By Senator Campbell

32-851-05

1 A bill to be entitled
2 An act relating to health care services;
3 amending s. 627.6131, F.S.; prohibiting a
4 health insurer from demanding repayment from a
5 provider under certain circumstances; reducing
6 the time allowed for a health insurer to submit
7 a claim of overpayment to a provider; requiring
8 a health insurer to pay a claim for treatment
9 upon proper authorization; providing for an
10 action for damages or declaratory relief;
11 providing for the recovery of attorney's fees
12 and court costs; providing a limit on the
13 recovery of attorney's fees under certain
14 circumstances; requiring the submission of a
15 sworn affidavit of time and cost incurred by
16 the attorney for the prevailing party;
17 providing that the award for attorney's fees or
18 court costs are a part of the judgment;
19 amending s. 641.19, F.S.; redefining the term
20 "schedule of reimbursements"; amending s.
21 641.31, F.S.; prohibiting a health maintenance
22 contract from preventing a subscriber from
23 assigning plan benefits to a physician who is
24 not under contract with the organization for
25 covered health care services; requiring a
26 health maintenance organization to recognize
27 and pay for health care services rendered by a
28 physician who is not under contract with the
29 organization under certain conditions;
30 providing that a physician who is not under
31 contract with the health maintenance

1 organization agrees by submitting the claim to
2 accept the amount paid by the organization as
3 payment in full; amending s. 641.315, F.S.;
4 increasing the period of advance notice
5 required for a health care provider to
6 terminate a contract with a health maintenance
7 organization without cause; requiring that a
8 contract between a health care provider and a
9 health maintenance organization contain a
10 termination provision; amending s. 641.3155,
11 F.S.; prohibiting a health maintenance
12 organization from demanding repayment from a
13 provider under certain circumstances; reducing
14 the time allowed for a health maintenance
15 organization to submit a claim for overpayment
16 to a provider; providing for an action for
17 damages or declaratory relief; providing for
18 the recovery of attorney's fees and court
19 costs; providing a limit on the recovery of
20 attorney's fees under certain circumstances;
21 requiring the submission of a sworn affidavit
22 of time and cost incurred by the attorney for
23 the prevailing party; providing that the award
24 for attorney's fees or court costs are a part
25 of the judgment; amending s. 641.3156, F.S.;
26 requiring a health maintenance organization to
27 pay certain claims for treatment whether or not
28 the health care provider has contracted with
29 the organization; amending s. 641.513, F.S.;
30 providing for reimbursement for emergency
31 services rendered by a physician who does not

1 have a contract with the health maintenance
2 organization; reducing the time allowed to
3 agree upon a charge; providing an effective
4 date.
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6 Be It Enacted by the Legislature of the State of Florida:
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8 Section 1. Subsection (6) of section 627.6131, Florida
9 Statutes, is amended, and subsections (18) and (19) are added
10 to that section, to read:
11 627.6131 Payment of claims.--
12 (6) If a health insurer determines that it has made an
13 overpayment to a provider for services rendered to an insured,
14 the health insurer must make a claim for such overpayment to
15 the provider's designated location. <u>The insurer may not demand</u>
16 <u>repayment from the provider in any instance in which the</u>
17 <u>overpayment is attributable to an error of the insurer in</u>
18 <u>determining eligibility.</u> A health insurer that makes a claim
19 for overpayment to a provider under this section shall give
20 the provider a written or electronic statement specifying the
21 basis for the retroactive denial or payment adjustment. The
22 insurer must identify the claim or claims, or overpayment
23 claim portion thereof, for which a claim for overpayment is
24 submitted.
25 (a) If an overpayment determination is the result of
26 retroactive review or audit of coverage decisions or payment
27 levels not related to fraud, a health insurer shall adhere to
28 the following procedures:
29 1. All claims for overpayment must be submitted to a
30 provider within <u>12</u> ~~30~~ months after the health insurer's
31 payment of the claim. A provider must pay, deny, or contest

1 the health insurer's claim for overpayment within 40 days
2 after the receipt of the claim. All contested claims for
3 overpayment must be paid or denied within 120 days after
4 receipt of the claim. Failure to pay or deny overpayment and
5 claim within 140 days after receipt creates an uncontestable
6 obligation to pay the claim.
7 2. A provider that denies or contests a health
8 insurer's claim for overpayment or any portion of a claim
9 shall notify the health insurer, in writing, within 35 days
10 after the provider receives the claim that the claim for
11 overpayment is contested or denied. The notice that the claim
12 for overpayment is denied or contested must identify the
13 contested portion of the claim and the specific reason for
14 contesting or denying the claim and, if contested, must
15 include a request for additional information. If the health
16 insurer submits additional information, the health insurer
17 must, within 35 days after receipt of the request, mail or
18 electronically transfer the information to the provider. The
19 provider shall pay or deny the claim for overpayment within 45
20 days after receipt of the information. The notice is
21 considered made on the date the notice is mailed or
22 electronically transferred by the provider.
23 3. The health insurer may not reduce payment to the
24 provider for other services unless the provider agrees to the
25 reduction in writing or fails to respond to the health
26 insurer's overpayment claim as required by this paragraph.
27 4. Payment of an overpayment claim is considered made
28 on the date the payment was mailed or electronically
29 transferred. An overdue payment of a claim bears simple
30 interest at the rate of 12 percent per year. Interest on an
31 overdue payment for a claim for an overpayment begins to

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accrue when the claim should have been paid, denied, or contested.

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

(18) A claim for treatment must be paid by a health insurer and may not be denied if a provider, whether contracted with the health insurer or not, follows the insurer's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the insurer with the willful intention to misinform the health insurer. Emergency services are subject to ss. 395.1041 and 401.45 and are not subject to this subsection.

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

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

(c)1. In any civil litigation brought pursuant to this subsection, the prevailing party, after judgment in the trial

1 court and after exhausting all appeals, if any, shall receive
2 his or her attorney's fees and costs from the losing party.
3 2. If the provider is the prevailing party, such fees
4 may not exceed three times the amount in controversy or
5 $10,000, whichever is greater.
6 3. If the health insurer is the prevailing party on
7 any claim or defense in which the court finds that the insured
8 or the insured's assignee knew or should have known that a
9 claim or defense was not supported by the material facts
10 necessary to establish the claim or defense, or would not be
11 supported by the application of then-existing law as to those
12 material facts, such fees may not exceed two times the amount
13 in controversy or $5,000, whichever is greater.
14 (d)1. In any civil litigation brought by a health
15 insurer pursuant to this subsection, the prevailing party,
16 after judgment in the trial court and after exhausting all
17 appeals, if any, shall receive his or her attorney's fees and
18 costs from the losing party.
19 2. If the health insurer is the prevailing party on
20 any claim or defense in which the court finds that the insured
21 or the insured's assignee knew or should have known that a
22 claim or defense was not supported by the material facts
23 necessary to establish the claim or defense, or would not be
24 supported by the application of then-existing law as to those
25 material facts, such fees may not exceed two times the amount
26 in controversy or $5,000, whichever is greater.
27 3. If the insured or the insured's assignee is the
28 prevailing party, such fees may not exceed three times the
29 amount in controversy or $10,000, whichever is greater.
30 (e) The attorney for the prevailing party shall submit
31 a sworn affidavit of his or her time spent on the case and his

or her costs incurred for all motions, hearings, and appeals to the trial judge who presided over the civil case.

(f) Any award of attorney's fees or court costs shall become a part of the judgment and are subject to execution as the law allows.

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

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

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

(16) "Schedule of reimbursements" means a schedule of fees to be paid by a health maintenance organization to a physician provider for reimbursement for specific services pursuant to the terms of a contract. The physician provider's net reimbursement may vary after consideration of other factors, including, but not limited to, bundling codes together into another code, modifiers used, and member cost-sharing responsibility, as long as these factors are disclosed and included in the terms of the contract between the health maintenance organization and provider. The reimbursement schedule may be stated as:

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

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

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

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1 Specific nonrelative-value services shall be stated separately
2 from relative-value services, and reimbursement for
3 unclassified services shall be on a reasonable basis.
4 Section 3. Subsection (41) is added to section 641.31,
5 Florida Statutes, to read:
6 641.31 Health maintenance contracts.--
7 (41)(a) A health maintenance contract may not prohibit
8 or restrict a subscriber from assigning plan benefits to a
9 physician who is not under contract with the organization for
10 covered health care services rendered by the physician to the
11 subscriber.
12 (b) Any assignment by a subscriber of plan benefits
13 which designates that the assignment has been accepted by a
14 physician who is not under contract with the organization must
15 be recognized by the organization and paid pursuant to s.
16 641.3155.
17 (c) Except for a physician providing services pursuant
18 to s. 641.513, any physician who accepts assignment pursuant
19 to this section agrees, by submitting the claim to the health
20 maintenance organization, to accept the amount paid by the
21 health maintenance organization as payment in full for the
22 health care services provided and agrees not to collect any
23 balance from the subscriber.
24 Section 4. Subsections (1) and (2) of section 641.315,
25 Florida Statutes, are amended to read:
26 641.315 Provider contracts.--
27 (1) Each contract between a health maintenance
28 organization and a provider of health care services must be in
29 writing and must contain a provision that, except as otherwise
30 provided, the subscriber is not liable to the provider for any
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services for which the health maintenance organization is liable as specified in s. 641.3154.

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

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

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

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

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

641.3155 Prompt payment of claims.--

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1 (5) If a health maintenance organization determines
2 that it has made an overpayment to a provider for services
3 rendered to a subscriber, the health maintenance organization
4 must make a claim for such overpayment to the provider's
5 designated location. The organization may not demand repayment
6 from the provider in any instance in which the overpayment is
7 attributable to an error of the organization in determining
8 eligibility. A health maintenance organization that makes a
9 claim for overpayment to a provider under this section shall
10 give the provider a written or electronic statement specifying
11 the basis for the retroactive denial or payment adjustment.
12 The health maintenance organization must identify the claim or
13 claims, or overpayment claim portion thereof, for which a
14 claim for overpayment is submitted.
15 (a) If an overpayment determination is the result of
16 retroactive review or audit of coverage decisions or payment
17 levels not related to fraud, a health maintenance organization
18 shall adhere to the following procedures:
19 1. All claims for overpayment must be submitted to a
20 provider within 12 ~~30~~ months after the health maintenance
21 organization's payment of the claim. A provider must pay,
22 deny, or contest the health maintenance organization's claim
23 for overpayment within 40 days after the receipt of the claim.
24 All contested claims for overpayment must be paid or denied
25 within 120 days after receipt of the claim. Failure to pay or
26 deny overpayment and claim within 140 days after receipt
27 creates an uncontestable obligation to pay the claim.
28 2. A provider that denies or contests a health
29 maintenance organization's claim for overpayment or any
30 portion of a claim shall notify the organization, in writing,
31 within 35 days after the provider receives the claim that the

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claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

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

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

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

(16)(a) Without regard to any other remedy or relief to which a person is entitled or obligated under contract,

1 anyone aggrieved by a violation of this section, s. 641.3156,
2 or s. 641.513 may bring an action for damages or to obtain a
3 declaratory judgment that an act or practice violates this
4 section, s. 641.3156, or s. 641.513 and to enjoin a person who
5 has violated, is violating, or is otherwise likely to violate
6 this section, s. 641.3156, or 641.513.
7 (b) In any action brought by a person who has suffered
8 damages as a result of a violation of this section, s.
9 641.3156, or s. 641.513, such person may recover any amounts
10 due the person, including accrued interest, plus attorney's
11 fees and court costs as provided in paragraphs (c) and (d).
12 (c)1. In any civil litigation brought pursuant to this
13 subsection, the prevailing party, after judgment in the trial
14 court and after exhausting all appeals, if any, shall receive
15 his or her attorney's fees and costs from the losing party.
16 2. If the provider is the prevailing party, such fees
17 may not exceed three times the amount in controversy or
18 $10,000, whichever is greater.
19 3. If the health maintenance organization is the
20 prevailing party on any claim or defense in which the court
21 finds that the provider knew or should have known that a claim
22 or defense was not supported by the material facts necessary
23 to establish the claim or defense, or would not be supported
24 by the application of then-existing law as to those material
25 facts, such fees may not exceed two times the amount in
26 controversy or $5,000, whichever is greater.
27 (d)1. In any civil litigation brought by a health
28 maintenance organization pursuant to this subsection, the
29 prevailing party, after judgment in the trial court and after
30 exhausting all appeals, if any, shall receive his or her
31 attorney's fees and costs from the losing party.

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1 2. If the health maintenance organization is the
2 prevailing party on any claim or defense in which the court
3 finds that the provider knew or should have known that a claim
4 or defense was not supported by the material facts necessary
5 to establish the claim or defense, or would not be supported
6 by the application of then-existing law as to those material
7 facts, such fees may not exceed two times the amount in
8 controversy or $5,000, whichever is greater.
9 3. If the provider is the prevailing party, such fees
10 may not exceed three times the amount in controversy or
11 $10,000, whichever is greater.
12 (e) 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 motions, hearings, and appeals
15 to the trial judge who presided over the civil case.
16 (f) Any award of attorney's fees or costs shall become
17 a part of the judgment and are subject to execution as the law
18 allows.
19 (g) This subsection applies in any proceeding in which
20 the provider alleges that the health maintenance organization
21 has failed to comply with its contractual obligations.
22 Section 6. Subsections (2) and (3) of section
23 641.3156, Florida Statutes, are amended to read:
24 641.3156 Treatment authorization; payment of claims.--
25 (2) A claim for treatment must be paid by a health
26 maintenance organization and may not be denied if a provider,
27 whether contracted with a health maintenance organization or
28 not, follows the health maintenance organization's
29 authorization procedures and receives authorization for a
30 covered service for an eligible subscriber, unless the
31 provider provided information to the health maintenance

1 organization with the willful intention to misinform the
2 health maintenance organization. Emergency services are
3 subject to the provisions of ss. 395.1041, 401.45, and 641.513
4 and are not subject to the provisions of this section.
5 ~~(3) Emergency services are subject to the provisions~~
6 ~~of s. 641.513 and are not subject to the provisions of this~~
7 ~~section.~~
8 Section 7. Subsection (5) of section 641.513, Florida
9 Statutes, is amended to read:
10 641.513 Requirements for providing emergency services
11 and care.--
12 (5) Reimbursement for services pursuant to this
13 section by a provider who does not have a contract with the
14 health maintenance organization shall be the lesser of:
15 (a) The provider's charges;
16 (b) The usual and customary provider charges for
17 similar services in the community where the services were
18 provided. For physicians only, the usual and customary charge
19 is the average gross charge for that service in the county
20 where the service is provided; or
21 (c) The charge mutually agreed to by the health
22 maintenance organization and the provider within 30 ~~60~~ days
23 after ~~of~~ the submittal of the claim.
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25 Such reimbursement shall be net of any applicable copayment
26 authorized pursuant to subsection (4).
27 Section 8. This act shall take effect October 1, 2005.
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2 SENATE SUMMARY

Prohibits a health insurer from demanding repayment from a provider under certain circumstances. Requires a health insurer to pay a claim for treatment under certain conditions. Provides for an action for damages or declaratory relief. Provides for the recovery of attorney's fees and court costs. Requires the submission of a sworn affidavit of time and cost incurred by the attorney for the prevailing party. Provides that the award for attorney's fees or court costs are a part of the judgment. Provides that a health maintenance contract may not prohibit a subscriber from assigning plan benefits to a physician not under contract with the organization. Requires a health maintenance organization to recognize and pay for health care services rendered by a physician who is not under contract by the organization under certain conditions. Provides that a physician who is not under contract by the health maintenance organization agrees by submitting the claim to accept the amount paid by the organization as payment in full. Authorizes a health care provider to terminate a contract with a health maintenance organization without cause by giving 90 days' advance written notice. Requires a contract between a health care provider and a health maintenance organization to contain a termination provision. Prohibits a health maintenance organization from demanding repayment from a provider under certain circumstances. Revises the time in which a health maintenance organization is required to submit a claim for overpayment. Requires a health maintenance organization to pay certain claims for treatment whether or not the health care provider has contracted with the organization. Provides for reimbursement for emergency services provided by a physician who does not have a contract with the health maintenance organization.

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