CHAMBER ACTION

Senate		House
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Senator Saunders moved the following amendment:

Senate Amendment

On page 3, line 18, through
page 4, line 29, delete those lines

and insert:

Section 1. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsections (3) and (4) of section 408.7057, Florida Statutes, are amended, and paragraphs (e) and (f) are added to subsection (2) of that 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. 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.

(3) The agency shall adopt rules to establish a

1 process to be used by the resolution organization in
2 considering claim disputes submitted by a provider or managed
3 care organization which must include the issuance by the
4 resolution organization of a written recommendation, supported
5 by findings of fact, to the agency within 60 days after the
6 requested information is received by the resolution
7 organization within the timeframes specified by the resolution
8 organization. The review time may not exceed 90 days following
9 receipt of the initial claim dispute submission by the
10 resolution organization.
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