

1 A bill to be entitled

2 An act relating to the provision of health care services;  
3 amending s. 627.6131, F.S.; prohibiting a health insurer  
4 from demanding repayment of an overpayment made due to  
5 error of the health insurer; reducing a period of time for  
6 a claim for overpayment; requiring a health insurer to  
7 pay, and prohibiting denial of, a claim for treatment  
8 under certain circumstances; providing exceptions;  
9 authorizing certain aggrieved persons to bring certain  
10 actions for certain violations; providing for recovery of  
11 amounts, interest, attorney's fees, and court costs;  
12 providing limits; requiring attorneys to submit affidavits  
13 for fees; providing for awards of fees or costs to become  
14 a part of the judgment and subject to execution; providing  
15 for application; amending s. 641.19, F.S.; clarifying a  
16 definition; amending s. 641.31, F.S.; prohibiting health  
17 maintenance contracts from prohibiting or restricting  
18 subscribers from assigning plan benefits to noncontract  
19 physicians for certain services; requiring recognition of  
20 the assignment and payment of services; providing  
21 requirements for certain physicians accepting such  
22 assignments; amending s. 641.315, F.S.; revising required  
23 contract termination provisions; amending s. 641.3155,  
24 F.S.; prohibiting a health maintenance organization from  
25 demanding repayment of an overpayment made due to error of  
26 the health maintenance organization; reducing a period of  
27 time for a claim for overpayment; authorizing certain  
28 aggrieved persons to bring certain actions for certain

29 | violations; providing for recovery of amounts, interest,  
 30 | attorney's fees, and court costs; providing limits;  
 31 | requiring attorneys to submit affidavits for fees;  
 32 | providing for awards of fees or costs to become a part of  
 33 | the judgment and subject to execution; providing for  
 34 | application; amending s. 641.3156, F.S.; requiring a  
 35 | health maintenance organization to pay, and prohibiting  
 36 | denial of, a claim for treatment under certain  
 37 | circumstances; providing exceptions; amending s. 641.513,  
 38 | F.S.; revising provisions for reimbursement of noncontract  
 39 | providers; providing an effective date.

40 |

41 | Be It Enacted by the Legislature of the State of Florida:

42 |

43 | Section 1. Subsection (6) of section 627.6131, Florida  
 44 | Statutes, is amended, and subsections (18) and (19) are added to  
 45 | said section, to read:

46 | 627.6131 Payment of claims.--

47 | (6) If a health insurer determines that it has made an  
 48 | overpayment to a provider for services rendered to an insured,  
 49 | the health insurer must make a claim for such overpayment to the  
 50 | provider's designated location. A health insurer may not demand  
 51 | repayment from the provider in any instance in which the  
 52 | overpayment is attributable to error of the health insurer. A  
 53 | health insurer that makes a claim for overpayment to a provider  
 54 | under this section shall give the provider a written or  
 55 | electronic statement specifying the basis for the retroactive  
 56 | denial or payment adjustment. The insurer must identify the

57 claim or claims, or overpayment claim portion thereof, for which  
58 a claim for overpayment is submitted.

59 (a) If an overpayment determination is the result of  
60 retroactive review or audit of coverage decisions or payment  
61 levels not related to fraud, a health insurer shall adhere to  
62 the following procedures:

63 1. All claims for overpayment must be submitted to a  
64 provider within 12 ~~30~~ months after the health insurer's payment  
65 of the claim. A provider must pay, deny, or contest the health  
66 insurer's claim for overpayment within 40 days after the receipt  
67 of the claim. All contested claims for overpayment must be paid  
68 or denied within 120 days after receipt of the claim. Failure to  
69 pay or deny overpayment and claim within 140 days after receipt  
70 creates an uncontestable obligation to pay the claim.

71 2. A provider that denies or contests a health insurer's  
72 claim for overpayment or any portion of a claim shall notify the  
73 health insurer, in writing, within 35 days after the provider  
74 receives the claim that the claim for overpayment is contested  
75 or denied. The notice that the claim for overpayment is denied  
76 or contested must identify the contested portion of the claim  
77 and the specific reason for contesting or denying the claim and,  
78 if contested, must include a request for additional information.  
79 If the health insurer submits additional information, the health  
80 insurer must, within 35 days after receipt of the request, mail  
81 or electronically transfer the information to the provider. The  
82 provider shall pay or deny the claim for overpayment within 45  
83 days after receipt of the information. The notice is considered

84 made on the date the notice is mailed or electronically  
 85 transferred by the provider.

86 3. The health insurer may not reduce payment to the  
 87 provider for other services unless the provider agrees to the  
 88 reduction in writing or fails to respond to the health insurer's  
 89 overpayment claim as required by this paragraph.

90 4. Payment of an overpayment claim is considered made on  
 91 the date the payment was mailed or electronically transferred.  
 92 An overdue payment of a claim bears simple interest at the rate  
 93 of 12 percent per year. Interest on an overdue payment for a  
 94 claim for an overpayment begins to accrue when the claim should  
 95 have been paid, denied, or contested.

96 (b) A claim for overpayment shall not be permitted beyond  
 97 12 ~~30~~ months after the health insurer's payment of a claim,  
 98 except that claims for overpayment may be sought beyond that  
 99 time from providers convicted of fraud pursuant to s. 817.234.

100 (18) A claim for treatment must be paid by a health  
 101 insurer and may not be denied if a provider, whether or not  
 102 under contract with the health insurer, follows the insurer's  
 103 authorization procedures and receives authorization for a  
 104 covered service for an eligible subscriber, unless the provider  
 105 provided information to the health insurer with willful intent  
 106 to misinform the health insurer. Emergency services are subject  
 107 to the provisions of ss. 395.1041 and 401.45 and are not subject  
 108 to the provisions of this subsection.

109 (19)(a) Without regard to any other remedy or relief to  
 110 which a person is entitled, or obligated to under contract,  
 111 anyone aggrieved by a violation of this section may bring an

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112 action for damages or to obtain a declaratory judgment that an  
113 act or practice violates this section and to enjoin a person who  
114 has violated, is violating, or is otherwise likely to violate  
115 this section.

116 (b) In any action brought by a person who has suffered  
117 damages as a result of a violation of this section, such person  
118 may recover any amounts due the person, including accrued  
119 interest, plus attorney's fees and court costs as provided in  
120 paragraphs (c) and (d).

121 (c)1. In any civil action brought pursuant to this  
122 subsection, the prevailing party, after judgment in the trial  
123 court and after exhausting all appeals, if any, shall receive  
124 his or her attorney's fees and costs from the nonprevailing  
125 party.

126 2. If the provider is the prevailing party, such fees  
127 shall not exceed three times the amount in controversy or  
128 \$10,000, whichever is greater.

129 3. If the health insurer is the prevailing party on any  
130 claim or defense for which the court finds that the insured or  
131 the insured's assignee knew or should have known that the claim  
132 or defense was not supported by the material facts necessary to  
133 establish the claim or defense, or would not be supported by the  
134 application of then-existing law as to those material facts,  
135 such fees shall not exceed two times the amount in controversy  
136 or \$5,000, whichever is greater.

137 (d)1. In any civil action brought by a health insurer  
138 pursuant to this subsection, the prevailing party, after  
139 judgment in the trial court and after exhausting all appeals, if

140 any, shall receive his or her attorney's fees and costs from the  
141 nonprevailing party.

142 2. If the health insurer is the prevailing party on any  
143 claim or defense for which the court finds that the insured or  
144 the insured's assignee knew or should have known that the claim  
145 or defense was not supported by the material facts necessary to  
146 establish the claim or defense, or would not be supported by the  
147 application of then-existing law as to those material facts,  
148 such fees shall not exceed two times the amount in controversy  
149 or \$5,000, whichever is greater.

150 3. If the insured or the insured's assignee is the  
151 prevailing party, such fees shall not exceed three times the  
152 amount in controversy or \$10,000, whichever is greater.

153 (e) The attorney for the prevailing party shall submit to  
154 the trial judge who presided over the civil case a sworn  
155 affidavit of his or her time spent on the case and his or her  
156 costs incurred for all the motions, hearings, and appeals.

157 (f) Any award of attorney's fees or court costs shall  
158 become a part of the judgment and subject to execution as  
159 provided by law.

160 (g) This subsection shall apply in any proceeding in which  
161 the provider alleges that the health insurer has failed to  
162 comply with its contractual obligations.

163 Section 2. Subsection (16) of section 641.19, Florida  
164 Statutes, is amended to read:

165 641.19 Definitions.--As used in this part, the term:

166 (16) "Schedule of reimbursements" means a schedule of fees  
167 to be paid by a health maintenance organization to a physician

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168 provider for reimbursement for specific services pursuant to the  
 169 terms of a contract. The physician provider's net reimbursement  
 170 may vary after consideration of other factors, including, but  
 171 not limited to, bundling codes together into another code,  
 172 modifiers used, and member cost-sharing responsibility, as long  
 173 as these factors are disclosed and included in the terms of the  
 174 contract between the health maintenance organization and  
 175 provider. The reimbursement schedule may be stated as:

176 (a) A percentage of the current Medicare fee schedule and  
 177 rules for specific relative-value services;

178 (b) A listing of the reimbursements to be paid by Current  
 179 Procedural Terminology codes for physicians that pertain to each  
 180 physician's practice; or

181 (c) Any other method agreed upon by the parties.

182  
 183 Specific nonrelative-value services shall be stated separately  
 184 from relative-value services, and reimbursement for unclassified  
 185 services shall be on a reasonable basis.

186 Section 3. Subsection (41) is added to section 641.31,  
 187 Florida Statutes, to read:

188 641.31 Health maintenance contracts.--

189 (41)(a) A health maintenance organization contract may not  
 190 prohibit or restrict a subscriber from assigning plan benefits  
 191 to physicians not under contract with the organization for  
 192 covered health care services rendered by the physician to the  
 193 subscriber.

194 (b) Any assignment by a subscriber of plan benefits that  
 195 designates that the subscriber has been accepted by a physician

196 not under contract with the organization must be recognized by  
 197 the organization and paid pursuant to s. 641.3155.

198 (c) Except for physicians providing services pursuant to  
 199 s. 641.513, any physician who accepts an assignment pursuant to  
 200 this subsection agrees, by submitting the claim to the health  
 201 maintenance organization, to accept the amount paid by the  
 202 health maintenance organization as payment in full for the  
 203 health care services provided and to not collect any balance  
 204 from the subscriber.

205 Section 4. Subsections (1) and (2) of section 641.315,  
 206 Florida Statutes, are amended to read:

207 641.315 Provider contracts.--

208 (1) Each contract between a health maintenance  
 209 organization and a provider of health care services must be in  
 210 writing and must contain a provision that, except as otherwise  
 211 provided, the subscriber is not liable to the provider for any  
 212 services for which the health maintenance organization is liable  
 213 as specified in s. 641.3154.

214 (2)(a) Each contract between a health maintenance  
 215 organization and a provider of health care services ~~For all~~  
 216 ~~provider contracts executed after October 1, 1991, and within~~  
 217 ~~180 days after October 1, 1991, for contracts in existence as of~~  
 218 ~~October 1, 1991:~~

219 ~~1. The contracts must provide that require the provider~~  
 220 ~~may terminate the contract, without cause, by giving 90 to give~~  
 221 ~~60 days' advance written notice to the health maintenance~~  
 222 ~~organization and the office, before canceling the contract with~~  
 223 ~~the health maintenance organization for any reason; and~~



224           ~~2.~~ The contract must also provide that nonpayment for  
 225 goods or services rendered by the provider to the health  
 226 maintenance organization is not a valid reason for avoiding the  
 227 90-day ~~60-day~~ advance notice of cancellation.

228           (b) Each contract between a health maintenance  
 229 organization and a provider of health care services ~~All provider~~  
 230 ~~contracts~~ must contain a provision providing ~~provide~~ that the  
 231 health maintenance organization may terminate the contract,  
 232 without cause, by giving 90 ~~will provide 60~~ days' advance  
 233 written notice to the provider and the office before canceling,  
 234 without cause, the contract with the provider, except in a case  
 235 in which a patient's health is subject to imminent danger or a  
 236 physician's ability to practice medicine is effectively impaired  
 237 by an action by the Board of Medicine or other governmental  
 238 agency.

239           Section 5. Subsection (5) of section 641.3155, Florida  
 240 Statutes, is amended, and subsection (16) is added to said  
 241 section, to read:

242           641.3155 Prompt payment of claims.--

243           (5) If a health maintenance organization determines that  
 244 it has made an overpayment to a provider for services rendered  
 245 to a subscriber, the health maintenance organization must make a  
 246 claim for such overpayment to the provider's designated  
 247 location. The health maintenance organization may not demand  
 248 repayment from the provider in any instance in which the  
 249 overpayment is attributable to error of the health maintenance  
 250 organization. A health maintenance organization that makes a  
 251 claim for overpayment to a provider under this section shall

252 give the provider a written or electronic statement specifying  
 253 the basis for the retroactive denial or payment adjustment. The  
 254 health maintenance organization must identify the claim or  
 255 claims, or overpayment claim portion thereof, for which a claim  
 256 for overpayment is submitted.

257 (a) If an overpayment determination is the result of  
 258 retroactive review or audit of coverage decisions or payment  
 259 levels not related to fraud, a health maintenance organization  
 260 shall adhere to the following procedures:

261 1. All claims for overpayment must be submitted to a  
 262 provider within 12 ~~30~~ months after the health maintenance  
 263 organization's payment of the claim. A provider must pay, deny,  
 264 or contest the health maintenance organization's claim for  
 265 overpayment within 40 days after the receipt of the claim. All  
 266 contested claims for overpayment must be paid or denied within  
 267 120 days after receipt of the claim. Failure to pay or deny  
 268 overpayment and claim within 140 days after receipt creates an  
 269 uncontestable obligation to pay the claim.

270 2. A provider that denies or contests a health maintenance  
 271 organization's claim for overpayment or any portion of a claim  
 272 shall notify the organization, in writing, within 35 days after  
 273 the provider receives the claim that the claim for overpayment  
 274 is contested or denied. The notice that the claim for  
 275 overpayment is denied or contested must identify the contested  
 276 portion of the claim and the specific reason for contesting or  
 277 denying the claim and, if contested, must include a request for  
 278 additional information. If the organization submits additional  
 279 information, the organization must, within 35 days after receipt

280 of the request, mail or electronically transfer the information  
 281 to the provider. The provider shall pay or deny the claim for  
 282 overpayment within 45 days after receipt of the information. The  
 283 notice is considered made on the date the notice is mailed or  
 284 electronically transferred by the provider.

285 3. The health maintenance organization may not reduce  
 286 payment to the provider for other services unless the provider  
 287 agrees to the reduction in writing or fails to respond to the  
 288 health maintenance organization's overpayment claim as required  
 289 by this paragraph.

290 4. Payment of an overpayment claim is considered made on  
 291 the date the payment was mailed or electronically transferred.  
 292 An overdue payment of a claim bears simple interest at the rate  
 293 of 12 percent per year. Interest on an overdue payment for a  
 294 claim for an overpayment payment begins to accrue when the claim  
 295 should have been paid, denied, or contested.

296 (b) A claim for overpayment shall not be permitted beyond  
 297 12 ~~30~~ months after the health maintenance organization's payment  
 298 of a claim, except that claims for overpayment may be sought  
 299 beyond that time from providers convicted of fraud pursuant to  
 300 s. 817.234.

301 (16)(a) Without regard to any other remedy or relief to  
 302 which a person is entitled, or obligated to under contract,  
 303 anyone aggrieved by a violation of this section, s. 641.3156, or  
 304 s. 641.513 may bring an action for damages or to obtain a  
 305 declaratory judgment that an act or practice violates this  
 306 section, s. 641.3156, or s. 641.513 and to enjoin a person who

307 has violated, is violating, or is otherwise likely to violate  
308 this section.

309 (b) In any action brought by a person who has suffered  
310 damages as a result of a violation of this section, s. 641.3156,  
311 or s. 641.513, such person may recover any amounts due the  
312 person, including accrued interest, plus attorney's fees and  
313 court costs as provided in paragraphs (c) and (d).

314 (c)1. In any civil action brought pursuant to this  
315 subsection, the prevailing party, after judgment in the trial  
316 court and after exhausting all appeals, if any, shall receive  
317 his or her attorney's fees and costs from the nonprevailing  
318 party.

319 2. If the provider is the prevailing party, such fees  
320 shall not exceed three times the amount in controversy or  
321 \$10,000, whichever is greater.

322 3. If the health maintenance organization is the  
323 prevailing party on any claim or defense for which the court  
324 finds that the provider knew or should have known that the claim  
325 or defense was not supported by the material facts necessary to  
326 establish the claim or defense, or would not be supported by the  
327 application of then-existing law as to those material facts,  
328 such fees shall not exceed two times the amount in controversy  
329 or \$5,000, whichever is greater.

330 (d)1. In any civil action brought by a health maintenance  
331 organization pursuant to this subsection, the prevailing party,  
332 after judgment in the trial court and after exhausting all  
333 appeals, if any, shall receive his or her attorney's fees and  
334 costs from the nonprevailing party.

335       2. If the health maintenance organization is the  
336 prevailing party on any claim or defense for which the court  
337 finds that the provider knew or should have known that the claim  
338 or defense was not supported by the material facts necessary to  
339 establish the claim or defense, or would not be supported by the  
340 application of then-existing law as to those material facts,  
341 such fees shall not exceed two times the amount in controversy  
342 or \$5,000, whichever is greater.

343       3. If the provider is the prevailing party, such fees  
344 shall not exceed three times the amount in controversy or  
345 \$10,000, whichever is greater.

346       (e) The attorney for the prevailing party shall submit to  
347 the trial judge who presided over the civil case a sworn  
348 affidavit of his or her time spent on the case and his or her  
349 costs incurred for all the motions, hearings, and appeals.

350       (f) Any award of attorney's fees or costs shall become a  
351 part of the judgment and subject to execution as provided by  
352 law.

353       (g) This subsection shall apply in any proceeding in which  
354 the provider alleges that the health maintenance organization  
355 has failed to comply with its contractual obligations.

356       Section 6. Subsection (2) of section 641.3156, Florida  
357 Statutes, is amended to read:

358       641.3156 Treatment authorization; payment of claims.--

359       (2) A claim for treatment must be paid by a health  
360 maintenance organization and may not be denied if a provider,  
361 whether or not under contract with a health maintenance  
362 organization, follows the health maintenance organization's

363 authorization procedures and receives authorization for a  
 364 covered service for an eligible subscriber, unless the provider  
 365 provided information to the health maintenance organization with  
 366 the willful intention to misinform the health maintenance  
 367 organization. Emergency services are subject to the provisions  
 368 of ss. 395.1041 and 401.45 and are not subject to the provisions  
 369 of this subsection.

370 Section 7. Subsection (5) of section 641.513, Florida  
 371 Statutes, is amended to read:

372 641.513 Requirements for providing emergency services and  
 373 care.--

374 (5) Reimbursement for services pursuant to this section by  
 375 a provider who does not have a contract with the health  
 376 maintenance organization, or provided to subscribers who are not  
 377 Medicaid recipients by a provider for whom no contract exists  
 378 between the provider and the health maintenance organization,  
 379 shall be the lesser of:

380 (a) The provider's charges;

381 (b) The usual and customary provider charges for similar  
 382 services in the community where the services were provided. For  
 383 physicians only, the usual and customary charge shall be the  
 384 average gross charge for that service in the county where the  
 385 service is provided; or

386 (c) The charge mutually agreed to by the health  
 387 maintenance organization and the provider within 30 ~~60~~ days  
 388 after ~~of~~ the submittal of the claim.

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390 Such reimbursement shall be net of any applicable copayment  
 391 authorized pursuant to subsection (4).

392 Section 8. Subsection (5) of section 641.513, Florida  
 393 Statutes, as created by section 9 of chapter 96-223, Laws of  
 394 Florida, is amended to read:

395 641.513 Requirements for providing emergency services and  
 396 care.--

397 (5) Reimbursement for services pursuant to ~~under~~ this  
 398 section by a provider who does not have a contract with the  
 399 health maintenance organization, or provided to subscribers who  
 400 are not Medicaid recipients by a provider for whom no contract  
 401 exists between the provider and the health maintenance  
 402 organization, shall be the lesser of:

403 (a) The provider's charges;

404 (b) The usual and customary provider charges for similar  
 405 services in the community where the services were provided. For  
 406 physicians only, the usual and customary charge shall be the  
 407 average gross charge for that service in the county where the  
 408 service is provided; or

409 (c) The charge mutually agreed to by the health  
 410 maintenance organization and the provider within 30 ~~60~~ days  
 411 after the submittal of the claim.

412  
 413 Such reimbursement shall be net of any applicable copayment  
 414 authorized pursuant to subsection (4).

415 Section 9. This act shall take effect October 1, 2005.