SENATE AMENDMENT

Bill No. CS for CS for SB 362

Amendment No. ___ Barcode 421980

CHAMBER ACTION

Senate		House
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11 Senator Saunders moved the following amendment:

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13 **Senate Amendment**

14 On page 16, line 4, through

15 page 23, line 31, delete those lines

16

17 and insert:

18 (1)~~(a)~~ As used in this section, the term "~~clean~~ claim"

19 for a noninstitutional provider means a paper or electronic

20 billing instrument submitted to the health maintenance

21 organization's designated location which consists of the HCFA

22 1500 data set, or its successor, having all mandatory entries

23 for a physician licensed under chapter 458, chapter 459,

24 chapter 460, or chapter 461 or other appropriate billing

25 instrument that has all mandatory entries for any other

26 noninstitutional provider. For institutional providers,

27 "claim" means a paper or electronic billing instrument

28 submitted to the insurer's designated location which consists

29 of the UB-92 data set, or its successor, having all mandatory

30 entries.~~claim submitted on a HCFA 1500 form which has no~~

31 ~~defect or impropriety, including lack of required~~

1 ~~substantiating documentation for noncontracted providers and~~
2 ~~suppliers, or particular circumstances requiring special~~
3 ~~treatment which prevent timely payment from being made on the~~
4 ~~claim. A claim may not be considered not clean solely because~~
5 ~~a health maintenance organization refers the claim to a~~
6 ~~medical specialist within the health maintenance organization~~
7 ~~for examination. If additional substantiating documentation,~~
8 ~~such as the medical record or encounter data, is required from~~
9 ~~a source outside the health maintenance organization, the~~
10 ~~claim is considered not clean. This definition of "clean~~
11 ~~claim" is repealed on the effective date of rules adopted by~~
12 ~~the department which define the term "clean claim."~~
13 ~~(b) Absent a written definition that is agreed upon~~
14 ~~through contract, the term "clean claim" for an institutional~~
15 ~~claim is a properly and accurately completed paper or~~
16 ~~electronic billing instrument that consists of the UB-92 data~~
17 ~~set or its successor with entries stated as mandatory by the~~
18 ~~National Uniform Billing Committee.~~
19 ~~(c) The department shall adopt rules to establish~~
20 ~~claim forms consistent with federal claim-filing standards for~~
21 ~~health maintenance organizations required by the federal~~
22 ~~Health Care Financing Administration. The department may adopt~~
23 ~~rules relating to coding standards consistent with Medicare~~
24 ~~coding standards adopted by the federal Health Care Financing~~
25 ~~Administration.~~
26 (2) All claims for payment, whether electronic or
27 nonelectronic:
28 (a) Are considered received on the date the claim is
29 received by the organization at its designated claims receipt
30 location.
31 (b) Must not duplicate a claim previously submitted

unless it is determined that the original claim was not received or is otherwise lost.~~(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 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 include a request for additional information. 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 45 days after receipt of the information.~~

(3)(a) For an electronically submitted claim, a health maintenance organization shall, within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

(b) For an electronically submitted claim, a health

1 maintenance organization shall, within 20 days after receipt
2 of the claim, pay the claim or notify a provider if a claim is
3 denied or contested. Notice of the organization's action on
4 the claim and payment of the claim are considered to be made
5 on the date the notice or payment is mailed or electronically
6 transferred.
7 (c)1. Notification of the health maintenance
8 organization's determination of a contested claim must be
9 accompanied by an itemized list of additional information or
10 documents the organization can reasonably determine are
11 necessary to process the claim.
12 2. A provider must submit the additional information
13 or documentation, as specified on the itemized list, within 35
14 days after receipt of the notification. Failure of a provider
15 to submit by mail or electronically the additional information
16 or documentation requested within 35 days after receipt of the
17 notification may result in denial of the claim.
18 3. A health maintenance organization may not make more
19 than one request for documents under this paragraph in
20 connection with a claim unless the provider fails to submit
21 all of the requested documents to process the claim or the
22 documents submitted by the provider raise new, additional
23 issues not included in the original written itemization, in
24 which case the organization may provide the provider with one
25 additional opportunity to submit the additional documents
26 needed to process the claim. In no case may the organization
27 request duplicate documents.
28 (d) For purposes of this subsection, electronic means
29 of transmission of claims, notices, documents, forms, and
30 payment shall be used to the greatest extent possible by the
31 health maintenance organization and the provider.

1 (e) A claim must be paid or denied within 90 days
2 after receipt of the claim. Failure to pay or deny a claim
3 within 120 days after receipt of the claim creates an
4 uncontestable obligation to pay the claim. ~~Payment of a claim~~
5 ~~is considered made on the date the payment was received or~~
6 ~~electronically transferred or otherwise delivered. An overdue~~
7 ~~payment of a claim bears simple interest at the rate of 10~~
8 ~~percent per year. Interest on an overdue payment for a clean~~
9 ~~claim or for any uncontested portion of a clean claim begins~~
10 ~~to accrue on the 36th day after the claim has been received.~~
11 ~~The interest is payable with the payment of the claim.~~
12 (4)(a) For all nonelectronically submitted claims, a
13 health maintenance organization shall, effective November 1,
14 2003, provide to the provider acknowledgement of receipt of
15 the claim within 15 days after receipt of the claim or provide
16 the provider, within 15 days after receipt, with electronic
17 access to the status of a submitted claim.
18 (b) For all nonelectronically submitted claims, a
19 health maintenance organization shall, within 40 days after
20 receipt of the claim, pay the claim or notify a provider if a
21 claim is denied or contested. Notice of the organization's
22 action on the claim and payment of the claim are considered to
23 be made on the date the notice or payment is mailed or
24 electronically transferred.
25 (c)1. Notification of the health maintenance
26 organization's determination of a contested claim must be
27 accompanied by an itemized list of additional information or
28 documents the organization can reasonably determine are
29 necessary to process the claim.
30 2. A provider must submit the additional information
31 or documentation, as specified on the itemized list, within 35

days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

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

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

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

(5) Payment of a claim is considered made on the date the payment is mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should

have been paid, denied, or contested. The interest is payable with the payment of the claim.

(6)(a)~~(5)(a)~~ If, as a result of retroactive review of coverage decisions or payment levels, 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. The organization may not reduce payment to that provider for other services unless the provider agrees to the reduction in writing after receipt of the claim for overpayment from the health maintenance organization or fails to respond to the organization's claim as required in this subsection.

(b) A provider shall pay a claim for an overpayment made by a health maintenance organization which the provider does not contest or deny within 35 days after receipt of the claim that is mailed or electronically transferred to the provider.

(c) A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information.

(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.

(7)~~(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 2 years after the date the claim was paid by the health maintenance organization, unless fraud in billing is involved.~~The look-back period may be specified by the terms of the contract.~~

(8)(a)~~(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, or on the date the delivery receipt is signed by the health maintenance organization if the claim is hand delivered. 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.

(9)~~(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.

(10)~~(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 provider prior to the receipt of services as to his or her

1 coverage eligibility commits insurance fraud punishable as
2 provided in s. 817.50.
3 (11)~~(10)~~ A health maintenance organization shall pay a
4 contracted primary care or admitting physician, pursuant to
5 such physician's contract, for providing inpatient services in
6 a contracted hospital to a subscriber, if such services are
7 determined by the organization to be medically necessary and
8 covered services under the organization's contract with the
9 contract holder.
10 (12)(a) Without regard to any other remedy or relief
11 to which a person is entitled, or obligated to under contract,
12 anyone aggrieved by a violation of this section may bring an
13 action to obtain a declaratory judgment that an act or
14 practice violates this section and to enjoin a person who has
15 violated, is violating, or is otherwise likely to violate this
16 section.
17 (b) In any action brought by a person who has suffered
18 a loss as a result of a violation of this section, such person
19 may recover any amounts due the person under this section,
20 including accrued interest, plus attorney's fees and court
21 costs as provided in paragraph (c).
22 (c) In any civil litigation resulting from an act or
23 practice involving a violation of this section by a health
24 maintenance organization in which the organization is found to
25 have violated this section, the provider, after judgment in
26 the trial court and after exhausting all appeals, if any,
27 shall receive his or her attorney's fees and costs from the
28 organization; however, such fees shall not exceed three times
29 the amount in controversy or $5,000, whichever is greater. In
30 any such civil litigation, if the organization is found not to
31 have violated this section, the organization, after judgment

1 in the trial court and exhaustion of all appeals, if any, may
2 receive its reasonable attorney's fees and costs from the
3 provider on any claim or defense that the court finds the
4 provider knew or should have known was not supported by the
5 material facts necessary to establish the claim or defense or
6 would not be supported by the application of then-existing law
7 as to those material facts.
8 (d) The attorney for the prevailing party shall submit
9 a sworn affidavit of his or her time spent on the case and his
10 or her costs incurred for all the motions, hearings, and
11 appeals to the trial judge who presided over the civil case.
12 (e) Any award of attorney's fees or costs shall become
13 a part of the judgment and subject to execution as the law
14 allows.
15 (13) A health maintenance organization subscriber is
16 entitled to prompt payment from the organization whenever a
17 subscriber pays an out-of-network provider for a covered
18 service and then submits a claim to the organization. The
19 organization shall pay the claim within 35 days after receipt
20 or the organization shall advise the subscriber of what
21 additional information is required to adjudicate the claim.
22 After receipt of the additional information, the organization
23 shall pay the claim within 10 days. If the organization fails
24 to pay claims submitted by subscribers within the time periods
25 specified in this subsection, the organization shall pay the
26 subscriber interest on the unpaid claim at the rate of 12
27 percent per year. Failure to pay claims and interest, if
28 applicable, within the time periods specified in this
29 subsection is a violation of the insurance code and each
30 occurrence shall be considered a separate violation.
31 (14) The provisions of this section may not be waived,

1 voided, or nullified by contract.

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