

Amendment No. 1 (for drafter's use only)

|   | <u>Senate</u> | CHAMBER ACTION | <u>House</u> |
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The Council for Healthy Communities offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause

and insert:

Section 1. Effective upon this act becoming a law, paragraphs (t), (u), and (v) are added to subsection (3) of section 408.036, Florida Statutes, to read:

408.036 Projects subject to review.--

(3) EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(t) For the provision of health services, long-term care hospital services, new construction, or tertiary health services excluding solid organ transplant services, by an existing hospital, provided that the hospital utilizes existing bed capacity and does not exceed the current licensed bed capacity for that facility. Utilizing existing bed capacity, a hospital may offer the exempted services within the hospital's respective health planning district.

1           1. In addition to any other documentation required by  
2 the agency, a request for an exemption submitted under this  
3 paragraph must certify that the applicant will meet and  
4 continuously maintain the minimum licensure requirements  
5 governing such programs adopted by the agency pursuant to  
6 subparagraph 2.

7           2. The agency shall adopt minimum licensure  
8 requirements by rule which govern the operation of health  
9 services, long-term care hospital services, and tertiary  
10 health services excluding solid organ transplant services,  
11 established pursuant to the exemption provided in this  
12 paragraph. The rules shall ensure that such programs:

13           a. Perform only services authorized by the exemption  
14 and will not provide any other services not authorized by the  
15 exemption.

16           b. Maintain sufficient appropriate equipment and  
17 health personnel to ensure quality and safety.

18           c. Maintain appropriate times of operation and  
19 protocols to ensure availability and appropriate referrals in  
20 emergencies.

21           d. Provide a minimum of 10 percent of its services to  
22 charity and Medicaid patients each year.

23           e. Establish quality outcome measures that are  
24 evidence-based. The performance of quality outcome measures  
25 for such programs must be at least at the 50th percentile of  
26 state and national outcome measures.

27           f. Be given an opportunity to correct any deficiencies  
28 as noted by the agency prior to the expiration of the  
29 authorized exemption.

30           3. The exemption provided by this paragraph shall not  
31 apply unless the agency determines that the program is in

1 compliance with the requirements of subparagraph 1. and that  
2 the program will, after beginning operation, continuously  
3 comply with the rules adopted pursuant to subparagraph 2. The  
4 agency shall monitor such programs to ensure compliance with  
5 the requirements of subparagraph 2.

6 4.a. The exemption for a program shall expire  
7 immediately when the agency determines that the program fails  
8 to comply with the rules adopted pursuant to sub-subparagraphs  
9 2.a., b., and c.

10 b. Beginning 24 months after a program first begins  
11 treating patients, the exemption for the program shall expire  
12 when the program fails to comply with the rules adopted  
13 pursuant to sub-subparagraph 2.d.

14 5. If the exemption for a program expires pursuant to  
15 sub-subparagraph 4.a. or sub-subparagraph 4.b., the agency  
16 shall not grant an exemption pursuant to this paragraph for a  
17 program located at the same hospital until 2 years following  
18 the date of the determination by the agency that the program  
19 failed to comply with the rules adopted pursuant to  
20 subparagraph 2.

21 (u) For the provision of adult open heart services in  
22 a hospital. When a clear problem exists in access to needed  
23 cardiac services, consideration must be given to creating an  
24 exemption. While such needs might be addressed by the changing  
25 of the specific need criteria under the certificate-of-need  
26 law, the problem of protracted administrative appeals would  
27 still remain. The exemption must be based upon objective  
28 criteria and address and solve the twin problems of geographic  
29 and temporal access. A hospital shall be exempt from the  
30 certificate-of-need review for the establishment of an open  
31 heart surgery program subject to the following conditions and

1 criteria:

2 1. The applicant must certify it will meet and  
3 continuously maintain the minimum licensure requirements  
4 adopted by the agency governing adult open heart programs,  
5 including the most current guidelines of the American College  
6 of Cardiology and American Heart Association Guidelines for  
7 Adult Open Heart Programs.

8 2. The applicant must certify it will maintain  
9 sufficient appropriate equipment and health personnel to  
10 ensure quality and safety.

11 3. The applicant must certify it will maintain  
12 appropriate times of operation and protocols to ensure  
13 availability and appropriate referrals in the event of  
14 emergencies.

15 4. The applicant can demonstrate that it is referring  
16 300 or more cardiac patients from the hospital, including the  
17 emergency room, per year to a hospital with cardiac services,  
18 or that the average wait for transfer for 50 percent or more  
19 of the cardiac patients exceeds 4 hours.

20 5. The applicant is a general acute care hospital that  
21 is in operation for 3 years or more.

22 6. The applicant is performing more than 500  
23 diagnostic cardiac catheterization procedures per year,  
24 combined inpatient and outpatient.

25 7. The applicant has a formal agreement with an  
26 existing statutory teaching hospital or cardiac program  
27 performing 750 open heart cases per year which creates at a  
28 minimum an external peer review process. The peer review shall  
29 be conducted quarterly the first year of operation and two  
30 times a year in the succeeding years until either the program  
31 reaches 350 cases per year or demonstrates consistency with

1 state-adopted quality and outcome standards for the service.

2 8. The applicant payor-mix at a minimum reflects the  
3 community average for Medicaid, charity care, and self-pay or  
4 the applicant must certify that it will provide a minimum of 5  
5 percent of Medicaid, charity care, and self-pay to open heart  
6 surgery patients.

7 9. If the applicant fails to meet the established  
8 criteria for open heart programs or fails to reach 300  
9 surgeries per year by the end of year 3, it must show cause  
10 why its exemption should not be revoked.

11 (v) For the establishment of a satellite hospital  
12 through the relocation of 100 general acute care beds from an  
13 existing hospital located in the same district, as defined in  
14 s. 408.032(5).

15 Section 2. Subsection (5) is added to section 408.043,  
16 Florida Statutes, to read:

17 408.043 Special provisions.--

18 (5) SOLE ACUTE CARE HOSPITAL IN A HIGH GROWTH  
19 COUNTY.--Notwithstanding any other provision of law, an acute  
20 care hospital licensed under chapter 395 may add up to 180  
21 additional beds without agency review, provided such hospital  
22 is located in a county that has experienced at least a  
23 60-percent growth rate since 1990, is under construction on  
24 January 1, 2002, is the sole acute care hospital in the  
25 county, and is located such that there is no other acute care  
26 hospital within a 10-mile radius of such hospital.

27 Section 3. Section 408.7057, Florida Statutes, is  
28 amended to read:

29 408.7057 Statewide provider and health plan managed  
30 ~~care organization~~ claim dispute resolution program.--

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

1           (a) "Agency" means the Agency for Health Care  
2 Administration.

3           (b)(a) "Health plan Managed care organization" means a  
4 health maintenance organization or a prepaid health clinic  
5 certified under chapter 641, a prepaid health plan authorized  
6 under s. 409.912, ~~or~~ an exclusive provider organization  
7 certified under s. 627.6472, or a major medical expense health  
8 insurance policy, as defined in s. 627.643(2)(e), offered by a  
9 group or an individual health insurer licensed pursuant to  
10 chapter 624, including a preferred provider organization under  
11 s. 627.6471.

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

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

29           (b) The resolution organization shall review claim  
30 disputes filed by contracted and noncontracted providers and  
31 health plans ~~managed care organizations~~ unless the disputed

1 claim:

- 2 1. Is related to interest payment;
- 3 2. Does not meet the jurisdictional amounts or the  
4 methods of aggregation established by agency rule, as provided  
5 in paragraph (a);
- 6 3. Is part of an internal grievance in a Medicare  
7 managed care organization or a reconsideration appeal through  
8 the Medicare appeals process;
- 9 4. Is related to a health plan that is not regulated  
10 by the state;
- 11 5. Is part of a Medicaid fair hearing pursued under 42  
12 C.F.R. ss. 431.220 et seq.;
- 13 6. Is the basis for an action pending in state or  
14 federal court; or
- 15 7. Is subject to a binding claim-dispute-resolution  
16 process provided by contract entered into prior to October 1,  
17 2000, between the provider and the managed care organization.
- 18 (c) Contracts entered into or renewed on or after  
19 October 1, 2000, may require exhaustion of an internal  
20 dispute-resolution process as a prerequisite to the submission  
21 of a claim by a provider or a health plan maintenance  
22 ~~organization~~ to the resolution organization ~~when the~~  
23 ~~dispute-resolution program becomes effective.~~
- 24 (d) A contracted or noncontracted provider or health  
25 plan maintenance organization may not file a claim dispute  
26 with the resolution organization more than 12 months after a  
27 final determination has been made on a claim by a health plan  
28 or provider maintenance organization.
- 29 (e) The resolution organization shall require the  
30 health plan or provider submitting the claim dispute to submit  
31 any supporting documentation to the resolution organization

1 within 15 days after receipt by the health plan or provider of  
2 a request from the resolution organization for documentation  
3 in support of the claim dispute. The resolution organization  
4 may extend the time if appropriate. Failure to submit the  
5 supporting documentation within such time period shall result  
6 in the dismissal of the submitted claim dispute.

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

23 (g)1. If on an ongoing basis during the preceding 12  
24 months, the agency has reason to believe that a pattern of  
25 noncompliance with s. 627.6131 and s. 641.3155 exists on the  
26 part of a particular health plan or provider, the agency shall  
27 evaluate the information contained in these cases to determine  
28 whether the information evidences a pattern and report its  
29 findings, together with substantiating evidence, to the  
30 appropriate licensure or certification entity for the health  
31 plan or provider.



1           2. In addition, the agency shall prepare an annual  
2 report to the Governor and the Legislature by February 1 of  
3 each year, enumerating: claims dismissed; defaults issued;  
4 and failures to comply with agency final orders issued under  
5 this section.

6           (3) The agency shall adopt rules to establish a  
7 process to be used by the resolution organization in  
8 considering claim disputes submitted by a provider or health  
9 plan managed care organization which must include the issuance  
10 by the resolution organization of a written recommendation,  
11 supported by findings of fact, to the agency within 60 days  
12 after the requested information is received by the resolution  
13 organization within the timeframes specified by the resolution  
14 organization. In no event shall the review time exceed 90 days  
15 following receipt of the initial claim dispute submission by  
16 the resolution organization ~~receipt of the claim dispute~~  
17 ~~submission.~~

18           (4) Within 30 days after receipt of the recommendation  
19 of the resolution organization, the agency shall adopt the  
20 recommendation as a final order.

21           (5) The agency shall notify within 7 days the  
22 appropriate licensure or certification entity whenever there  
23 is a violation of a final order issued by the agency pursuant  
24 to this section.

25           ~~(6)~~~~(5)~~ The entity that does not prevail in the  
26 agency's order must pay a review cost to the review  
27 organization, as determined by agency rule. Such rule must  
28 provide for an apportionment of the review fee in any case in  
29 which both parties prevail in part. If the nonprevailing party  
30 fails to pay the ordered review cost within 35 days after the  
31 agency's order, the nonpaying party is subject to a penalty of

1 not more than \$500 per day until the penalty is paid.

2 ~~(7)(6)~~ The agency for Health Care Administration may  
3 adopt rules to administer this section.

4 Section 4. Subsection (1) of section 626.88, Florida  
5 Statutes, is amended to read:

6 626.88 Definitions of "administrator" and "insurer".--

7 (1) For the purposes of this part, an "administrator"  
8 is any person who directly or indirectly solicits or effects  
9 coverage of, collects charges or premiums from, or adjusts or  
10 settles claims on residents of this state in connection with  
11 authorized commercial self-insurance funds or with insured or  
12 self-insured programs which provide life or health insurance  
13 coverage or coverage of any other expenses described in s.  
14 624.33(1) or any person who, through a health care risk  
15 contract as defined in s. 641.234 with an insurer or health  
16 maintenance organization, provides billing and collection  
17 services to health insurers and health maintenance  
18 organizations on behalf of health care providers, other than  
19 any of the following persons:

20 (a) An employer on behalf of such employer's employees  
21 or the employees of one or more subsidiary or affiliated  
22 corporations of such employer.

23 (b) A union on behalf of its members.

24 (c) An insurance company which is either authorized to  
25 transact insurance in this state or is acting as an insurer  
26 with respect to a policy lawfully issued and delivered by such  
27 company in and pursuant to the laws of a state in which the  
28 insurer was authorized to transact an insurance business.

29 (d) A health care services plan, health maintenance  
30 organization, professional service plan corporation, or person  
31 in the business of providing continuing care, possessing a

1 valid certificate of authority issued by the department, and  
2 the sales representatives thereof, if the activities of such  
3 entity are limited to the activities permitted under the  
4 certificate of authority.

5 (e) An insurance agent licensed in this state whose  
6 activities are limited exclusively to the sale of insurance.

7 (f) An adjuster licensed in this state whose  
8 activities are limited to the adjustment of claims.

9 (g) A creditor on behalf of such creditor's debtors  
10 with respect to insurance covering a debt between the creditor  
11 and its debtors.

12 (h) A trust and its trustees, agents, and employees  
13 acting pursuant to such trust established in conformity with  
14 29 U.S.C. s. 186.

15 (i) A trust exempt from taxation under s. 501(a) of  
16 the Internal Revenue Code, a trust satisfying the requirements  
17 of ss. 624.438 and 624.439, or any governmental trust as  
18 defined in s. 624.33(3), and the trustees and employees acting  
19 pursuant to such trust, or a custodian and its agents and  
20 employees, including individuals representing the trustees in  
21 overseeing the activities of a service company or  
22 administrator, acting pursuant to a custodial account which  
23 meets the requirements of s. 401(f) of the Internal Revenue  
24 Code.

25 (j) A financial institution which is subject to  
26 supervision or examination by federal or state authorities or  
27 a mortgage lender licensed under chapter 494 who collects and  
28 remits premiums to licensed insurance agents or authorized  
29 insurers concurrently or in connection with mortgage loan  
30 payments.

31 (k) A credit card issuing company which advances for

1 and collects premiums or charges from its credit card holders  
2 who have authorized such collection if such company does not  
3 adjust or settle claims.

4 (l) A person who adjusts or settles claims in the  
5 normal course of such person's practice or employment as an  
6 attorney at law and who does not collect charges or premiums  
7 in connection with life or health insurance coverage.

8 (m) A person approved by the Division of Workers'  
9 Compensation of the Department of Labor and Employment  
10 Security who administers only self-insured workers'  
11 compensation plans.

12 (n) A service company or service agent and its  
13 employees, authorized in accordance with ss. 626.895-626.899,  
14 serving only a single employer plan, multiple-employer welfare  
15 arrangements, or a combination thereof.

16 (o) Any provider or group practice, as defined in s.  
17 456.053, providing services under the scope of the license of  
18 the provider or the member of the group practice.

19  
20 A person who provides billing and collection services to  
21 health insurers and health maintenance organizations on behalf  
22 of health care providers shall comply with the provisions of  
23 ss. 627.6131, 641.3155, and 641.51(4).

24 Section 5. Section 627.6131, Florida Statutes, is  
25 created to read:

26 627.6131 Payment of claims.--

27 (1) The contract shall include the following  
28 provision:

29  
30 "Time of Payment of Claims: After receiving  
31 written proof of loss, the insurer will pay

1           monthly all benefits then due for ... (type of  
2           benefit).... Benefits for any other loss  
3           covered by this policy will be paid as soon as  
4           the insurer receives proper written proof."

5  
6           (2) As used in this section, the term "claim" for a  
7           noninstitutional provider means a paper or electronic billing  
8           instrument submitted to the insurer's designated location that  
9           consists of the HCFA 1500 data set, or its successor, that has  
10           all mandatory entries for a physician licensed under chapter  
11           458, chapter 459, chapter 460, chapter 461, chapter 463, or  
12           chapter 490 or any appropriate billing instrument that has all  
13           mandatory entries for any other noninstitutional provider. For  
14           institutional providers, "claim" means a paper or electronic  
15           billing instrument submitted to the insurer's designated  
16           location that consists of the UB-92 data set or its successor  
17           that has all mandatory entries.

18           (3) All claims for payment, whether electronic or  
19           nonelectronic:

20           (a) Are considered received on the date the claim is  
21           received by the insurer at its designated claims receipt  
22           location.

23           (b) Must be mailed or electronically transferred to an  
24           insurer within 9 months after completion of the service and  
25           the provider is furnished with the correct name and address of  
26           the patient's health insurer.

27           (c) Must not duplicate a claim previously submitted  
28           unless it is determined that the original claim was not  
29           received or is otherwise lost.

30           (4) For all electronically submitted claims, a health  
31           insurer shall:

1           (a) Within 24 hours after the beginning of the next  
2 business day after receipt of the claim, provide electronic  
3 acknowledgment of the receipt of the claim to the electronic  
4 source submitting the claim.

5           (b) Within 20 days after receipt of the claim, pay the  
6 claim or notify a provider or designee if a claim is denied or  
7 contested. Notice of the insurer's action on the claim and  
8 payment of the claim is considered to be made on the date the  
9 notice or payment was mailed or electronically transferred.

10           (c)1. Notification of the health insurer's  
11 determination of a contested claim must be accompanied by an  
12 itemized list of additional information or documents the  
13 insurer can reasonably determine are necessary to process the  
14 claim.

15           2. A provider must submit the additional information  
16 or documentation, as specified on the itemized list, within 35  
17 days after receipt of the notification. Failure of a provider  
18 to submit by mail or electronically the additional information  
19 or documentation requested within 35 days after receipt of the  
20 notification may result in denial of the claim.

21           3. A health insurer may not make more than one request  
22 for documents under this paragraph in connection with a claim,  
23 unless the provider fails to submit all of the requested  
24 documents to process the claim or if documents submitted by  
25 the provider raise new additional issues not included in the  
26 original written itemization, in which case the health insurer  
27 may provide the provider with one additional opportunity to  
28 submit the additional documents needed to process the claim.  
29 In no case may the health insurer request duplicate documents.

30           (d) For purposes of this subsection, electronic means  
31 of transmission of claims, notices, documents, forms, and

1 payments shall be used to the greatest extent possible by the  
2 health insurer and the provider.

3 (e) A claim must be paid or denied within 90 days  
4 after receipt of the claim. Failure to pay or deny a claim  
5 within 120 days after receipt of the claim creates an  
6 uncontestable obligation to pay the claim.

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

9 (a) Effective November 1, 2003, provide acknowledgment  
10 of receipt of the claim within 15 days after receipt of the  
11 claim to the provider or provide a provider within 15 days  
12 after receipt with electronic access to the status of a  
13 submitted claim.

14 (b) Within 40 days after receipt of the claim, pay the  
15 claim or notify a provider or designee if a claim is denied or  
16 contested. Notice of the insurer's action on the claim and  
17 payment of the claim is considered to be made on the date the  
18 notice or payment was mailed or electronically transferred.

19 (c)1. Notification of the health insurer's  
20 determination of a contested claim must be accompanied by an  
21 itemized list of additional information or documents the  
22 insurer can reasonably determine are necessary to process the  
23 claim.

24 2. A provider must submit the additional information  
25 or documentation, as specified on the itemized list, within 35  
26 days after receipt of the notification. Failure of a provider  
27 to submit by mail or electronically the additional information  
28 or documentation requested within 35 days after receipt of the  
29 notification may result in denial of the claim.

30 3. A health insurer may not make more than one request  
31 for documents under this paragraph in connection with a claim

1 unless the provider fails to submit all of the requested  
2 documents to process the claim or if documents submitted by  
3 the provider raise new additional issues not included in the  
4 original written itemization, in which case the health insurer  
5 may provide the provider with one additional opportunity to  
6 submit the additional documents needed to process the claim.  
7 In no case may the health insurer request duplicate documents.

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

12 (e) A claim must be paid or denied within 120 days  
13 after receipt of the claim. Failure to pay or deny a claim  
14 within 140 days after receipt of the claim creates an  
15 uncontestable obligation to pay the claim.

16 (6) If a health insurer determines that it has made an  
17 overpayment to a provider for services rendered to an insured,  
18 the health insurer must make a claim for such overpayment. A  
19 health insurer that makes a claim for overpayment to a  
20 provider under this section shall give the provider a written  
21 or electronic statement specifying the basis for the  
22 retroactive denial or payment adjustment. The insurer must  
23 identify the claim or claims, or overpayment claim portion  
24 thereof, for which a claim for overpayment is submitted.

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

29 1. All claims for overpayment must be submitted to a  
30 provider within 30 months after the health insurer's payment  
31 of the claim. A provider must pay, deny, or contest the health



1 insurer's claim for overpayment within 40 days after the  
2 receipt of the claim. All contested claims for overpayment  
3 must be paid or denied within 120 days after receipt of the  
4 claim. Failure to pay or deny overpayment and claim within 140  
5 days after receipt creates an uncontestable obligation to pay  
6 the claim.

7 2. A provider that denies or contests a health  
8 insurer's claim for overpayment or any portion of a claim  
9 shall notify the health insurer, in writing, within 35 days  
10 after the provider receives the claim that the claim for  
11 overpayment is contested or denied. The notice that the claim  
12 for overpayment is denied or contested must identify the  
13 contested portion of the claim and the specific reason for  
14 contesting or denying the claim and, if contested, must  
15 include a request for additional information. If the health  
16 insurer submits additional information, the health insurer  
17 must, within 35 days after receipt of the request, mail or  
18 electronically transfer the information to the provider. The  
19 provider shall pay or deny the claim for overpayment within 45  
20 days after receipt of the information. The notice is  
21 considered made on the date the notice is mailed or  
22 electronically transferred by the provider.

23 3. Failure of a health insurer to respond to a  
24 provider's contesting of claim or request for additional  
25 information regarding the claim within 35 days after receipt  
26 of such notice may result in denial of the claim.

27 4. The health insurer may not reduce payment to the  
28 provider for other services unless the provider agrees to the  
29 reduction in writing or fails to respond to the health  
30 insurer's overpayment claim as required by this paragraph.

31 5. Payment of an overpayment claim is considered made

1 on the date the payment was mailed or electronically  
2 transferred. An overdue payment of a claim bears simple  
3 interest at the rate of 12 percent per year. Interest on an  
4 overdue payment for a claim for an overpayment begins to  
5 accrue when the claim should have been paid, denied, or  
6 contested.

7 (b) A claim for overpayment shall not be permitted  
8 beyond 30 months after the health insurer's payment of a  
9 claim, except that claims for overpayment may be sought beyond  
10 that time from providers convicted of fraud pursuant to s.  
11 817.234.

12 (7) Payment of a claim is considered made on the date  
13 the payment was mailed or electronically transferred. An  
14 overdue payment of a claim bears simple interest of 12 percent  
15 per year. Interest on an overdue payment for a claim or for  
16 any portion of a claim begins to accrue when the claim should  
17 have been paid, denied, or contested. The interest is payable  
18 with the payment of the claim.

19 (8) For all contracts entered into or renewed on or  
20 after October 1, 2002, a health insurer's internal dispute  
21 resolution process related to a denied claim not under active  
22 review by a mediator, arbitrator, or third-party dispute  
23 entity must be finalized within 60 days after the receipt of  
24 the provider's request for review or appeal.

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

1 claim for payment made by the provider to the health insurer  
2 for payment of the services or internal dispute resolution  
3 process to determine whether the health insurer is liable for  
4 the services. For a claim, this pendency applies from the  
5 date the claim or a portion of the claim is denied to the date  
6 of the completion of the health insurer's internal dispute  
7 resolution process, not to exceed 60 days.

8 (10) The provisions of this section may not be waived,  
9 voided, or nullified by contract.

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

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

19 (13) Upon written notification by an insured, an  
20 insurer shall investigate any claim of improper billing by a  
21 physician, hospital, or other health care provider. The  
22 insurer shall determine if the insured was properly billed for  
23 only those procedures and services that the insured actually  
24 received. If the insurer determines that the insured has been  
25 improperly billed, the insurer shall notify the insured and  
26 the provider of its findings and shall reduce the amount of  
27 payment to the provider by the amount determined to be  
28 improperly billed. If a reduction is made due to such  
29 notification by the insured, the insurer shall pay to the  
30 insured 20 percent of the amount of the reduction up to \$500.

31 (14) A permissible error ratio of 5 percent is

1 established for insurer's claims payment violations of s.  
2 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and  
3 (e). If the error ratio of a particular insurer does not  
4 exceed the permissible error ratio of 5 percent for an audit  
5 period, no fine shall be assessed for the noted claims  
6 violations for the audit period. The error ratio shall be  
7 determined by dividing the number of claims with violations  
8 found on a statistically valid sample of claims for the audit  
9 period by the total number of claims in the sample. If the  
10 error ratio exceeds the permissible error ratio of 5 percent,  
11 a fine may be assessed according to s. 624.4211 for those  
12 claims payment violations which exceed the error ratio.  
13 Notwithstanding the provisions of this section, the department  
14 may fine a health insurer for claims payment violations of s.  
15 627.6131(4)(e) and (5)(e) which create an uncontestable  
16 obligation to pay the claim. The department shall not fine  
17 insurers for violations which the department determines were  
18 due to circumstances beyond the insurer's control.

19 (15) This section is applicable only to a major  
20 medical expense health insurance policy as defined in s.  
21 627.643(2)(e) offered by a group or an individual health  
22 insurer licensed pursuant to chapter 624, including a  
23 preferred provider policy under s. 627.6471 and an exclusive  
24 provider organization under s. 627.6472 or a group or  
25 individual insurance contract that only provides direct  
26 payments to dentists for enumerated dental services.

27 (16) Notwithstanding s. 627.6131(4)(b), where an  
28 electronic pharmacy claim is submitted to a pharmacy benefits  
29 manager acting on behalf of a health insurer the pharmacy  
30 benefits manager shall, within 30 days of receipt of the  
31 claim, pay the claim or notify a provider or designee if a

1 claim is denied or contested. Notice of the insurer's action  
2 on the claim and payment of the claim is considered to be made  
3 on the date the notice or payment was mailed or electronically  
4 transferred.

5 (17) Notwithstanding s. 627.6131(5)(a), effective  
6 November 1, 2003, where a nonelectronic pharmacy claim is  
7 submitted to a pharmacy benefits manager acting on behalf of a  
8 health insurer the pharmacy benefits manager shall provide  
9 acknowledgment of receipt of the claim within 30 days after  
10 receipt of the claim to the provider or provide a provider  
11 within 30 days after receipt with electronic access to the  
12 status of a submitted claim.

13 Section 6. Section 627.6135, Florida Statutes, is  
14 created to read:

15 627.6135 Treatment authorization; payment of claims.--

16 (1) For purposes of this section, "authorization"  
17 consists of any requirement of a provider to obtain prior  
18 approval or to provide documentation relating to the necessity  
19 of a covered medical treatment or service as a condition for  
20 reimbursement for the treatment or service prior to the  
21 treatment or service. Each authorization request from a  
22 provider must be assigned an identification number by the  
23 health insurer.

24 (2) Upon receipt of a request from a provider for  
25 authorization, the health insurer shall make a determination  
26 within a reasonable time appropriate to medical circumstance  
27 indicating whether the treatment or services are authorized.  
28 For urgent care requests for which the standard timeframe for  
29 the health insurer to make a determination would seriously  
30 jeopardize the life or health of an insured or would  
31 jeopardize the insured's ability to regain maximum function, a

1 health insurer must notify the provider as to its  
2 determination as soon as possible taking into account medical  
3 exigencies.

4 (3) Each response to an authorization request must be  
5 assigned an identification number. Each authorization provided  
6 by a health insurer must include the date of request of  
7 authorization, a timeframe of the authorization, length of  
8 stay if applicable, identification number of the  
9 authorization, place of service, and type of service.

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

16 (5) A health insurer's requirements for authorization  
17 for medical treatment or services and 30-day advance notice of  
18 material change in such requirements must be provided to all  
19 contracted providers and upon request to all noncontracted  
20 providers. A health insurer that makes such requirements and  
21 advance notices accessible to providers and insureds  
22 electronically shall be deemed to be in compliance with this  
23 subsection.

24 Section 7. Paragraph (a) of subsection (2) of section  
25 627.6425, Florida Statutes, is amended to read:

26 627.6425 Renewability of individual coverage.--

27 (2) An insurer may nonrenew or discontinue health  
28 insurance coverage of an individual in the individual market  
29 based only on one or more of the following:

30 (a) The individual has failed to pay premiums, ~~or~~  
31 contributions, or a required copayment payable to the insurer

1 in accordance with the terms of the health insurance coverage  
2 or the insurer has not received timely premium payments. When  
3 the copayment is payable to the insurer and exceeds \$300 the  
4 insurer shall allow the insured up to ninety days from the  
5 date of the procedure to pay the required copayment. The  
6 insurer shall print in 10 point type on the Declaration of  
7 Benefits page notification that the insured could be  
8 terminated for failure to make any required copayment to the  
9 insurer.

10 Section 8. Subsection (4) of section 627.651, Florida  
11 Statutes, is amended to read:

12 627.651 Group contracts and plans of self-insurance  
13 must meet group requirements.--

14 (4) This section does not apply to any plan which is  
15 established or maintained by an individual employer in  
16 accordance with the Employee Retirement Income Security Act of  
17 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
18 arrangement as defined in s. 624.437(1), except that a  
19 multiple-employer welfare arrangement shall comply with ss.  
20 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,  
21 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~.  
22 This subsection does not allow an authorized insurer to issue  
23 a group health insurance policy or certificate which does not  
24 comply with this part.

25 Section 9. Section 627.662, Florida Statutes, is  
26 amended to read:

27 627.662 Other provisions applicable.--The following  
28 provisions apply to group health insurance, blanket health  
29 insurance, and franchise health insurance:

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

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

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

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

6           (5) Section 627.640, relating to filing and  
7 classification of rates.

8           (6) Section 627.613, relating to timely payment of  
9 claims, or s. 627.6131, relating to payment of claims.

10           (7) Section 627.6135, relating to treatment  
11 authorizations and payment of claims.

12           ~~(8)(6)~~ Section 627.645(1), relating to denial of  
13 claims.

14           ~~(9)(7)~~ Section 627.613, relating to time of payment of  
15 claims.

16           ~~(10)(8)~~ Section 627.6471, relating to preferred  
17 provider organizations.

18           ~~(11)(9)~~ Section 627.6472, relating to exclusive  
19 provider organizations.

20           ~~(12)(10)~~ Section 627.6473, relating to combined  
21 preferred provider and exclusive provider policies.

22           ~~(13)(11)~~ Section 627.6474, relating to provider  
23 contracts.

24           Section 10. Subsection (2) of section 627.638, Florida  
25 Statutes, is amended to read:

26           627.638 Direct payment for hospital, medical  
27 services.--

28           (2) Whenever, in any health insurance claim form, an  
29 insured specifically authorizes payment of benefits directly  
30 to any recognized hospital or physician, the insurer shall  
31 make such payment to the designated provider of such services,



1 unless otherwise provided in the insurance contract. However,  
2 if:

3 (a) The benefit is determined to be covered under the  
4 terms of the policy;

5 (b) The claim is limited to treatment of mental health  
6 or substance abuse, including drug and alcohol abuse; and

7 (c) The insured authorizes the insurer, in writing, as  
8 part of the claim to make direct payment of benefits to a  
9 recognized hospital, physician, or other licensed provider,  
10  
11 payments shall be made directly to the recognized hospital,  
12 physician, or other licensed provider, notwithstanding any  
13 contrary provisions in the insurance contract.

14 Section 11. Paragraph (e) of subsection (1) of section  
15 641.185, Florida Statutes, is amended to read:

16 641.185 Health maintenance organization subscriber  
17 protections.--

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

26 (e) A health maintenance organization subscriber  
27 should receive timely, concise information regarding the  
28 health maintenance organization's reimbursement to providers  
29 and services pursuant to ss. 641.31 and 641.31015 and should  
30 receive prompt payment from the organization pursuant to s.  
31 641.3155.

1           Section 12. Subsection (4) is added to section  
2 641.234, Florida Statutes, to read:

3           641.234 Administrative, provider, and management  
4 contracts.--

5           (4)(a) If a health maintenance organization, through a  
6 health care risk contract, transfers to any entity the  
7 obligations to pay any provider for any claims arising from  
8 services provided to or for the benefit of any subscriber of  
9 the organization, the health maintenance organization shall  
10 remain responsible for any violations of ss. 641,3155,  
11 641.3156, and 641.51(4). The provisions of ss.  
12 624.418-624.4211 and 641.52 shall apply to any such  
13 violations.

14           (b) As used in this subsection:

15           1. The term "health care risk contract" means a  
16 contract under which an entity receives compensation in  
17 exchange for providing to the health maintenance organization  
18 a provider network or other services, which may include  
19 administrative services.

20           2. The term "entity" means a person licensed as an  
21 administrator under s. 626.88 and does not include any  
22 provider or group practice, as defined in s. 456.053,  
23 providing services under the scope of the license of the  
24 provider or the members of the group practice.

25           Section 13. Subsection (1) of section 641.30, Florida  
26 Statutes, is amended to read:

27           641.30 Construction and relationship to other laws.--

28           (1) Every health maintenance organization shall accept  
29 the ~~standard health~~ claim form prescribed pursuant to s.  
30 641.3155 ~~627-647~~.

31           Section 14. Subsection (4) of section 641.3154,

1 Florida Statutes, is amended to read:

2           641.3154 Organization liability; provider billing  
3 prohibited.--

4           (4) A provider or any representative of a provider,  
5 regardless of whether the provider is under contract with the  
6 health maintenance organization, may not collect or attempt to  
7 collect money from, maintain any action at law against, or  
8 report to a credit agency a subscriber of an organization for  
9 payment of services for which the organization is liable, if  
10 the provider in good faith knows or should know that the  
11 organization is liable. This prohibition applies during the  
12 pendency of any claim for payment made by the provider to the  
13 organization for payment of the services and any legal  
14 proceedings or dispute resolution process to determine whether  
15 the organization is liable for the services if the provider is  
16 informed that such proceedings are taking place. It is  
17 presumed that a provider does not know and should not know  
18 that an organization is liable unless:

19           (a) The provider is informed by the organization that  
20 it accepts liability;

21           (b) A court of competent jurisdiction determines that  
22 the organization is liable; ~~or~~

23           (c) The department or agency makes a final  
24 determination that the organization is required to pay for  
25 such services subsequent to a recommendation made by the  
26 Statewide Provider and Subscriber Assistance Panel pursuant to  
27 s. 408.7056; or

28           (d) The agency issues a final order that the  
29 organization is required to pay for such services subsequent  
30 to a recommendation made by a resolution organization pursuant  
31 to s. 408.7057.

1           Section 15. Section 641.3155, Florida Statutes, is  
2 amended to read:

3           (Substantial rewording of section. See  
4           s. 641.3155, F.S., for present text.)  
5           641.3155 Prompt payment of claims.--

6           (1) As used in this section, the term "claim" for a  
7 noninstitutional provider means a paper or electronic billing  
8 instrument submitted to the health maintenance organization's  
9 designated location that consists of the HCFA 1500 data set,  
10 or its successor, that has all mandatory entries for a  
11 physician licensed under chapter 458, chapter 459, chapter  
12 460, chapter 461, chapter 463, or chapter 490 or any  
13 appropriate billing instrument that has all mandatory entries  
14 for any other noninstitutional provider. For institutional  
15 providers, "claim" means a paper or electronic billing  
16 instrument submitted to the health maintenance organization's  
17 designated location that consists of the UB-92 data set or its  
18 successor that has all mandatory entries.

19           (2) All claims for payment, whether electronic or  
20 nonelectronic:

21           (a) Are considered received on the date the claim is  
22 received by the organization at its designated claims receipt  
23 location.

24           (b) Must be mailed or electronically transferred to an  
25 organization within 9 months after completion of the service  
26 and the provider is furnished with the correct name and  
27 address of the patient's health insurer.

28           (c) Must not duplicate a claim previously submitted  
29 unless it is determined that the original claim was not  
30 received or is otherwise lost.

31           (3) For all electronically submitted claims, a health

1 maintenance organization shall:

2 (a) Within 24 hours after the beginning of the next  
3 business day after receipt of the claim, provide electronic  
4 acknowledgment of the receipt of the claim to the electronic  
5 source submitting the claim.

6 (b) Within 20 days after receipt of the claim, pay the  
7 claim or notify a provider or designee if a claim is denied or  
8 contested. Notice of the organization's action on the claim  
9 and payment of the claim is considered to be made on the date  
10 the notice or payment was mailed or electronically  
11 transferred.

12 (c)1. Notification of the health maintenance  
13 organization's determination of a contested claim must be  
14 accompanied by an itemized list of additional information or  
15 documents the insurer can reasonably determine are necessary  
16 to process the claim.

17 2. A provider must submit the additional information  
18 or documentation, as specified on the itemized list, within 35  
19 days after receipt of the notification. Failure of a provider  
20 to submit by mail or electronically the additional information  
21 or documentation requested within 35 days after receipt of the  
22 notification may result in denial of the claim.

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

1 may the health maintenance organization request duplicate  
2 documents.

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

7 (e) A claim must be paid or denied within 90 days  
8 after receipt of the claim. Failure to pay or deny a claim  
9 within 120 days after receipt of the claim creates an  
10 uncontestable obligation to pay the claim.

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

13 (a) Effective November 1, 2003, provide  
14 acknowledgement of receipt of the claim within 15 days after  
15 receipt of the claim to the provider or designee or provide a  
16 provider or designee within 15 days after receipt with  
17 electronic access to the status of a submitted claim.

18 (b) Within 40 days after receipt of the claim, pay the  
19 claim or notify a provider or designee if a claim is denied or  
20 contested. Notice of the health maintenance organization's  
21 action on the claim and payment of the claim is considered to  
22 be made on the date the notice or payment was mailed or  
23 electronically transferred.

24 (c)1. Notification of the health maintenance  
25 organization's determination of a contested claim must be  
26 accompanied by an itemized list of additional information or  
27 documents the organization can reasonably determine are  
28 necessary to process the claim.

29 2. A provider must submit the additional information  
30 or documentation, as specified on the itemized list, within 35  
31 days after receipt of the notification. Failure of a provider

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

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

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

19 (e) A claim must be paid or denied within 120 days  
20 after receipt of the claim. Failure to pay or deny a claim  
21 within 140 days after receipt of the claim creates an  
22 uncontestable obligation to pay the claim.

23 (5) If a health maintenance organization determines  
24 that it has made an overpayment to a provider for services  
25 rendered to a subscriber, the health maintenance organization  
26 must make a claim for such overpayment. A health maintenance  
27 organization that makes a claim for overpayment to a provider  
28 under this section shall give the provider a written or  
29 electronic statement specifying the basis for the retroactive  
30 denial or payment adjustment. The health maintenance  
31 organization must identify the claim or claims, or overpayment

1 claim portion thereof, for which a claim for overpayment is  
2 submitted.

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

7 1. All claims for overpayment must be submitted to a  
8 provider within 30 months after the health maintenance  
9 organization's payment of the claim. A provider must pay,  
10 deny, or contest the health maintenance organization's claim  
11 for overpayment within 40 days after the receipt of the claim.  
12 All contested claims for overpayment must be paid or denied  
13 within 120 days after receipt of the claim. Failure to pay or  
14 deny overpayment and claim within 140 days after receipt  
15 creates an uncontestable obligation to pay the claim.

16 2. A provider that denies or contests a health  
17 maintenance organization's claim for overpayment or any  
18 portion of a claim shall notify the organization, in writing,  
19 within 35 days after the provider receives the claim that the  
20 claim for overpayment is contested or denied. The notice that  
21 the claim for overpayment is denied or contested must identify  
22 the contested portion of the claim and the specific reason for  
23 contesting or denying the claim and, if contested, must  
24 include a request for additional information. If the  
25 organization submits additional information, the organization  
26 must, within 35 days after receipt of the request, mail or  
27 electronically transfer the information to the provider. The  
28 provider shall pay or deny the claim for overpayment within 45  
29 days after receipt of the information. The notice is  
30 considered made on the date the notice is mailed or  
31 electronically transferred by the provider.



1           3. Failure of a health maintenance organization to  
2 respond to a provider's contestment of claim or request for  
3 additional information regarding the claim within 35 days  
4 after receipt of such notice may result in denial of the  
5 claim.

6           4. The health maintenance organization may not reduce  
7 payment to the provider for other services unless the provider  
8 agrees to the reduction in writing or fails to respond to the  
9 health maintenance organization's overpayment claim as  
10 required by this paragraph.

11           5. Payment of an overpayment claim is considered made  
12 on the date the payment was mailed or electronically  
13 transferred. An overdue payment of a claim bears simple  
14 interest at the rate of 12 percent per year. Interest on an  
15 overdue payment for a claim for an overpayment payment begins  
16 to accrue when the claim should have been paid, denied, or  
17 contested.

18           (b) A claim for overpayment shall not be permitted  
19 beyond 30 months after the health maintenance organization's  
20 payment of a claim, except that claims for overpayment may be  
21 sought beyond that time from providers convicted of fraud  
22 pursuant to s. 817.234.

23           (6) Payment of a claim is considered made on the date  
24 the payment was mailed or electronically transferred. An  
25 overdue payment of a claim bears simple interest of 12 percent  
26 per year. Interest on an overdue payment for a claim or for  
27 any portion of a claim begins to accrue when the claim should  
28 have been paid, denied, or contested. The interest is payable  
29 with the payment of the claim.

30           (7)(a) For all contracts entered into or renewed on or  
31 after October 1, 2002, a health maintenance organization's

1 internal dispute resolution process related to a denied claim  
2 not under active review by a mediator, arbitrator, or  
3 third-party dispute entity must be finalized within 60 days  
4 after the receipt of the provider's request for review or  
5 appeal.

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

13 (8) A provider or any representative of a provider,  
14 regardless of whether the provider is under contract with the  
15 health maintenance organization, may not collect or attempt to  
16 collect money from, maintain any action at law against, or  
17 report to a credit agency a subscriber for payment of covered  
18 services for which the health maintenance organization  
19 contested or denied the provider's claim. This prohibition  
20 applies during the pendency of any claim for payment made by  
21 the provider to the health maintenance organization for  
22 payment of the services or internal dispute resolution process  
23 to determine whether the health maintenance organization is  
24 liable for the services. For a claim, this pendency applies  
25 from the date the claim or a portion of the claim is denied to  
26 the date of the completion of the health maintenance  
27 organization's internal dispute resolution process, not to  
28 exceed 60 days.

29 (9) The provisions of this section may not be waived,  
30 voided, or nullified by contract.

31 (10) A health maintenance organization may not

1 retroactively deny a claim because of subscriber ineligibility  
2 more than 1 year after the date of payment of the claim.

3 (11) 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 health maintenance organization to be  
8 medically necessary and covered services under the health  
9 maintenance organization's contract with the contract holder.

10 (12) Upon written notification by a subscriber, a  
11 health maintenance organization shall investigate any claim of  
12 improper billing by a physician, hospital, or other health  
13 care provider. The organization shall determine if the  
14 subscriber was properly billed for only those procedures and  
15 services that the subscriber actually received. If the  
16 organization determines that the subscriber has been  
17 improperly billed, the organization shall notify the  
18 subscriber and the provider of its findings and shall reduce  
19 the amount of payment to the provider by the amount determined  
20 to be improperly billed. If a reduction is made due to such  
21 notification by the insured, the insurer shall pay to the  
22 insured 20 percent of the amount of the reduction up to \$500.

23 (13) A permissible error ratio of 5 percent is  
24 established for health maintenance organizations' claims  
25 payment violations of s. 641.3155(3)(a), (b), (c), and (e) and  
26 (4)(a), (b), (c), and (e). If the error ratio of a particular  
27 insurer does not exceed the permissible error ratio of 5  
28 percent for an audit period, no fine shall be assessed for the  
29 noted claims violations for the audit period. The error ratio  
30 shall be determined by dividing the number of claims with  
31 violations found on a statistically valid sample of claims for

1 the audit period by the total number of claims in the sample.  
2 If the error ratio exceeds the permissible error ratio of 5  
3 percent, a fine may be assessed according to s. 624.4211 for  
4 those claims payment violations which exceed the error ratio.  
5 Notwithstanding the provisions of this section, the department  
6 may fine a health maintenance organization for claims payment  
7 violations of s. 641.3155(3)(e) and (4)(e) which create an  
8 uncontestable obligation to pay the claim. The department  
9 shall not fine organizations for violations which the  
10 department determines were due to circumstances beyond the  
11 organization's control.

12 (14) This section shall apply to all claims or any  
13 portion of a claim submitted by a health maintenance  
14 organization subscriber under a health maintenance  
15 organization subscriber contract to the organization for  
16 payment.

17 (15) Notwithstanding s. 641.3155(3)(b), where an  
18 electronic pharmacy claim is submitted to a pharmacy benefits  
19 manager acting on behalf of a health maintenance organization  
20 the pharmacy benefits manager shall, within 30 days of receipt  
21 of the claim, pay the claim or notify a provider or designee  
22 if a claim is denied or contested. Notice of the  
23 organization's action on the claim and payment of the claim is  
24 considered to be made on the date the notice or payment was  
25 mailed or electronically transferred.

26 (16) Notwithstanding s. 641.3155(4)(a), effective  
27 November 1, 2003, where a nonelectronic pharmacy claim is  
28 submitted to a pharmacy benefits manager acting on behalf of a  
29 health maintenance organization the pharmacy benefits manager  
30 shall provide acknowledgment of receipt of the claim within 30  
31 days after receipt of the claim to the provider or provide a

1 provider within 30 days after receipt with electronic access  
2 to the status of a submitted claim.

3 Section 16. Section 641.3156, Florida Statutes, is  
4 amended to read:

5 641.3156 Treatment authorization; payment of claims.--

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

24 (2) A claim for treatment may not be denied if a  
25 provider follows the health maintenance organization's  
26 authorization procedures and receives authorization for a  
27 covered service for an eligible subscriber, unless the  
28 provider provided information to the health maintenance  
29 organization with the ~~willful~~ intention to misinform the  
30 health maintenance organization.

31 (3) Upon receipt of a request from a provider for

1 authorization, the health maintenance organization shall make  
2 a determination within a reasonable time appropriate to  
3 medical circumstance indicating whether the treatment or  
4 services are authorized. For urgent care requests for which  
5 the standard timeframe for the health maintenance organization  
6 to make a determination would seriously jeopardize the life or  
7 health of a subscriber or would jeopardize the subscriber's  
8 ability to regain maximum function, a health maintenance  
9 organization must notify the provider as to its determination  
10 as soon as possible taking into account medical exigencies.

11 (4) Each response to an authorization request must be  
12 assigned an identification number. Each authorization provided  
13 by a health maintenance organization must include the date of  
14 request of authorization, timeframe of the authorization,  
15 length of stay if applicable, identification number of the  
16 authorization, place of service, and type of service.

17 (5) A health maintenance organization's requirements  
18 for authorization for medical treatment or services and 30-day  
19 advance notice of material change in such requirements must be  
20 provided to all contracted providers and upon request to all  
21 noncontracted providers. A health maintenance organization  
22 that makes such requirements and advance notices accessible to  
23 providers and subscribers electronically shall be deemed to be  
24 in compliance with this paragraph.

25 (6)(3) Emergency services are subject to the  
26 provisions of s. 641.513 and are not subject to the provisions  
27 of this section.

28 Section 17. Except as otherwise provided herein, this  
29 act shall take effect October 1, 2002, and shall apply to  
30 claims for services rendered after such date.

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           An act relating to health care; amending s.  
7           408.036, F.S.; exempting certain services,  
8           construction, or programs from  
9           certificate-of-need review requirements for  
10          existing health facilities under certain  
11          circumstances; specifying requirements;  
12          requiring the Agency for Health Care  
13          Administration to adopt rules and monitor  
14          programs for compliance; providing conditions  
15          for expiration of an exemption and for  
16          prohibiting another exemption for a specified  
17          period; providing application; revising the  
18          exemption from certificate-of-need requirements  
19          for a satellite hospital; amending s. 408.043,  
20          F.S.; specifying that certain hospitals in  
21          certain counties may add additional beds  
22          without agency review under certain  
23          circumstances; amending s. 408.7057, F.S.;  
24          redesignating a program title; revising  
25          definitions; including preferred provider  
26          organizations and health insurers in the claim  
27          dispute resolution program; specifying  
28          timeframes for submission of supporting  
29          documentation necessary for dispute resolution;  
30          providing consequences for failure to comply;  
31          providing additional responsibilities for the

1 agency relating to patterns of claim disputes;  
2 providing timeframes for review by the  
3 resolution organization; directing the agency  
4 to notify appropriate licensure and  
5 certification entities as part of violation of  
6 final orders; amending s. 626.88, F.S.;  
7 redefining the term "administrator," with  
8 respect to regulation of insurance  
9 administrators; creating s. 627.6131, F.S.;  
10 specifying payment of claims provisions  
11 applicable to certain health insurers;  
12 providing a definition; providing requirements  
13 and procedures for paying, denying, or  
14 contesting claims; providing criteria and  
15 limitations; requiring payment within specified  
16 periods; specifying rate of interest charged on  
17 overdue payments; providing for electronic and  
18 nonelectronic transmission of claims; providing  
19 procedures for overpayment recovery; specifying  
20 timeframes for adjudication of claims,  
21 internally and externally; prohibiting action  
22 to collect payment from an insured under  
23 certain circumstances; providing applicability;  
24 prohibiting contractual modification of  
25 provisions of law; specifying circumstances for  
26 retroactive claim denial; specifying claim  
27 payment requirements; providing for billing  
28 review procedures; specifying claim content  
29 requirements; establishing a permissible error  
30 ratio, specifying its applicability, and  
31 providing for fines; providing specified



1 exceptions from notice and acknowledgment  
2 requirements for pharmacy benefit manager  
3 claims; creating s. 627.6135, F.S., relating to  
4 treatment authorization; providing a  
5 definition; specifying circumstances for  
6 authorization timeframes; specifying content  
7 for response to authorization requests;  
8 providing for an obligation for payment, with  
9 exception; providing authorization procedure  
10 notice requirements; amending s. 627.6425,  
11 F.S., relating to renewability of individual  
12 coverage; providing for circumstances relating  
13 to nonrenewal or discontinuance of coverage;  
14 amending s. 627.651, F.S.; correcting a cross  
15 reference, to conform; amending s. 627.662,  
16 F.S.; specifying application of certain  
17 additional provisions to group, blanket, and  
18 franchise health insurance; amending s.  
19 627.638, F.S.; revising requirements relating  
20 to direct payment of benefits to specified  
21 providers under certain circumstances; amending  
22 s. 641.185, F.S.; specifying that health  
23 maintenance organization subscribers should  
24 receive prompt payment from the organization;  
25 amending s. 641.234, F.S.; specifying  
26 responsibility of a health maintenance  
27 organization for certain violations under  
28 certain circumstances; amending s. 641.30,  
29 F.S.; conforming a cross reference; amending s.  
30 641.3154, F.S.; modifying the circumstances  
31 under which a provider knows that an

1 organization is liable for service  
2 reimbursement; amending s. 641.3155, F.S.;  
3 revising payment of claims provisions  
4 applicable to certain health maintenance  
5 organizations; providing a definition;  
6 providing requirements and procedures for  
7 paying, denying, or contesting claims;  
8 providing criteria and limitations; requiring  
9 payment within specified periods; revising rate  
10 of interest charged on overdue payments;  
11 providing for electronic and nonelectronic  
12 transmission of claims; providing procedures  
13 for overpayment recovery; specifying timeframes  
14 for adjudication of claims, internally and  
15 externally; prohibiting action to collect  
16 payment from a subscriber under certain  
17 circumstances; prohibiting contractual  
18 modification of provisions of law; specifying  
19 circumstances for retroactive claim denial;  
20 specifying claim payment requirements;  
21 providing for billing review procedures;  
22 specifying claim content requirements;  
23 establishing a permissible error ratio,  
24 specifying its applicability, and providing for  
25 fines; providing specified exceptions from  
26 notice and acknowledgment requirements for  
27 pharmacy benefit manager claims; amending s.  
28 641.3156, F.S., relating to treatment  
29 authorization; providing a definition;  
30 specifying circumstances for authorization  
31 timeframes; specifying content for response to

1 authorization requests; providing for an  
2 obligation for payment, with exception;  
3 providing authorization procedure notice  
4 requirements; providing effective dates.  
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