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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/13/2010	.	
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The Committee on Banking and Insurance (Fasano) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.6141, Florida Statutes, is amended to read:

627.6141 Denial of claims.—

(1) Each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group.

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The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

(2) If a hospital claim or a portion of a hospital claim is denied because the hospital, due to an unintentional act of error or omission, failed to obtain the necessary authorization, the hospital may appeal the denial to the insurer's licensed physician who is responsible for medical necessity reviews. The health insurer shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the health insurer determines upon review that the service was medically necessary, the insurer shall reverse the denial and pay the claim. If the insurer determines that the service was not medically necessary, the insurer shall provide to the hospital specific written clinical justification for the determination.

Section 2. Present subsection (3) of section 641.3156, Florida Statutes, is renumbered as subsection (4), and a new subsection (3) is added to that section, to read:

641.3156 Treatment authorization; payment of claims.—

(3) If a hospital claim or a portion of a hospital claim of a contracted provider is denied because the hospital, due to an unintentional act of error or omission, failed to obtain the necessary authorization, the hospital may appeal the denial to the health maintenance organization's licensed physician who is responsible for medical necessity reviews. The health maintenance organization shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the

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health maintenance organization determines upon review that the service was medically necessary, the health maintenance organization shall reverse the denial and pay the claim. If the health maintenance organization determines that the service was not medically necessary, the health maintenance organization shall provide the hospital with specific written clinical justification for the determination.

Section 3. This act shall take effect July 1, 2010.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health services claims; amending s. 627.6141, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health insurer to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health insurer to submit a written justification for a determination that a service was not medically necessary; amending s. 641.3156, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health maintenance organization to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health maintenance organization to submit a written justification for a determination that a service was

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not medically necessary; providing an effective date.