

By Senator Saunders

25-299-02

See HB 293

1                                   A bill to be entitled

2           An act relating to health insurance; amending

3           s. 408.7057, F.S.; redefining the term "managed

4           care organization"; providing for filing

5           certain claim disputes with a

6           dispute-resolution organization under certain

7           circumstances; amending s. 627.4235, F.S.;

8           providing a definition; including prepaid

9           health plans under coordination of benefits

10          provisions; providing for coordination of

11          benefits under multiple health insurance

12          policies regardless of time periods under

13          certain circumstances; amending s. 627.613,

14          F.S.; revising time of payment of claims

15          provisions; requiring the Department of

16          Insurance to adopt rules consistent with

17          federal standards; providing requirements and

18          procedures for payment or denial of claims;

19          providing criteria and limitations; amending s.

20          627.614, F.S.; entitling insureds to prompt

21          insurer payments of claims for covered

22          services; requiring payment within specified

23          periods; providing payment procedures;

24          providing penalties; creating s. 627.6142,

25          F.S.; providing a definition; requiring health

26          insurers to provide lists of medical care and

27          health care services that require

28          authorization; prohibiting denial of certain

29          claims; providing procedural requirements for

30          determination and issuance of authorizations of

31          services; amending s. 627.6471, F.S.; revising

1 limitations on policies providing differing  
2 schedules of payments for preferred provider  
3 services and nonpreferred provider services;  
4 amending s. 627.662, F.S.; specifying  
5 application of certain additional provisions to  
6 group, blanket, and franchise health insurance;  
7 amending s. 641.185, F.S.; entitling health  
8 maintenance organization subscribers to prompt  
9 payment by the organization for covered  
10 services by an out-of-network provider;  
11 requiring payment within specified periods;  
12 providing payment procedures; providing  
13 penalties; amending s. 641.30, F.S.; conforming  
14 a cross-reference; amending s. 641.3155, F.S.;  
15 providing a definition; requiring the  
16 Department of Insurance to adopt rules  
17 consistent with federal claim-filing standards;  
18 providing requirements and procedures for  
19 payment of claims; requiring payment within  
20 specified periods; requiring the payment of  
21 interest on overdue payments; requiring  
22 coordination of benefits; providing remedies  
23 for certain violations; providing for  
24 attorney's fees and costs under certain  
25 circumstances; amending s. 641.3156, F.S.;  
26 providing a definition; requiring health  
27 maintenance organizations to provide lists of  
28 medical care and health care services that  
29 require authorization; prohibiting denial of  
30 certain claims; providing procedural  
31 requirements for determination and issuance of

1 authorizations of services; amending s.  
2 627.651, F.S.; conforming a cross-reference;  
3 repealing s. 627.647, F.S., relating to  
4 standard health claim forms; providing  
5 effective dates.  
6

7 Be It Enacted by the Legislature of the State of Florida:  
8

9 Section 1. Paragraph (a) of subsection (1) and  
10 paragraph (c) of subsection (2) of section 408.7057, Florida  
11 Statutes, are amended to read:

12 408.7057 Statewide provider and managed care  
13 organization claim dispute resolution program.--

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

15 (a) "Managed care organization" means a health  
16 maintenance organization or a prepaid health clinic certified  
17 under chapter 641, a prepaid health plan authorized under s.  
18 409.912, ~~or~~ an exclusive provider organization certified under  
19 s. 627.6472, or a preferred provider organization.

20 (2)

21 (c) Contracts entered into or renewed on or after  
22 October 1, 2000, may require exhaustion of an internal  
23 dispute-resolution process as a prerequisite to the submission  
24 of a claim by a provider or health maintenance organization to  
25 the resolution organization when the dispute-resolution  
26 program becomes effective; provided that, if the internal  
27 dispute-resolution process is not completed within 60 calendar  
28 days after the filing of the claim dispute with the managed  
29 care maintenance organization, the provider may file a claim  
30 dispute with a dispute-resolution organization.  
31

1 Section 2. Section 627.4235, Florida Statutes, is  
2 amended to read:

3 627.4235 Coordination of benefits.--

4 (1) For purposes of this section, the term  
5 "coordination of benefits" or "coordinating benefits" means  
6 establishing an order, or operating pursuant to an established  
7 order, under which primary plans pay claims and secondary  
8 plans are permitted to reduce benefits paid so that the  
9 combined benefits paid under all plans do not exceed covered  
10 charges.

11 (2)(1) A group hospital, medical, or surgical expense  
12 policy, group health care services plan, prepaid health plan  
13 licensed pursuant to chapter 641, or group-type self-insurance  
14 plan that provides protection or insurance against hospital,  
15 medical, or surgical expenses delivered or issued for delivery  
16 in this state must contain a provision for coordinating its  
17 benefits with any similar benefits provided by any other group  
18 hospital, medical, or surgical expense policy, any group  
19 health care services plan, prepaid health plan licensed  
20 pursuant to chapter 641, or any group-type self-insurance plan  
21 that provides protection or insurance against hospital,  
22 medical, or surgical expenses for the same loss.

23 (3)(2) A hospital, medical, or surgical expense  
24 policy, health care services plan, prepaid health plan  
25 licensed pursuant to chapter 641, or self-insurance plan that  
26 provides protection or insurance against hospital, medical, or  
27 surgical expenses issued in this state or issued for delivery  
28 in this state shall ~~may~~ contain a provision whereby the  
29 insurer may reduce or refuse to pay benefits otherwise payable  
30 thereunder solely on account of the existence of similar  
31 benefits provided under insurance policies issued by the same

1 or another insurer, health care services plan, prepaid health  
2 plan licensed pursuant to chapter 641, or self-insurance plan  
3 which provides protection or insurance against hospital,  
4 medical, or surgical expenses only if, as a condition of  
5 coordinating benefits with another insurer, the insurers  
6 together pay 100 percent of the total covered charges for  
7 ~~reasonable expenses actually incurred of the type of expense~~  
8 ~~within the~~ benefits described in the policies and presented to  
9 the insurer for payment.

10 ~~(4)(3)~~ The standards provided in subsection ~~(3)(2)~~  
11 apply to coordination of benefits payable under Medicare,  
12 Title XVIII of the Social Security Act.

13 ~~(5)(4)~~ If a claim is submitted in accordance with any  
14 group hospital, medical, or surgical expense policy, or in  
15 accordance with any group health care service plan or  
16 group-type self-insurance plan, that provides protection,  
17 insurance, or indemnity against hospital, medical, or surgical  
18 expenses, and the policy or any other document that provides  
19 coverage includes a coordination-of-benefits provision and the  
20 claim involves another policy or plan which has a  
21 coordination-of-benefits provision, the following rules  
22 determine the order in which benefits under the respective  
23 health policies or plans will be determined:

24 (a)1. The benefits of a policy or plan which covers  
25 the person as an employee, member, or subscriber, other than  
26 as a dependent, are determined before those of the policy or  
27 plan which covers the person as a dependent.

28 2. However, if the person is also a Medicare  
29 beneficiary, and if the rule established under the Social  
30 Security Act of 1965, as amended, makes Medicare secondary to  
31

1 the plan covering the person as a dependent of an active  
2 employee, the order of benefit determination is:  
3       a. First, benefits of a plan covering a person as an  
4 employee, member, or subscriber.  
5       b. Second, benefits of a plan of an active worker  
6 covering a person as a dependent.  
7       c. Third, Medicare benefits.  
8       (b) Except as stated in paragraph (c), if two or more  
9 policies or plans cover the same child as a dependent of  
10 different parents:  
11       1. The benefits of the policy or plan of the parent  
12 whose birthday, excluding year of birth, falls earlier in a  
13 year are determined before the benefits of the policy or plan  
14 of the parent whose birthday, excluding year of birth, falls  
15 later in that year; but  
16       2. If both parents have the same birthday, the  
17 benefits of the policy or plan which covered the parent for a  
18 longer period of time are determined before those of the  
19 policy or plan which covered the parent for a shorter period  
20 of time.  
21  
22 However, if a policy or plan subject to the rule based on the  
23 birthdays of the parents coordinates with an out-of-state  
24 policy or plan which contains provisions under which the  
25 benefits of a policy or plan which covers a person as a  
26 dependent of a male are determined before those of a policy or  
27 plan which covers the person as a dependent of a female and  
28 if, as a result, the policies or plans do not agree on the  
29 order of benefits, the provisions of the other policy or plan  
30 determine the order of benefits.  
31

1 (c) If two or more policies or plans cover a dependent  
2 child of divorced or separated parents, benefits for the child  
3 are determined in this order:

4 1. First, the policy or plan of the parent with  
5 custody of the child.

6 2. Second, the policy or plan of the spouse of the  
7 parent with custody of the child.

8 3. Third, the policy or plan of the parent not having  
9 custody of the child.

10

11 However, if the specific terms of a court decree state that  
12 one of the parents is responsible for the health care expenses  
13 of the child and if the entity obliged to pay or provide the  
14 benefits of the policy or plan of that parent has actual  
15 knowledge of those terms, the benefits of that policy or plan  
16 are determined first, except with respect to any claim  
17 determination period or plan or policy year during which any  
18 benefits are actually paid or provided before the entity has  
19 the actual knowledge.

20 (d) The benefits of a policy or plan which covers a  
21 person as an employee who is neither laid off nor retired, or  
22 as that employee's dependent, are determined before those of a  
23 policy or plan which covers the person as a laid-off or  
24 retired employee or as the employee's dependent. If the other  
25 policy or plan is not subject to this rule, and if, as a  
26 result, the policies or plans do not agree on the order of  
27 benefits, this paragraph does not apply.

28 (e) If none of the rules in paragraph (a), paragraph  
29 (b), paragraph (c), or paragraph (d) determine the order of  
30 benefits, the benefits of the policy or plan which covered an  
31 employee, member, or subscriber for a longer period of time

1 are determined before those of the policy or plan which  
2 covered the person for the shorter period of time.

3 (6)~~(5)~~ Coordination of benefits is not permitted  
4 against an indemnity-type policy, an excess insurance policy  
5 as defined in s. 627.635, a policy with coverage limited to  
6 specified illnesses or accidents, or a Medicare supplement  
7 policy.

8 (7)~~(6)~~ If an individual is covered under a COBRA  
9 continuation plan as a result of the purchase of coverage as  
10 provided under the Consolidation Omnibus Budget Reconciliation  
11 Act of 1987 (Pub. L. No. 99-272), and also under another group  
12 plan, the following order of benefits applies:

13 (a) First, the plan covering the person as an  
14 employee, or as the employee's dependent.

15 (b) Second, the coverage purchased under the plan  
16 covering the person as a former employee, or as the former  
17 employee's dependent provided according to the provisions of  
18 COBRA.

19 (8) If the insured fails to furnish the provider with  
20 the correct name and address of the insured's primary insurer,  
21 and the claim is submitted to a secondary insurer or prepaid  
22 health plan licensed pursuant to chapter 641 and the claim is  
23 subsequently rejected, the provider has 60 calendar days from  
24 the date the provider obtains the correct billing information  
25 to submit a claim to either the primary or secondary insurer,  
26 regardless of any time periods for filing of claims  
27 established by any applicable contract.

28 Section 3. Effective October 16, 2002, section  
29 627.613, Florida Statutes, is amended to read:

30 (Substantial rewording of section.

31 See s. 627.613, F.S., for present text.)



1           627.613 Time of payment of claims.--  
2           (1)(a) As used in this section, for a noninstitutional  
3 provider, the term "claim" means a paper or electronic billing  
4 instrument that consists of the HCFA 1500 data set that has  
5 all mandatory entries completed for a physician licensed under  
6 chapter 458 or chapter 459 or other appropriate form for any  
7 other noninstitutional provider, or its successor. For  
8 institutional providers, "claim" means a paper or electronic  
9 billing instrument that consists of the UB-92 data set or its  
10 successor that has all mandatory entries completed.  
11           (b) The department shall adopt rules to establish  
12 claim forms consistent with federal claim-filing standards for  
13 health insurers required by the Secretary of the United States  
14 Department of Health and Human Services. The department shall  
15 adopt rules to require code sets consistent with code sets  
16 adopted by the Secretary of the United States Department of  
17 Health and Human Services. The code sets shall apply to  
18 electronic claims. A code set, as defined by the secretary,  
19 includes both the codes and the descriptors of the codes and  
20 shall include, but not be limited to:  
21           1. Medical data code sets, including the International  
22 Classification of Diseases, the HCFA Common Procedure Coding  
23 System and current procedure terminology, and the HCFA Common  
24 Procedure Coding System for supplies and other health care  
25 items.  
26           2. Health care claims or equivalent encounter  
27 information for professional health care claims and  
28 institutional health care claims.  
29           3. Eligibility for a health plan standard.  
30           4. Referral certification and authorization standard.  
31           5. Health care claim status standard.

1           6. Enrollment and disenrollment in a health plan  
2 standard.

3           7. Health care payment and remittance advice standard.

4           8. Coordination of benefits standard.

5           9. Revenue codes used by Medicare for processing  
6 claims.

7           10. National Correct Coding Initiative edits used by  
8 Medicare.

9           (c) All providers and payors shall use only the  
10 standard code sets defined for their area of operation by the  
11 Secretary of the United States Department of Health and Human  
12 Services for the filing and adjudication of electronic claims.  
13 The version of the code set shall be the version that is valid  
14 at the time the health care is furnished, defined as the date  
15 of discharge for inpatient services and date of service for  
16 health care provided in an outpatient or ambulatory setting.

17           (2)(a) A health insurer shall pay any claim or any  
18 portion of a claim made by a contract provider for services or  
19 goods provided under a contract with the health insurer or a  
20 claim made by a noncontracted provider, which the insurer does  
21 not contest or deny, within 15 calendar days after receipt of  
22 the claim by the health insurer that is electronically  
23 submitted by the provider, or within 35 calendar days after  
24 receipt of the claim by the health insurer that is submitted  
25 by the provider using either hand delivery, the United States  
26 mail, or a reputable overnight delivery service. The  
27 investigation and determination of eligibility for payment,  
28 including any coordination of any other payments, does not  
29 extend the time periods specified in this paragraph.

30           (b) A health insurer that denies or contests a  
31 provider's claim or any portion of a claim shall notify the

1 provider within 35 calendar days after the health insurer  
2 receives the claim, if submitted by hand delivery, United  
3 States mail, or overnight delivery service, or within 15  
4 calendar days after the health insurer receives the claim if  
5 submitted by electronic means, that the claim is contested or  
6 denied. The notice that the claim is contested or denied shall  
7 identify the contested portion of the claim and the specific  
8 reason for contesting or denying the claim and, if contested,  
9 shall give the provider a written itemization of any  
10 additional information or additional documents needed to  
11 process the claim or any portion of the claim that is not  
12 being paid. The health insurer shall pay or deny the claim or  
13 portion of the claim within 35 calendar days after receipt of  
14 the information. A health insurer may not make more than one  
15 request under this paragraph in connection with a claim,  
16 unless the provider fails to submit all of the requested  
17 information to process the claim, in which case the health  
18 insurer may provide the health care provider with one  
19 additional opportunity to submit the additional information  
20 needed to process the claim.

21 (c) If a health insurer requests additional  
22 information or additional documents from a person other than  
23 the provider who submitted the claim, the health insurer shall  
24 provide a copy of the request to the provider who submitted  
25 the claim. The health insurer may not withhold payment  
26 pending receipt of information or documents requested under  
27 this paragraph. A health insurer may not deny or withhold  
28 payment on a claim because the insured has not paid a required  
29 deductible or copayment.

30 (3) Payment of a claim is considered made on the date  
31 the payment is received, electronically transferred, or

1 otherwise delivered. An insurer that does not pay a claim when  
2 payment is due as provided in subsection (4) shall pay the  
3 provider submitting the claim the provider's billed charges  
4 submitted on the claim.

5 (4) A health insurer shall pay or deny any claim no  
6 later than 50 calendar days after receiving the claim if the  
7 claim is submitted electronically, or no later than 70  
8 calendar days if the claim is submitted by hand delivery,  
9 United States mail, or a reputable overnight delivery service.  
10 Failure to pay or deny a claim within such time periods  
11 creates an uncontestable obligation of the health insurer to  
12 pay the claim to the provider. The running of the time  
13 specified in this subsection shall be tolled by the number of  
14 days taken by the provider who submitted the claim to submit  
15 the additional information requested by the insurer pursuant  
16 to paragraph (2)(b).

17 (5) If, as a result of retroactive review of coverage  
18 decisions or payment levels, a health insurer determines that  
19 the insurer has made an overpayment to a provider for services  
20 rendered to an insured, the insurer may not reduce payment to  
21 that provider for other services. The look-back or audit  
22 review period may not exceed 1 year from the date of discharge  
23 or 1 year from the date the health service was provided.

24 (6) A provider claim for payment shall be considered  
25 received by the health insurer, if the claim has been  
26 electronically transmitted to the health insurer, when receipt  
27 is verified electronically; if the claim is mailed by United  
28 States mail to the address disclosed by the insurer, on the  
29 date indicated on the return receipt; or, if the claim is hand  
30 delivered, on the date the delivery receipt is signed by the  
31 health insurer. A health insurer shall not require a provider

1 to resubmit a claim for payment if the claim has been received  
2 by the insurer. A provider shall wait 35 calendar days  
3 following receipt of a claim before submitting a duplicate  
4 claim.

5 (7) A health insurer shall provide a provider or the  
6 provider's designee, who bills electronically, electronic  
7 acknowledgment of the receipt of a claim within 24 hours after  
8 receipt.

9 (8) A health insurer may not retroactively deny a  
10 claim because of subscriber ineligibility.

11 (9)(a) Without regard to any other remedy or relief to  
12 which a provider is entitled, any provider aggrieved by a  
13 violation of this section by a health insurer may bring an  
14 action to enjoin a person who has violated, or is violating,  
15 this section. In any such action, the provider who has  
16 suffered a loss as a result of the violation may recover any  
17 amounts due the provider by the health insurer, including  
18 accrued interest, plus attorney's fees and costs as provided  
19 in paragraph (b).

20 (b) In any action arising out of a violation of this  
21 section by a health insurer where the health insurer is found  
22 to have violated this section, the provider, after judgment in  
23 the trial court and after exhausting all appeals, if any,  
24 shall receive his or her reasonable attorney's fees and costs  
25 from the health insurer.

26 (10) The provisions of this section apply to contracts  
27 entered into pursuant to ss. 627.6471 and 627.6472.

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

30 Section 4. Subsection (3) is added to section 627.614,  
31 Florida Statutes, to read:

1           627.614 Payment of claims.--  
2           (3) An insured is entitled to prompt payment from an  
3 insurer for claims submitted for a covered service. If the  
4 claim is submitted electronically by the insured or on the  
5 insured's behalf, the claim shall be paid to the insured  
6 within 15 days or the insurer shall advise the insured of what  
7 additional information is required to adjudicate the claim.  
8 After receipt of the additional information, the insurer shall  
9 pay the claim within 10 days. If the claim is submitted by  
10 electronic facsimile, United States mail, or overnight  
11 delivery service, the insurer shall pay the claim within 30  
12 days or the insurer shall advise the insured of what  
13 additional information is required to adjudicate the claim.  
14 After receipt of the additional information, the insurer shall  
15 pay the claim within 10 days. If the insurer fails to pay a  
16 claim submitted by an insured within the time periods  
17 specified in this subsection, the insurer shall pay the  
18 insured twice the amount of the claim. Failure to pay claims  
19 and penalties, if applicable, within the time periods  
20 specified in this subsection is a violation of the insurance  
21 code and each occurrence shall be considered a separate  
22 violation.

23           Section 5. Section 627.6142, Florida Statutes, is  
24 created to read:

25           627.6142 Treatment authorization; payment of claims.--  
26           (1) For purposes of this section, "authorization"  
27 includes any requirement of a provider to notify an insurer in  
28 advance of providing a covered service, regardless of whether  
29 the actual terminology used by the insurer includes, but is  
30 not limited to, preauthorization, precertification,  
31 notification, or any other similar terminology.

1           (2) A health insurer that requires authorization for  
2 medical care or health care services shall provide to each  
3 provider with whom the health insurer has contracted pursuant  
4 to s. 627.6471 or s. 627.6472 a list of the medical care and  
5 health care services that require authorization and the  
6 authorization procedures used by the health insurer at the  
7 time a contract becomes effective. A health insurer that  
8 requires authorization for medical care or health care  
9 services shall provide to all other providers, not later than  
10 10 working days after a request is made, a list of the medical  
11 care and health care services that require authorization and  
12 the authorization procedures established by the insurer. The  
13 medical care or health care services that require  
14 authorization and the authorization procedures used by the  
15 insurer shall not be modified unless written notice is  
16 provided at least 30 days in advance of any changes to all  
17 affected insureds as well as to all contracted providers and  
18 all other providers that had previously requested in writing a  
19 list of medical care or health care services that require  
20 authorization.

21           (3) Any claim for treatment that does not require  
22 authorization that is ordered by a physician and entered on  
23 the medical record may not be denied.

24           (4)(a) Any claim for treatment may not be denied if a  
25 provider follows the health insurer's published authorization  
26 procedures and receives authorization, unless the provider  
27 submits information to the health insurer with the willful  
28 intention to misinform the health insurer.

29           (b) Upon receipt of a request from a provider for  
30 authorization, the health insurer shall issue a determination  
31 indicating whether the service or services are authorized. The

1 determination shall be transmitted to the provider making the  
2 request in writing no later than 8 hours after the request is  
3 made by the provider. If the health insurer denies the request  
4 for authorization, the health insurer shall notify the insured  
5 at the same time the insurer notifies the provider requesting  
6 the authorization. A health insurer that fails to respond to a  
7 request for an authorization pursuant to this paragraph within  
8 8 hours is considered to have authorized the requested medical  
9 care or health care service and payment shall not be denied.

10 (5) If the proposed medical care or health care  
11 service or services involve an inpatient admission and the  
12 health insurer requires an authorization as a condition of  
13 payment, the health insurer shall review and issue a written  
14 or electronic authorization for the total estimated length of  
15 stay for the admission, based on the recommendation of the  
16 patient's physician. If the proposed medical care or health  
17 care service or services are to be provided to an insured who  
18 is an inpatient in a health care facility and authorization is  
19 required, the health insurer shall issue a written  
20 determination indicating whether the proposed services are  
21 authorized or denied no later than 1 hour after the request is  
22 made by the provider. A health insurer who fails to respond to  
23 such request within 1 hour is considered to have authorized  
24 the requested medical service or health care service and  
25 payment shall not be denied.

26 (6) Emergency services and care are subject to the  
27 provisions of s. 641.513 and are not subject to the provisions  
28 of this section, including any inpatient admission required in  
29 order to stabilize the patient pursuant to federal and state  
30 law.

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1           (7) The provisions of this section may not be waived,  
2 voided, or nullified by contract.

3           (8) The provisions of this section apply to contracts  
4 entered into pursuant to ss. 627.6471 and 627.6472.

5           Section 6. Paragraph (h) of subsection (4) of section  
6 627.6471, Florida Statutes, is amended to read:

7           627.6471 Contracts for reduced rates of payment;  
8 limitations; coinsurance and deductibles.--

9           (4) Any policy that provides schedules of payments for  
10 services provided by preferred providers that differ from the  
11 schedules of payments for services provided by nonpreferred  
12 providers is subject to the following limitations:

13           (h) Each preferred provider shall be given a list of  
14 all payors with whom the insurer has entered into agreements  
15 to use the services of the preferred provider and no  
16 additional payors shall be added to the agreement unless  
17 approved by the preferred provider. Neither the insurer nor  
18 the insurer's claims administrator shall disclose contract  
19 rate information without the written approval of the preferred  
20 provider.~~If any service or treatment is not within the scope~~  
21 ~~of services provided by the network of preferred providers,~~  
22 ~~but is within the scope of services or treatment covered by~~  
23 ~~the policy, the service or treatment shall be reimbursed at a~~  
24 ~~rate not less than 10 percentage points lower than the~~  
25 ~~percentage rate paid to preferred providers. The~~  
26 ~~reimbursement rate must be applied to the usual and customary~~  
27 ~~charges in the area.~~

28           Section 7. Section 627.662, Florida Statutes, is  
29 amended to read:

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1           627.662 Other provisions applicable.--The following  
2 provisions apply to group health insurance, blanket health  
3 insurance, and franchise health insurance:

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

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

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

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

11           (5) Section 627.640, relating to filing and  
12 classification of rates.

13           (6) Section 627.4235, relating to coordination of  
14 benefits.

15           (7) Section 627.614, relating to payment of claims.

16           (8) Section 627.6142, relating to treatment  
17 authorizations.

18           ~~(9)(6)~~ Section 627.645(1), relating to denial of  
19 claims.

20           ~~(10)(7)~~ Section 627.613, relating to time of payment  
21 of claims.

22           ~~(11)(8)~~ Section 627.6471, relating to preferred  
23 provider organizations.

24           ~~(12)(9)~~ Section 627.6472, relating to exclusive  
25 provider organizations.

26           ~~(13)(10)~~ Section 627.6473, relating to combined  
27 preferred provider and exclusive provider policies.

28           ~~(14)(11)~~ Section 627.6474, relating to provider  
29 contracts.

30           Section 8. Paragraph (m) is added to subsection (1) of  
31 section 641.185, Florida Statutes, to read:

1           641.185 Health maintenance organization subscriber  
2 protections.--

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

11           (m) A health maintenance organization subscriber is  
12 entitled to prompt payment from the organization whenever a  
13 subscriber pays an out-of-network provider for a covered  
14 service and then submits a claim to the organization. If the  
15 claim is submitted electronically by the subscriber or on the  
16 subscriber's behalf by the out-of-network provider, the claim  
17 shall be paid to the subscriber within 15 days or the  
18 organization shall advise the subscriber of what additional  
19 information is required to adjudicate the claim. After receipt  
20 of the additional information, the organization shall pay the  
21 claim within 10 days. If the claim is submitted by United  
22 States mail or overnight delivery service, the organization  
23 shall pay the claim within 30 days or the organization shall  
24 advise the subscriber of what additional information is  
25 required to adjudicate the claim. After receipt of the  
26 additional information, the organization shall pay the claim  
27 within 10 days. If the organization fails to pay claims  
28 submitted by subscribers within the time periods specified in  
29 this paragraph, the organization shall pay the subscriber  
30 twice the amount of the claim. Failure to pay claims and  
31 penalties, if applicable, within the time periods specified in

1 this paragraph, is a violation of the insurance code and each  
2 occurrence shall be considered a separate violation.

3 Section 9. Effective October 16, 2002, subsection (1)  
4 of section 641.30, Florida Statutes, is amended to read:

5 641.30 Construction and relationship to other laws.--

6 (1) Every health maintenance organization shall accept  
7 the ~~standard health~~ claim form prescribed pursuant to s.  
8 641.3155 ~~627-647~~.

9 Section 10. Effective October 16, 2002, section  
10 641.3155, Florida Statutes, is amended to read:

11 641.3155 Payment of claims.--

12 (1)(a) As used in this section, the term "~~clean~~ claim"  
13 for a noninstitutional provider means a paper or electronic  
14 billing instrument that consists of the HCFA 1500 data set  
15 that has all mandatory entries for a physician licensed under  
16 chapter 458 or chapter 459 or other appropriate form for any  
17 other noninstitutional provider, or its successor. For  
18 institutional providers, "claim" means a paper or electronic  
19 billing instrument that consists of the UB-92 data set or its  
20 successor that has all mandatory entries.~~claim submitted on a~~  
21 ~~HCFA 1500 form which has no defect or impropriety, including~~  
22 ~~lack of required substantiating documentation for~~  
23 ~~noncontracted providers and suppliers, or particular~~  
24 ~~circumstances requiring special treatment which prevent timely~~  
25 ~~payment from being made on the claim. A claim may not be~~  
26 ~~considered not clean solely because a health maintenance~~  
27 ~~organization refers the claim to a medical specialist within~~  
28 ~~the health maintenance organization for examination. If~~  
29 ~~additional substantiating documentation, such as the medical~~  
30 ~~record or encounter data, is required from a source outside~~  
31 ~~the health maintenance organization, the claim is considered~~

1 ~~not clean. This definition of "clean claim" is repealed on the~~  
2 ~~effective date of rules adopted by the department which define~~  
3 ~~the term "clean claim."~~

4 ~~(b) Absent a written definition that is agreed upon~~  
5 ~~through contract, the term "clean claim" for an institutional~~  
6 ~~claim is a properly and accurately completed paper or~~  
7 ~~electronic billing instrument that consists of the UB-92 data~~  
8 ~~set or its successor with entries stated as mandatory by the~~  
9 ~~National Uniform Billing Committee.~~

10 ~~(b)(c)~~ The department shall adopt rules to establish  
11 claim forms consistent with federal claim-filing standards for  
12 health maintenance organizations required by the Secretary of  
13 the United States Department of Health and Human Services  
14 ~~federal Health Care Financing Administration~~. The department  
15 shall may adopt rules to require code sets consistent with  
16 code sets adopted by the Secretary of the United States  
17 Department of Health and Human Services. The code sets shall  
18 apply to electronic claims. A code set, as defined by the  
19 secretary, shall include both the codes and the descriptors of  
20 the codes and shall also include, but not be limited to:

21 1. Medical data code sets, including the International  
22 Classification of Diseases, the HCFA Common Procedure Coding  
23 System and current procedure terminology, and the HCFA Common  
24 Procedure Coding System for supplies or other items used in  
25 health care services.

26 2. Health care claims or equivalent encounter  
27 information for professional and institutional health care  
28 claims.

29 3. Eligibility for a health plan standard.

30 4. Referral certification and authorization standard.

31 5. Health care claim status standard.

1           6. Health care payment and remittance advice standard.  
2           7. Enrollment and disenrollment in a health plan  
3 standard.  
4           8. Coordination of benefits standard.  
5           9. Revenue codes used by Medicare for processing  
6 claims.  
7           10. National Correct Coding Initiative edits used by  
8 Medicare relating to coding standards consistent with Medicare  
9 coding standards adopted by the federal Health Care Financing  
10 Administration.  
11           (c) All providers and payors shall use the standard  
12 code sets defined for their area of operation by the Secretary  
13 of the United States Department of Health and Human Services  
14 for the filing and adjudication of electronic claims. The  
15 version of the code set shall be the version that is valid at  
16 the time the health care is furnished, defined as the date of  
17 discharge for inpatient services and date of service for  
18 health care provided in an outpatient or ambulatory setting.  
19           (2)(a) A health maintenance organization shall pay any  
20 ~~clean~~ claim or any portion of a ~~clean~~ claim made by a contract  
21 provider for services or goods provided under a contract with  
22 the health maintenance organization or a ~~clean~~ claim made by a  
23 noncontract provider which the organization does not contest  
24 or deny, within 15 35 days after receipt of the claim by the  
25 health maintenance organization which is ~~mailed or~~  
26 electronically submitted ~~transferred~~ by the provider, or  
27 within 35 calendar days after receipt of the claim by the  
28 health maintenance organization that is submitted by the  
29 provider using either hand delivery, the United States mail,  
30 or a reputable overnight delivery service. The investigation  
31 and determination of eligibility for payment, including any

1 coordination of any other payments, does not extend the time  
2 periods contained in this paragraph.

3 (b) A health maintenance organization that denies or  
4 contests a provider's claim or any portion of a claim shall  
5 notify the provider, ~~in writing,~~ within 35 calendar days after  
6 the health maintenance organization receives the claim, if  
7 submitted by hand delivery, United States mail, or overnight  
8 delivery service, or within 15 calendar days after the health  
9 maintenance organization receives the claim if submitted by  
10 electronic means, that the claim is contested or denied. The  
11 notice that the claim is denied or contested must identify the  
12 contested portion of the claim and the specific reason for  
13 contesting or denying the claim, and, if contested, must give  
14 the provider a written itemization of any ~~include a request~~  
15 for additional information or additional documents needed to  
16 process the claim or any portion of the claim that is not  
17 being paid. ~~if the provider submits additional information,~~  
18 the provider must, within 35 days after receipt of the  
19 request, mail or electronically transfer the information to  
20 the health maintenance organization.The health maintenance  
21 organization shall pay or deny the claim or portion of the  
22 claim within 35 calendar ~~45~~ days after receipt of the  
23 information from the provider. A health maintenance  
24 organization may not make more than one request under this  
25 paragraph in connection with a claim, unless the provider  
26 fails to submit all of the requested information to process  
27 the claim, in which case the health maintenance organization  
28 may provide the health care provider with one additional  
29 opportunity to submit the additional information needed to  
30 process the claim.

31

1           (c) If a health maintenance organization requests  
2 additional information or additional documents from a person  
3 other than the provider who submitted the claim, the health  
4 maintenance organization shall provide a copy of the request  
5 to the provider who submitted the claim. The health  
6 maintenance organization shall not withhold payment pending  
7 receipt of information or documents requested under this  
8 paragraph. If, upon receiving information or documents  
9 requested under this paragraph, the health maintenance  
10 organization determines the existence of an error in payment  
11 of the claim, the health maintenance organization may recover  
12 the payment under subsection (5).

13           (d) A health maintenance organization shall not deny  
14 or withhold payment on a claim because the insured has not  
15 paid a requested deductible or copayment.

16           (3) Payment of a claim is considered made on the date  
17 the payment was received or electronically transferred or  
18 otherwise delivered. An insurer that does not pay a claim when  
19 payment is due as provided in subsection (4) shall pay the  
20 provider submitting the claim the full amount of the  
21 provider's billed charges submitted on the claim or twice the  
22 provider's contracted rate, whichever is less.~~An overdue~~  
23 ~~payment of a claim bears simple interest at the rate of 10~~  
24 ~~percent per year. Interest on an overdue payment for a clean~~  
25 ~~claim or for any uncontested portion of a clean claim begins~~  
26 ~~to accrue on the 36th day after the claim has been received.~~  
27 ~~The interest is payable with the payment of the claim.~~

28           (4) A health maintenance organization shall pay or  
29 deny any claim no later than 50 calendar ~~120~~ days after  
30 receiving the claim if the claim is submitted electronically  
31 or no later than 70 calendar days if the claim is submitted by



1 hand delivery, United States mail, or a reputable overnight  
2 delivery service. Failure to pay or deny a claim within such  
3 time periods ~~do so~~ creates an uncontestable obligation for the  
4 health maintenance organization to pay the claim to the  
5 provider. The running of the time specified in this subsection  
6 shall be tolled by the number of days taken by the provider  
7 who submitted the claim to submit the additional information  
8 requested by the health maintenance organization pursuant to  
9 paragraph (2)(b).

10 (5)(a) If, as a result of retroactive review of  
11 coverage decisions or payment levels, a health maintenance  
12 organization determines that it has made an overpayment to a  
13 provider for services rendered to a subscriber, the  
14 organization must make a claim for such overpayment. The  
15 organization may not reduce payment to that provider for other  
16 services unless the provider agrees to the reduction in  
17 writing after receipt of the claim for overpayment from the  
18 health maintenance organization or fails to respond to the  
19 organization's claim as required in this subsection.

20 (b) A provider shall pay a claim for an overpayment  
21 made by a health maintenance organization which the provider  
22 does not contest or deny within 15 calendar ~~35~~ days after  
23 receipt of the claim that is ~~mailed or~~ electronically  
24 transferred to the provider, or within 35 calendar days after  
25 receipt of the claim that is submitted to the provider using  
26 either United States mail or a reputable overnight delivery  
27 service.

28 (c) A provider that denies or contests an  
29 organization's claim for overpayment or any portion of a claim  
30 shall notify the organization, in writing, within 35 calendar  
31 days after the provider receives the claim if the claim is

1 submitted by United States mail or overnight delivery service,  
2 or within 15 calendar days after the provider receives the  
3 claim if the claim is electronically transferred to the  
4 provider, that the claim for overpayment is contested or  
5 denied. The notice that the claim for overpayment is denied or  
6 contested must identify the contested portion of the claim and  
7 the specific reason for contesting or denying the claim, and,  
8 if contested, must include a request for additional  
9 information. If the organization submits additional  
10 information, the organization must, within 21 calendar ~~35~~ days  
11 after receipt of the request, mail or electronically transfer  
12 the information to the provider. The provider shall pay or  
13 deny the claim for overpayment within 30 calendar ~~45~~ days  
14 after receipt of the information.

15 (d) Payment of a claim for overpayment is considered  
16 made on the date payment was received or electronically  
17 transferred or otherwise delivered to the organization, or the  
18 date that the provider receives a payment from the  
19 organization that reduces or deducts the overpayment. An  
20 overdue payment of a claim bears simple interest at the rate  
21 of 18 ~~10~~ percent a year. Interest on an overdue payment of a  
22 claim for overpayment or for any uncontested portion of a  
23 claim for overpayment begins to accrue on the 36th day after  
24 the claim for overpayment has been received.

25 (e) A provider shall pay or deny any claim for  
26 overpayment no later than 71 calendar ~~120~~ days after receiving  
27 the claim if submitted electronically or no later than 91  
28 calendar days if the claim for overpayment is submitted by  
29 United States mail or overnight delivery service. Failure to  
30 do so creates an uncontestable obligation for the provider to  
31 pay the claim to the organization.

1           (6) Any retroactive reductions of payments or demands  
2 for refund of previous overpayments which are due to  
3 retroactive review-of-coverage decisions or payment levels  
4 must be reconciled to specific claims unless the parties agree  
5 to other reconciliation methods and terms. Any retroactive  
6 demands by providers for payment due to underpayments or  
7 nonpayments for covered services must be reconciled to  
8 specific claims unless the parties agree to other  
9 reconciliation methods and terms. The look-back or audit  
10 review period shall not exceed 1 year ~~may be specified by the~~  
11 ~~terms of the contract.~~

12           (7)(a) A provider claim for payment shall be  
13 considered received by the health maintenance organization  
14 when receipt is verified electronically, if the claim has been  
15 electronically transmitted to the health maintenance  
16 organization, on the date indicated on the return receipt ~~when~~  
17 ~~receipt is verified electronically or~~, if the claim is mailed  
18 by United States mail to the address disclosed by the  
19 organization, or on the date the delivery receipt is signed by  
20 the health maintenance organization if the claim is hand  
21 delivered on the date indicated on the return receipt. A  
22 health maintenance organization shall not require a provider  
23 to resubmit a claim for payment if the claim has been received  
24 by the organization. A provider must wait 45 calendar days  
25 following receipt of a claim before submitting a duplicate  
26 claim.

27           (b) A health maintenance organization claim for  
28 overpayment shall be considered received by a provider, if the  
29 claim has been electronically transmitted to the provider,  
30 when receipt is verified electronically or, if the claim is  
31 mailed to the address disclosed by the provider, on the date

1 indicated on the return receipt. A provider shall not require  
2 a health maintenance organization to resubmit a claim for  
3 payment if the claim for overpayment has been received by the  
4 provider. An organization must wait 45 calendar days following  
5 the provider's receipt of a claim for overpayment before  
6 submitting a duplicate claim.

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

10 (8) A health maintenance organization shall provide a  
11 provider, or the provider's designee who bills electronically,  
12 electronic acknowledgment of the receipt of a claim within 24  
13 hours after receipt. ~~A provider, or the provider's designee,~~  
14 ~~who bills electronically is entitled to electronic~~  
15 ~~acknowledgment of the receipt of a claim within 72 hours.~~

16 (9) A health maintenance organization may not  
17 retroactively deny a claim because of subscriber ineligibility  
18 ~~more than 1 year after the date of payment of the clean claim.~~

19 (10) A health maintenance organization shall pay a  
20 contracted primary care or admitting physician, pursuant to  
21 such physician's contract, for providing inpatient services in  
22 a contracted hospital to a subscriber, if such services are  
23 determined by the organization to be medically necessary and  
24 covered services under the organization's contract with the  
25 contract holder.

26 (11)(a) Each policy issued by a health maintenance  
27 organization shall contain a provision for coordinating  
28 benefits under the policy with any similar benefits provided  
29 by any other health maintenance organization, group hospital,  
30 medical, or surgical expense policy; any group health care  
31 services plan; any auto medical policy; any governmental

1 medical expense policy; or any group-type self-insurance plan  
2 that provides protection or insurance against hospital,  
3 medical, or surgical expenses for the same loss.

4 (b) A policy issued by a health maintenance  
5 organization shall contain a provision whereby the health  
6 maintenance organization may reduce or refuse to pay benefits  
7 otherwise payable under the policy solely due to the existence  
8 of similar benefits provided under insurance policies issued  
9 by the same or another health maintenance organization,  
10 insurer, health care services plan, or self-insurance plan if  
11 the similar benefits provide protection or insurance against  
12 hospital, medical, or surgical expenses only if, as a  
13 condition of coordinating benefits with another insurer, 100  
14 percent of the total covered charges described in the policies  
15 and presented for payment are paid.

16 (c) If a subscriber fails to furnish the provider with  
17 the correct name and address of the subscriber's primary  
18 prepaid health plan, group hospital, medical, or surgical  
19 expense policy, group health care services plan, or group-type  
20 self-insurance plan that provides protection or insurance  
21 against hospital, medical, or surgical expenses delivered or  
22 issued for delivery in this state, and the claim is submitted  
23 to a secondary prepaid health plan or insurer and is  
24 subsequently rejected, the provider has 60 calendar days from  
25 the date the provider obtains the correct billing information  
26 for the primary or secondary insurer or prepaid health plan to  
27 submit the claim, regardless of any time periods for  
28 submission of claims established by any applicable contract.  
29 For the purposes of this subsection, "insurer" includes  
30 persons contracting with preferred provider networks pursuant  
31

1 to s. 627.6471 and exclusive provider networks pursuant to s.  
2 627.6472.

3 (12)(a) Without regard to any other remedy or relief  
4 to which a provider is entitled, any provider aggrieved by a  
5 violation of this section by a health maintenance organization  
6 may bring an action to enjoin a person who has violated, or is  
7 violating, this section. In any such action, the provider who  
8 has suffered a loss as a result of the violation may recover  
9 any amounts due the provider by the health maintenance  
10 organization, including accrued interest, plus attorney's fees  
11 and costs as provided in paragraph (b).

12 (b) In any action arising out of a violation of this  
13 section by a health maintenance organization in which the  
14 health maintenance organization is found to have violated this  
15 section, the provider, after judgment in the trial court and  
16 after exhausting all appeals, if any, shall receive his or her  
17 reasonable attorney's fees and costs from the health  
18 maintenance organization.

19 (13) The provisions of this section may not be waived,  
20 voided, or nullified by contract.

21 Section 11. Section 641.3156, Florida Statutes, is  
22 amended to read:

23 641.3156 Treatment authorization; payment of claims.--

24 (1) For purposes of this section, "authorization"  
25 includes any requirement of a provider to notify a health  
26 maintenance organization in advance of providing a covered  
27 service, regardless of whether the actual terminology used by  
28 the organization includes, but is not limited to,  
29 preauthorization, precertification, notification, or any other  
30 similar terminology.

31

1           (2) A health maintenance organization that requires  
2 authorization for medical care and health care services shall  
3 provide to each contracted provider at the time a contract is  
4 signed a list of the medical care and health care services  
5 that require authorization and the authorization procedures  
6 used by the organization. A health maintenance organization  
7 that requires authorization for medical care and health care  
8 services shall provide to each noncontracted provider, not  
9 later than 10 working days after a request is made, a list of  
10 the medical care and health care services that require  
11 authorization and the authorization procedures used by the  
12 organization. The list of medical care or health care services  
13 that require authorization and the authorization procedures  
14 used by the organization shall not be modified unless written  
15 notice is provided at least 30 days in advance of any changes  
16 to all subscribers, contracted providers, and noncontracted  
17 providers who had previously requested a list of medical care  
18 or health care services that require authorization.

19           (3) Any claim for treatment that does not require an  
20 authorization for a covered service that is ordered by a  
21 contracted physician may not be denied.~~A health maintenance~~  
22 ~~organization must pay any hospital service or referral service~~  
23 ~~claim for treatment for an eligible subscriber which was~~  
24 ~~authorized by a provider empowered by contract with the health~~  
25 ~~maintenance organization to authorize or direct the patient's~~  
26 ~~utilization of health care services and which was also~~  
27 ~~authorized in accordance with the health maintenance~~  
28 ~~organization's current and communicated procedures, unless the~~  
29 ~~provider provided information to the health maintenance~~  
30 ~~organization with the willful intention to misinform the~~  
31 ~~health maintenance organization.~~

1           ~~(4)(a)(2)~~ A claim for treatment may not be denied if a  
2 provider follows the health maintenance organization's  
3 authorization procedures and receives authorization for a  
4 covered service for an eligible subscriber, unless the  
5 provider provided information to the health maintenance  
6 organization with the willful intention to misinform the  
7 health maintenance organization.

8           (b) On receipt of a request from a provider for  
9 authorization pursuant to this section, the health maintenance  
10 organization shall issue a determination indicating whether  
11 the service or services are authorized. The determination must  
12 be transmitted to the provider making the request in writing  
13 no later than 8 hours after the request is made by the  
14 provider. If the organization denies the request for an  
15 authorization, the health maintenance organization must notify  
16 the subscriber at the same time when notifying the provider  
17 requesting the authorization. A health maintenance  
18 organization that fails to respond to a request for an  
19 authorization from a provider pursuant to this paragraph is  
20 considered to have authorized the requested medical care or  
21 health care service and payment may not be denied.

22           (5) If the proposed medical care or health care  
23 service or services involve an inpatient admission and the  
24 health maintenance organization requires authorization as a  
25 condition of payment, the health maintenance organization  
26 shall issue a written or electronic authorization for the  
27 total estimated length of stay for the admission. If the  
28 proposed medical care or health care service or services are  
29 to be provided to a patient who is an inpatient in a health  
30 care facility at the time the services are proposed and the  
31 medical care or health care service requires an authorization,



1 the health maintenance organization shall issue a  
2 determination indicating whether the proposed services are  
3 authorized no later than 1 hour after the request by the  
4 health care provider. A health maintenance organization that  
5 fails to respond to such request within 1 hour is considered  
6 to have authorized the requested medical care or health care  
7 service and payment may not be denied.

8 (6)(3) Emergency services are subject to the  
9 provisions of s. 641.513 and are not subject to the provisions  
10 of this section, including any inpatient admission required in  
11 order to stabilize the patient pursuant to federal and state  
12 law.

13 (7) The provisions of this section may not be waived,  
14 voided, or nullified by contract.

15 Section 12. Subsection (4) of section 627.651, Florida  
16 Statutes, is amended to read:

17 627.651 Group contracts and plans of self-insurance  
18 must meet group requirements.--

19 (4) This section does not apply to any plan which is  
20 established or maintained by an individual employer in  
21 accordance with the Employee Retirement Income Security Act of  
22 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
23 arrangement as defined in s. 624.437(1), except that a  
24 multiple-employer welfare arrangement shall comply with ss.  
25 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,  
26 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(9)~~(6)~~.  
27 This subsection does not allow an authorized insurer to issue  
28 a group health insurance policy or certificate which does not  
29 comply with this part.

30 Section 13. Effective October 16, 2002, section  
31 627.647, Florida Statutes, is repealed.

1           Section 14. Except as otherwise provided in this act,  
2 this act shall take effect October 1, 2002.

3  
4           \*\*\*\*\*

5                           LEGISLATIVE SUMMARY

6  
7           Includes preferred provider organizations within the  
8 definition of managed care organization and provides for  
9 filing unresolved internal dispute-resolution processes  
10 with a dispute-resolution organization. Provides for  
11 coordination of benefits under multiple health insurance  
12 policies regardless of time periods. Revises time of  
13 payment of claims provisions. Requires the Department of  
14 Insurance to adopt insurance claim-filing rules  
15 consistent with federal standards and provides  
16 requirements and procedures for payment or denial of  
17 claims. Entitles insureds and health maintenance  
18 organization subscribers to prompt payment of claims for  
19 covered services. Requires health insurers and health  
20 maintenance organizations to provide lists of medical  
21 care and health care services that require authorization  
22 and provides procedural requirements for determination  
23 and issuance of authorizations for services. Revises  
24 limitations on policies providing differing schedules of  
25 payments for preferred provider services and nonpreferred  
26 provider services. Applies coordination of benefits,  
27 payment of claims, and treatment authorizations  
28 provisions to group, blanket, and franchise health  
29 insurance. (See bill for details.)  
30  
31