

By the Committee on Banking and Insurance; and Senators
Saunders, Campbell, Peaden and Cowin

311-1784-02

1 A bill to be entitled
2 An act relating to health insurance; amending
3 s. 408.7057, F.S.; redefining "managed care
4 organization"; including preferred provider
5 organization and health insurers in the claim
6 dispute resolution program; specifying
7 timeframes for submission of supporting
8 documentation necessary for dispute resolution;
9 providing consequences for failure to comply;
10 authorizing the agency to impose fines and
11 sanctions as part of final orders; amending s.
12 627.613, F.S.; revising time of payment of
13 claims provisions; providing requirements and
14 procedures for payment or denial of claims;
15 providing criteria and limitations; revising
16 rate of interest charged on overdue payments;
17 providing for electronic transmission of
18 claims; providing a penalty; providing for
19 attorney's fees and costs; prohibiting
20 contractual modification of provisions of law;
21 creating s. 627.6142, F.S.; defining the term
22 "authorization"; requiring health insurers to
23 provide lists of medical care and health care
24 services that require authorization;
25 prohibiting denial of certain claims; providing
26 procedural requirements for determination and
27 issuance of authorizations of services;
28 amending s. 627.638, F.S.; providing for direct
29 payment for services in treatment of a
30 psychological disorder or substance abuse;
31 amending s. 627.651, F.S.; conforming a

1 cross-reference; amending s. 627.662, F.S.;

2 specifying application of certain additional

3 provisions to group, blanket, and franchise

4 health insurance; amending s. 641.185, F.S.;

5 entitling health maintenance organization

6 subscribers to prompt payment when appropriate;

7 amending s. 641.30, F.S.; conforming a

8 cross-reference; amending s. 641.3155, F.S.;

9 revising definitions; eliminating provisions

10 that require the Department of Insurance to

11 adopt rules consistent with federal

12 claim-filing standards; providing requirements

13 and procedures for payment of claims; requiring

14 payment within specified periods; revising rate

15 of interest charged on overdue payments;

16 requiring employers to provide notice of

17 changes in eligibility status within a

18 specified time period; providing a penalty;

19 entitling health maintenance organization

20 subscribers to prompt payment by the

21 organization for covered services by an

22 out-of-network provider; requiring payment

23 within specified periods; providing payment

24 procedures; providing penalties; amending s.

25 641.3156, F.S.; defining the term

26 "authorization"; requiring health maintenance

27 organizations to provide lists of medical care

28 and health care services that require

29 authorization; prohibiting denial of certain

30 claims; providing procedural requirements for

31 determination and issuance of authorizations of

1 services; amending ss. 626.9541, 641.3903,
2 F.S.; providing that untruthfully notifying a
3 provider that a filed claim has not been
4 received constitutes an unfair claim-settlement
5 practice by insurers and health maintenance
6 organizations; providing penalties; providing
7 an effective date.

8

9 Be It Enacted by the Legislature of the State of Florida:

10

11 Section 1. Paragraph (a) of subsection (1), paragraph
12 (c) of subsection (2), and subsection (4) of section 408.7057,
13 Florida Statutes, are amended, and paragraphs (e) and (f) are
14 added to subsection (2) of that section, to read:

15 408.7057 Statewide provider and managed care
16 organization claim dispute resolution program.--

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

18 (a) "Managed care organization" means a health
19 maintenance organization or a prepaid health clinic certified
20 under chapter 641, a prepaid health plan authorized under s.
21 409.912, ~~or~~ an exclusive provider organization certified under
22 s. 627.6472, a preferred provider organization under s.
23 627.6471, or a health insurer licensed pursuant to chapter
24 627.

25 (2)

26 (c) Contracts entered into or renewed on or after
27 October 1, 2000, may require exhaustion of an internal
28 dispute-resolution process as a prerequisite to the submission
29 of a claim by a provider, ~~or~~ health maintenance organization,
30 or health insurer to the resolution organization ~~when the~~
31 ~~dispute-resolution program becomes effective.~~

1 (e) The resolution organization shall require the
2 managed care organization or provider submitting the claim
3 dispute to submit any supporting documentation to the
4 resolution organization within 15 days after receipt by the
5 managed care organization or provider of a request from the
6 resolution organization for documentation in support of the
7 claim dispute. Failure to submit the supporting documentation
8 within such time period shall result in the dismissal of the
9 submitted claim dispute.

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

23 (4) Within 30 days after receipt of the recommendation
24 of the resolution organization, the agency shall adopt the
25 recommendation as a final order. The agency may issue a final
26 order imposing fines or sanctions, including those contained
27 in s. 641.52. All fines collected under this subsection shall
28 be deposited into the Health Care Trust Fund.

29 Section 2. Section 627.613, Florida Statutes, is
30 amended to read:

31 627.613 Time of payment of claims.--

1 (1) The contract shall include the following
2 provision:

3
4 "Time of Payment of Claims: After receiving written
5 proof of loss, the insurer will pay monthly all benefits then
6 due for (type of benefit). Benefits for any other loss covered
7 by this policy will be paid as soon as the insurer receives
8 proper written proof."
9

10 (2) Health insurers shall reimburse all claims or any
11 portion of any claim from an insured or an insured's
12 assignees, for payment under a health insurance policy, within
13 35 ~~45~~ days after receipt of the claim by the health insurer.
14 If a claim or a portion of a claim is contested by the health
15 insurer, the insured or the insured's assignees shall be
16 notified, in writing, that the claim is contested or denied,
17 within 35 ~~45~~ days after receipt of the claim by the health
18 insurer. The notice that a claim is contested shall identify
19 the contested portion of the claim, and the specific reasons
20 for contesting the claim, and written itemization of any
21 additional information or additional documents needed to
22 process the claim or the contested portion of the claim. A
23 health insurer may not make more than one request under this
24 subsection in connection with a claim unless the provider
25 fails to submit all of the requested information to process
26 the claim or if information submitted by the provider raises
27 new, additional issues not included in the original written
28 itemization, in which case the health insurer may provide the
29 health care provider with one additional opportunity to submit
30 the additional information needed to process the claim. In no
31 case may the health insurer request duplicate information.

1 (3) A health insurer, upon receipt of the additional
2 information requested from the insured or the insured's
3 assignees shall pay or deny the contested claim or portion of
4 the contested claim, within 35 ~~60~~ days.

5 (4) A health An insurer shall pay or deny any claim no
6 later than 120 days after receiving the claim. Failure to do
7 so creates an uncontestable obligation for the health insurer
8 to pay the claim to the provider.

9 (5) Payment of a claim is considered ~~shall be treated~~
10 ~~as being~~ made on the date the payment was electronically
11 transferred or otherwise delivered ~~a draft or other valid~~
12 ~~instrument which is equivalent to payment was placed in the~~
13 ~~United States mail in a properly addressed, postpaid envelope~~
14 ~~or, if not so posted, on the date of delivery.~~

15 (6) All overdue payments shall bear simple interest at
16 the rate of 12 ~~10~~ percent per year. Interest on a late payment
17 of a claim or uncontested portion of a claim begins to accrue
18 on the 36th day after the claim has been received. Interest
19 due is payable with the payment of the claim.

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

1 (8) A provider claim for payment shall be considered
2 received by the health insurer, if the claim has been
3 electronically transmitted to the health insurer, when receipt
4 is verified electronically or, if the claim is mailed to the
5 address disclosed by the health insurer, on the date indicated
6 on the return receipt. A provider must wait 35 days following
7 receipt of a claim before submitting a duplicate claim.

8 (9)(a) If, as a result of retroactive review of
9 coverage decisions or payment levels, a health insurer
10 determines that it has made an overpayment to a provider for
11 services rendered to an insured, the health insurer must make
12 a claim for such overpayment. The health insurer may not
13 reduce payment to that provider for other services unless the
14 provider agrees to the reduction or fails to respond to the
15 health insurer's claim as required in this subsection.

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

20 (c) A provider that denies or contests a health
21 insurer's claim for overpayment or any portion of a claim
22 shall notify the health insurer, in writing, within 35 days
23 after the provider receives the claim that the claim for
24 overpayment is contested or denied. The notice that the claim
25 for overpayment is contested or denied must identify the
26 contested portion of the claim and the specific reason for
27 contesting or denying the claim, and, if contested, must
28 include a request for additional information. The provider
29 shall pay or deny the claim for overpayment within 35 days
30 after receipt of the information.

31

1 (d) Payment of a claim for overpayment is considered
2 made on the date payment was electronically transferred or
3 otherwise delivered to the health insurer or on the date that
4 the provider receives a payment from the health insurer that
5 reduces or deducts the overpayment. An overdue payment of a
6 claim bears simple interest at the rate of 12 percent per
7 year. Interest on an overdue payment of a claim for
8 overpayment or for any uncontested portion of a claim for
9 overpayment begins to accrue on the 36th day after the claim
10 for overpayment has been received.

11 (e) A provider shall pay or deny any claim for
12 overpayment no later than 120 days after receiving the claim.
13 Failure to do so creates an uncontestable obligation for the
14 provider to pay the claim to the health insurer.

15 (f) A health insurer's claim for overpayment shall be
16 considered received by a provider, if the claim has been
17 electronically transmitted to the provider, when receipt is
18 verified electronically, or, if the claim is mailed to the
19 address disclosed by the provider, on the date indicated on
20 the return receipt. A health insurer must wait 35 days
21 following the provider's receipt of a claim for overpayment
22 before submitting a duplicate claim.

23 (10) Any retroactive reductions of payments or demands
24 for refund of previous overpayments that are due to
25 retroactive review of coverage decisions or payment levels
26 must be reconciled to specific claims. Any retroactive demands
27 by providers for payment due to underpayments or nonpayments
28 for covered services must be reconciled to specific claims.
29 The look-back or audit-review period shall not exceed 2 years
30 after the date the claim was paid by the health insurer,
31 unless fraud in billing is involved.

1 (11) A health insurer may not deny a claim because of
2 the insured's ineligibility if the provider can document
3 receipt of the insured's eligibility confirmation by the
4 health insurer prior to the date or time covered services were
5 provided. Any person who knowingly and willfully misinforms a
6 provider prior to receipt of services as to his or her
7 coverage eligibility commits insurance fraud, punishable as
8 provided in s. 817.50.

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

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

24 (13) The provisions of this section may not be waived,
25 voided, or nullified by contracts.

26 Section 3. Section 627.6142, Florida Statutes, is
27 created to read:

28 627.6142 Treatment authorization; payment of claims.--

29 (1) For purposes of this section, "authorization"
30 includes any requirement of a provider to notify an insurer in
31 advance of providing a covered service, regardless of whether

1 the actual terminology used by the insurer includes, but is
2 not limited to, preauthorization, precertification,
3 notification, or any other similar terminology.

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

31

1 (3) Any claim for a covered service that does not
2 require authorization that is ordered by a contracted
3 physician and entered on the medical record may not be denied.
4 If the health insurer determines that an overpayment has been
5 made, then a claim for overpayment should be submitted to the
6 provider pursuant to s. 627.613.

7 (4)(a) Any claim for treatment may not be denied if a
8 provider follows the health insurer's published authorization
9 procedures and receives authorization, unless the provider
10 submits information to the health insurer with the willful
11 intention to misinform the health insurer.

12 (b) Upon receipt of a request from a provider for
13 authorization, the health insurer shall issue a written
14 determination indicating whether the service or services are
15 authorized. If the request for an authorization is for an
16 inpatient admission, the determination shall be transmitted to
17 the provider making the request in writing no later than 24
18 hours after the request is made by the provider. If the health
19 insurer denies the request for authorization, the health
20 insurer shall notify the insured at the same time the insurer
21 notifies the provider requesting the authorization. A health
22 insurer that fails to respond to a request for an
23 authorization pursuant to this paragraph within 24 hours is
24 considered to have authorized the inpatient admission and
25 payment shall not be denied.

26 (5) If the proposed medical care or health care
27 service or services involve an inpatient admission and the
28 health insurer requires an authorization as a condition of
29 payment, the health insurer shall review and issue a written
30 or electronic authorization for the total estimated length of
31 stay for the admission, based on the recommendation of the

1 patient's physician. If the proposed medical care or health
2 care service or services are to be provided to an insured who
3 is an inpatient in a health care facility and authorization is
4 required, the health insurer shall issue a written
5 determination indicating whether the proposed services are
6 authorized or denied no later than 4 hours after the request
7 is made by the provider. A health insurer who fails to respond
8 to such request within 4 hours is considered to have
9 authorized the requested medical care or health care service
10 and payment shall not be denied.

11 (6) Authorization may not be required for emergency
12 services and care or emergency medical services as provided
13 pursuant to ss. 395.002, 395.1041, 401.45, and 401.252. Such
14 emergency services and care shall extend through any inpatient
15 admission required in order to provide for stabilization of an
16 emergency medical condition pursuant to state and federal law.

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

19 Section 4. Subsection (3) is added to section 627.638,
20 Florida Statutes, to read:

21 627.638 Direct payment for hospital, medical
22 services.--

23 (3) Under any health insurance policy insuring against
24 loss or expense due to hospital confinement or to medical and
25 related services, payment of benefits shall be made directly
26 to any recognized hospital, doctor, or other person who
27 provided services for the treatment of a psychological
28 disorder or treatment for substance abuse, including drug and
29 alcohol abuse, when the treatment is in accordance with the
30 provisions of the policy and the insured specifically
31 authorizes direct payment of benefits. Payments shall be made

1 under this section, notwithstanding any contrary provisions in
2 the health insurance contract. This subsection applies to all
3 health insurance policies now or hereafter in force as of the
4 effective date of this act.

5 Section 5. Subsection (4) of section 627.651, Florida
6 Statutes, is amended to read:

7 627.651 Group contracts and plans of self-insurance
8 must meet group requirements.--

9 (4) This section does not apply to any plan which is
10 established or maintained by an individual employer in
11 accordance with the Employee Retirement Income Security Act of
12 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
13 arrangement as defined in s. 624.437(1), except that a
14 multiple-employer welfare arrangement shall comply with ss.
15 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
16 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(8)(6)~~.
17 This subsection does not allow an authorized insurer to issue
18 a group health insurance policy or certificate which does not
19 comply with this part.

20 Section 6. Section 627.662, Florida Statutes, is
21 amended to read:

22 627.662 Other provisions applicable.--The following
23 provisions apply to group health insurance, blanket health
24 insurance, and franchise health insurance:

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

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

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

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

1 (5) Section 627.640, relating to filing and
2 classification of rates.

3 (6) Section 627.6142, relating to treatment
4 authorizations.

5 ~~(7)(6)~~ Section 627.645(1), relating to denial of
6 claims.

7 ~~(8)(7)~~ Section 627.613, relating to time of payment of
8 claims.

9 ~~(9)(8)~~ Section 627.6471, relating to preferred
10 provider organizations.

11 ~~(10)(9)~~ Section 627.6472, relating to exclusive
12 provider organizations.

13 ~~(11)(10)~~ Section 627.6473, relating to combined
14 preferred provider and exclusive provider policies.

15 ~~(12)(11)~~ Section 627.6474, relating to provider
16 contracts.

17 Section 7. Paragraph (e) of subsection (1) of section
18 641.185, Florida Statutes, is amended to read:

19 641.185 Health maintenance organization subscriber
20 protections.--

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

29 (e) A health maintenance organization subscriber
30 should receive timely, concise information regarding the
31 health maintenance organization's reimbursement to providers

1 and services pursuant to ss. 641.31 and 641.31015 and is
2 entitled to prompt payment from the organization when
3 appropriate pursuant to s. 641.3155.

4 Section 8. Subsection (1) of section 641.30, Florida
5 Statutes, is amended to read:

6 641.30 Construction and relationship to other laws.--

7 (1) Every health maintenance organization shall accept
8 the ~~standard health~~ claim form prescribed pursuant to s.
9 641.3155 ~~627.647~~.

10 Section 9. Section 641.3155, Florida Statutes, is
11 amended to read:

12 641.3155 Payment of claims.--

13 (1)~~(a)~~ As used in this section, the term "~~clean~~ claim"
14 for a noninstitutional provider means a paper or electronic
15 billing instrument that consists of the HCFA 1500 data set
16 that has all mandatory entries for a physician licensed under
17 chapter 458, chapter 459, chapter 460, chapter 461, or chapter
18 490 or other appropriate form for any other noninstitutional
19 provider, or its successor. For institutional providers,
20 "claim" means a paper or electronic billing instrument that
21 consists of the UB-92 data set or its successor that has all
22 mandatory entries.~~claim submitted on a HCFA 1500 form which~~
23 ~~has no defect or impropriety, including lack of required~~
24 ~~substantiating documentation for noncontracted providers and~~
25 ~~suppliers, or particular circumstances requiring special~~
26 ~~treatment which prevent timely payment from being made on the~~
27 ~~claim. A claim may not be considered not clean solely because~~
28 ~~a health maintenance organization refers the claim to a~~
29 ~~medical specialist within the health maintenance organization~~
30 ~~for examination. If additional substantiating documentation,~~
31 ~~such as the medical record or encounter data, is required from~~

1 ~~a source outside the health maintenance organization, the~~
2 ~~claim is considered not clean. This definition of "clean~~
3 ~~claim" is repealed on the effective date of rules adopted by~~
4 ~~the department which define the term "clean claim."~~

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

11 ~~(c) The department shall adopt rules to establish~~
12 ~~claim forms consistent with federal claim filing standards for~~
13 ~~health maintenance organizations required by the federal~~
14 ~~Health Care Financing Administration. The department may adopt~~
15 ~~rules relating to coding standards consistent with Medicare~~
16 ~~coding standards adopted by the federal Health Care Financing~~
17 ~~Administration.~~

18 (2)(a) A health maintenance organization shall pay any
19 ~~clean~~ claim or any portion of a ~~clean~~ claim made by a contract
20 provider for services or goods provided under a contract with
21 the health maintenance organization or a ~~clean~~ claim made by a
22 noncontract provider which the organization does not contest
23 or deny within 35 days after receipt of the claim by the
24 health maintenance organization which is submitted ~~mailed or~~
25 ~~electronically transferred~~ by the provider, either
26 electronically or using hand delivery, the United States mail,
27 or a reputable overnight delivery service.

28 (b) A health maintenance organization that denies or
29 contests a provider's claim or any portion of a claim shall
30 notify the provider, in writing, within 35 days after the
31 health maintenance organization receives the claim that the

1 claim is contested or denied. The notice that the claim is
2 denied or contested must identify the contested portion of the
3 claim and the specific reason for contesting or denying the
4 claim, and, if contested, must give the provider a written
5 itemization of any ~~include a request for~~ additional
6 information or additional documents needed to process the
7 claim or any portion of the claim that is not being paid. If
8 the provider submits additional information, the provider
9 must, within 35 days after receipt of the request, mail or
10 electronically transfer the information to the health
11 maintenance organization. The health maintenance organization
12 shall pay or deny the claim or portion of the claim within 35
13 45 days after receipt of the information. A health maintenance
14 organization may not make more than one request under this
15 paragraph in connection with a claim, unless the provider
16 fails to submit all of the requested information to process
17 the claim or if information submitted by the provider raises
18 new, additional issues not included in the original written
19 itemization, in which case the health maintenance organization
20 may provide the health care provider with one additional
21 opportunity to submit the additional information needed to
22 process the claim. In no case may the health insurer request
23 duplicate information.

24 (c) A health maintenance organization shall not deny
25 or withhold payment on a claim because the insured has not
26 paid a required deductible or copayment.

27 (3) Payment of a claim is considered made on the date
28 the payment was received or electronically transferred or
29 otherwise delivered. An overdue payment of a claim bears
30 simple interest at the rate of 12 ~~10~~ percent per year.
31 Interest on an overdue payment for a clean claim or for any

1 uncontested portion of a clean claim begins to accrue on the
2 36th day after the claim has been received. The interest is
3 payable with the payment of the claim.

4 (4) A health maintenance organization shall pay or
5 deny any claim no later than 120 days after receiving the
6 claim. Failure to do so creates an uncontestable obligation
7 for the health maintenance organization to pay the claim to
8 the provider.

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

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

24 (c) A provider that denies or contests an
25 organization's claim for overpayment or any portion of a claim
26 shall notify the organization, in writing, within 35 days
27 after the provider receives the claim that the claim for
28 overpayment is contested or denied. The notice that the claim
29 for overpayment is denied or contested must identify the
30 contested portion of the claim and the specific reason for
31 contesting or denying the claim, and, if contested, must

1 include a request for additional information. If the
2 organization submits additional information, the organization
3 must, within 35 days after receipt of the request, mail or
4 electronically transfer the information to the provider. The
5 provider shall pay or deny the claim for overpayment within 45
6 days after receipt of the information.

7 (d) Payment of a claim for overpayment is considered
8 made on the date payment was received or electronically
9 transferred or otherwise delivered to the organization, or the
10 date that the provider receives a payment from the
11 organization that reduces or deducts the overpayment. An
12 overdue payment of a claim bears simple interest at the rate
13 of 12 ~~10~~ percent a year. Interest on an overdue payment of a
14 claim for overpayment or for any uncontested portion of a
15 claim for overpayment begins to accrue on the 36th day after
16 the claim for overpayment has been received.

17 (e) A provider shall pay or deny any claim for
18 overpayment no later than 120 days after receiving the claim.
19 Failure to do so creates an uncontestable obligation for the
20 provider to pay the claim to the organization.

21 (6) Any retroactive reductions of payments or demands
22 for refund of previous overpayments which are due to
23 retroactive review-of-coverage decisions or payment levels
24 must be reconciled to specific claims unless the parties agree
25 to other reconciliation methods and terms. Any retroactive
26 demands by providers for payment due to underpayments or
27 nonpayments for covered services must be reconciled to
28 specific claims unless the parties agree to other
29 reconciliation methods and terms. The look-back or
30 audit-review period shall not exceed 2 years after the date
31 the claim was paid by the health maintenance organization,

1 unless fraud in billing is involved.~~The look-back period may~~
2 ~~be specified by the terms of the contract.~~

3 (7)(a) A provider claim for payment shall be
4 considered received by the health maintenance organization, if
5 the claim has been electronically transmitted to the health
6 maintenance organization, when receipt is verified
7 electronically or, if the claim is mailed to the address
8 disclosed by the organization, on the date indicated on the
9 return receipt, or on the date the delivery receipt is signed
10 by the health maintenance organization if the claim is hand
11 delivered. A provider must wait 45 days following receipt of a
12 claim before submitting a duplicate claim.

13 (b) A health maintenance organization claim for
14 overpayment shall be considered received by a provider, if the
15 claim has been electronically transmitted to the provider,
16 when receipt is verified electronically or, if the claim is
17 mailed to the address disclosed by the provider, on the date
18 indicated on the return receipt. An organization must wait 45
19 days following the provider's receipt of a claim for
20 overpayment before submitting a duplicate claim.

21 (c) This section does not preclude the health
22 maintenance organization and provider from agreeing to other
23 methods of submission ~~transmission~~ and receipt of claims.

24 (8) A provider, or the provider's designee, who bills
25 electronically is entitled to electronic acknowledgment of the
26 receipt of a claim within 72 hours.

27 (9) A health maintenance organization may not
28 ~~retroactively~~ deny a claim because of subscriber ineligibility
29 if the provider can document receipt of subscriber eligibility
30 confirmation by the organization prior to the date or time
31 covered services were provided. Every health maintenance

1 organization contract with an employer shall include a
2 provision that requires the employer to notify the health
3 maintenance organization of changes in eligibility status
4 within 30 days ~~more than 1 year after the date of payment of~~
5 ~~the clean claim.~~ Any person who knowingly misinforms a
6 provider prior to the receipt of services as to his or her
7 coverage eligibility commits insurance fraud punishable as
8 provided in s. 817.50.

9 (10) A health maintenance organization shall pay a
10 contracted primary care or admitting physician, pursuant to
11 such physician's contract, for providing inpatient services in
12 a contracted hospital to a subscriber, if such services are
13 determined by the organization to be medically necessary and
14 covered services under the organization's contract with the
15 contract holder.

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

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

31

1 (12) A health maintenance organization subscriber is
2 entitled to prompt payment from the organization whenever a
3 subscriber pays an out-of-network provider for a covered
4 service and then submits a claim to the organization. The
5 organization shall pay the claim within 35 days after receipt
6 or the organization shall advise the subscriber of what
7 additional information is required to adjudicate the claim.
8 After receipt of the additional information, the organization
9 shall pay the claim within 10 days. If the organization fails
10 to pay claims submitted by subscribers within the time periods
11 specified in this subsection, the organization shall pay the
12 subscriber interest on the unpaid claim at the rate of 12
13 percent per year. Failure to pay claims and interest, if
14 applicable, within the time periods specified in this
15 subsection is a violation of the insurance code and each
16 occurrence shall be considered a separate violation.

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

19 Section 10. Section 641.3156, Florida Statutes, is
20 amended to read:

21 641.3156 Treatment authorization; payment of claims.--

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

29 (2) A health maintenance organization that requires
30 authorization for medical care and health care services shall
31 provide to each contracted provider at the time a contract is

1 signed a list of the medical care and health care services
2 that require authorization and the authorization procedures
3 used by the organization. A health maintenance organization
4 that requires authorization for medical care and health care
5 services shall provide to each noncontracted provider, not
6 later than 10 working days after a request is made, a list of
7 the medical care and health care services that require
8 authorization and the authorization procedures used by the
9 organization. The list of medical care or health care services
10 that require authorization and the authorization procedures
11 used by the organization shall not be modified unless written
12 notice is provided at least 30 days in advance of any changes
13 to all subscribers, contracted providers, and noncontracted
14 providers who had previously requested a list of medical care
15 or health care services that require authorization. An
16 organization that makes such list and procedures accessible to
17 providers and subscribers electronically is in compliance with
18 this section so long as notice is provided at least 30 days in
19 advance of any changes in such list or procedures to all
20 subscribers, contracted providers, and noncontracted providers
21 who had previously requested a list of medical care or health
22 care services that require authorization.

23 (3) Any claim for a covered service that does not
24 require an authorization that is ordered by a contracted
25 physician may not be denied. If an organization determines
26 that an overpayment has been made, then a claim for
27 overpayment should be submitted pursuant to s. 641.3155. ~~A~~
28 ~~health maintenance organization must pay any hospital-service~~
29 ~~or referral-service claim for treatment for an eligible~~
30 ~~subscriber which was authorized by a provider empowered by~~
31 ~~contract with the health maintenance organization to authorize~~

1 ~~or direct the patient's utilization of health care services~~
2 ~~and which was also authorized in accordance with the health~~
3 ~~maintenance organization's current and communicated~~
4 ~~procedures, unless the provider provided information to the~~
5 ~~health maintenance organization with the willful intention to~~
6 ~~misinform the health maintenance organization.~~

7 (4)(a)(2) A claim for treatment may not be denied if a
8 provider follows the health maintenance organization's
9 authorization procedures and receives authorization for a
10 covered service for an eligible subscriber, unless the
11 provider provided information to the health maintenance
12 organization with the willful intention to misinform the
13 health maintenance organization.

14 (b) On receipt of a request from a provider for
15 authorization pursuant to this section, the health maintenance
16 organization shall issue a written determination indicating
17 whether the service or services are authorized. If the request
18 for an authorization is for an inpatient admission, the
19 determination must be transmitted to the provider making the
20 request in writing no later than 24 hours after the request is
21 made by the provider. If the organization denies the request
22 for an authorization, the health maintenance organization must
23 notify the subscriber at the same time when notifying the
24 provider requesting the authorization. A health maintenance
25 organization that fails to respond to a request for an
26 authorization from a provider pursuant to this paragraph is
27 considered to have authorized the inpatient admission within
28 24 hours and payment may not be denied.

29 (5) If the proposed medical care or health care
30 service or services involve an inpatient admission and the
31 health maintenance organization requires authorization as a

1 condition of payment, the health maintenance organization
2 shall issue a written or electronic authorization for the
3 total estimated length of stay for the admission. If the
4 proposed medical care or health care service or services are
5 to be provided to a patient who is an inpatient in a health
6 care facility at the time the services are proposed and the
7 medical care or health care service requires an authorization,
8 the health maintenance organization shall issue a
9 determination indicating whether the proposed services are
10 authorized no later than 4 hours after the request by the
11 health care provider. A health maintenance organization that
12 fails to respond to such request within 4 hours is considered
13 to have authorized the requested medical care or health care
14 service and payment may not be denied.

15 (6)(3) Emergency services are subject to the
16 provisions of s. 641.513 and are not subject to the provisions
17 of this section. Such emergency services and care shall extend
18 through any inpatient admission required in order to provide
19 for stabilization of an emergency medical condition pursuant
20 to state and federal law.

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

23 Section 11. Paragraph (i) of subsection (1) of section
24 626.9541, Florida Statutes, is amended to read:

25 626.9541 Unfair methods of competition and unfair or
26 deceptive acts or practices defined.--

27 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR
28 DECEPTIVE ACTS.--The following are defined as unfair methods
29 of competition and unfair or deceptive acts or practices:

30 (i) Unfair claim settlement practices.--

31

- 1 1. Attempting to settle claims on the basis of an
2 application, when serving as a binder or intended to become a
3 part of the policy, or any other material document which was
4 altered without notice to, or knowledge or consent of, the
5 insured;
- 6 2. A material misrepresentation made to an insured or
7 any other person having an interest in the proceeds payable
8 under such contract or policy, for the purpose and with the
9 intent of effecting settlement of such claims, loss, or damage
10 under such contract or policy on less favorable terms than
11 those provided in, and contemplated by, such contract or
12 policy; or
- 13 3. Committing or performing with such frequency as to
14 indicate a general business practice any of the following:
- 15 a. Failing to adopt and implement standards for the
16 proper investigation of claims;
- 17 b. Misrepresenting pertinent facts or insurance policy
18 provisions relating to coverages at issue;
- 19 c. Failing to acknowledge and act promptly upon
20 communications with respect to claims;
- 21 d. Denying claims without conducting reasonable
22 investigations based upon available information;
- 23 e. Failing to affirm or deny full or partial coverage
24 of claims, and, as to partial coverage, the dollar amount or
25 extent of coverage, or failing to provide a written statement
26 that the claim is being investigated, upon the written request
27 of the insured within 30 days after proof-of-loss statements
28 have been completed;
- 29 f. Failing to promptly provide a reasonable
30 explanation in writing to the insured of the basis in the
31 insurance policy, in relation to the facts or applicable law,

1 for denial of a claim or for the offer of a compromise
2 settlement;

3 g. Failing to promptly notify the insured of any
4 additional information necessary for the processing of a
5 claim; or

6 h. Failing to clearly explain the nature of the
7 requested information and the reasons why such information is
8 necessary; ~~or-~~

9 (i) Notifying providers that claims filed under s.
10 627.613 have not been received when, in fact, the claims have
11 been received.

12 Section 12. Subsection (5) of section 641.3903,
13 Florida Statutes, is amended to read:

14 641.3903 Unfair methods of competition and unfair or
15 deceptive acts or practices defined.--The following are
16 defined as unfair methods of competition and unfair or
17 deceptive acts or practices:

18 (5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

19 (a) Attempting to settle claims on the basis of an
20 application or any other material document which was altered
21 without notice to, or knowledge or consent of, the subscriber
22 or group of subscribers to a health maintenance organization;

23 (b) Making a material misrepresentation to the
24 subscriber for the purpose and with the intent of effecting
25 settlement of claims, loss, or damage under a health
26 maintenance contract on less favorable terms than those
27 provided in, and contemplated by, the contract; or

28 (c) Committing or performing with such frequency as to
29 indicate a general business practice any of the following:

30 1. Failing to adopt and implement standards for the
31 proper investigation of claims;

- 1 2. Misrepresenting pertinent facts or contract
2 provisions relating to coverage at issue;
- 3 3. Failing to acknowledge and act promptly upon
4 communications with respect to claims;
- 5 4. Denying of claims without conducting reasonable
6 investigations based upon available information;
- 7 5. Failing to affirm or deny coverage of claims upon
8 written request of the subscriber within a reasonable time not
9 to exceed 30 days after a claim or proof-of-loss statements
10 have been completed and documents pertinent to the claim have
11 been requested in a timely manner and received by the health
12 maintenance organization;
- 13 6. Failing to promptly provide a reasonable
14 explanation in writing to the subscriber of the basis in the
15 health maintenance contract in relation to the facts or
16 applicable law for denial of a claim or for the offer of a
17 compromise settlement;
- 18 7. Failing to provide, upon written request of a
19 subscriber, itemized statements verifying that services and
20 supplies were furnished, where such statement is necessary for
21 the submission of other insurance claims covered by individual
22 specified disease or limited benefit policies, provided that
23 the organization may receive from the subscriber a reasonable
24 administrative charge for the cost of preparing such
25 statement;
- 26 8. Failing to provide any subscriber with services,
27 care, or treatment contracted for pursuant to any health
28 maintenance contract without a reasonable basis to believe
29 that a legitimate defense exists for not providing such
30 services, care, or treatment. To the extent that a national
31 disaster, war, riot, civil insurrection, epidemic, or any

1 other emergency or similar event not within the control of the
2 health maintenance organization results in the inability of
3 the facilities, personnel, or financial resources of the
4 health maintenance organization to provide or arrange for
5 provision of a health service in accordance with requirements
6 of this part, the health maintenance organization is required
7 only to make a good faith effort to provide or arrange for
8 provision of the service, taking into account the impact of
9 the event. For the purposes of this paragraph, an event is
10 not within the control of the health maintenance organization
11 if the health maintenance organization cannot exercise
12 influence or dominion over its occurrence; or

13 9. Systematic downcoding with the intent to deny
14 reimbursement otherwise due; ~~or-~~

15 10. Notifying providers that claims filed under s.
16 641.3155 have not been received when, in fact, the claims have
17 been received.

18 Section 13. This act shall take effect October 1,
19 2002.

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1 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
2 COMMITTEE SUBSTITUTE FOR
3 Senate Bill 362

4 Standardizes all time periods for health insurers and HMOs to
5 pay, deny, or contest any claim, or portion of a claim, to 35
6 days.

6 Reduces interest rate penalties for overdue payments of claims
7 from 18 to 12 percent a year.

8 Deletes coordination of benefits and removes the requirement
9 that the Department of Insurance adopt rules to establish
10 claim forms consistent with federal claim-filing and code set
11 standards.

10 Adds health insurers to provisions of statewide dispute
11 resolution program and specifies time frames for submission of
12 supporting documentation necessary for dispute resolution;
13 provides consequences for failure to comply and authorizes the
14 Agency for Health Care Administration to impose fines or
15 sanctions.

14 Allows insurers and HMOs to make one request for additional
15 information from a provider if information previously
16 submitted by the provider raises new or additional issues.

16 Expands the time frame for requests for HMO or health insurer
17 authorizations from 8 to 24 hours for inpatient admissions and
18 from 1 to 4 hours for inpatients in a health care facility.

17 Increases the review period from 1 to 2 years for "look-back"
18 or audit reviews and provides an exception for fraud.

19 Provides that an HMO or health insurer may not deny a claim
20 for subscriber ineligibility under certain circumstances.

21 Mandates that any health insurance policy insuring against
22 loss or expense due to hospital confinement or to medical
23 services, provide that payment of benefits must be made
24 directly to any hospital, doctor, or other person who provides
25 treatment of a psychological disorder for substance abuse,
26 including drug and alcohol abuse, when such treatment is in
27 accordance with provisions of such policy and the insured
28 authorizes direct payment of benefits. Payments must be made
29 under this provision, notwithstanding contrary provisions in
30 health insurance contracts.

26 Provides that untruthfully notifying a provider that a filed
27 claim has not been received constitutes an unfair trade
28 practice for insurers and HMOs.