of the additional information requested from the insured or the insured's assignees shall pay or deny the contested claim or portion of the contested claim, within 35 ~~60~~ days.

(4) A health ~~An~~ insurer shall pay or deny any claim no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the health insurer to pay the claim to the provider.

(5) Payment of a claim is considered ~~shall be treated as being~~ made on the date the payment was electronically transferred or otherwise delivered ~~a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery~~.

(6) All overdue payments shall bear simple interest at the rate of 12 ~~10~~ percent per year. Interest on a late payment of a claim or uncontested portion of a claim begins to accrue on the 36th day after the claim has been received. Interest due is payable with the payment of the claim.

(7) 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

1 improperly billed, the insurer shall notify the insured and
2 the provider of its findings and shall reduce the amount of
3 payment to the provider by the amount determined to be
4 improperly billed. If a reduction is made due to such
5 notification by the insured, the insurer shall pay to the
6 insured 20 percent of the amount of the reduction up to $500.
7 (8) A provider claim for payment shall be considered
8 received by the health insurer, if the claim has been
9 electronically transmitted to the health insurer, when receipt
10 is verified electronically or, if the claim is mailed to the
11 address disclosed by the organization, on the date indicated
12 on the return receipt. A provider must wait 35 days following
13 receipt of a claim before submitting a duplicate claim.
14 (9)(a) If, as a result of retroactive review of
15 coverage decisions or payment levels, a health insurer
16 determines that it has made an overpayment to a provider for
17 services rendered to an insured, the health insurer must make
18 a claim for such overpayment. The health insurer may not
19 reduce payment to that provider for other services unless the
20 provider agrees to the reduction or fails to respond to the
21 health insurer's claim as required in this subsection.
22 (b) A provider shall pay a claim for an overpayment
23 made by a health insurer that the provider does not contest or
24 deny within 35 days after receipt of the claim that is mailed
25 or electronically transferred to the provider.
26 (c) A provider that denies or contests a health
27 insurer's claim for overpayment or any portion of a claim
28 shall notify the health insurer, in writing, within 35 days
29 after the provider receives the claim that the claim for
30 overpayment is contested or denied. The notice that the claim
31 for overpayment is contested or denied must identify the

1 contested portion of the claim and the specific reason for
2 contesting or denying the claim, and, if contested, must
3 include a request for additional information. The provider
4 shall pay or deny the claim for overpayment within 35 days
5 after receipt of the information.
6 (d) Payment of a claim for overpayment is considered
7 made on the date payment was electronically transferred or
8 otherwise delivered to the organization or on the date that
9 the provider receives a payment from the organization that
10 reduces or deducts the overpayment. An overdue payment of a
11 claim bears simple interest at the rate of 12 percent per
12 year. Interest on an overdue payment of a claim for
13 overpayment or for any uncontested portion of a claim for
14 overpayment begins to accrue on the 36th day after the claim
15 for overpayment has been received.
16 (e) A provider shall pay or deny any claim for
17 overpayment no later than 120 days after receiving the claim.
18 Failure to do so creates an uncontestable obligation for the
19 provider to pay the claim to the organization.
20 (f) A health insurer's claim for overpayment shall be
21 considered received by a provider, if the claim has been
22 electronically transmitted to the provider, when receipt is
23 verified electronically, or, if the claim is mailed to the
24 address disclosed by the provider, on the date indicated on
25 the return receipt. A health insurer must wait 35 days
26 following the provider's receipt of a claim for overpayment
27 before submitting a duplicate claim.
28 (10) Any retroactive reductions of payments or demands
29 for refund of previous overpayments that are due to
30 retroactive review of coverage decisions or payment levels
31 must be reconciled to specific claims. Any retroactive demands

1 by providers for payment due to underpayments or nonpayments
2 for covered services must be reconciled to specific claims.
3 The look-back or audit review period may not exceed 1 year
4 after the date the claim was received by the health insurer.
5 (11) A health insurer may not deny a claim because of
6 subscriber ineligibility if the provider can document receipt
7 of subscriber eligibility confirmation by the health insurer
8 prior to the date or time covered services were provided. Any
9 person who knowingly and willfully misinforms a provider prior
10 to receipt of services as to his or her coverage eligibility
11 commits insurance fraud, punishable as provided in s. 817.50.
12 (12) The provisions of this section may not be waived,
13 voided, or nullified by contracts.
14 (13) Effective October 1, 2003, the provisions of this
15 section are applicable only to claims submitted
16 electronically.
17 Section 3. Section 627.6142, Florida Statutes, is
18 created to read:
19 627.6142 Treatment authorization; payment of claims.--
20 (1) For purposes of this section, "authorization"
21 includes any requirement of a provider to notify an insurer in
22 advance of providing a covered service, regardless of whether
23 the actual terminology used by the insurer includes, but is
24 not limited to, preauthorization, precertification,
25 notification, or any other similar terminology.
26 (2) A health insurer that requires authorization for
27 medical care or health care services shall provide to each
28 provider with whom the health insurer has contracted pursuant
29 to s. 627.6471 or s. 627.6472 a list of the medical care and
30 health care services that require authorization and the
31 authorization procedures used by the health insurer at the

1 time a contract becomes effective. A health insurer that
2 requires authorization for medical care or health care
3 services shall provide to all other providers, not later than
4 10 working days after a request is made, a list of the medical
5 care and health care services that require authorization and
6 the authorization procedures established by the insurer. The
7 medical care or health care services that require
8 authorization and the authorization procedures used by the
9 insurer shall not be modified unless written notice is
10 provided at least 30 days in advance of any material changes
11 to all affected insureds as well as to all contracted
12 providers and all other providers that had previously
13 requested in writing a list of medical care or health care
14 services that require authorization. An insurer that makes
15 such list and procedures accessible to providers and insureds
16 electronically shall be deemed to be in compliance with this
17 subsection.
18 (3) Any claim for a covered service that does not
19 require authorization that is ordered by a contracted
20 physician and entered on the medical record may not be denied.
21 If the health insurer determines that an overpayment has been
22 made, then a claim for overpayment should be submitted to the
23 provider pursuant to s. 627.613.
24 (4)(a) Any claim for treatment may not be denied if a
25 provider follows the health insurer's published authorization
26 procedures and receives authorization, unless the provider
27 submits information to the health insurer with the willful
28 intention to misinform the health insurer.
29 (b) Upon receipt of a request from a provider for
30 authorization, the health insurer shall issue a written
31 determination indicating whether the service or services are

1 authorized. If the request for an authorization is for an
2 inpatient admission, the determination shall be transmitted to
3 the provider making the request in writing no later than 24
4 hours after the request is made by the provider. If the health
5 insurer denies the request for authorization, the health
6 insurer shall notify the insured at the same time the insurer
7 notifies the provider requesting the authorization. A health
8 insurer that fails to respond to a request for an
9 authorization pursuant to this paragraph within 24 hours is
10 considered to have authorized the inpatient admission and
11 payment shall not be denied.
12 (5) If the proposed medical care or health care
13 service or services involve an inpatient admission and the
14 health insurer requires an authorization as a condition of
15 payment, the health insurer shall review and issue a written
16 or electronic authorization for the total estimated length of
17 stay for the admission, based on the recommendation of the
18 patient's physician. If the proposed medical care or health
19 care service or services are to be provided to an insured who
20 is an inpatient in a health care facility and authorization is
21 required, the health insurer shall issue a written
22 determination indicating whether the proposed services are
23 authorized or denied no later than 4 hours after the request
24 is made by the provider. A health insurer who fails to respond
25 to such request within 4 hours is considered to have
26 authorized the requested medical care or health care service
27 and payment shall not be denied.
28 (6) Emergency services and care are subject to the
29 provisions of s. 641.513 and are not subject to the provisions
30 of this section, including any inpatient admission required in
31 order to stabilize the patient pursuant to federal and state

1 law.
2 (7) The provisions of this section may not be waived,
3 voided, or nullified by contract.
4 (8) The provisions of this section apply to contracts
5 entered into pursuant to ss. 627.6471 and 627.6472.
6 Section 4. Subsection (4) of section 627.651, Florida
7 Statutes, is amended to read:
8 627.651 Group contracts and plans of self-insurance
9 must meet group requirements.--
10 (4) This section does not apply to any plan which is
11 established or maintained by an individual employer in
12 accordance with the Employee Retirement Income Security Act of
13 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
14 arrangement as defined in s. 624.437(1), except that a
15 multiple-employer welfare arrangement shall comply with ss.
16 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
17 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~.
18 This subsection does not allow an authorized insurer to issue
19 a group health insurance policy or certificate which does not
20 comply with this part.
21 Section 5. Section 627.662, Florida Statutes, is
22 amended to read:
23 627.662 Other provisions applicable.--The following
24 provisions apply to group health insurance, blanket health
25 insurance, and franchise health insurance:
26 (1) Section 627.569, relating to use of dividends,
27 refunds, rate reductions, commissions, and service fees.
28 (2) Section 627.602(1)(f) and (2), relating to
29 identification numbers and statement of deductible provisions.
30 (3) Section 627.635, relating to excess insurance.
31 (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 627.614, relating to payment of claims.

(7) Section 627.6142, relating to treatment authorizations.

(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. Paragraph (e) of subsection (1) of section 641.185, Florida Statutes, is amended, and paragraph (m) is added to said subsection, to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

1 (e) A health maintenance organization subscriber
2 should receive timely, concise information regarding the
3 health maintenance organization's reimbursement to providers
4 and services pursuant to ss. 641.31 and 641.31015 and is
5 entitled to prompt payment from the organization when
6 appropriate pursuant to s. 641.3155.
7 (m)1. A health maintenance organization shall
8 reimburse any claim or portion of any claim from a subscriber
9 or a subscriber's assignee for payment under a health
10 maintenance organization subscriber contract within 35 days
11 after receipt of the claim by the organization. The notice
12 that a claim is contested shall identify the contested portion
13 of the claim, the specific reasons for contesting the claim,
14 and written itemization of any additional information or
15 additional documents needed to process the claim or the
16 contested portion of the claim.
17 2. A health maintenance organization, upon receipt of
18 the additional information requested from the subscriber or
19 the subscriber's assignee, shall pay or deny the contested
20 claim or portion of the contested claim within 35 days.
21 3. A health maintenance organization shall pay or deny
22 any claim no later than 120 days after receiving the claim.
23 Failure to do so creates an incontestable obligation of the
24 health maintenance organization to pay the claim to the
25 provider.
26 4. Payment of a claim is considered made on the date
27 the payment was electronically transferred or otherwise
28 delivered.
29 5. All overdue payments shall bear simple interest at
30 the rate of 12 percent per year. Interest on a late payment of
31 a claim or uncontested portion of a claim begins to accrue on

the 36th day after the claim has been received. Interest due is payable with the payment of the claim.

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 ~~627.647~~.

Section 8. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Payment of claims.--

(1)~~(a)~~ As used in this section, the term "~~clean~~ claim" for a noninstitutional provider means a paper or electronic billing instrument that consists of the HCFA 1500 data set that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 or other appropriate form for any other noninstitutional provider, or its successor. For institutional providers, "claim" means a paper or electronic billing instrument that consists of the UB-92 data set or its successor that has all mandatory entries ~~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 considered not clean 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~~

~~is considered not clean. 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 Health Care Financing Administration. The department may adopt rules relating to coding standards consistent with Medicare coding standards adopted by the federal Health Care Financing Administration~~.

(2)(a) A health maintenance organization shall pay any ~~clean~~ claim or any portion of a ~~clean~~ claim made by a contract provider for services or goods provided under a contract with the health maintenance organization or a ~~clean~~ claim made by a noncontract provider which the organization does not contest or deny within 35 days after receipt of the claim by the health maintenance organization which is mailed or electronically submitted ~~transferred~~ by the provider.

(b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall notify the provider, in writing, within 35 days after the health maintenance organization receives the claim that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the

claim, and, if contested, must give the provider a written itemization of any ~~include a request for~~ additional information or additional documents needed to process the claim or any portion of the claim that is not being paid. If the provider submits additional information, the provider must, within 35 days after receipt of the request, mail or electronically transfer the information to the health maintenance organization. The health maintenance organization shall pay or deny the claim or portion of the claim within 35 ~~45~~ days after receipt of the information. A health maintenance organization may not make more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information to process the claim or if information submitted by the provider raises new, additional issues not included in the original written itemization, in which case the health maintenance organization may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim. In no case may the health insurer request duplicate information.

(c) A health maintenance organization shall not deny or withhold payment on a claim because the insured has not paid a required deductible or copayment.

(3) Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 12 ~~10~~ percent per year. Interest on an overdue payment for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received. The interest is payable with the payment of the claim.

1 (4) A health maintenance organization shall pay or
2 deny any claim no later than 120 days after receiving the
3 claim. Failure to do so creates an uncontestable obligation
4 for the health maintenance organization to pay the claim to
5 the provider.
6 (5)(a) If, as a result of retroactive review of
7 coverage decisions or payment levels, a health maintenance
8 organization determines that it has made an overpayment to a
9 provider for services rendered to a subscriber, the
10 organization must make a claim for such overpayment. The
11 organization may not reduce payment to that provider for other
12 services unless the provider agrees to the reduction in
13 writing after receipt of the claim for overpayment from the
14 health maintenance organization or fails to respond to the
15 organization's claim as required in this subsection.
16 (b) A provider shall pay a claim for an overpayment
17 made by a health maintenance organization which the provider
18 does not contest or deny within 35 days after receipt of the
19 claim that is mailed or electronically transferred to the
20 provider, or within 35 days after receipt of the claim that is
21 submitted to the provider.
22 (c) A provider that denies or contests an
23 organization's claim for overpayment or any portion of a claim
24 shall notify the organization, in writing, within 35 days
25 after the provider receives the claim that the claim for
26 overpayment is contested or denied. The notice that the claim
27 for overpayment is denied or contested must identify the
28 contested portion of the claim and the specific reason for
29 contesting or denying the claim, and, if contested, must
30 include a request for additional information. If the
31 organization submits additional information, the organization

must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information.

(d) Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of 12 ~~10~~ percent a year. Interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

(e) A provider shall pay or deny any claim for overpayment no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the provider to pay the claim to the organization.

(6) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back or audit review period shall not exceed 1 year after the date the claim was received by the health maintenance organization ~~may be specified by the terms of the contract~~.

(7)(a) A provider claim for payment shall be

considered received by the health maintenance organization, if the claim has been electronically transmitted to the health maintenance organization, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization, on the date indicated on the return receipt. A provider must wait 45 days following receipt of a claim before submitting a duplicate claim.

(b) A health maintenance organization claim for overpayment shall be considered received by a provider, if the claim has been electronically transmitted to the provider, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the provider, on the date indicated on the return receipt. An organization must wait 45 days following the provider's receipt of a claim for overpayment before submitting a duplicate claim.

(c) This section does not preclude the health maintenance organization and provider from agreeing to other methods of submission ~~transmission~~ and receipt of claims.

(8) A provider, or the provider's designee, who bills electronically is entitled to electronic acknowledgment of the receipt of a claim within 72 hours.

(9) A health maintenance organization may not ~~retroactively~~ deny a claim because of subscriber ineligibility if the provider can document receipt of subscriber eligibility confirmation by the organization prior to the date or time covered services were provided. Every health maintenance organization contract with an employer shall include a provision that requires the employer to notify the health maintenance organization of changes in eligibility status within 30 days ~~more than 1 year after the date of payment of the clean claim~~. Any person who knowingly misinforms a

1 provider prior to the receipt of services as to his or her
2 coverage eligibility commits insurance fraud punishable as
3 provided in s. 817.50.
4 (10) A health maintenance organization shall pay a
5 contracted primary care or admitting physician, pursuant to
6 such physician's contract, for providing inpatient services in
7 a contracted hospital to a subscriber, if such services are
8 determined by the organization to be medically necessary and
9 covered services under the organization's contract with the
10 contract holder.
11 (11) A health maintenance organization subscriber is
12 entitled to prompt payment from the organization whenever a
13 subscriber pays an out-of-network provider for a covered
14 service and then submits a claim to the organization. The
15 organization shall pay the claim within 35 days after receipt
16 or the organization shall advise the subscriber of what
17 additional information is required to adjudicate the claim.
18 After receipt of the additional information, the organization
19 shall pay the claim within 10 days. If the organization fails
20 to pay claims submitted by subscribers within the time periods
21 specified in this subsection, the organization shall pay the
22 subscriber interest on the unpaid claim at the rate of 18
23 percent per year. Failure to pay claims and interest, if
24 applicable, within the time periods specified in this
25 subsection is a violation of the insurance code and each
26 occurrence shall be considered a separate violation.
27 (12) The provisions of this section may not be waived,
28 voided, or nullified by contract.
29 Section 9. Section 641.3156, Florida Statutes, is
30 amended to read:
31 641.3156 Treatment authorization; payment of claims.--

1 (1) For purposes of this section, "authorization"
2 includes any requirement of a provider to notify a health
3 maintenance organization in advance of providing a covered
4 service, regardless of whether the actual terminology used by
5 the organization includes, but is not limited to,
6 preauthorization, precertification, notification, or any other
7 similar terminology.
8 (2) A health maintenance organization that requires
9 authorization for medical care and health care services shall
10 provide to each contracted provider at the time a contract is
11 signed a list of the medical care and health care services
12 that require authorization and the authorization procedures
13 used by the organization. A health maintenance organization
14 that requires authorization for medical care and health care
15 services shall provide to each noncontracted provider, not
16 later than 10 working days after a request is made, a list of
17 the medical care and health care services that require
18 authorization and the authorization procedures used by the
19 organization. The list of medical care or health care services
20 that require authorization and the authorization procedures
21 used by the organization shall not be modified unless written
22 notice is provided at least 30 days in advance of any material
23 changes to all subscribers, contracted providers, and
24 noncontracted providers who had previously requested a list of
25 medical care or health care services that require
26 authorization. An organization that makes such list and
27 procedures accessible to providers and subscribers
28 electronically shall be deemed to be in compliance with this
29 section.
30 (3) Any claim for a covered service that does not
31 require an authorization that is ordered by a contracted

1 physician may not be denied. If an organization determines
2 that an overpayment has been made, then a claim for
3 overpayment should be submitted pursuant to s. 641.3155.~~A~~
4 ~~health maintenance organization must pay any hospital-service~~
5 ~~or referral-service claim for treatment for an eligible~~
6 ~~subscriber which was authorized by a provider empowered by~~
7 ~~contract with the health maintenance organization to authorize~~
8 ~~or direct the patient's utilization of health care services~~
9 ~~and which was also authorized in accordance with the health~~
10 ~~maintenance organization's current and communicated~~
11 ~~procedures, unless the provider provided information to the~~
12 ~~health maintenance organization with the willful intention to~~
13 ~~misinform the health maintenance organization.~~
14 (4)(a)~~(2)~~ A claim for treatment may not be denied if a
15 provider follows the health maintenance organization's
16 authorization procedures and receives authorization for a
17 covered service for an eligible subscriber, unless the
18 provider provided information to the health maintenance
19 organization with the willful intention to misinform the
20 health maintenance organization.
21 (b) On receipt of a request from a provider for
22 authorization pursuant to this section, the health maintenance
23 organization shall issue a written determination indicating
24 whether the service or services are authorized. If the request
25 for an authorization is for an inpatient admission, the
26 determination must be transmitted to the provider making the
27 request in writing no later than 24 hours after the request is
28 made by the provider. If the organization denies the request
29 for an authorization, the health maintenance organization must
30 notify the subscriber at the same time when notifying the
31 provider requesting the authorization. A health maintenance

1 organization that fails to respond to a request for an
2 authorization from a provider pursuant to this paragraph is
3 considered to have authorized the inpatient admission within
4 24 hours and payment may not be denied.
5 (5) If the proposed medical care or health care
6 service or services involve an inpatient admission and the
7 health maintenance organization requires authorization as a
8 condition of payment, the health maintenance organization
9 shall issue a written or electronic authorization for the
10 total estimated length of stay for the admission. If the
11 proposed medical care or health care service or services are
12 to be provided to a patient who is an inpatient in a health
13 care facility at the time the services are proposed and the
14 medical care or health care service requires an authorization,
15 the health maintenance organization shall issue a
16 determination indicating whether the proposed services are
17 authorized no later than 4 hours after the request by the
18 health care provider. A health maintenance organization that
19 fails to respond to such request within 4 hours is considered
20 to have authorized the requested medical care or health care
21 service and payment may not be denied.
22 (6)~~(3)~~ Emergency services are subject to the
23 provisions of s. 641.513 and are not subject to the provisions
24 of this section, including any inpatient admission required in
25 order to stabilize the patient pursuant to federal and state
26 law.
27 (7) The provisions of this section may not be waived,
28 voided, or nullified by contract.
29 Section 10. This act shall take effect October 1,
30 2002.
31

1 =============== T I T L E A M E N D M E N T ===============
2 And the title is amended as follows:
3 remove: the entire title
4
5 and insert:
6 A bill to be entitled
7 An act relating to health insurance; amending
8 s. 408.7057, F.S.; redefining "managed care
9 organization"; including health insurers in the
10 claim dispute resolution program; specifying
11 timeframes for submission of supporting
12 documentation necessary for dispute resolution;
13 providing consequences for failure to comply;
14 authorizing the agency to impose fines and
15 sanctions as part of final orders; amending s.
16 627.613, F.S.; revising time of payment of
17 claims provisions; providing requirements and
18 procedures for payment or denial of claims;
19 providing criteria and limitations; revising
20 rate of interest charged on overdue payments;
21 providing for electronic transmission of
22 claims; providing a penalty; prohibiting
23 contractual modification of provisions of law;
24 limiting application to claims submitted
25 electronically; creating s. 627.6142, F.S.;
26 providing a definition; requiring health
27 insurers to provide lists of medical care and
28 health care services that require
29 authorization; prohibiting denial of certain
30 claims; providing procedural requirements for
31 determination and issuance of authorizations of

1 services; amending s. 627.651, F.S.; correcting
2 a cross reference, to conform; amending s.
3 627.662, F.S.; specifying application of
4 certain additional provisions to group,
5 blanket, and franchise health insurance;
6 amending s. 641.185, F.S.; entitling health
7 maintenance organization subscribers to prompt
8 payment when appropriate; conforming time of
9 payment provisions; amending s. 641.30, F.S.;
10 conforming a cross reference; amending s.
11 641.3155, F.S.; providing a definition;
12 deleting provisions that require the Department
13 of Insurance to adopt rules consistent with
14 federal claim-filing standards; providing
15 requirements and procedures for payment of
16 claims; requiring payment within specified
17 periods; revising rate of interest charged on
18 overdue payments; requiring employers to
19 provide notice of changes in eligibility status
20 within a specified time period; providing a
21 penalty; entitling health maintenance
22 organization subscribers to prompt payment by
23 the organization for covered services by an
24 out-of-network provider; requiring payment
25 within specified periods; providing payment
26 procedures; providing penalties; amending s.
27 641.3156, F.S.; providing a definition;
28 requiring health maintenance organizations to
29 provide lists of medical care and health care
30 services that require authorization;
31 prohibiting denial of certain claims; providing

1 procedural requirements for determination and
2 issuance of authorizations of services;
3 providing an effective date.
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31