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HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: CS/CS/SB 362, 2ND ENGROSSED

RELATING TO: Health Insurance

SPONSOR(S): Health, Aging and Long-Term Care, Banking and Insurance, Senator(s) Saunders & others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) COUNCIL FOR HEALTHY COMMUNITIES YEAS 12 NAYS 4
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I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

Committee Substitute for Committee Substitute for Senate Bill 362 revises various provisions relating to health insurers, health maintenance organizations (HMOs), health providers, insureds, and subscribers specific to claims processing and payment, as follows:

- Substantially revises requirements and procedures for payment of claims by health insurers and HMOs;
- Standardizes all time periods for health insurers and HMOs to pay, deny or contest any claim, or portion of a claim, to 35 days;
- Increases interest rate penalties for overdue payments of claims from 10 to 12 percent a year;
- Provides for a civil remedy in the event the HMO or health insurer violates the prompt pay provisions, plus attorneys fees, interest, and costs, within limits established in the bill;
- Eliminates the current law requirement of a “clean claim” which means that the provider submits a claim which has no defect or impropriety, including lack of required substantiating documentation, and removes the requirement that the Department of Insurance adopt rules consistent with federal claim-filing standards;
- Mandates that insurers and HMOs may make only one request for information in connection with a claim unless the provider fails to submit all requested information or if information submitted by a provider raises new, additional issues in which case such entities may make one more request for information;
- Entitles insureds and subscribers to prompt insurance payments of claims for covered services and provides penalties;
- Substantially revises health insurer and HMO requirements related to treatment authorization; defines “authorization;” requires such entities that require authorization to provide lists of medical care and health care services, prohibits denial of certain claims, and provides procedural requirements for determination of authorization;

- Requests for HMO or health insurer authorization must be answered within 24 hours of such request as to inpatient admissions or within 4 hours of such request for inpatients in a health care facility;
- Specifies that the "look-back" or audit review period must not exceed 2 years after the date a claim was paid, unless fraud in billing is involved;
- Redefines "managed care organization" to allow preferred provider organizations and health insurers to be eligible to utilize the statewide provider and managed care organization claim dispute resolution program; specifies time frames for submission of supporting documentation necessary for dispute resolution; provides consequences for failure to comply and authorizes the Agency for Health Care Administration to impose fines or sanctions;
- Authorizes a process whereby health insurers may file claims for overpayments with providers, a process which is similar to the one developed for HMOs in the prompt pay law of 2000. This process requires providers to respond to claims for overpayments using the same timetable as applies to claims submitted by providers to health insurers;
- Provides for eligibility determination procedures and electronic transference of payments of claims;
- Specifies application of certain additional provisions to group, blanket, and franchise health insurance;
- Provides that untruthfully notifying a provider that a filed claim has not been received constitutes an unfair trade practice for insurers and HMOs;
- Mandates that for any health insurance policy insuring against loss or expense due to hospital confinement or to medical services, the payment of benefits must be made directly to any hospital, doctor, or other person who provides treatment of a psychological disorder for substance abuse, including drug and alcohol abuse, when such treatment is in accordance with provisions of such policy and the benefits. Payments must be made under this provision, notwithstanding contrary provisions in health insurance contracts;
- Requires emergency services to extend through any inpatient admission required in order to provide for stabilization of any emergency medical condition pursuant to state and federal law; and
- Provides that prompt pay provisions may not be waived, voided, or nullified by contract.

This bill substantially amends the following sections of the Florida Statutes: 408.7057, 626.9541, 627.613, 627.638, 627.651, 627.662, 641.185, 641.30, 641.3155, 641.3156, and 641.3903.
The bill creates section 627.6142, Florida Statutes.

CS/CS/SB 362 was substantially amended by a series of floor amendments when heard by the Senate on February 28 and March 6, 2002.

On March 15, 2002, CS/CS/SB 362, 2nd Engrossed, was heard in the House Council for Healthy Communities. A "strike-everything" amendment, as amended, was adopted. See Section VI of this analysis for a detailed summary of Amendment #645115.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A []
2.	Lower Taxes	Yes []	No []	N/A []
3.	Individual Freedom	Yes []	No []	N/A []
4.	Personal Responsibility	Yes []	No []	N/A []
5.	Family Empowerment	Yes []	No []	N/A []

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Prompt Payment of Claims - National Perspective

The submission and payment of health insurance claims is a critical component of the health care economy. In recent years a total of forty-seven states, including Florida, have enacted legislation to require HMOs and insurers to promptly pay their claims.[1] During the 2000-2001 legislative session, nine states, Florida among them, revised their laws to tighten deadlines, stiffen fines, and attempt to close other loopholes that providers say allow plans to evade state-mandated time limits. Such laws in effect put HMOs and health insurers on notice to pay clean claims in a timely fashion or face possible penalties and fines. The term "clean claim" generally means a claim that has no defect or impropriety or particular circumstance requiring special treatment.[2]

Most states require insurers to pay clean claims within 30 to 45 days, however state requirements range from 15 days (North Dakota) to 60 days (Michigan and Nevada). Under Georgia law, insurers are required to pay 18 percent interest on claims not paid within 15 days. Although Georgia's law is considered to be the strictest, Hawaii requires that claims filed electronically be paid within 15 days.

The trend in the most recent state "prompt pay" legislation is to adopt the Medicare standard of requiring 95 percent of clean claims to be paid within 30 days and all claims approved or denied within 60 days from the date of the request, with time tolled for supplying additional information. Medicare does define a "clean claim" as a claim that has no defect or impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which is the same language as is in current Florida law.[3] Medicare also has authority to audit the billing practices of providers and has strict fraud provisions incorporating civil and criminal penalties, which include requiring the offender to pay restitution and investigative costs.

During their 2001 sessions, five states passed "prompt-pay" laws with specified interest requirements. Typically, these standards are similar, if not identical, to the Medicare 30-day prompt pay requirement.

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[1] The American Medical Association Report, July 2001. The three states which do not presently have prompt pay provisions are Idaho, Nebraska and South Carolina.
[2] See s. 641.3155, F.S.
[3] S. 641.3155, F.S.

State	Prompt-Pay Deadline	Interest Rate
Arizona	30 days	Rate equal to state legal rate
Kansas	30 days	1% per month
Kentucky	30 days	12% for up to 60 days and 21% after 90 days
Minnesota	30 days	1.5% per month
New Mexico	45 days	1.5 times state legal rate

Even given the above referenced reforms, some health care providers continue to complain that the laws requiring prompt payment of claims have not resulted in insurers and HMOs actually paying claims promptly. Health providers assert that HMOs in particular are chronically paying claims late. According to a June 4, 2001, American Medical Association News Report, more states are likely to consider further revisions to their prompt pay statutes and regulations in their next regular legislative sessions.

However, insurers and HMOs dispute the alleged magnitude of payment problems and state that the overwhelming majority of claims have been paid on time. Further, these entities assert that the recent prompt pay laws need to be given time to work. In many cases, the time health plans spend processing claims is used to protect consumers from fraud, thereby keeping health care costs down.

Florida: Prompt Payment of Health Claims Affecting Health Maintenance Organizations

In February 2000, the Florida Advisory Group on the Submission and Payment of Health Claims issued its report and recommendations to the Legislature on prompt payment of health claims and related issues affecting providers and managed care organizations (MCOs), specifically health maintenance organizations (HMOs).[4] Subsequently, legislation was enacted during the 2000 session based on those recommendations and subsequent discussions among the affected parties (ch. 2000-252, L.O.F.; s. 641.3155, F.S. et al. - other sections were also amended by the law). That law included the following provisions:

- Required HMOs to pay a claim for treatment if a provider followed the HMO's authorization procedures and received authorization for a covered service for an eligible subscriber, unless the provider submitted information to the HMO with the intent to misinform the HMO.
- Created the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The Agency for Health Care Administration (AHCA) must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and a provider with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, F.S., subject to a final agency order.
- Required HMOs to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization would not be held pending by the HMO unless the requesting provider contractually agreed to take a pending or tracking number.
- Clarified the "balance billing" provisions by prohibiting a provider from collecting from a subscriber any money for services authorized by an HMO; specified that the prohibition applies to both contract and noncontract providers rendering covered services; prohibiting a provider from billing the subscriber during the pendency of any claim; prohibiting a provider from reporting a subscriber to a credit agency for unpaid claims due from an HMO; and required referral of violations by physicians and facilities to the appropriate regulatory agency for final disciplinary action.

[4] The 1999 Florida Legislature authorized the Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group. A health maintenance organization (HMO) is considered to be the prototype managed care organization and such entities are issued certificates of authority and approved by the Department of Insurance and AHCA.

- The prompt payment requirements of s. 641.3155, F.S., would be applied to claims made by either contract or noncontract providers. The requirement for an HMO to pay claims within 35 days of receipt would be limited to a "clean claim" or any portion of a "clean claim" filed by a provider. A "clean claim" is defined until such time as the Department of Insurance adopts a revised definition, consistent with federal standards.
- Clarified that the current 10 percent annual simple interest penalty on a claim against an HMO begins to accrue on the 36th day after the clean claim has been received, and requires that the interest be payable with the payment of the claim.
- Required an HMO to file a claim against a provider for an overpayment and prohibited the HMO from reducing payment to the provider (termed a "take back"), unless the provider agrees to the reduction or fails to respond to the HMO's claim pursuant to specified time frames and requirements, which are the same requirements that apply to provider claims against an HMO.
- Entitled providers who bill electronically to electronic acknowledgment of receipts of claims within 72 hours.
- Prohibited an HMO from retroactively denying a claim due to subscriber ineligibility more than 1 year after the date of payment of the clean claim.
- Prohibited as an unfair claim settlement practice, an HMO committing or performing with such frequency as to indicate a general business practice, systematic downcoding with the intent to deny reimbursement otherwise due.
- Authorizes AHCA to impose fines against hospitals and other regulated facilities for a violation of the "balance billing" prohibitions of s. 641.3154, F.S.
- Provided that in addition to any other provision of law, systematic upcoding by a provider, with the intent to obtain reimbursement otherwise not due from an insurer is punishable by fines in amounts the same as those that may be imposed against an HMO for a violation of chapter 641, F.S.

The above provisions were in addition to the 1998 and 1999 legislative changes addressing the issue of requiring HMOs to pay claims within certain time frames. (See ch. 98-79, L.O.F.; CS/SB 1584 (1998) and ch. 99-393, L.O.F.; CS/HBs 1927 and 961 (1999) (s. 641.3155, F.S.)

In summary, the provisions of s. 641.3155, F.S., relating to prompt payment of claims, require HMOs to pay claims for services provided under contract with the provider within 35 days after receipt of the claim. For contested claims, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, and identify the contested portion of the claim and the specific reason for contesting or denying the claim. In the event the HMO requests additional information, the provider must provide the information within 35 days, and within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim. In any event, all claims must be paid or denied no later than 120 days after the HMO receives the claim. Overdue payment of a claim accrues a simple interest penalty at the rate of 10 percent per year.

Florida: Health Insurers-Prompt Payment of Health Claims

Health insurers are required to pay claims under a health insurance policy within 45 days after receipt of the claim by the health insurer (s. 627.613, F.S.). If a claim or a portion of a claim is contested by the health insurer within the 45 days, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied. Upon receipt of the additional information, a health insurer must pay or deny the contested claim or portion of the contested claim within 60 days. All claims must be paid or denied no later than 120 days after receiving the claim. Overdue payment of a claim accrues a simple interest penalty at the rate of 10 percent per year.

Department of Insurance-Enforcement of Prompt Pay Provisions

The Department of Insurance has jurisdiction to examine the affairs, transactions, accounts, and business records of both insurers[5] and HMOs,[6] to investigate such entities and assess fines,[7] seek injunctive relief,[8] and sanction them for unfair or deceptive trade practices.[9] In an effort to monitor the effectiveness of the HMO prompt pay law enacted in 2000, the department issued a special data call to the 24 HMOs operating in Florida and requested records as to all claims paid in the second quarter of 2001. After identifying the claims, which were paid more than 35 days after receipt of the claim (i.e., late claims), the department picked a random sample of 100 such claims from each HMO to review and requested the particular HMO to explain why there was a delay in paying the claim. According to representatives with the department, they are in the process of reviewing the data received from the HMOs and have not reached any conclusions at this time. However, these officials did state that if they found that an HMO had engaged in a practice and pattern of late claims' payments, it would be sanctioned by the department.[10]

In general, department officials did state that the number of prompt pay complaints against both insurers and HMOs have declined in 2001 from previous years. For example, for 2001, the number of complaints received by the department against health insurers totaled 2,755 as compared to 3,124 for 2000, and for HMOs, the number of complaints received totaled 3,653 for 2001 as compared to 4,746 for 2000.

According to information provided by the largest insurer in the state, Blue Cross and Blue Shield of Florida, which has a total statewide enrollment of 3.4 million Floridians (i.e., this includes all their plans, HMO, PPO and indemnity), the company paid 96.4 percent of its 2001 claims within 30 days, and nearly 90 percent within 20 days for its HMO (Health Options). Its insurance and PPO (PPC) claims payment performance for 2001 was the following: 99.4 percent of claims were paid within 30 days and 97.3 percent were paid within 20 days. According to company representatives, for its insurance and PPO claims, on an annualized basis for 2001, it paid $2.475 billion in claims within 30 days, with less than $70 million paid thereafter even though the statutory threshold is 45 days.

Statewide Provider and Managed Care Organization Claim Dispute Resolution Program

The Statewide Provider and Managed Care Organization Claim Dispute Resolution Program (Dispute Program), administered by AHCA, was established 2 years ago (s. 408.7057, F.S.; ch. 2000-252, L.O.F.). According to the parties involved in proposing the legislation, the Dispute Program was to serve as an alternative to providers suing HMOs. Under the law, AHCA has contracted with Maximus, an independent dispute resolution organization, which conducts "paper reviews" of disputes between HMOs and providers with regard to amounts paid for services. Maximus, in turn, recommends to AHCA an appropriate resolution of the claims dispute and the agency has 30 days to review it before taking final agency action.

The Dispute Program requires that physicians have at least $500 (in aggregate) in disputed claims to enter the dispute process, while hospitals must have $25,000 (in aggregate) for inpatient treatment and $10,000 (in aggregate) for outpatient services they believe they are owed. In addition, HMOs are able to initiate the dispute process after meeting the same $500 monetary

[5] S. 624.3161, F.S.
[6] S. 641.27, F.S.
[7] S. 624.310, F.S.
[8] S. 641.281, F.S.
[9] S. 641.3903, F.S., for HMOs and Part IX of ch. 626, F.S., for insurers.
[10] Department representatives state that the National Association of Insurance Commissioners (NAIC) has established a statistical error rate of 7 percent for late claims' payments. For example, if an HMO had an failed to timely pay more than 7 percent of its claims during a particular period, it could be sanctioned.

threshold as physicians. In each case, the loser pays the cost for the dispute review. The Dispute Program became operational on May 1, 2001, and as of January 25, 2002, Maximus has received eight claims (one was a duplication). Three of the claims have been submitted to AHCA for final order, two are outstanding and two have been dismissed.

Representatives with provider groups assert that the Dispute Program has not been utilized because it has not been publicized by ACHA (for example, it is not on their web site), therefore not enough providers know about the program. Agency representatives respond that they have spoken about the program to various groups, but that there were no funds appropriated to publicize the program and therefore have left it up to the various stakeholders in the process (i.e., providers groups and HMOs) to tell their constituents. The agency also comments that the Dispute Program statute lacks sanctions for nonresponding plans or providers. In addition, some HMOs assert that they are hesitant to participate in the Dispute Program because the law does not contain a public records exemption for confidential and proprietary information (i.e., health plan reimbursement agreements with providers). Further, some providers feel that the costs associated with the review process to the non-prevailing party are too high. But according to ACHA records, the costs as to the current claims submitted to the Dispute Program are very low and range from $175 to $187.

Health Insurance Fraud

According to estimates by the National Health Care Anti-Fraud Association, the losses due to fraud add $100 billion to the annual cost of health care in this country. The Florida Division of Insurance Fraud within the Department of Insurance and the Coalition Against Insurance Fraud estimate that insurance fraud in Florida costs $6.5 billion annually and every insurance consumer family in the state annually pays over $1,414 in additional premiums as a result of such fraud with health care fraud constituting a significant percentage of that amount. Further, according to a recent report by the Office of Program Policy Analysis and Government Accountability (OPPAGA), Florida's losses due to Medicaid fraud and abuse range from $2.1 billion to $4.3 billion, or between 5 percent and 10 percent of total Medicaid health services expenditures.[11]

The risks posed by health care fraud and abuse to insurers and managed care plans are enormous: financial loss, consumer dissatisfaction, provider desertion, malpractice lawsuits by patients, shareholder lawsuits, sanctions and criminal investigations, a damaged reputation and loss of customers. For most employers, fraud increases the cost of providing benefits to their employees and, therefore, their overall cost of doing business. That translates into higher premiums and out-of-pocket expenses.

According to the report issued to the Legislature on the submission and payment of health claims, the vast majority of providers, insurers and managed care plans maintain high ethical standards and do not knowingly abuse or defraud our complex health care finance system, however, a few unscrupulous individuals do extract or withhold billions of dollars fraudulently.[12] Division of Insurance Fraud officials state that the common types of health care fraud involve billing for a treatment or procedure never rendered (i.e., X-rays, laboratory tests, or drugs never dispensed) or double billing wherein a provider obtains payment from two sources. In the area of automated processing of claims, there have been charges of abusive practices against both providers and insurers. For instance, certain providers may fraudulently "upcode" various medical procedures so that a minor service can be upcoded as a more labor intensive or expensive service. "Kickbacks" are also common in healthcare fraud cases. Another scheme involves misrepresenting the

[11] Report No. 01-39, Sept. 2001. This estimate is over a six-year period (FY 1995-96 to 2000-01).
[12] February 2000 Report by the Florida Advisory Group on the Submission and Payment of Health Claims. The Report noted that in the area of automated processing of claims, there have been charges of abusive practices against both providers and insurers. Automated "upcoding or downcoding of claims is an area of particular concern."

diagnosis and symptoms on patient records and then submitting invoices to insurers to receive a higher rate of reimbursement. An example of this would be a patient who visited the doctor for a common cold treatment, but the health insurer was billed for a condition diagnosed as pneumonia, with associated pneumonia testing.

Additional Health Care Payment Provisions under Current Florida Law

Section 627.613, F.S., relates to time of payment of claims requirements for health insurance policies. Health insurers are required to reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied, within the 45 days after receipt of the claim by the health insurer. A health insurer, upon receipt of the additional information requested from the insured or the insured's assignees shall pay or deny the contested claim or portion of the contested claim, within 60 days. An insurer shall pay or deny any claim no later than 120 days after receiving the claim. In addition, all overdue payments shall bear simple interest at the rate of 10 percent per year.

Section 627.6141, F.S., relating to denial of claims, provides that each claimant, or provider acting for a claimant, who has had a claim denied as “not medically necessary” must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. Further, the appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

Section 627.647, F.S., relating to standard health claim form requirements for indemnity plans, requires all hospitals, physicians, dentists, and pharmacists to use a standard health claim form as prescribed by the Department of Insurance. This section specifies that the form must be one that allows for the use of generally accepted coding systems by providers and must provide for disclosure by the claimant of the name, policy number, and address of every insurance policy which may cover the claimant with respect the to submitted claim. Required information on diagnosis, dental procedures, medical procedures, services, date of service, supplies, and fees may also be met by an attachment. This requirement does not apply to Medicaid claims or to claims submitted by electronic or electromechanical means. These requirements do not apply to coordination of benefits against an indemnity-type policy, an excess insurance policy as defined in s. 627.635, F.S., a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy. (Note: Rule 4-161.004-007, F.A.C., requires the use of specified health insurance claim forms; dental claim forms; pharmacy claim forms; and hospital claim forms. In addition, Rule 4-161.008, F.A.C., clarifies that additional information not contained on the forms may be requested by the insurer.)

Section 641.3155, F.S, regulates payment of claims for HMOs and relates to HMO provider contracts and payment of claims. Specifically authorized are temporary timeframes for payment of noncontested claims, contesting of claims, prompt payment of claims, and payment reconciliation until adoption of a rule by the department. Rule 4-191.066, F.A.C., provides specific timeframes for the payment of “clean claims” and refers to “clean claims” as “valid undisputed claims.” Specific authority for this rule is derived from s. 641.36, F.S., relating to the adoption of rules, s. 641.31(12), F.S., relating to health maintenance contracts, and s. 641.3903(5)(c)3., 5., and 6., F.S., relating to unfair methods of competition and unfair or deceptive acts or practices.

Federal Activities Relating to Managed Care

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, as part of its administration of the Medicare program, currently requires organizations, including health care providers and institutions, to:

- Pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of Medicare for services that are not furnished under a written agreement between the organization and the provider; and
- Pay interest on clean claims that are not paid within 30 days; and
- All other claims must be approved or denied within 60 calendar days from the date of the request.

A “clean claim” is defined to mean a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (Social Security Act, §§ 1816(c)(2)(B) and 1842(c)(2)(B)).

Health Insurance Portability and Accountability Act (HIPAA) of 1996

In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), commonly known as HIPAA, which required the Health Care Financing Administration (HCFA) to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility and payments. Rule-making was begun to implement a nationwide standard format so as to provide for common claims forms, procedure codes and data sets. The implementation of the rule, known as the Administrative Simplification (AS) rule, was recently delayed for a year by Congress due in part to the enormity of its impact.
The requirements outlined by the AS rule are far-reaching, and all health care organizations that maintain or transmit electronic health information must comply. This includes: payers (health plans, health insurers, and health care clearinghouses) and health care providers, from large integrated delivery networks to individual physician offices. When implemented, all health care providers will be required to submit specified transactions in specified formats with standardized transaction codes and all insurance carriers will be required to accept these forms and codes by specified compliance dates.

Currently, there is no federal common standard for the transfer of information between health care providers and payers. As a result, providers have been required by payers to meet many different requirements. For some providers who submit claims to multiple payers, determining which data to submit and on which form has been a difficult and expensive process whether done manually or electronically. HIPAA will ultimately simplify this process by requiring payers to accept specific transaction standards for Electronic Data Interchange (EDI), depending on provider type and service type. Providers are given the option of whether to submit the transactions electronically or “on paper,” however, if they elect to submit them electronically, they must use the standards agreed upon under the law. Payers are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect a provider who wants to submit the transactions electronically.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS which follows.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program (Dispute Program), to expand the definition of "managed care organization" (MCO) to include preferred provider organizations (PPOs) and health insurers licensed pursuant to chapter 627, F.S. This will allow PPO providers and health insurers to file claim disputes with the Dispute Program.

The bill further provides for a time limit (15 days) for MCOs or providers to submit requisite documentation to the Dispute Program and failure to submit such documentation will result in a dismissal of the claim dispute. Also, a default will be entered against a respondent in a claims dispute in which the respondent fails to provide supporting documentation within the requisite 15 day period. The defaulting entity must pay the full amount of the claims dispute, plus accrued interest, upon recommendation by the Dispute Program. The Agency for Health Care Administration may impose fines or sanctions including certification revocation. There are no such time limits or sanction provisions in current law. According to representatives with AHCA, this provision will increase the number of claim disputes filed with the Dispute Program and result in a fiscal impact to the agency. (See Economic Impact and Fiscal Note Section below.)

Section 2. Amends s. 627.613, F.S., relating to time of payment of claims by health insurers, as follows:

Reduces the time frames (under current law) for health insurers to pay claims or portion of claims made by an insured or an insured's assignees, for payment under a policy, from 45 to 35 days after receipt of the claim by the insurer. Requires health insurers to notify insureds within 35 days after receipt of claims, if the claims are contested or denied. Requires the notice contesting the claim to contain specific reasons for contesting the claim and written itemization of any additional information or documentation needed to process the claim. Prohibits health insurers from making more than one request in connection with a claim unless the provider fails to submit all requested information to process the claim, or if information submitted by the provider raises new or additional issues not included in the original written itemization, in which case the insurer may have one more opportunity to request additional information. In no case can the insurer request duplicate information.

Requires a health insurer, upon receipt of the additional information requested from the insured or the insured's assignees, to pay or deny the contested claim within 35 days. (Current law is 60 days.) Creates an *uncontestable obligation* on the health insurer who fails to pay or deny any claim within 120 days after receiving the claim. Provides that payment of a claim is considered made on the date the payment was electronically transferred or otherwise delivered and increases the interest rate from 10 to 12 percent on overdue payments, with interest accruing on the 36th day.

Provides that a provider's claim for payment is considered received if the claim has been electronically transmitted, when the receipt is verified electronically and that a provider's claim for payment is considered received if the claim has been mailed to the address disclosed by the health insurer, on the date indicated on the return receipt. Requires a provider to wait 35 days following a receipt of a claim before submitting a duplicate claim.

Prohibits health insurers from reducing payments for other provider services based on a retroactive review of coverage decisions or payment levels unless the provider agrees to such reduction. Provides that a provider must pay a claim for an overpayment made by a health insurer that the provider does not contest or deny within 35 days after receipt of the claim that is mailed or electronically transferred to the provider. A provider that denies or contests a claim for overpayment must notify the insurer in writing within 35 days after receipt of the claim. Such notice must identify

the contested or denied portion of the claim, specify reasons and, if contested, include a request for additional information. Requires the provider to pay or deny the claim for overpayment within 35 days after receipt of such information.

Payment of a claim for overpayment is considered made on the date payment was electronically transferred or otherwise delivered or on the date the provider receives payment from the health insurer that reduces or deducts the overpayment. Such overdue payments bear interest at a rate of 12 percent per year with such interest accruing on the 36th day. Providers must pay or deny claims for overpayment no later than 120 days after receiving the claim and failure to do so creates an uncontestable obligation for the provider to pay the insurer.

Provides that a health insurer's claim for overpayment is 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, on the date indicated on the return receipt. A health insurer must wait 35 days following the provider's receipt of the claim for overpayment before submitting a duplicate claim. Retroactive reductions of payments or previous overpayments due to retroactive review of coverage decisions or payment levels must be reconciled to specific claims and retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims. Specifies that look-back or audit review periods may not exceed 2 years after the date the claim was paid by the insurer, except in situations where fraud in billing is involved.

Provides that an insurer may not deny a claim due to an insured's ineligibility if the provider can document receipt of the insured's eligibility confirmation by the insurer prior to the date or time covered services were provided. A person who knowingly misinforms a provider before receipt of services as to coverage eligibility commits insurance fraud (second degree misdemeanor).

Provides that, regardless of other remedies or relief to which a person is entitled, or obligated to under contract, anyone who is aggrieved by a violation of this section may bring an action to obtain a declaratory judgment that an act or practice violates this section and to enjoin a person who has violated, is violating, or is likely to violate this section.

Provides that a person who has suffered a loss as a result of a violation of this section may recover any amounts due the person, including accrued interest, plus attorney's fees and court costs as specified in this section.

Provides that in any civil litigation resulting from an act or practice involving a violation of this section by a health insurer, after judgment in trial court and exhaustion of all appeals, the provider will be awarded his or her attorney's fees and costs from the health insurer, not to exceed three times the amount in controversy or $5,000 whichever is greater. If the insurer is found not to have violated this section, the insurer, after judgment in trial court and exhaustion of all appeals, may receive its reasonable attorney's fees and costs from the provider on any claim or defense that he court finds the provider knows or should have known was not supported by the material facts necessary to establish the claim or defense, or which would not be supported by the application of the law that existed at the time of the litigation.

Requires the attorney for the prevailing party to submit a sworn affidavit of his or her time spent on the case. Any award of attorney's fees or costs will become a part of the judgment and will be subject to execution as the law allows.

Prohibits the provisions of this section from being waived, voided, or nullified by contracts.

Section 3. Creates s. 627.6142, F.S., relating to treatment authorization and payment of claims, as follows:

Defines "authorization" to mean any requirement of a provider to notify an insurer in advance of providing a covered service. Provides that health insurers that require authorization must provide PPO and EPO contracted providers with a list of the medical care and health care services that require authorization and the authorization procedures used by the health insurer at the time the contract becomes effective. Health insurers that require authorization are also required to provide such list and procedures to all other providers, within 10 working days after a request is made. Health insurers that require authorization are prohibited from modifying the list or procedures unless written notice is provided, at least 30 days in advance, to all affected insureds, all contracted providers, and to all other providers that had previously requested the list and procedures.

Insurers that make such lists and procedures accessible to providers and insureds electronically are in compliance with the above provision so long as such notice is provided at least 30 days in advance of any changes in such lists or procedures to all insureds, contracted providers, and non contracted providers who had previously requested a list of medical care or services that require authorization.

Specifies that any claim for a covered service that does not require authorization that is ordered by a contracted physician and entered on the medical record, may not be denied. If the health insurer determines that an overpayment has been made, then a claim for overpayment should be submitted to the provider pursuant to s. 627.613, F.S.

Prohibits denial of a claim for treatment if the provider follows the health insurer's published authorization procedures and receives authorization, unless the provider submits information with the willful intent to misinform a health insurer.

Requires a health insurer to issue a written determination indicating if the authorization is granted or denied upon receipt of such a request from a provider. If the request for authorization is for an *inpatient admission*, the determination by the insurer must be issued no later than *24 hours* after the request is made by the provider. If authorization is denied, the health insurer must notify the insured at the same time notification is sent to the provider. Failure of a health insurer to respond to a written request for authorization within the 24-hour period, results in automatic authorization of the request and payment shall not be denied.

If the proposed medical care or health care service involves an inpatient admission requiring authorization, the insurer must review and issue a written or electronic authorization for the total estimated length of the stay for the admission, based on the recommendation of the patient's physician. If the proposed care or service is provided to an insured who is an inpatient in a health care facility and authorization is required, the insurer must issue a written determination indicating whether the services are authorized or denied no later than *4 hours* after the request is made by the provider. A health insurer who fails to respond to such a request within *4 hours* is considered to have authorized the requested medical care or service and denial of payment is prohibited.

Authorization may not be required for emergency services and care or emergency medical services as provided pursuant to ss. 395.002 (emergency services and care), 395.1041 (access to emergency services and care), 401.45 (denial of emergency treatment) and 401.252 (interfacility transfer). Further, such emergency services and care shall extend through any inpatient admission required in order to provide for stabilization of an emergency medical condition pursuant to state and federal law.

Prohibits the provisions of this section from being waived, voided, or nullified by contract.

Section 4. Amends s. 627.638, F.S., relating to direct payment for hospital or medical services, to provide that under any health insurance policy insuring against loss or expense due to hospital confinement or to medical services, that payment of benefits must be made directly to any recognized hospital, doctor, or other person who provides treatment of a psychological disorder for substance abuse, including drug and alcohol abuse, when such treatment is in accordance with provisions of such policy and the insured authorizes direct payment of benefits. Payments must be made under this provision, notwithstanding contrary provisions in an insurance contract.

This provision applies to all health insurance policies now or hereafter in force as of the effective date of this act.

Section 5. Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance, to revise a citation to s. 627.662(8), F.S., (time of payment of claims) as specified under Section 6 of this bill.

Section 6. Amends s. 627.662, F.S., relating to group health insurance, blanket health insurance and franchise health insurance, to provide that s. 627.6142, F.S., (treatment authorization) applies to such insurance.

Section 7. Amends s. 641.185, F.S., relating to HMO subscriber protections, to provide that such subscribers are entitled to prompt payment from the HMO when appropriate under s. 641.3155, F.S.

Section 8. Amends s. 641.30, F.S., relating to construction and relationship of other laws, to provide that HMOs must accept claim forms prescribed pursuant to s. 641.3155, F.S.

Section 9. Amends s. 641.3155, F.S, relating to payment of claims for HMOs, as follows:

Deletes the term “clean claim” and the language clarifying what a “clean claim” is, and defines the term “claim” for *noninstitutional providers* to mean a paper or electronic billing instrument consisting of the HCFA 1500 data set with all mandatory entries completed for a physician licensed under ch. 458, F.S. (allopathic medicine), ch. 459, F.S. (osteopathic medicine), ch. 460, F.S. (chiropractic medicine), ch. 461, F.S. (podiatric medicine), or ch. 490, F.S. (psychological services) or other appropriate form for any other noninstitutional provider, or its successor. (Note: This would apply to all noninstitutional providers not just to physicians licensed under the specified chapters.) Defines “claim” for *institutional providers* to mean a paper or electronic billing instrument that consists of the UB-92 (claim form for hospitals) data set or its successors that has all mandatory entries completed.

Deletes the Department of Insurance’s rulemaking authority to adopt rules to establish claim forms consistent with federal claim filings standards for HMOs.

Current Florida law utilizes the definition of “clean claim” as used under the Medicare provisions. The effect of deleting the requirement that provider claims be “clean,” which means they be accurately completed with “no defect or impropriety, including lack of required substantiating documentation,” may result in claims processing delays and added administrative costs by forcing plans to investigate and correct any misinformation submitted by providers.

Requires HMOs to pay any claim or portion of a claim after the receipt of a claim by the HMO which is submitted by the provider either electronically or using hand delivery, mail, or overnight delivery. Requires an HMO denying or contesting a claim or portion of a claim, in addition to current requirements (identify the contested portion and the specific reason for contesting) to give the

provider a written itemization of any additional information or additional documents needed to process the claim or any portion of the claim that is not being paid.

Requires an HMO to pay or deny a claim within 35 days after receipt of requisite additional information from a provider (current law is 45 days). Prohibits an HMO from making more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information to process the claim, or if information submitted raises new, additional issues, in which case the HMO may allow the provider one additional opportunity to submit the additional information. Prohibits an HMO from denying or withholding payment on a claim because the insured has not paid a requested deductible or co-payment. An overdue payment of a claim bears interest at a rate of 12 percent (current law provides for 10 percent interest).

If an HMO determines an overpayment has been made to a provider as a result of a retroactive review, the HMO 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 HMO. Increases the simple interest rate for an overdue payment of a claim from 10 percent a year to 12 percent a year. Limits the time for a "look-back" or audit review to 2 years after the date the claim was paid by the HMO, except in the case where fraud in billing is involved.

Establishes that a provider's claim for payment is considered to be received by the HMO on the date the delivery receipt is signed by the HMO if the claim is hand delivered. Specifies that an HMO may not deny a claim because of subscriber ineligibility if the provider can document receipt of eligibility confirmation by the HMO prior to the date or time covered services were provided. Every HMO contract with an employer must include a provision that requires the employer to notify the HMO of changes in eligibility status within 30 days (deletes authorization for such denials to 1 year after the date of payment of the clean claim). A person who knowingly misinforms a provider prior to receipt of services as to coverage eligibility commits insurance fraud (second degree misdemeanor).

Provides that, regardless of other remedies or relief to which a person is entitled, or obligated to under contract, anyone who is aggrieved by a violation of this section may bring an action to obtain a declaratory judgment that an act or practice violates this section and to enjoin a person who has violated, is violating, or is likely to violate this section.

Provides that a person who has suffered a loss as a result of a violation of this section may recover any amounts due the person, including accrued interest, plus attorney's fees and court costs as specified in this section.

Provides that in any civil litigation resulting from an act or practice involving a violation of this section by an HMO, after judgment in trial court and exhaustion of all appeals, the provider will be awarded his or her attorney's fees and costs from the HMO, not to exceed three times the amount in controversy or $5,000 whichever is greater. If the HMO is found not to have violated this section, after judgment in trial court and exhaustion of all appeals, the HMO may receive its reasonable attorney's fees and costs from the provider on any claim or defense that he court finds the provider knows or should have known was not supported by the material facts necessary to establish the claim or defense, or which would not be supported by the application of the law that existed at the time of the litigation.

Requires the attorney for the prevailing party to submit a sworn affidavit of his or her time spent on the case. Any award of attorney's fees or costs will become a part of the judgment and will be subject to execution as the law allows.

Provides that an HMO subscriber is entitled to prompt payment from an HMO whenever the subscriber pays an out-of-network provider for a covered service and then submits a claim to the HMO. The HMO must pay the claim within 35 days after receipt or must advise the subscriber of what additional information is required. After receipt of such information, the HMO must pay the claim within 10 days. If the HMO fails to pay claims submitted by subscribers within the time periods specified, the HMO must pay interest at a rate of 12 percent. Failure to timely pay claims and interest is a violation of the Insurance Code and each occurrence is considered a separate violation. Prohibits the waiver, voidance, or nullification by contract of the provisions of this section.

Section 10. Amends s. 641.3156, F.S., relating to treatment authorization, as follows:

Defines "authorization" for the purposes of this section to include, but is not limited to, direct or indirect use of preauthorization, precertification, notification, or any other similar terminology.

Requires the following from HMOs that require authorization for medical care and health services:

- Provide each contracted provider at the time a contract is signed with a list of medical and health care services that require authorization and the authorization procedures used by the HMO.
- Provide to each noncontracted provider, within 10 working days after a request is made, a list of medical and health care services that require authorization and the authorization procedures used by the HMO.
- Notify all subscribers, contracted providers, and noncontracted providers who had previously requested a list, in writing and at least 30 days in advance, of any changes or modification to the list. An HMO that makes such list and procedures accessible electronically is deemed to be in compliance, so long as notice is provided at least 30 days in advance of any changes in such list or procedures to all subscribers, contracted providers and non contracted providers who had previously requested such list and procedures.

Prohibits the denial of any claim for treatment that does not require authorization for a covered service which is ordered by a contracted physician.

Deletes existing language relating to the requirement of payment by HMOs for certain services which were authorized in accordance with the HMO's current and communicated procedures, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Requires an HMO to issue a written determination indicating whether the service or services are authorized upon receipt of a request from a provider for authorization. If the request for authorization is for an inpatient admission, the determination must be transmitted to the provider making the request within 24 *hours* after the request is made. Requires the HMO to notify both the subscriber and the provider at the same time if the HMO denies the request for authorization. Provides that an HMO that fails to respond to a request for authorization from a provider pursuant to this paragraph is considered to have authorized the inpatient admission within 24 hours and payment may not be denied.

If the proposed medical care or services involve an inpatient admission and the HMO requires authorization as a condition of payment, the HMO must issue a written or electronic authorization for the total estimated length of stay for the admission. Requires HMOs that require authorization for proposed medical care or health care service or services for a subscriber who is an inpatient at the health care facility at the time the services are proposed, to issue a determination indicating whether the proposed services are authorized no later than 4 *hours* after the request by the provider.

Provides that the failure of an HMO to respond to a request for authorization within 4 *hours* is considered to have authorized the requested medical care or health care service and such payment may not be denied.

Expands the exemption of emergency services from the authorization provisions of this section (and subjects such services to s. 641.513, F.S.) and provides that emergency services and care extends through any inpatient admission required in order to stabilize the patient pursuant to federal and state law.

Prohibits the waiver, voidance, or nullification of the provisions of this section by contract.

Section 11. Amends s. 626.9541, F.S., to make it an unfair or deceptive practice for insurers to notify providers that claims filed under s. 627.613, F.S., (payment of claims) have not been received when, in fact, the claims have been received.

Section 12. Amends s. 641.3903, F.S., to make it an unfair or deceptive practice for HMOs to notify providers that claims filed under s. 641.3155, F.S., (payment of claims) have not been received when, in fact, the claims have been received.

Section 13. Specifies that this act takes effect October 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The bill appears to have a direct fiscal impact on the Department of Insurance. Under the bill, the department would have to expand its monitoring activities to ensure that health insurers and HMOs are in compliance with the various prompt pay provisions. In addition, the bill classifies certain violations of time frames by HMOs as violations of the Insurance Code, thereby requiring additional enforcement activities by the department. Such enforcement activities by the department include suspension or revocation of an HMO's certificate of authority or imposition of administrative fines in lieu of such suspension or revocation.

According to AHCA, the bill has a direct fiscal impact on the agency because it permits all health insurers, as opposed to just managed care organizations, to access the Statewide Provider and Managed Care Claim Dispute Resolution Program (Dispute Program). The agency is responsible for issuing final orders for all claim disputes submitted to the Dispute Program and while the Program's current caseload is very low, the inclusion of all health insurance will likely increase the caseload.[13] Based on information from the Department of Insurance, an insurance expert, and based on the expansion of the dispute resolution program to include over 2400 health indemnity plans and PPOs, AHCA estimates that the number of claim disputes would equal 700 cases (final orders) and therefore request one attorney position

[13] The agency's costs incurred for the issuance of these final orders are funded from its trust fund.

for FY 2002-03 ($57,727).[14] The need for this position is based on the estimated 700 cases, the number of attorney hours required per final order or case, and the number of attorney hours required for the dispute resolution program. The attorney would be responsible for drafting all final orders, attending meetings and consulting with department and resolution organization representatives as needed.[15]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providers of health care services should receive more timely reimbursement for claims submitted to HMOs and health insurers and potentially achieve greater reimbursement under the provisions of this bill. Also, providers could bring civil law suits, plus collect costs and attorney's fees, against insurers and HMOs for suffering a loss as a result of an HMO or insurer violating specified provisions of the bill.

According to the Department of Insurance Fiscal Impact Report on the bill, this legislation "could result in significant increase in litigation and legal expense fees for insurers/HMOs, providers and policyholders/subscribers. If system costs increase, resulting premium increases could result in the elimination or reduction in benefits of some employer/employee health plans."

The Agency for Health Care Administration states in its report that this legislation has a "fiscal impact on health insurers and HMOs by shortening treatment authorization timeframes, and giving subscribers new rights for prompt payment."
The following provisions of this bill may result in increased costs to health insurers and HMOs, and ultimately policyholders:

- Deleting the requirements that providers submit accurate "clean" claims with supporting documentation before triggering payment timeframes;
- Limiting the number of times that HMOs and insurers can request specified information from providers before paying a claim;
- Authorizing that providers may bring civil causes of action against health insurers and HMOs which violate provisions relating to claims payment and subjecting such entities to attorney's fees, interest, and costs, regardless of the minor nature of the violation;
- Eliminating health insurers' and HMOs' abilities to conduct audits and look-back reviews beyond 2 years after the payment of a claim (although this exception does not involve instances where fraud in billing occurs); and
- Eliminating the insurers' and HMOs' ability to require adequate information regarding insured's or subscriber's eligibility due to abbreviated authorization timeframes.

[14] The cost estimate for 1 FTE for FY 2003-04 is $71,275.
[15] The agency estimates that each final order will require approximately 2.8 hours; approximately 60 hours for consulting with Department of Insurance and resolution organization representatives. Based on the foregoing, approximately 2,020 hours annually and one attorney will be needed to meet this workload. The estimate is based on 1,854 working hours per year per person.

The provision allowing providers a civil cause of action against insurers and HMOs may result in providers not utilizing the Claims Dispute Resolution Program authorized under AHCA.

There could be indeterminate cost increases to local government health plans arising from claims handling and/or claims settlement expenses.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take actions requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the expenditure of funds.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

When CS/CS/SB 362 was heard on second reading in the Senate on February 28, 2002, a series of amendments were adopted. When the bill was heard on third reading in the Senate on March 6, 2002, a series of amendments were adopted. The effect of those amendments was to substantially revise the bill.

When CS/CS/SB 362, 2nd Engrossed, was heard in the House Council for Healthy Communities on March 15, 2002, a “strike-everything” amendment, as amended, was adopted. The following is a detailed description of Amendment #645115.

Section 1. Amends subsection (3) of s. 408.036, F.S., creating paragraph (t), providing an exemption to the CON review process for providers that offer health services, long-term care hospitals services, new construction, or tertiary health services excluding solid organ transplant services, by an existing hospital provided that the hospital does not exceed the current licensed bed capacity for that facility. The hospital may offer services, utilizing existing bed capacity within the hospital's respective health planning district.

The Agency for Health Care Administration is authorized to develop rules requiring licensure requirements for the services exempted from the CON review process. The rules are to include that the facility maintain sufficient staff, maintain appropriate referrals in the event of an emergency, provide 10% of services to charity and Medicaid patients, and to develop quality outcome measures that must be at least at the 50th percentile of national and state standards for care. In the event the facility fails to meet the required provisions of licensure, the facility will have an opportunity to correct any deficiencies before the expiration of the granted exemption.

If the exemption for a program expires, the Agency may not grant another exemption for a program in the same facility until 2 years following the date of the determination.

The proposed council bill recognizes that when a problem exists in accessing needed cardiac services, consideration must be given to creating an exemption to the CON process and further recognizes that the exemption needs to be based upon objective criteria. The provisions for the exemption from the CON review process for open heart surgery programs specifies that facilities must meet the following criteria:

- The applicant for exemption must demonstrate that they are referring 300 or more cardiac patients from the hospital for cardiac open heart surgery or that the average wait time for transfer to another facility for treatment for 50% of more of the cardiac patients exceeds four hours.
- The applicant is a general acute care hospital that has been in operation for more than 3 years.
- The applicant is performing more than 500 diagnostic cardiac catheterization procedures per year, a combination of both inpatient and outpatient procedures.
- The applicant must create a formal peer review program with an existing statutory teaching hospital or cardiac program doing 750 open heart cases and that the peer review program will conduct quarterly reviews the first year and biannually the second yeas and subsequent years until either the program reaches 350 cases per year or demonstrates consistency with state adopted quality outcome standards for the service.
- The hospital payor mix, at a minimum reflects the community average for Medicaid, charity care, and self-pay for open heart surgery patients. If the applicant fails to reach the required minimum volume of 300 procedures per year, it must show cause why its exemption should not be revoked.
- Maintain minimum licensure requirements adopted by the Agency governing open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for adult open-heart programs.
- The applicant must certify it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.
- The applicant shall certify it will maintain sufficient appropriate times of operation and protocols to ensure the availability and appropriate referrals in the event of emergencies.

In addition, an exemption is created for the establishment of a satellite hospital through the relocation of 100 general acute care beds from an existing hospital located in the same district, as defined in s. 408.032(5).

Section 2. Creates s. 408.043, F.S., "Sole Acute Care Hospital in a High Growth County." Provides that an acute care hospital licensed under chapter 395 may add up to 180 additional beds without

agency CON review, provided such hospital is located in a county that has experienced at least a 60% growth rate since 1990, is under construction on January 1, 2002, is the sole acute care hospital in the county, and is located such that there is no other acute care hospital within a 10-mile radius of such hospital.

Section 3. Amends s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program, redesignating the program title to reflect "health plan" rather than "managed care organization."

Subsection (1), defining the terms used in the section, is amended as follows:

Adds paragraph (a), to define "agency" to mean the Agency for Health Care Administration.

Amends paragraph (b), to define the term "health plan" rather than "managed care organization," and expand the definition to include exclusive provider organizations (s. 627.6472, F.S.), and major medical expense health insurance policy (s. 627.643(2)(3), F.S.), offered by a group or individual health insurer licensed pursuant to chapter 624, F.S., including preferred provider organizations (s. 627.6471, F.S.).

Amends subsection (2), to update references replacing "Agency for Health Care Administration" with "agency" and "managed care organizations" with "health plans."

Adds paragraph (e), to require those seeking dispute resolution to submit supporting documentation within specified timeframes. Authorizes the resolution organization to extend timeframes. Provides that failure to submit supporting documents within the timeframe results in the dismissal of the claim of the submitter.

Adds paragraph (f), to require the resolution organization to require the respondent to submit all documentation in support of its position within 15 days after receiving a request from the dispute resolution organization for supporting documentation. Authorizes the resolution organization to extend the time, if appropriate. Provides that failure to submit the requested documentation within the timeframe will result in a default against the health plan or provider. Provides that, in the event of default, the resolution organization must issue its written recommendation to the Agency that a default be entered against the defaulting entity. The written recommendation must include a recommendation to the Agency that the defaulting entity pay the entity submitting the claim the full amount of the claim dispute, plus all accrued interest, and must be considered a nonprevailing party for the purposes of this section.

Adds paragraph (g), to require the agency, if it has reason to believe that a pattern of prompt pay noncompliance exists on the part of a particular health plan or provider, to evaluate the cases to determine whether there is evidence of a pattern of violations, and report its findings and evidence to the appropriate licensure or certification entity. Also requires the agency to prepare an annual report enumerating claims dismissed, defaults issued, and final order noncompliance.

Amends subsection (3), to update terminology and to specify that the Agency's rules establishing the process to be used by the resolution organization must specify that the written recommendation must be submitted to the Agency within 60 days after the requested information is received by the resolution organization, and prohibits the extension of the timeframes from exceeding 90 days following the receipt of the initial claim dispute.

Adds subsection (5), to require the Agency to notify within 7 days the appropriate licensure or certification entity whenever there is a violation of the final order issued by the Agency pursuant to this section.

Section 4. Amends s. 626.88, F.S., relating to definitions of "administrator" and "insurer", as follows:

Amends subsection (1) expanding the definition of "administrator" to include any entities, through a health care risk contract, that provide provider billing and collection services to health insurers and health maintenance organizations on behalf of health care providers.

Adds paragraph (1)(o) providing an exception for any provider or group practice providing services under the scope of the license of the provider or the member of the group practice, pursuant to s. 456.053, relating to financial arrangements between referring health care providers and providers of health care services.

Adding a stipulation to subsection (1) specifying that a person who provides billing and collection services to health insurers and HMOs on behalf of the providers are to comply with insurer and HMO prompt payment and adverse determination requirements.

Section 5. Creates s. 627.6131, F.S., relating to payment of claims by health insurers, as follows:

Subsection (1) requires health insurance policy contracts to contain specific language relating to payment notice requirements.

Subsection (2) provides a definition of "claim" for institutional and noninstitutional providers, delivered to the insurer's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, or chapter 490, or any appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (3) specifies for all claims, electronic or nonelectronic, the following:
- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the insurer within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (4) specifies requirements for electronically submitted claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the insurer must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.

Subparagraph (c)3. prohibits an insurer from making 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. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the insurer may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an insurer request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the health insurer and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (5) specifies requirements for nonelectronically submitted health insurer claims, as follows:

Paragraph (a), beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the insurer must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the insurer's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an insurer from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the insurer may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the insurer from requesting duplicate documents.
Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the health insurer and provider.

Paragraph (e) requires a claim to be paid or denied within 120 days of receipt of the claim. Provides that failure to pay or deny a claim with 140 days of receipt of the claim creates an uncontestable obligation to pay.

Subsection (6) requires an insurer to make a claim for overpayment if it determines that an overpayment has occurred. Requires an insurer to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the insurer to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the health insurer must do the following:

- Submit the claim for overpayment to the provider within 30 months after the insurer's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the insurer, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the insurer submits the additional information, the insurer must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within n45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An insurer is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the insurer's overpayment claim, as required by this paragraph.
- Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue overpayment claim bears simple interest of 12 percent per year. Interest begins to accrue when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the insurer's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (7) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

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

Subsection (9) prohibits providers or provider's designee from billing an insured or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the health insurer

contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (10) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (11) prohibits retroactive denial of a claim due to insured ineligibility more than 1 year after the date of the payment of the claim.

Subsection (12) requires the health insurer to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the insured if the services are determined by the insurer to be medically necessary and covered.

Subsection (13) requires an insurer, upon written notification by an insured, to investigate any claim of improper billing by a provider. Requires the insurer to determine if the insured was properly billed. If the insured was improperly billed, the insurer must notify the insured and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due to the insured's notification, the insurer must pay the insured 20 percent of the amount of the reduction up to $500.

Subsection (14) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the insurer's control.

Subsection (15) limits the applicability of this section to major medical expense health insurance policies, as defined by statute, or individual health insurers licensed pursuant to statute, including specified preferred provider policies, exclusive provider organizations, and group or individual dental insurance contracts that only provide direct payments to dentists for enumerated dental services.

Subsection (16) provides an exemption from the 20 day pay, deny, or notify requirement for electronically submitted claims pursuant to s. 627.6131(4)(b), F.S., and provides a 30 day pay, deny, or notify requirement for an electronic pharmacy claim submitted by a health insurance pharmacy benefits manager, and provides that such claims are considered made on the date the notice or payment was mailed or electronically transferred.

Subsection (17) effective November 1, 2003, provides an exemption from the 15 day acknowledgement of receipt requirement for nonelectronically submitted claims by a health insurance pharmacy benefits manager pursuant to s. 627.6131 (5)(a), F.S., and provides that such claims are to be acknowledged within 30 days of receipt or provide a provider within 30 days electronic access to the status of a submitted claim.

Section 6. Creates s. 627.6135, F.S., relating to treatment authorization, as follows:

Subsection (1) specifies what an "authorization" is and specifies that each authorization request from a provider must be assigned a unique identification number by the health insurer.

Subsection (2) requires submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Subsection (3) requires each authorization to be assigned an identification number and must include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Subsection (4) prohibits the denial of a claim for treatment if the provider follows the authorization process and receives authorization for a covered service of an eligible insured, unless the provider provided information with the intention to misinform the insurer.

Subsection (5) requires a health insurer making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health insurer that makes such procedures accessible to providers and insureds electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Section 7. Amends paragraph (2)(a) of s. 627.6425, F.S., relating to renewability of individual health insurance coverage, to expand the health insurer's ability to not renew or discontinue health insurance coverage to include an individual's failure to pay required copayments which are payable to the health insurer. Requires the health insurer to allow, for copayments exceeding $300, the insured up to 90 days from the date of the provision of the service to pay the copayment.

Section 8. Amends s. 627.651(4), F.S., relating to group contracts, to correct a cross-reference.

Section 9. Amends and renumbers s. 627.662, F.S., relating to other provisions applicable to group health insurance, blanket health insurance, and franchise health insurance, to make applicable to such coverage the payment of claims and authorization requirements specified in the bill.

Section 10. Amends subsection (2) of s. 627.638, F.S., relating to direct payment for hospital and medical services, to specify that notwithstanding any contrary provisions contained in the insurance contract, payments must be made directly to the hospital, physician, or other licensed provider for services for the treatment of mental health or substance abuse, including drug and alcohol treatment if,

- The benefit is covered under the terms of the policy;
- The claim is limited to treatment of mental health or substance abuse, including drug and alcohol abuse; and
- The insured authorized the insurer, in writing, as part of the claim to make a direct payment to the recognized hospital, physician, or other licensed provider.

Section 11. Amends paragraph (e) of subsection (1) of s. 641.185, F.S., relating to health maintenance organization subscriber protections, to include that a subscriber should receive prompt payment from the HMO in accordance with the prompt payment requirements for HMOs, s. 641.3155, F.S.

Section 12. Adds subsection (4) to s. 641.234, F.S, relating to health care service programs administrative, provider, and management contracts, as follows:

Requires an HMO which through a health care risk contract, transfers the HMO's obligation to pay any provider for any claims arising from services provided to or for the benefit of any subscriber of the HMO to any entity to remain responsible for any violations of the requirements related to payment of claims (s. 641.3155, F.S.) and requirements related to adverse determinations (s. 641.51(4), F.S.). Applies the provisions of ss. 624.418-624.4211, F.S., relating to various provisions of the Florida Insurance Code, to such violations. Provides the following definitions:

- "Health care risk contract" means a contract in which an entity receives compensation in exchange for providing to the HMO a provider network or other services. Such services may include administrative services.
- "Entity" is defined to mean a person licensed as an administrator under s. 626.88, F.S., and does not include any provider or group practice, as defined in s. 456.053, who provides services under the scope of the license of the provider or members of the group practice.

Section 13. Amends subsection (1) of s. 641.30, F.S., relating to HMO contract construction and relationship to other laws, to delete obsolete language and provide a cross-reference relating to HMO claim forms pursuant to s. 641.3155, F.S.

Section 14. Adds paragraph (d) of subsection (4) of s. 641.3154, F.S., relating to HMO liability and timeframes of the prohibition from collecting money from a subscriber, maintaining a cause of action against a subscriber, or reporting to a credit agency of a subscriber, adding to the existing presumptions of a provider to know that an HMO is liable when the Agency issues a final order of the claim dispute resolution organization requiring the HMO to pay for services pursuant to s. 408.7057, F.S.

Section 15. Substantially rewrites s. 641.3155, F.S., relating to HMO payment of claims, as follows:

Subsection (1) provides definition of "claim" for institutional and noninstitutional providers, delivered to the HMO's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, or chapter 490 or any appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (2) specifies for all claims, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the HMO within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (3) specifies requirements for electronically submitted HMO claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the HMO must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the HMO's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.
Subparagraph (c)3. prohibits an HMO from making 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. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the HMO may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an HMO request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the HMO and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (4) specifies for nonelectronically submitted HMO claims, as follows:

Paragraph (a), beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the HMO must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the HMO's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an HMO from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the HMO may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the HMO from requesting duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the HMO and provider.

Paragraph (e) requires all claims to be paid or denied within 120 days after receipt of the claim. Creates an uncontestable obligation to pay the claim if the claim is not paid or denied within 140 days after the receipt of the claim.

Subsection (5) requires an HMO to make a claim for overpayment if it determines that an overpayment has occurred. Requires an HMO to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the HMO to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the HMO must do the following:

- Submit the claim for overpayment to the provider within 30 months after the HMO's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the HMO, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the HMO submits the additional information, the HMO must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within 45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An HMO is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the HMO's overpayment claim, as required by this paragraph.
- Provides that a payment for an overpayment claim is considered made on the date the payment was mailed or electronically transferred. Provides that an overdue payment for a claim for overpayment bears a simple interest rate of 12 percent per year. Provides that interest begins to accrue on an overdue payment for claim on the date when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the HMO's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (6) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Paragraph (7)(a) requires, for all contracts entered into or renewed on or after October 1, 2002, an HMO's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Paragraph (b) requires all HMO claims begun after October 1, 2000, which are not under active review by a mediator, arbitrator, or third-party dispute entity, to have a final decision on the clam by the HMO by January 2, 2003, for the purposes of the statewide provider and managed care organization claim dispute resolution program pursuant to s. 408.7057, F.S.

Subsection (8) prohibits providers or provider's designee from billing a subscriber or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the HMO contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (9) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (10) prohibits retroactive denial of a claim due to subscriber ineligibility more than 1 year after the date of the payment of the claim.

Subsection (11) requires the HMO to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the subscriber if the services are determined by the HMO to be medically necessary and covered.

Subsection (12) requires an HMO, upon written notification by an HMO, to investigate any claim of improper billing by a provider. Requires the HMO to determine if the subscriber was properly billed. If the HMO was improperly billed, the HMO must notify the subscriber and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due to the subscriber's notification, the HMO must pay the subscriber 20 percent of the amount of the reduction up to $500.

Subsection (13) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the HMO's control.

Subsection (14) specifies that the requirements of this section apply to all claims or any portion of a claim submitted by an HMO subscriber under contract to the HMO for payment.

Subsection (15) provides an exemption from the 20 day pay, deny, or notify requirement for electronically submitted claims pursuant to s. 627.6131(4)(b), F.S., and provides a 30 day pay, deny, or notify requirement for an electronic pharmacy claim submitted by an HMO pharmacy benefits manager, and provides that such claims are considered made on the date the notice or payment was mailed or electronically transferred.

Subsection (16) effective November 1, 2003, provides an exemption from the 15 day acknowledgement of receipt requirement for nonelectronically submitted claims by an HMO pharmacy benefits manager pursuant to s. 627.6131 (5)(a), F.S., and provides that such claims are to be acknowledged within 30 days of receipt or provide a provider within 30 days electronic access to the status of a submitted claim.

Section 16. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims, as follows:

Amends subsection (1) to specify, for the purposes of this section, an "authorization" is "any requirement of a provider to obtain prior approval or to provide documentation relating to the necessity of a covered medical treatment or service as a condition for reimbursement for treatment or service prior to the treatment or service." Specifies that each authorization request from a provider must be assigned an

identification number by the HMO. Deletes existing language requiring an HMO to pay any hospital service or referral service claim for treatment of an eligible subscriber if it was authorized by a provider empowered by contract with the HMO to authorize or direct the patient's use of health care services which was in accordance with the HMO's current and communicated procedures, except if the provider provided information with the willful intent to misinform the HMO.

Adds new subsection (3) to require submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Adds subsection (4) to require each authorization to be assigned an identification number and to include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Adds subsection (5) to prohibit the denial of a claim for treatment if the provider followed the authorization process and receives authorization for a covered service of an eligible subscriber, unless the provider provided information with the intention to misinform the insurer. Requires a health maintenance organization making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health maintenance organization that makes such procedures accessible to providers and subscribers electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Renumbers subsection (3) as subsection (6), relating to emergency services.

Section 17. Specifies that, except as otherwise provided, this act takes effect October 1, 2002, and applies to all claims for services rendered after that date.

VII. SIGNATURES:

COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Tonya Sue Chavis/Lisa Maurer	David De La Paz