

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. 641.234, F.S.; providing that  
8 health maintenance organizations remain liable  
9 for certain violations that occur after the  
10 transfer of certain financial obligations  
11 through health care risk contracts; amending s.  
12 641.30, F.S.; conforming a cross-reference;  
13 amending s. 641.3155, F.S.; revising  
14 definitions; eliminating provisions that  
15 require the Department of Insurance to adopt  
16 rules consistent with federal claim-filing  
17 standards; providing requirements and  
18 procedures for payment of claims; requiring  
19 payment within specified periods; revising rate  
20 of interest charged on overdue payments;  
21 requiring employers to provide notice of  
22 changes in eligibility status within a  
23 specified time period; providing a penalty;  
24 entitling health maintenance organization  
25 subscribers to prompt payment by the  
26 organization for covered services by an  
27 out-of-network provider; requiring payment  
28 within specified periods; providing payment  
29 procedures; providing penalties; amending s.  
30 641.3156, F.S.; defining the term  
31 "authorization"; requiring health maintenance

1 organizations to provide lists of medical care  
2 and health care services that require  
3 authorization; prohibiting denial of certain  
4 claims; providing procedural requirements for  
5 determination and issuance of authorizations of  
6 services; amending ss. 626.9541, 641.3903,  
7 F.S.; providing that untruthfully notifying a  
8 provider that a filed claim has not been  
9 received constitutes an unfair claim-settlement  
10 practice by insurers and health maintenance  
11 organizations; providing penalties; amending s.  
12 641.51, F.S.; revising provisions governing  
13 examinations by ophthalmologists; providing an  
14 effective date.

15  
16 Be It Enacted by the Legislature of the State of Florida:

17  
18 Section 1. Paragraph (a) of subsection (1), paragraph  
19 (c) of subsection (2), and subsection (4) of section 408.7057,  
20 Florida Statutes, are amended, and paragraphs (e) and (f) are  
21 added to subsection (2) of that section, to read:

22 408.7057 Statewide provider and managed care  
23 organization claim dispute resolution program.--

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

25 (a) "Managed care organization" means a health  
26 maintenance organization or a prepaid health clinic certified  
27 under chapter 641, a prepaid health plan authorized under s.  
28 409.912, ~~or~~ an exclusive provider organization certified under  
29 s. 627.6472, a preferred provider organization under s.  
30 627.6471, or a health insurer licensed pursuant to chapter  
31 627.

1 (2)

2 (c) Contracts entered into or renewed on or after  
3 October 1, 2000, may require exhaustion of an internal  
4 dispute-resolution process as a prerequisite to the submission  
5 of a claim by a provider, ~~or~~ health maintenance organization,  
6 or health insurer to the resolution organization ~~when the~~  
7 ~~dispute-resolution program becomes effective.~~

8 (e) The resolution organization shall require the  
9 managed care organization or provider submitting the claim  
10 dispute to submit any supporting documentation to the  
11 resolution organization within 15 days after receipt by the  
12 managed care organization or provider of a request from the  
13 resolution organization for documentation in support of the  
14 claim dispute. Failure to submit the supporting documentation  
15 within such time period shall result in the dismissal of the  
16 submitted claim dispute.

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

30 (4) Within 30 days after receipt of the recommendation  
31 of the resolution organization, the agency shall adopt the

1 recommendation as a final order. The agency may issue a final  
2 order imposing fines or sanctions, including those contained  
3 in s. 641.52. All fines collected under this subsection shall  
4 be deposited into the Health Care Trust Fund.

5 Section 2. Section 627.613, Florida Statutes, is  
6 amended to read:

7 627.613 Time of payment of claims.--

8 (1) The contract shall include the following  
9 provision:

10  
11 "Time of Payment of Claims: After receiving written  
12 proof of loss, the insurer will pay monthly all benefits then  
13 due for (type of benefit). Benefits for any other loss covered  
14 by this policy will be paid as soon as the insurer receives  
15 proper written proof."

16  
17 (2) As used in this section, the term "claim" for a  
18 noninstitutional provider means a paper or electronic billing  
19 instrument submitted to the insurer's designated location  
20 which consists of the HCFA 1500 data set, or its successor,  
21 which has all mandatory entries for a physician licensed under  
22 chapter 458, chapter 459, chapter 460, or chapter 461 or other  
23 appropriate billing instrument that has all mandatory entries  
24 for any other noninstitutional provider. For institutional  
25 providers, "claim" means a paper or electronic billing  
26 instrument submitted to the insurer's designated location  
27 which consists of the UB-92 data set or its successor having  
28 all mandatory entries.~~Health insurers shall reimburse all~~  
29 ~~claims or any portion of any claim from an insured or an~~  
30 ~~insured's assignees, for payment under a health insurance~~  
31 ~~policy, within 45 days after receipt of the claim by the~~

1 ~~health insurer. If a claim or a portion of a claim is~~  
2 ~~contested by the health insurer, the insured or the insured's~~  
3 ~~assignees shall be notified, in writing, that the claim is~~  
4 ~~contested or denied, within 45 days after receipt of the claim~~  
5 ~~by the health insurer. The notice that a claim is contested~~  
6 ~~shall identify the contested portion of the claim and the~~  
7 ~~reasons for contesting the claim.~~

8 (3) All claims for payment, whether electronic or  
9 nonelectronic:

10 (a) Are considered received on the date the claim is  
11 received by the insurer at its designated claims receipt  
12 location.

13 (b) Must not duplicate a claim previously submitted  
14 unless it is determined that the original claim was not  
15 received or is otherwise lost. ~~A health insurer, upon receipt~~  
16 ~~of the additional information requested from the insured or~~  
17 ~~the insured's assignees shall pay or deny the contested claim~~  
18 ~~or portion of the contested claim, within 60 days.~~

19 (4)(a) For an electronically submitted claim, a health  
20 insurer shall, within 24 hours after the beginning of the next  
21 business day after receipt of the claim, provide electronic  
22 acknowledgement of the receipt of the claim to the electronic  
23 source submitting the claim.

24 (b) For an electronically submitted claim, a health  
25 insurer shall, within 20 days after receipt of the claim, pay  
26 the claim or notify a provider or designee if a claim is  
27 denied or contested. Notice of the insurer's action on the  
28 claim and payment of the claim is considered to be made on the  
29 date the notice or payment is mailed or electronically  
30 transferred.

31

1           (c)1. Notification of the health insurer's  
2 determination of a contested claim must be accompanied by an  
3 itemized list of additional information or documents the  
4 insurer can reasonably determine are necessary to process the  
5 claim.

6           2. A provider must submit the additional information  
7 or documentation, as specified on the itemized list, within 35  
8 days after receipt of the notification. Failure of a provider  
9 to submit by mail or electronically the additional information  
10 or documentation requested within 35 days after receipt of the  
11 notification may result in denial of the claim.

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

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

25           (e) A claim must be paid or denied within 90 days  
26 after receipt of the claim. Failure to pay or deny a claim  
27 within 120 days after receipt of the claim creates an  
28 uncontestable obligation to pay the claim.~~An insurer shall~~  
29 ~~pay or deny any claim no later than 120 days after receiving~~  
30 ~~the claim.~~

31

1           (5)(a) For all nonelectronically submitted claims, a  
2 health insurer shall, effective November 1, 2003, provide to  
3 the provider acknowledgement of receipt of the claim within 15  
4 days after receipt of the claim or provide the provider,  
5 within 15 days after receipt, with electronic access to the  
6 status of a submitted claim.

7           (b) For all nonelectronically submitted claims, a  
8 health insurer shall, within 40 days after receipt of the  
9 claim, pay the claim or notify a provider or designee if a  
10 claim is denied or contested. Notice of the insurer's action  
11 on the claim and payment of the claim are considered to be  
12 made on the date the notice or payment was mailed or  
13 electronically transferred.

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

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

25           3. A health insurer may not make more than one request  
26 for documents under this paragraph in connection with a claim  
27 unless the provider fails to submit all of the requested  
28 documents to process the claim or the documents submitted by  
29 the provider raise new, additional issues not included in the  
30 original written itemization, in which case the health insurer  
31 may provide the provider with one additional opportunity to



1 submit the additional documents needed to process the claim.  
2 In no case may the health insurer request duplicate documents.

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

7 (e) A claim must be paid or denied within 120 days  
8 after receipt of the claim. Failure to pay or deny a claim  
9 within 140 days after receipt of the claim creates an  
10 uncontestable obligation to pay the claim.~~Payment shall be~~  
11 ~~treated as being made on the date 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) Payment of a claim is considered made on the date  
16 the payment is mailed or electronically transferred. An  
17 overdue payment of a claim bears simple interest of 12 percent  
18 per year. Interest on an overdue payment for a claim or for  
19 any portion of a claim begins to accrue when the claim should  
20 have been paid, denied, or contested. The interest is payable  
21 with the payment of the claim.~~All overdue payments shall bear~~  
22 ~~simple interest at the rate of 10 percent per year.~~

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

1 improperly billed. If a reduction is made due to such  
2 notification by the insured, the insurer shall pay to the  
3 insured 20 percent of the amount of the reduction up to \$500.

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

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

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

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

1 shall pay or deny the claim for overpayment within 35 days  
2 after receipt of the information.

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

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

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

25 (10) Any retroactive reductions of payments or demands  
26 for refund of previous overpayments that are due to  
27 retroactive review of coverage decisions or payment levels  
28 must be reconciled to specific claims. Any retroactive demands  
29 by providers for payment due to underpayments or nonpayments  
30 for covered services must be reconciled to specific claims.  
31 The look-back or audit-review period shall not exceed 2 years

1 after the date the claim was paid by the health insurer,  
2 unless fraud in billing is involved.

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

11 (12)(a) Without regard to any other remedy or relief  
12 to which a person is entitled, or obligated to under contract,  
13 anyone aggrieved by a violation of this section may bring an  
14 action to obtain a declaratory judgment that an act or  
15 practice violates this section and to enjoin a person who has  
16 violated, is violating, or is otherwise likely to violate this  
17 section.

18 (b) In any action brought by a person who has suffered  
19 a loss as a result of a violation of this section, such person  
20 may recover any amounts due the person under this section,  
21 including accrued interest, plus attorney's fees and court  
22 costs as provided in paragraph (c).

23 (c) In any civil litigation resulting from an act or  
24 practice involving a violation of this section by a health  
25 insurer in which the health insurer is found to have violated  
26 this section, the provider, after judgment in the trial court  
27 and after exhausting all appeals, if any, shall receive his or  
28 her attorney's fees and costs from the insurer; however, such  
29 fees shall not exceed three times the amount in controversy or  
30 \$5,000, whichever is greater. In any such civil litigation, if  
31 the insurer is found not to have violated this section, the

1 insurer, after judgment in the trial court and exhaustion of  
2 all appeals, if any, may receive its reasonable attorney's  
3 fees and costs from the provider on any claim or defense that  
4 the court finds the provider knew or should have known was not  
5 supported by the material facts necessary to establish the  
6 claim or defense or would not be supported by the application  
7 of then-existing law as to those material facts.

8 (d) The attorney for the prevailing party shall submit  
9 a sworn affidavit of his or her time spent on the case and his  
10 or her costs incurred for all the motions, hearings, and  
11 appeals to the trial judge who presided over the civil case.

12 (e) Any award of attorney's fees or costs shall become  
13 a part of the judgment and subject to execution as the law  
14 allows.

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

17 Section 3. Section 627.6142, Florida Statutes, is  
18 created to read:

19 627.6142 Treatment authorization; payment of claims.--

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

26 (2) A health insurer that requires authorization for  
27 medical care or health care services shall provide to each  
28 provider with whom the health insurer has contracted pursuant  
29 to s. 627.6471 or s. 627.6472 a list of the medical care and  
30 health care services that require authorization and the  
31 authorization procedures used by the health insurer at the

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

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

28 (4)(a) Any claim for treatment may not be denied if a  
29 provider follows the health insurer's published authorization  
30 procedures and receives authorization, unless the provider  
31

1 submits information to the health insurer with the willful  
2 intention to misinform the health insurer.

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

17 (5) If the proposed medical care or health care  
18 service or services involve an inpatient admission and the  
19 health insurer requires an authorization as a condition of  
20 payment, the health insurer shall review and issue a written  
21 or electronic authorization for the total estimated length of  
22 stay for the admission, based on the recommendation of the  
23 patient's physician. If the proposed medical care or health  
24 care service or services are to be provided to an insured who  
25 is an inpatient in a health care facility and authorization is  
26 required, the health insurer shall issue a written  
27 determination indicating whether the proposed services are  
28 authorized or denied no later than 4 hours after the request  
29 is made by the provider. A health insurer who fails to respond  
30 to such request within 4 hours is considered to have

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1 authorized the requested medical care or health care service  
2 and payment shall not be denied.

3 (6) Authorization may not be required for emergency  
4 services and care or emergency medical services as provided  
5 pursuant to ss. 395.002, 395.1041, 401.45, and 401.252. Such  
6 emergency services and care shall extend through any inpatient  
7 admission required in order to provide for stabilization of an  
8 emergency medical condition pursuant to state and federal law.

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

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

13 627.638 Direct payment for hospital, medical  
14 services.--

15 (3) Under any health insurance policy insuring against  
16 loss or expense due to hospital confinement or to medical and  
17 related services, payment of benefits shall be made directly  
18 to any recognized hospital, doctor, or other person who  
19 provided services for the treatment of a psychological  
20 disorder or treatment for substance abuse, including drug and  
21 alcohol abuse, when the treatment is in accordance with the  
22 provisions of the policy and the insured specifically  
23 authorizes direct payment of benefits. Payments shall be made  
24 under this section, notwithstanding any contrary provisions in  
25 the health insurance contract. This subsection applies to all  
26 health insurance policies now or hereafter in force as of the  
27 effective date of this act.

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

30 627.651 Group contracts and plans of self-insurance  
31 must meet group requirements.--



1           (4) This section does not apply to any plan which is  
2 established or maintained by an individual employer in  
3 accordance with the Employee Retirement Income Security Act of  
4 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
5 arrangement as defined in s. 624.437(1), except that a  
6 multiple-employer welfare arrangement shall comply with ss.  
7 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,  
8 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(8)~~~~(6)~~.  
9 This subsection does not allow an authorized insurer to issue  
10 a group health insurance policy or certificate which does not  
11 comply with this part.

12           Section 6. Section 627.662, Florida Statutes, is  
13 amended to read:

14           627.662 Other provisions applicable.--The following  
15 provisions apply to group health insurance, blanket health  
16 insurance, and franchise health insurance:

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

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

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

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

24           (5) Section 627.640, relating to filing and  
25 classification of rates.

26           (6) Section 627.6142, relating to treatment  
27 authorizations.

28           ~~(7)~~~~(6)~~ Section 627.645(1), relating to denial of  
29 claims.

30           ~~(8)~~~~(7)~~ Section 627.613, relating to time of payment of  
31 claims.

1           ~~(9)(8)~~ Section 627.6471, relating to preferred  
2 provider organizations.

3           ~~(10)(9)~~ Section 627.6472, relating to exclusive  
4 provider organizations.

5           ~~(11)(10)~~ Section 627.6473, relating to combined  
6 preferred provider and exclusive provider policies.

7           ~~(12)(11)~~ Section 627.6474, relating to provider  
8 contracts.

9           Section 7. Paragraph (e) of subsection (1) of section  
10 641.185, Florida Statutes, is amended to read:

11           641.185 Health maintenance organization subscriber  
12 protections.--

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

21           (e) A health maintenance organization subscriber  
22 should receive timely, concise information regarding the  
23 health maintenance organization's reimbursement to providers  
24 and services pursuant to ss. 641.31 and 641.31015 and is  
25 entitled to prompt payment from the organization when  
26 appropriate pursuant to s. 641.3155.

27           Section 8. Subsection (4) is added to section 641.234,  
28 Florida Statutes, to read:

29           641.234 Administrative, provider, and management  
30 contracts.--

31

1           (4)(a) If a health maintenance organization, through a  
2 health care risk contract, transfers to any entity the  
3 obligations to pay any provider for any claims arising from  
4 services provided to or for the benefit of any subscriber of  
5 the organization, the health maintenance organization shall  
6 remain responsible for any violations of ss. 641.3155,  
7 641.3156, and 641.51(4). The provisions of ss.  
8 624.418-624.4211 and 641.52 shall apply to any such  
9 violations.

10           (b) As used in this subsection:

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

16           2. The term "entity" does not include any provider or  
17 group practice, as defined in s. 456.053, providing services  
18 under the scope of the license of the provider or the members  
19 of the group practice.

20           Section 9. Subsection (1) of section 641.30, Florida  
21 Statutes, is amended to read:

22           641.30 Construction and relationship to other laws.--

23           (1) Every health maintenance organization shall accept  
24 the ~~standard health~~ claim form prescribed pursuant to s.  
25 641.3155 ~~627-647~~.

26           Section 10. Section 641.3155, Florida Statutes, is  
27 amended to read:

28           641.3155 Payment of claims.--

29           (1)~~(a)~~ As used in this section, the term "~~clear~~ claim"  
30 for a noninstitutional provider means a paper or electronic  
31 billing instrument submitted to the health maintenance

1 organization's designated location which consists of the HCFA  
2 1500 data set, or its successor, having all mandatory entries  
3 completed for a physician licensed under chapter 458, chapter  
4 459, chapter 460, or chapter 461 or other appropriate billing  
5 instrument that has all mandatory entries for any other  
6 noninstitutional provider. For institutional providers,  
7 "claim" means a paper or electronic billing instrument  
8 submitted to the insurer's designated location which consists  
9 of the UB-92 data set, or its successor, having all mandatory  
10 entries completed.~~claim submitted on a HCFA 1500 form which~~  
11 ~~has no defect or impropriety, including lack of required~~  
12 ~~substantiating documentation for noncontracted providers and~~  
13 ~~suppliers, or particular circumstances requiring special~~  
14 ~~treatment which prevent timely payment from being made on the~~  
15 ~~claim. A claim may not be considered not clean solely because~~  
16 ~~a health maintenance organization refers the claim to a~~  
17 ~~medical specialist within the health maintenance organization~~  
18 ~~for examination. If additional substantiating documentation,~~  
19 ~~such as the medical record or encounter data, is required from~~  
20 ~~a source outside the health maintenance organization, the~~  
21 ~~claim is considered not clean. This definition of "clean~~  
22 ~~claim" is repealed on the effective date of rules adopted by~~  
23 ~~the department which define the term "clean claim."~~

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

30 (c) ~~The department shall adopt rules to establish~~  
31 ~~claim forms consistent with federal claim-filing standards for~~

1 ~~health maintenance organizations required by the federal~~  
2 ~~Health Care Financing Administration. The department may adopt~~  
3 ~~rules relating to coding standards consistent with Medicare~~  
4 ~~coding standards adopted by the federal Health Care Financing~~  
5 ~~Administration.~~

6 (2) All claims for payment, whether electronic or  
7 nonelectronic:

8 (a) Are considered received on the date the claim is  
9 received by the organization at its designated claims receipt  
10 location.

11 (b) Must not duplicate a claim previously submitted  
12 unless it is determined that the original claim was not  
13 received or is otherwise lost. ~~(a) A health maintenance~~

14 ~~organization shall pay any clean claim or any portion of a~~  
15 ~~clean claim made by a contract provider for services or goods~~  
16 ~~provided under a contract with the health maintenance~~  
17 ~~organization or a clean claim made by a noncontract provider~~  
18 ~~which the organization does not contest or deny within 35 days~~  
19 ~~after receipt of the claim by the health maintenance~~  
20 ~~organization which is mailed or electronically transferred by~~  
21 ~~the provider.~~

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

1 ~~of the request, mail or electronically transfer the~~  
2 ~~information to the health maintenance organization. The health~~  
3 ~~maintenance organization shall pay or deny the claim or~~  
4 ~~portion of the claim within 45 days after receipt of the~~  
5 ~~information.~~

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

11 (b) For an electronically submitted claim, a health  
12 maintenance organization shall, within 20 days after receipt  
13 of the claim, pay the claim or notify a provider if a claim is  
14 denied or contested. Notice of the organization's action on  
15 the claim and payment of the claim are considered to be made  
16 on the date the notice or payment is mailed or electronically  
17 transferred.

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

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

29 3. A health maintenance organization may not make more  
30 than one request for documents under this paragraph in  
31 connection with a claim unless the provider fails to submit

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

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

12 (e) A claim must be paid or denied within 90 days  
13 after receipt of the claim. Failure to pay or deny a claim  
14 within 120 days after receipt of the claim creates an  
15 uncontestable obligation to pay the claim.~~Payment of a claim~~  
16 ~~is considered made on the date the payment was received or~~  
17 ~~electronically transferred or otherwise delivered. An overdue~~  
18 ~~payment of a claim bears simple interest at the rate of 10~~  
19 ~~percent per year. Interest on an overdue payment for a clean~~  
20 ~~claim or for any uncontested portion of a clean claim begins~~  
21 ~~to accrue on the 36th day after the claim has been received.~~  
22 ~~The interest is payable with the payment of the claim.~~

23 (4)(a) For all nonelectronically submitted claims, a  
24 health maintenance organization shall, effective November 1,  
25 2003, provide to the provider acknowledgement of receipt of  
26 the claim within 15 days after receipt of the claim or provide  
27 the provider, within 15 days after receipt, with electronic  
28 access to the status of a submitted claim.

29 (b) For all nonelectronically submitted claims, a  
30 health maintenance organization shall, within 40 days after  
31 receipt of the claim, pay the claim or notify a provider if a

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

5 (c)1. Notification of the health maintenance  
6 organization's determination of a contested claim must be  
7 accompanied by an itemized list of additional information or  
8 documents the organization can reasonably determine are  
9 necessary to process the claim.

10 2. A provider must submit the additional information  
11 or documentation, as specified on the itemized list, within 35  
12 days after receipt of the notification. Failure of a provider  
13 to submit by mail or electronically the additional information  
14 or documentation requested within 35 days after receipt of the  
15 notification may result in denial of the claim.

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

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

30 (e) A claim must be paid or denied within 120 days  
31 after receipt of the claim. Failure to pay or deny a claim



1 within 140 days after receipt of the claim creates an  
2 uncontestable obligation to pay the claim. ~~A health~~  
3 ~~maintenance organization shall pay or deny any claim no later~~  
4 ~~than 120 days after receiving the claim. Failure to do so~~  
5 ~~creates an uncontestable obligation for the health maintenance~~  
6 ~~organization to pay the claim to the provider.~~

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

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

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

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

1 after the provider receives the claim that the claim for  
2 overpayment is contested or denied. The notice that the claim  
3 for overpayment is denied or contested must identify the  
4 contested portion of the claim and the specific reason for  
5 contesting or denying the claim, and, if contested, must  
6 include a request for additional information. If the  
7 organization submits additional information, the organization  
8 must, within 35 days after receipt of the request, mail or  
9 electronically transfer the information to the provider. The  
10 provider shall pay or deny the claim for overpayment within 45  
11 days after receipt of the information.

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

22 (e) A provider shall pay or deny any claim for  
23 overpayment no later than 120 days after receiving the claim.  
24 Failure to do so creates an uncontestable obligation for the  
25 provider to pay the claim to the organization.

26 (7)~~(6)~~ Any retroactive reductions of payments or  
27 demands for refund of previous overpayments which are due to  
28 retroactive review-of-coverage decisions or payment levels  
29 must be reconciled to specific claims unless the parties agree  
30 to other reconciliation methods and terms. Any retroactive  
31 demands by providers for payment due to underpayments or

1 nonpayments for covered services must be reconciled to  
2 specific claims unless the parties agree to other  
3 reconciliation methods and terms. The look-back or  
4 audit-review period shall not exceed 2 years after the date  
5 the claim was paid by the health maintenance organization,  
6 unless fraud in billing is involved.~~The look-back period may~~  
7 ~~be specified by the terms of the contract.~~

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

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

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

29 ~~(9)(8)~~ A provider, or the provider's designee, who  
30 bills electronically is entitled to electronic acknowledgment  
31 of the receipt of a claim within 72 hours.

1           ~~(10)(9)~~ A health maintenance organization may not  
2 ~~retroactively~~ deny a claim because of subscriber ineligibility  
3 if the provider can document receipt of subscriber eligibility  
4 confirmation by the organization prior to the date or time  
5 covered services were provided. Every health maintenance  
6 organization contract with an employer shall include a  
7 provision that requires the employer to notify the health  
8 maintenance organization of changes in eligibility status  
9 within 30 days ~~more than 1 year after the date of payment of~~  
10 ~~the clean claim.~~ Any person who knowingly misinforms a  
11 provider prior to the receipt of services as to his or her  
12 coverage eligibility commits insurance fraud punishable as  
13 provided in s. 817.50.

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

21           ~~(12)(a)~~ Without regard to any other remedy or relief  
22 to which a person is entitled, or obligated to under contract,  
23 anyone aggrieved by a violation of this section may bring an  
24 action to obtain a declaratory judgment that an act or  
25 practice violates this section and to enjoin a person who has  
26 violated, is violating, or is otherwise likely to violate this  
27 section.

28           ~~(b)~~ In any action brought by a person who has suffered  
29 a loss as a result of a violation of this section, such person  
30 may recover any amounts due the person under this section,  
31

1 including accrued interest, plus attorney's fees and court  
2 costs as provided in paragraph (c).

3 (c) In any civil litigation resulting from an act or  
4 practice involving a violation of this section by a health  
5 maintenance organization in which the organization is found to  
6 have violated this section, the provider, after judgment in  
7 the trial court and after exhausting all appeals, if any,  
8 shall receive his or her attorney's fees and costs from the  
9 organization; however, such fees shall not exceed three times  
10 the amount in controversy or \$5,000, whichever is greater. In  
11 any such civil litigation, if the organization is found not to  
12 have violated this section, the organization, after judgment  
13 in the trial court and exhaustion of all appeals, if any, may  
14 receive its reasonable attorney's fees and costs from the  
15 provider on any claim or defense that the court finds the  
16 provider knew or should have known was not supported by the  
17 material facts necessary to establish the claim or defense or  
18 would not be supported by the application of then-existing law  
19 as to those material facts.

20 (d) The attorney for the prevailing party shall submit  
21 a sworn affidavit of his or her time spent on the case and his  
22 or her costs incurred for all the motions, hearings, and  
23 appeals to the trial judge who presided over the civil case.

24 (e) Any award of attorney's fees or costs shall become  
25 a part of the judgment and subject to execution as the law  
26 allows.

27 (13) A health maintenance organization subscriber is  
28 entitled to prompt payment from the organization whenever a  
29 subscriber pays an out-of-network provider for a covered  
30 service and then submits a claim to the organization. The  
31 organization shall pay the claim within 35 days after receipt

1 or the organization shall advise the subscriber of what  
2 additional information is required to adjudicate the claim.  
3 After receipt of the additional information, the organization  
4 shall pay the claim within 10 days. If the organization fails  
5 to pay claims submitted by subscribers within the time periods  
6 specified in this subsection, the organization shall pay the  
7 subscriber interest on the unpaid claim at the rate of 12  
8 percent per year. Failure to pay claims and interest, if  
9 applicable, within the time periods specified in this  
10 subsection is a violation of the insurance code and each  
11 occurrence shall be considered a separate violation.

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

14 Section 11. Section 641.3156, Florida Statutes, is  
15 amended to read:

16 641.3156 Treatment authorization; payment of claims.--

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

24 (2) A health maintenance organization that requires  
25 authorization for medical care and health care services shall  
26 provide to each contracted provider at the time a contract is  
27 signed a list of the medical care and health care services  
28 that require authorization and the authorization procedures  
29 used by the organization. A health maintenance organization  
30 that requires authorization for medical care and health care  
31 services shall provide to each noncontracted provider, not

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

18 (3) Any claim for a covered service that does not  
19 require an authorization that is ordered by a contracted  
20 physician may not be denied. If an organization determines  
21 that an overpayment has been made, then a claim for  
22 overpayment should be submitted pursuant to s. 641.3155. A  
23 ~~health maintenance organization must pay any hospital-service~~  
24 ~~or referral-service claim for treatment for an eligible~~  
25 ~~subscriber which was authorized by a provider empowered by~~  
26 ~~contract with the health maintenance organization to authorize~~  
27 ~~or direct the patient's utilization of health care services~~  
28 ~~and which was also authorized in accordance with the health~~  
29 ~~maintenance organization's current and communicated~~  
30 ~~procedures, unless the provider provided information to the~~  
31

1 ~~health maintenance organization with the willful intention to~~  
2 ~~misinform the health maintenance organization.~~

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

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

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



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

11 (6)(3) Emergency services are subject to the  
12 provisions of s. 641.513 and are not subject to the provisions  
13 of this section. Such emergency services and care shall extend  
14 through any inpatient admission required in order to provide  
15 for stabilization of an emergency medical condition pursuant  
16 to state and federal law.

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

19 Section 12. Paragraph (i) of subsection (1) of section  
20 626.9541, Florida Statutes, is amended to read:

21 626.9541 Unfair methods of competition and unfair or  
22 deceptive acts or practices defined.--

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

26 (i) Unfair claim settlement practices.--

27 1. Attempting to settle claims on the basis of an  
28 application, when serving as a binder or intended to become a  
29 part of the policy, or any other material document which was  
30 altered without notice to, or knowledge or consent of, the  
31 insured;

1           2. A material misrepresentation made to an insured or  
2 any other person having an interest in the proceeds payable  
3 under such contract or policy, for the purpose and with the  
4 intent of effecting settlement of such claims, loss, or damage  
5 under such contract or policy on less favorable terms than  
6 those provided in, and contemplated by, such contract or  
7 policy; or

8           3. Committing or performing with such frequency as to  
9 indicate a general business practice any of the following:

10           a. Failing to adopt and implement standards for the  
11 proper investigation of claims;

12           b. Misrepresenting pertinent facts or insurance policy  
13 provisions relating to coverages at issue;

14           c. Failing to acknowledge and act promptly upon  
15 communications with respect to claims;

16           d. Denying claims without conducting reasonable  
17 investigations based upon available information;

18           e. Failing to affirm or deny full or partial coverage  
19 of claims, and, as to partial coverage, the dollar amount or  
20 extent of coverage, or failing to provide a written statement  
21 that the claim is being investigated, upon the written request  
22 of the insured within 30 days after proof-of-loss statements  
23 have been completed;

24           f. Failing to promptly provide a reasonable  
25 explanation in writing to the insured of the basis in the  
26 insurance policy, in relation to the facts or applicable law,  
27 for denial of a claim or for the offer of a compromise  
28 settlement;

29           g. Failing to promptly notify the insured of any  
30 additional information necessary for the processing of a  
31 claim; or

1 h. Failing to clearly explain the nature of the  
2 requested information and the reasons why such information is  
3 necessary; ~~or~~

4 (i) Notifying providers that claims filed under s.  
5 627.613 have not been received when, in fact, the claims have  
6 been received.

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

9 641.3903 Unfair methods of competition and unfair or  
10 deceptive acts or practices defined.--The following are  
11 defined as unfair methods of competition and unfair or  
12 deceptive acts or practices:

13 (5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

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

18 (b) Making a material misrepresentation to the  
19 subscriber for the purpose and with the intent of effecting  
20 settlement of claims, loss, or damage under a health  
21 maintenance contract on less favorable terms than those  
22 provided in, and contemplated by, the contract; or

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

25 1. Failing to adopt and implement standards for the  
26 proper investigation of claims;

27 2. Misrepresenting pertinent facts or contract  
28 provisions relating to coverage at issue;

29 3. Failing to acknowledge and act promptly upon  
30 communications with respect to claims;

31

1           4. Denying of claims without conducting reasonable  
2 investigations based upon available information;

3           5. Failing to affirm or deny coverage of claims upon  
4 written request of the subscriber within a reasonable time not  
5 to exceed 30 days after a claim or proof-of-loss statements  
6 have been completed and documents pertinent to the claim have  
7 been requested in a timely manner and received by the health  
8 maintenance organization;

9           6. Failing to promptly provide a reasonable  
10 explanation in writing to the subscriber of the basis in the  
11 health maintenance contract in relation to the facts or  
12 applicable law for denial of a claim or for the offer of a  
13 compromise settlement;

14           7. Failing to provide, upon written request of a  
15 subscriber, itemized statements verifying that services and  
16 supplies were furnished, where such statement is necessary for  
17 the submission of other insurance claims covered by individual  
18 specified disease or limited benefit policies, provided that  
19 the organization may receive from the subscriber a reasonable  
20 administrative charge for the cost of preparing such  
21 statement;

22           8. Failing to provide any subscriber with services,  
23 care, or treatment contracted for pursuant to any health  
24 maintenance contract without a reasonable basis to believe  
25 that a legitimate defense exists for not providing such  
26 services, care, or treatment. To the extent that a national  
27 disaster, war, riot, civil insurrection, epidemic, or any  
28 other emergency or similar event not within the control of the  
29 health maintenance organization results in the inability of  
30 the facilities, personnel, or financial resources of the  
31 health maintenance organization to provide or arrange for

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

9 9. Systematic downcoding with the intent to deny  
10 reimbursement otherwise due; or.

11 10. Notifying providers that claims filed under s.  
12 641.3155 have not been received when, in fact, the claims have  
13 been received.

14 Section 14. Subsection (12) of section 641.51, Florida  
15 Statutes, is amended to read:

16 641.51 Quality assurance program; second medical  
17 opinion requirement.--

18 (12) If a contracted primary care physician, licensed  
19 under chapter 458 or chapter 459, determines ~~and the~~  
20 ~~organization determine~~ that a subscriber requires examination  
21 by a licensed ophthalmologist for medically necessary,  
22 contractually covered services, then the organization shall  
23 authorize the contracted primary care physician to send the  
24 subscriber to a contracted licensed ophthalmologist.

25 Section 15. This act shall take effect October 1,  
26 2002.

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