

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.
12 626.88, F.S.; redefining the term
13 "administrator," with respect to regulation of
14 insurance administrators; amending s. 627.613,
15 F.S.; revising time of payment of claims
16 provisions; providing requirements and
17 procedures for payment or denial of claims;
18 providing criteria and limitations; revising
19 rate of interest charged on overdue payments;
20 providing for electronic transmission of
21 claims; providing a penalty; providing for
22 attorney's fees and costs; establishing a
23 permissive error ratio and providing guidelines
24 for applying the ratio; prohibiting contractual
25 modification of provisions of law; providing
26 applicability; creating s. 627.6142, F.S.;
27 defining the term "authorization"; requiring
28 health insurers to provide lists of medical
29 care and health care services that require
30 authorization; prohibiting denial of certain
31 claims; providing procedural requirements for

1 determination and issuance of authorizations of
2 services; amending s. 627.638, F.S.; providing
3 for direct payment for services in treatment of
4 a psychological disorder or substance abuse;
5 amending s. 627.651, F.S.; conforming a
6 cross-reference; amending s. 627.662, F.S.;
7 specifying application of certain additional
8 provisions to group, blanket, and franchise
9 health insurance; amending s. 641.185, F.S.;
10 entitling health maintenance organization
11 subscribers to prompt payment when appropriate;
12 amending s. 641.234, F.S.; providing that
13 health maintenance organizations remain liable
14 for certain violations that occur after the
15 transfer of certain financial obligations
16 through health care risk contracts; amending s.
17 641.30, F.S.; conforming a cross-reference;
18 amending s. 641.3155, F.S.; revising
19 definitions; eliminating provisions that
20 require the Department of Insurance to adopt
21 rules consistent with federal claim-filing
22 standards; providing requirements and
23 procedures for payment of claims; requiring
24 payment within specified periods; revising rate
25 of interest charged on overdue payments;
26 requiring employers to provide notice of
27 changes in eligibility status within a
28 specified time period; providing a penalty;
29 entitling health maintenance organization
30 subscribers to prompt payment by the
31 organization for covered services by an

1 out-of-network provider; requiring payment
2 within specified periods; providing payment
3 procedures; establishing a permissive error
4 ratio and providing guidelines for applying the
5 ratio; providing penalties; amending s.
6 641.3156, F.S.; defining the term
7 "authorization"; requiring health maintenance
8 organizations to provide lists of medical care
9 and health care services that require
10 authorization; prohibiting denial of certain
11 claims; providing procedural requirements for
12 determination and issuance of authorizations of
13 services; amending ss. 626.9541, 641.3903,
14 F.S.; providing that untruthfully notifying a
15 provider that a filed claim has not been
16 received constitutes an unfair claim-settlement
17 practice by insurers and health maintenance
18 organizations; providing penalties; amending s.
19 641.51, F.S.; revising provisions governing
20 examinations by ophthalmologists; providing an
21 effective date.

22
23 Be It Enacted by the Legislature of the State of Florida:

24
25 Section 1. Paragraph (a) of subsection (1), paragraph
26 (c) of subsection (2), and subsection (4) of section 408.7057,
27 Florida Statutes, are amended, and paragraphs (e) and (f) are
28 added to subsection (2) of that section, to read:

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

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

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

10 (2)

11 (c) Contracts entered into or renewed on or after
12 October 1, 2000, may require exhaustion of an internal
13 dispute-resolution process as a prerequisite to the submission
14 of a claim by a provider, ~~or~~ health maintenance organization,
15 or health insurer to the resolution organization ~~when the~~
16 ~~dispute-resolution program becomes effective.~~

17 (e) The resolution organization shall require the
18 managed care organization or provider submitting the claim
19 dispute to submit any supporting documentation to the
20 resolution organization within 15 days after receipt by the
21 managed care organization or provider of a request from the
22 resolution organization for documentation in support of the
23 claim dispute. Failure to submit the supporting documentation
24 within such time period shall result in the dismissal of the
25 submitted claim dispute.

26 (f) The resolution organization shall require the
27 respondent in the claim dispute to submit all documentation in
28 support of its position within 15 days after receiving a
29 request from the resolution organization for supporting
30 documentation. Failure to submit the supporting documentation
31 within such time period shall result in a default against the

1 managed care organization or provider. In the event of such a
2 default, the resolution organization shall issue its written
3 recommendation to the agency that a default be entered against
4 the defaulting entity. The written recommendation shall
5 include a recommendation to the agency that the defaulting
6 entity shall pay the entity submitting the claim dispute the
7 full amount of the claim dispute, plus all accrued interest.

8 (4) Within 30 days after receipt of the recommendation
9 of the resolution organization, the agency shall adopt the
10 recommendation as a final order. The agency may issue a final
11 order imposing fines or sanctions, including those contained
12 in s. 641.52. All fines collected under this subsection shall
13 be deposited into the Health Care Trust Fund.

14 Section 2. Subsection (1) of section 626.88, Florida
15 Statutes, is amended to read:

16 626.88 Definitions of "administrator" and "insurer".--

17 (1) For the purposes of this part, an "administrator"
18 is any person who directly or indirectly solicits or effects
19 coverage of, collects charges or premiums from, or adjusts or
20 settles claims on residents of this state in connection with
21 authorized commercial self-insurance funds or with insured or
22 self-insured programs which provide life or health insurance
23 coverage or coverage of any other expenses described in s.
24 624.33(1) or any person who provides billing and collection
25 services to health insurers and health maintenance
26 organizations on behalf of health care providers, other than
27 any of the following persons:

28 (a) An employer on behalf of such employer's employees
29 or the employees of one or more subsidiary or affiliated
30 corporations of such employer.

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

1 (c) An insurance company which is either authorized to
2 transact insurance in this state or is acting as an insurer
3 with respect to a policy lawfully issued and delivered by such
4 company in and pursuant to the laws of a state in which the
5 insurer was authorized to transact an insurance business.

6 (d) A health care services plan, health maintenance
7 organization, professional service plan corporation, or person
8 in the business of providing continuing care, possessing a
9 valid certificate of authority issued by the department, and
10 the sales representatives thereof, if the activities of such
11 entity are limited to the activities permitted under the
12 certificate of authority.

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

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

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

20 (h) A trust and its trustees, agents, and employees
21 acting pursuant to such trust established in conformity with
22 29 U.S.C. s. 186.

23 (i) A trust exempt from taxation under s. 501(a) of
24 the Internal Revenue Code, a trust satisfying the requirements
25 of ss. 624.438 and 624.439, or any governmental trust as
26 defined in s. 624.33(3), and the trustees and employees acting
27 pursuant to such trust, or a custodian and its agents and
28 employees, including individuals representing the trustees in
29 overseeing the activities of a service company or
30 administrator, acting pursuant to a custodial account which
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1 meets the requirements of s. 401(f) of the Internal Revenue
2 Code.

3 (j) A financial institution which is subject to
4 supervision or examination by federal or state authorities or
5 a mortgage lender licensed under chapter 494 who collects and
6 remits premiums to licensed insurance agents or authorized
7 insurers concurrently or in connection with mortgage loan
8 payments.

9 (k) A credit card issuing company which advances for
10 and collects premiums or charges from its credit card holders
11 who have authorized such collection if such company does not
12 adjust or settle claims.

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

17 (m) A person approved by the Division of Workers'
18 Compensation of the Department of Labor and Employment
19 Security who administers only self-insured workers'
20 compensation plans.

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

25
26 A person who provides billing and collection services to
27 health insurers and health maintenance organizations on behalf
28 of health care providers shall comply with the provisions of
29 ss. 627.6131, 641.3155, and 641.51(4).

30 Section 3. Section 627.613, Florida Statutes, is
31 amended to read:

1 627.613 Time of payment of claims.--

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

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

10

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

31

1 ~~is contested shall identify the contested portion of the claim~~
2 ~~and the reasons for contesting the claim.~~

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

5 (a) Are considered received on the date the claim is
6 received by the insurer at its designated claims receipt
7 location.

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

14 (c) For noninstitutional providers, all claims must be
15 mailed or electronically transferred to an insurer within 90
16 days after completion of the service and after the provider
17 has been furnished with the correct name and address of the
18 patient's insurer. For institutional providers, unless
19 otherwise agreed to through contract, all claims must be
20 mailed or electronically transferred to an insurer within 90
21 days after completion of the service and after the provider
22 has been furnished with the correct name and address of the
23 patient's health insurer.

24 (4)(a) For an electronically submitted claim, a health
25 insurer shall, within 24 hours after the beginning of the next
26 business day after receipt of the claim, provide electronic
27 acknowledgement of the receipt of the claim to the electronic
28 source submitting the claim.

29 (b) For an electronically submitted claim, a health
30 insurer shall, within 20 days after receipt of the claim, pay
31 the claim or notify a provider or designee if a claim is

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

5 (c)1. Notification of the health insurer's
6 determination of a contested claim must be accompanied by an
7 itemized list of additional information or documents the
8 insurer can reasonably determine are necessary to process the
9 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 insurer may not make more than one request
17 for documents under this paragraph in connection with a claim
18 unless the provider fails to submit all of the requested
19 documents to process the claim or the documents submitted by
20 the provider raise new, additional issues not included in the
21 original written itemization, in which case the health insurer
22 may provide the provider with one additional opportunity to
23 submit the additional documents needed to process the claim.
24 In no case may the health insurer request duplicate documents.

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

29 (e) A claim must be paid or denied within 90 days
30 after receipt of the claim. Failure to pay or deny a claim
31 within 120 days after receipt of the claim creates an

1 uncontestable obligation to pay the claim.~~An insurer shall~~
2 ~~pay or deny any claim no later than 120 days after receiving~~
3 ~~the claim.~~

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

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

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

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

28 3. A health insurer may not make more than one request
29 for documents under this paragraph in connection with a claim
30 unless the provider fails to submit all of the requested
31 documents to process the claim or the documents submitted by

1 the provider raise new, additional issues not included in the
2 original written itemization, in which case the health insurer
3 may provide the provider with one additional opportunity to
4 submit the additional documents needed to process the claim.
5 In no case may the health insurer request duplicate documents.

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

10 (e) A claim must be paid or denied within 120 days
11 after receipt of the claim. Failure to pay or deny a claim
12 within 140 days after receipt of the claim creates an
13 uncontestable obligation to pay the claim. ~~Payment shall be~~
14 ~~treated as being made on the date a draft or other valid~~
15 ~~instrument which is equivalent to payment was placed in the~~
16 ~~United States mail in a properly addressed, postpaid envelope~~
17 ~~or, if not so posted, on the date of delivery.~~

18 (6) Payment of a claim is considered made on the date
19 the payment is mailed or electronically transferred. An
20 overdue payment of a claim bears simple interest of 12 percent
21 per year. Interest on an overdue payment for a claim or for
22 any portion of a claim begins to accrue when the claim should
23 have been paid, denied, or contested. The interest is payable
24 with the payment of the claim. ~~All overdue payments shall bear~~
25 ~~simple interest at the rate of 10 percent per year.~~

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

1 improperly billed, the insurer shall notify the insured and
2 the provider of its findings and shall reduce the amount of
3 payment to the provider by the amount determined to be
4 improperly billed. If a reduction is made due to such
5 notification by the insured, the insurer shall pay to the
6 insured 20 percent of the amount of the reduction up to \$500.

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

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

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

27 (c) A provider that denies or contests a health
28 insurer's claim for overpayment or any portion of a claim
29 shall notify the health insurer, in writing, within 35 days
30 after the provider receives the claim that the claim for
31 overpayment is contested or denied. The notice that the claim

1 for overpayment is contested or denied must identify the
2 contested portion of the claim and the specific reason for
3 contesting or denying the claim, and, if contested, must
4 include a request for additional information. The provider
5 shall pay or deny the claim for overpayment within 35 days
6 after receipt of the information.

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

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

29 (10) Any retroactive reductions of payments or demands
30 for refund of previous overpayments that are due to
31 retroactive review of coverage decisions or payment levels

1 must be reconciled to specific claims. Any retroactive demands
2 by providers for payment due to underpayments or nonpayments
3 for covered services must be reconciled to specific claims.
4 The look-back or audit-review period shall not exceed 2 years
5 after the date the claim was paid by the health insurer,
6 unless fraud in billing is involved.

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

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

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

27 (c) In any civil litigation resulting from an act or
28 practice involving a violation of this section by a health
29 insurer in which the health insurer is found to have violated
30 this section, the provider, after judgment in the trial court
31 and after exhausting all appeals, if any, shall receive his or

1 her attorney's fees and costs from the insurer; however, such
2 fees shall not exceed three times the amount in controversy or
3 \$5,000, whichever is greater. In any such civil litigation, if
4 the insurer is found not to have violated this section, the
5 insurer, after judgment in the trial court and exhaustion of
6 all appeals, if any, may receive its reasonable attorney's
7 fees and costs from the provider on any claim or defense that
8 the court finds the provider knew or should have known was not
9 supported by the material facts necessary to establish the
10 claim or defense or would not be supported by the application
11 of then-existing law as to those material facts.

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

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

19 (13) A permissive error ratio of 5 percent is
20 established for insurers claims payment violations of s.
21 627.613(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and
22 (e). If the error ratio of a particular insurer does not
23 exceed the permissible error ratio of 5 percent for an audit
24 period, a fine may not be assessed for the noted claims
25 violations for the audit period. The error ratio shall be
26 determined by dividing the number of claims with violations
27 found on a statistically valid sample of claims for the audit
28 period, divided by the total number of claims in the sample.
29 If the error ratio exceeds the permissible error ratio of 5
30 percent, a fine may be assessed according to s. 624.4211 for
31 the claims payment violations that exceed the error ratio.

1 Notwithstanding the provisions of this section, the department
2 may fine a health insurer for claims payment violations of s.
3 627.613(4)(e) and (5)(e) which create an uncontestable
4 obligation to pay the claim. The department may not fine
5 insurers for violations that the department determines were
6 due to circumstances beyond the insurer's control.

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

9 (15) The amendments to this section by this act apply
10 only to a major medical expense health insurance policy as
11 defined in s. 627.643(2)(e) which is offered by a group or an
12 individual health insurer licensed under chapter 624,
13 including a preferred provider policy under s. 627.6417, an
14 exclusive provider organization under 627.6472, or a group or
15 individual insurance contract that provides payment for
16 enumerated dental services.

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

27 (b) Upon receipt of a request from a provider for
28 authorization, the health insurer shall issue a written
29 determination indicating whether the service or services are
30 authorized. If the request for an authorization is for an
31 inpatient admission, the determination shall be transmitted to

1 the provider making the request in writing no later than 24
2 hours after the request is made by the provider. If the health
3 insurer denies the request for authorization, the health
4 insurer shall notify the insured at the same time the insurer
5 notifies the provider requesting the authorization. A health
6 insurer that fails to respond to a request for an
7 authorization pursuant to this paragraph within 24 hours is
8 considered to have authorized the inpatient admission and
9 payment shall not be denied.

10 (4) If the proposed medical care or health care
11 service or services involve an inpatient admission and the
12 health insurer requires an authorization as a condition of
13 payment, the health insurer shall review and issue a written
14 or electronic authorization for the total estimated length of
15 stay for the admission, based on the recommendation of the
16 patient's physician. If the proposed medical care or health
17 care service or services are to be provided to an insured who
18 is an inpatient in a health care facility and authorization is
19 required, the health insurer shall issue a written
20 determination indicating whether the proposed services are
21 authorized or denied no later than 4 hours after the request
22 is made by the provider. A health insurer who fails to respond
23 to such request within 4 hours is considered to have
24 authorized the requested medical care or health care service
25 and payment shall not be denied.

26 (5) Authorization may not be required for emergency
27 services and care or emergency medical services as provided
28 pursuant to ss. 395.002, 395.1041, 401.45, and 401.252.

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

31

1 Section 5. Subsection (3) is added to section 627.638,
2 Florida Statutes, to read:

3 627.638 Direct payment for hospital, medical
4 services.--

5 (3) Under any health insurance policy insuring against
6 loss or expense due to hospital confinement or to medical and
7 related services, payment of benefits shall be made directly
8 to any recognized hospital, doctor, or other person who
9 provided services for the treatment of a psychological
10 disorder or treatment for substance abuse, including drug and
11 alcohol abuse, when the treatment is in accordance with the
12 provisions of the policy and the insured specifically
13 authorizes direct payment of benefits. Payments shall be made
14 under this section, notwithstanding any contrary provisions in
15 the health insurance contract. This subsection applies to all
16 health insurance policies now or hereafter in force as of the
17 effective date of this act.

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

20 627.651 Group contracts and plans of self-insurance
21 must meet group requirements.--

22 (4) This section does not apply to any plan which is
23 established or maintained by an individual employer in
24 accordance with the Employee Retirement Income Security Act of
25 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
26 arrangement as defined in s. 624.437(1), except that a
27 multiple-employer welfare arrangement shall comply with ss.
28 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
29 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~.
30 This subsection does not allow an authorized insurer to issue
31

1 a group health insurance policy or certificate which does not
2 comply with this part.

3 Section 7. Section 627.662, Florida Statutes, is
4 amended to read:

5 627.662 Other provisions applicable.--The following
6 provisions apply to group health insurance, blanket health
7 insurance, and franchise health insurance:

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

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

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

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

15 (5) Section 627.640, relating to filing and
16 classification of rates.

17 (6) Section 627.6142, relating to treatment
18 authorizations.

19 ~~(7)(6)~~ Section 627.645(1), relating to denial of
20 claims.

21 ~~(8)(7)~~ Section 627.613, relating to time of payment of
22 claims.

23 ~~(9)(8)~~ Section 627.6471, relating to preferred
24 provider organizations.

25 ~~(10)(9)~~ Section 627.6472, relating to exclusive
26 provider organizations.

27 ~~(11)(10)~~ Section 627.6473, relating to combined
28 preferred provider and exclusive provider policies.

29 ~~(12)(11)~~ Section 627.6474, relating to provider
30 contracts.

31

1 Section 8. Paragraph (e) of subsection (1) of section
2 641.185, Florida Statutes, is amended to read:

3 641.185 Health maintenance organization subscriber
4 protections.--

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

13 (e) A health maintenance organization subscriber
14 should receive timely, concise information regarding the
15 health maintenance organization's reimbursement to providers
16 and services pursuant to ss. 641.31 and 641.31015 and is
17 entitled to prompt payment from the organization when
18 appropriate pursuant to s. 641.3155.

19 Section 9. Subsection (4) is added to section 641.234,
20 Florida Statutes, to read:

21 641.234 Administrative, provider, and management
22 contracts.--

23 (4)(a) If a health maintenance organization, through a
24 health care risk contract, transfers to any entity the
25 obligations to pay any provider for any claims arising from
26 services provided to or for the benefit of any subscriber of
27 the organization, the health maintenance organization shall
28 remain responsible for any violations of ss. 641,3155,
29 641.3156, and 641.51(4). The provisions of ss.
30 624.418-624.4211 and 641.52 shall apply to any such
31 violations.

1 (b) As used in this subsection:

2 1. The term "health care risk contract" means a
3 contract under which an entity receives compensation in
4 exchange for providing to the health maintenance organization
5 a provider network or other services, which may include
6 administrative services.

7 2. The term "entity" means a person licensed as an
8 administrator under s. 626.88 and does not include any
9 provider or group practice, as defined in s. 456.053,
10 providing services under the scope of the license of the
11 provider or the members of the group practice.

12 Section 10. Subsection (1) of section 641.30, Florida
13 Statutes, is amended to read:

14 641.30 Construction and relationship to other laws.--

15 (1) Every health maintenance organization shall accept
16 the ~~standard health~~ claim form prescribed pursuant to s.
17 641.3155 ~~627.647~~.

18 Section 11. Section 641.3155, Florida Statutes, is
19 amended to read:

20 641.3155 Payment of claims.--

21 (1)~~(a)~~ As used in this section, the term "~~clean~~ claim"
22 for a noninstitutional provider means a paper or electronic
23 billing instrument submitted to the health maintenance
24 organization's designated location which consists of the HCFA
25 1500 data set, or its successor, having all mandatory entries
26 completed for a physician licensed under chapter 458, chapter
27 459, chapter 460, or chapter 461 or other appropriate billing
28 instrument that has all mandatory entries for any other
29 noninstitutional provider. For institutional providers,
30 "claim" means a paper or electronic billing instrument
31 submitted to the insurer's designated location which consists

1 of the UB-92 data set with entries stated as mandatory by the
2 National Uniform Billing Committee.~~claim submitted on a HFCA~~
3 ~~1500 form which has no defect or impropriety, including lack~~
4 ~~of required substantiating documentation for noncontracted~~
5 ~~providers and suppliers, or particular circumstances requiring~~
6 ~~special treatment which prevent timely payment from being made~~
7 ~~on the claim. A claim may not be considered not clean solely~~
8 ~~because a health maintenance organization refers the claim to~~
9 ~~a medical specialist within the health maintenance~~
10 ~~organization for examination. If additional substantiating~~
11 ~~documentation, such as the medical record or encounter data,~~
12 ~~is required from a source outside the health maintenance~~
13 ~~organization, the claim is considered not clean. This~~
14 ~~definition of "clean claim" is repealed on the effective date~~
15 ~~of rules adopted by the department which define the term~~
16 ~~"clean claim."~~

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

23 ~~(c) The department shall adopt rules to establish~~
24 ~~claim forms consistent with federal claim-filing standards for~~
25 ~~health maintenance organizations required by the federal~~
26 ~~Health Care Financing Administration. The department may adopt~~
27 ~~rules relating to coding standards consistent with Medicare~~
28 ~~coding standards adopted by the federal Health Care Financing~~
29 ~~Administration.~~

30 (2) All claims for payment, whether electronic or
31 nonelectronic:

1 (a) Are considered received on the date the claim is
2 received by the organization at its designated claims receipt
3 location.

4 (b) Must not duplicate a claim previously submitted
5 unless it is determined that the original claim was not
6 received or is otherwise lost.

7 ~~(a) A health maintenance organization shall pay any~~
8 ~~clean claim or any portion of a clean claim made by a contract~~
9 ~~provider for services or goods provided under a contract with~~
10 ~~the health maintenance organization or a clean claim made by a~~
11 ~~noncontract provider which the organization does not contest~~
12 ~~or deny within 35 days after receipt of the claim by the~~
13 ~~health maintenance organization which is mailed or~~
14 ~~electronically transferred by the provider.~~

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

30 (c) For noninstitutional providers, all claims must be
31 mailed or electronically transferred to a health maintenance

1 organization within 90 days after completion of the service
2 and after the provider is furnished with the correct name and
3 address of the patient's health maintenance organization. For
4 institutional providers, unless otherwise agreed to through
5 contract, all claims must be mailed or electronically
6 transferred to a health maintenance organization within 90
7 days after completion of the service and after the provider is
8 furnished with the correct name and address of the patient's
9 health maintenance organization. Submission of a provider's
10 claim is considered made on the date it is electronically
11 transferred or mailed.

12 (3)(a) For an electronically submitted claim, a health
13 maintenance organization shall, within 24 hours after the
14 beginning of the next business day after receipt of the claim,
15 provide electronic acknowledgement of the receipt of the claim
16 to the electronic source submitting the claim.

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

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

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

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

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

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

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

29 (4)(a) For all nonelectronically submitted claims, a
30 health maintenance organization shall, effective November 1,
31 2003, provide to the provider acknowledgement of receipt of

1 the claim within 15 days after receipt of the claim or provide
2 the provider, within 15 days after receipt, with electronic
3 access to the status of a submitted claim.

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

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

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

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

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

5 (e) A claim must be paid or denied within 120 days
6 after receipt of the claim. Failure to pay or deny a claim
7 within 140 days after receipt of the claim creates an
8 uncontestable obligation to pay the claim.~~A health~~
9 ~~maintenance organization shall pay or deny any claim no later~~
10 ~~than 120 days after receiving the claim. Failure to do so~~
11 ~~creates an uncontestable obligation for the health maintenance~~
12 ~~organization to pay the claim to the provider.~~

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

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

31

1 (b) A provider shall pay a claim for an overpayment
2 made by a health maintenance organization which the provider
3 does not contest or deny within 35 days after receipt of the
4 claim that is mailed or electronically transferred to the
5 provider.

6 (c) A provider that denies or contests an
7 organization's claim for overpayment or any portion of a claim
8 shall notify the organization, in writing, within 35 days
9 after the provider receives the claim that the claim for
10 overpayment is contested or denied. The notice that the claim
11 for overpayment is denied or contested must identify the
12 contested portion of the claim and the specific reason for
13 contesting or denying the claim, and, if contested, must
14 include a request for additional information. If the
15 organization submits additional information, the organization
16 must, within 35 days after receipt of the request, mail or
17 electronically transfer the information to the provider. The
18 provider shall pay or deny the claim for overpayment within 45
19 days after receipt of the information.

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

30 (e) A provider shall pay or deny any claim for
31 overpayment no later than 120 days after receiving the claim.

1 Failure to do so creates an uncontestable obligation for the
2 provider to pay the claim to the organization.

3 ~~(7)(6)~~ Any retroactive reductions of payments or
4 demands for refund of previous overpayments which are due to
5 retroactive review-of-coverage decisions or payment levels
6 must be reconciled to specific claims unless the parties agree
7 to other reconciliation methods and terms. Any retroactive
8 demands by providers for payment due to underpayments or
9 nonpayments for covered services must be reconciled to
10 specific claims unless the parties agree to other
11 reconciliation methods and terms. The look-back or
12 audit-review period shall not exceed 2 years after the date
13 the claim was paid by the health maintenance organization,
14 unless fraud in billing is involved.~~The look-back period may~~
15 ~~be specified by the terms of the contract.~~

16 ~~(8)(a)(7)(a)~~ A provider claim for payment shall be
17 considered received by the health maintenance organization, if
18 the claim has been electronically transmitted to the health
19 maintenance organization, when receipt is verified
20 electronically or, if the claim is mailed to the address
21 disclosed by the organization, on the date indicated on the
22 return receipt, or on the date the delivery receipt is signed
23 by the health maintenance organization if the claim is hand
24 delivered. A provider must wait 45 days following receipt of a
25 claim before submitting a duplicate claim.

26 (b) A health maintenance organization claim for
27 overpayment shall be considered received by a provider, if the
28 claim has been electronically transmitted to the provider,
29 when receipt is verified electronically or, if the claim is
30 mailed to the address disclosed by the provider, on the date
31 indicated on the return receipt. An organization must wait 45

1 days following the provider's receipt of a claim for
2 overpayment before submitting a duplicate claim.

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

6 ~~(9)(8)~~ A provider, or the provider's designee, who
7 bills electronically is entitled to electronic acknowledgment
8 of the receipt of a claim within 72 hours.

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

22 ~~(11)(10)~~ A health maintenance organization shall pay a
23 contracted primary care or admitting physician, pursuant to
24 such physician's contract, for providing inpatient services in
25 a contracted hospital to a subscriber, if such services are
26 determined by the organization to be medically necessary and
27 covered services under the organization's contract with the
28 contract holder.

29 (12)(a) Without regard to any other remedy or relief
30 to which a person is entitled, or obligated to under contract,
31 anyone aggrieved by a violation of this section may bring an

1 action to obtain a declaratory judgment that an act or
2 practice violates this section and to enjoin a person who has
3 violated, is violating, or is otherwise likely to violate this
4 section.

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

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

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

31

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

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

20 (14) A permissive error ratio of 5 percent is
21 established for organizations claims payment violations of s.
22 641.3155(3)(a), (b), (c), and (e) and (4)(a), (b), (c), and
23 (e). If the error ratio of a particular organization does not
24 exceed the permissible error ratio of 5 percent for an audit
25 period, a fine may not be assessed for the noted claims
26 violations for the audit period. The error ratio shall be
27 determined by dividing the number of claims with violations
28 found on a statistically valid sample of claims for the audit
29 period divided by the total number of claims in the sample. If
30 the error ratio exceeds the permissible error ratio of 5
31 percent, a fine may be assessed according to s. 624.4211 for

1 the claims payment violations that exceed the error ratio.
2 Notwithstanding the provisions of this section, the department
3 may fine a health maintenance organization for claims payment
4 violations of s. 641.3155(3)(e) and (4)(e) which create an
5 uncontestable obligation to pay the claim. The department may
6 not fine organizations for violations that the department
7 determines were due to circumstances beyond the organization's
8 control.

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

11 Section 12. Section 641.3156, Florida Statutes, is
12 amended to read:

13 641.3156 Treatment authorization; payment of claims.--

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

21 (2) A health maintenance organization that requires
22 authorization for medical care and health care services shall
23 provide to each contracted provider at the time a contract is
24 signed a list of the medical care and health care services
25 that require authorization and the authorization procedures
26 used by the organization. A health maintenance organization
27 that requires authorization for medical care and health care
28 services shall provide to each noncontracted provider, not
29 later than 10 working days after a request is made, a list of
30 the medical care and health care services that require
31 authorization and the authorization procedures used by the

1 organization. The list of medical care or health care services
2 that require authorization and the authorization procedures
3 used by the organization shall not be modified unless written
4 notice is provided at least 30 days in advance of any changes
5 to all subscribers, contracted providers, and noncontracted
6 providers who had previously requested a list of medical care
7 or health care services that require authorization. An
8 organization that makes such list and procedures accessible to
9 providers and subscribers electronically is in compliance with
10 this section so long as notice is provided at least 30 days in
11 advance of any changes in such list or procedures to all
12 subscribers, contracted providers, and noncontracted providers
13 who had previously requested a list of medical care or health
14 care services that require authorization.~~A health maintenance~~
15 ~~organization must pay any hospital-service or referral-service~~
16 ~~claim for treatment for an eligible subscriber which was~~
17 ~~authorized by a provider empowered by contract with the health~~
18 ~~maintenance organization to authorize or direct the patient's~~
19 ~~utilization of health care services and which was also~~
20 ~~authorized in accordance with the health maintenance~~
21 ~~organization's current and communicated procedures, unless the~~
22 ~~provider provided information to the health maintenance~~
23 ~~organization with the willful intention to misinform the~~
24 ~~health maintenance organization.~~

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

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

16 (4) If the proposed medical care or health care
17 service or services involve an inpatient admission and the
18 health maintenance organization requires authorization as a
19 condition of payment, the health maintenance organization
20 shall issue a written or electronic authorization for the
21 total estimated length of stay for the admission. If the
22 proposed medical care or health care service or services are
23 to be provided to a patient who is an inpatient in a health
24 care facility at the time the services are proposed and the
25 medical care or health care service requires an authorization,
26 the health maintenance organization shall issue a
27 determination indicating whether the proposed services are
28 authorized no later than 4 hours after the request by the
29 health care provider. A health maintenance organization that
30 fails to respond to such request within 4 hours is considered

31

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

3 (5)(3) Emergency services are subject to the
4 provisions of s. 641.513 and are not subject to the provisions
5 of this section.

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

8 Section 13. Paragraph (i) of subsection (1) of section
9 626.9541, Florida Statutes, is amended to read:

10 626.9541 Unfair methods of competition and unfair or
11 deceptive acts or practices defined.--

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

15 (i) Unfair claim settlement practices.--

16 1. Attempting to settle claims on the basis of an
17 application, when serving as a binder or intended to become a
18 part of the policy, or any other material document which was
19 altered without notice to, or knowledge or consent of, the
20 insured;

21 2. A material misrepresentation made to an insured or
22 any other person having an interest in the proceeds payable
23 under such contract or policy, for the purpose and with the
24 intent of effecting settlement of such claims, loss, or damage
25 under such contract or policy on less favorable terms than
26 those provided in, and contemplated by, such contract or
27 policy; or

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

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

1 b. Misrepresenting pertinent facts or insurance policy
2 provisions relating to coverages at issue;

3 c. Failing to acknowledge and act promptly upon
4 communications with respect to claims;

5 d. Denying claims without conducting reasonable
6 investigations based upon available information;

7 e. Failing to affirm or deny full or partial coverage
8 of claims, and, as to partial coverage, the dollar amount or
9 extent of coverage, or failing to provide a written statement
10 that the claim is being investigated, upon the written request
11 of the insured within 30 days after proof-of-loss statements
12 have been completed;

13 f. Failing to promptly provide a reasonable
14 explanation in writing to the insured of the basis in the
15 insurance policy, in relation to the facts or applicable law,
16 for denial of a claim or for the offer of a compromise
17 settlement;

18 g. Failing to promptly notify the insured of any
19 additional information necessary for the processing of a
20 claim; or

21 h. Failing to clearly explain the nature of the
22 requested information and the reasons why such information is
23 necessary; ~~or~~

24 (i) Notifying providers that claims filed under s.
25 627.613 have not been received when, in fact, the claims have
26 been received.

27 Section 14. Subsection (5) of section 641.3903,
28 Florida Statutes, is amended to read:

29 641.3903 Unfair methods of competition and unfair or
30 deceptive acts or practices defined.--The following are
31

1 defined as unfair methods of competition and unfair or
2 deceptive acts or practices:

3 (5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

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

8 (b) Making a material misrepresentation to the
9 subscriber for the purpose and with the intent of effecting
10 settlement of claims, loss, or damage under a health
11 maintenance contract on less favorable terms than those
12 provided in, and contemplated by, the contract; or

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

15 1. Failing to adopt and implement standards for the
16 proper investigation of claims;

17 2. Misrepresenting pertinent facts or contract
18 provisions relating to coverage at issue;

19 3. Failing to acknowledge and act promptly upon
20 communications with respect to claims;

21 4. Denying of claims without conducting reasonable
22 investigations based upon available information;

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

29 6. Failing to promptly provide a reasonable
30 explanation in writing to the subscriber of the basis in the
31 health maintenance contract in relation to the facts or

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

3 7. Failing to provide, upon written request of a
4 subscriber, itemized statements verifying that services and
5 supplies were furnished, where such statement is necessary for
6 the submission of other insurance claims covered by individual
7 specified disease or limited benefit policies, provided that
8 the organization may receive from the subscriber a reasonable
9 administrative charge for the cost of preparing such
10 statement;

11 8. Failing to provide any subscriber with services,
12 care, or treatment contracted for pursuant to any health
13 maintenance contract without a reasonable basis to believe
14 that a legitimate defense exists for not providing such
15 services, care, or treatment. To the extent that a national
16 disaster, war, riot, civil insurrection, epidemic, or any
17 other emergency or similar event not within the control of the
18 health maintenance organization results in the inability of
19 the facilities, personnel, or financial resources of the
20 health maintenance organization to provide or arrange for
21 provision of a health service in accordance with requirements
22 of this part, the health maintenance organization is required
23 only to make a good faith effort to provide or arrange for
24 provision of the service, taking into account the impact of
25 the event. For the purposes of this paragraph, an event is
26 not within the control of the health maintenance organization
27 if the health maintenance organization cannot exercise
28 influence or dominion over its occurrence; or

29 9. Systematic downcoding with the intent to deny
30 reimbursement otherwise due; or-

31

1 10. Notifying providers that claims filed under s.
2 641.3155 have not been received when, in fact, the claims have
3 been received.

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

6 641.51 Quality assurance program; second medical
7 opinion requirement.--

8 (12) If a contracted primary care physician, licensed
9 under chapter 458 or chapter 459, determines ~~and the~~
10 ~~organization determine~~ that a subscriber requires examination
11 by a licensed ophthalmologist for medically necessary,
12 contractually covered services, then the organization shall
13 authorize the contracted primary care physician to send the
14 subscriber to a contracted licensed ophthalmologist.

15 Section 16. This act shall take effect October 1,
16 2002.

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