By Senator Jones

34-01577-24 20241574__

A bill to be entitled

An act relating to health care services; amending s. 627.42392, F.S.; defining terms; revising the definitions of the terms "health insurer" as "utilization review entity"; requiring utilization review entities to establish and offer a prior authorization process for accepting electronic prior authorization requests by a specified date; specifying a requirement for the process; specifying additional requirements and procedures for, and restrictions and limitations on, utilization review entities relating to prior authorization for covered health care benefits; defining the term "medications for opioid use disorder"; providing construction; creating s. 627.4262, F.S.; defining terms; prohibiting payment adjudicators from downcoding health care services under certain circumstances; requiring payment adjudicators to provide certain information prior to making their initial payment or notice of denial of payment; prohibiting downcoding by payment adjudicators for certain orders; providing that a payment adjudicator is solely responsible for certain violations of law; requiring payment adjudicators to maintain downcoding policies on their websites; specifying the requirements of such policies; providing that payment adjudicators are responsible for compliance with certain provisions; requiring payment adjudicators to develop certain internal procedures; authorizing the Office of Insurance

Regulation to investigate and take appropriate actions under certain circumstances; providing severability; authorizing a provider to bring a private cause of action under certain circumstances; amending s. 627.6131, F.S.; revising the requirements of insurer contracts; revising the definition of the term "claim"; defining terms; revising the requirements for health insurers submitting claims electronically and nonelectronically; making technical changes; deleting the prohibition against waiving, voiding, or nullifying certain provisions by contract; prohibiting a health insurer from retrospectively denying a claim under certain circumstances; revising procedures for investigation of claims of improper billing; providing construction; prohibiting health care insurers from requesting certain information or resubmission of claims under certain circumstances; prohibiting an insurer from requiring information from a provider before the provision of emergency services and care; providing an effective date.

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

Section 1. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

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

(a) "Adverse determination" means a decision by a health insurer or utilization review entity to deny, reduce, or

terminate health care services furnished or proposed to be furnished to an insured. The term does not include a decision to deny, reduce, or terminate services that were determined to be duplicate bills or that are confirmed with the provider to have been billed in error.

(b) "Electronic prior authorization process" does not include transmissions through a facsimile machine.

(c) "Emergency health care services" has the same meaning as "emergency services and care" as defined in s. 395.002.

(d) "Prior authorization" means the process by which health insurers, third-party payors, or utilization review entities determine the medical necessity of nonemergency health care services before the rendering of such services by the provider. Such prior authorization is authorized by the applicable agreement with the health care provider or such prior authorization is otherwise obtained by a provider that does not have such an agreement. The term also includes a health insurer's or utilization review entity's requirement, if such requirement is permitted by the applicable agreement with a health care provider or otherwise permitted by a health care provider that does not have such an agreement, that a patient or health care provider notify the health insurer or utilization review entity before the provision of a nonemergency health care service.

(e) "Urgent health care service" means a health care service to treat a medical condition that, if the timeframe for making a nonexpedited prior authorization were to be applied, could, in the opinion of a physician with knowledge of the patient's medical condition:

1. Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

2. Subject the patient to severe pain that cannot be adequately managed without the care, treatment, or prescription drug that is the subject of the prior authorization request.

(f) "Utilization review activity" means any action taken prospective to, concurrent with, or retrospective to the provision of nonemergency health care services to determine whether a claim is paid or is subject to an adverse determination. Utilization review activity is not allowed to the extent restricted or prohibited by an agreement with a health care provider or, other than to verify a presenting emergency medical condition, for emergency health care services. For purposes of this paragraph, the term "a presenting emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition or situation described in s. 395.002(8).

(g) "Utilization review entity" ~~"health insurer"~~ means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962(10), ~~or~~ a health maintenance organization as defined in s. 641.19(12), a pharmacy benefit manager as defined in s. 624.490, or any other individual or entity that provides, offers to provide, or administers payment for hospital services, outpatient services, medical services, prescription drugs, or other health care services to a person treated by a health care professional or

facility in this state under a policy, plan, or contract.

(2) Beginning January 1, 2025, a utilization review entity shall establish and offer a secure, interactive, online, electronic prior authorization process for accepting electronic prior authorization requests. The process must allow a person seeking prior authorization the ability to upload documentation if such documentation is required by the utilization review entity to make a determination on the prior authorization request.

(3) Notwithstanding any other ~~provision of~~ law, effective January 1, 2017, or 6 ~~six (6)~~ months after the effective date of the rule adopting the prior authorization form, whichever is later, a utilization review entity that ~~health insurer, or a pharmacy benefits manager on behalf of the health insurer, which~~ does not provide an electronic prior authorization process for use by its contracted providers~~,~~ shall use only ~~use~~ the prior authorization form ~~that has been~~ approved by the ~~Financial Services~~ commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the utilization review entity ~~health insurer~~ to make a decision. At a minimum, the form must include:

(a) ~~(1)~~ Sufficient patient information to identify the member, date of birth, full name, and health plan ID number;

(b) ~~(2)~~ The provider's ~~provider~~ name, address, and phone number;

(c) ~~(3)~~ The medical procedure, course of treatment, or

prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed;

(d) ~~(4)~~ Any laboratory documentation required; and

(e) ~~(5)~~ An attestation that all information provided is true and accurate.

(4) ~~(3)~~ The ~~Financial Services~~ commission, in consultation with the Agency for Health Care Administration, shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(5) ~~(4)~~ Electronic prior authorization approvals do not preclude benefit verification or medical review by the utilization review entity ~~insurer~~ under either the medical or pharmacy benefits.

(6) A utilization review entity's prior authorization process may not require information that is not needed to make a determination or facilitate a determination of medical necessity of the requested medical procedure, course of treatment, or prescription drug benefit.

(7) A utilization review entity shall disclose all of its prior authorization requirements and restrictions, including any written clinical criteria, in a publicly accessible manner on its website. Such information must be explained in detail and in clear and ordinary terms.

(8) A utilization review entity may not implement any new requirement or restriction or make changes to existing requirements for or restrictions on obtaining prior authorization unless both of the following conditions are met:

(a) The changes have been available on a publicly accessible website for at least 60 days before they are

implemented.

(b) Insureds and health care providers affected by the new requirements and restrictions or by the changes to the requirements and restrictions are provided with a written notice of the changes at least 60 days before they are implemented. Such notice must be delivered electronically or by other means as agreed to by the insured or the health care provider.

(9) A utilization review entity shall make available on its website, in a readily accessible format, data regarding prior authorization approvals and denials, which must include all of the following:

(a) All items and services requiring prior authorization.

(b) The percentage, in aggregate, of prior authorization requests approved.

(c) The percentage, in aggregate, of prior authorization requests denied.

(d) The percentage of prior authorization requests approved after appeal.

(e) The percentage of prior authorization requests in which the timeframe for review was extended and the prior authorization request was approved.

(f) The percentage of expedited prior authorization requests approved.

(g) The average and median time between submission of a request for prior authorization and a determination of the outcome.

(h) The average and median time between submission of a request for an expedited prior authorization and a determination of the outcome.

This subsection does not apply to the expansion of health care services coverage.

(10) A utilization review entity shall ensure that all adverse determinations are made by a physician licensed pursuant to chapter 458 or chapter 459. All of the following requirements apply to such physicians:

(a) The physician must possess a current and valid nonrestricted license to practice medicine in this state.

(b) The physician must be of the same specialty as the physician who typically manages the medical condition or disease or who provides the health care service that is the subject of the request.

(c) The physician must have experience treating patients with the medical condition or disease for which the health care service is being requested.

(11) Notice of an adverse determination must be provided by e-mail to the health care provider that initiated the prior authorization. The notice must include all of the following:

(a) The name, title, e-mail address, and telephone number of the physician responsible for making the adverse determination.

(b) Any written clinical criteria and any internal rule, guideline, or protocol that the utilization review entity relied upon in making the adverse determination, and how such rule, guideline, or protocol applies to the insured's specific medical circumstance.

(c) Information for the insured and the insured's health care provider which describes the procedure through which the

insured or health care provider may request a copy of any report developed by the health care provider performing the review that led to the adverse determination.

(d) An explanation to the insured and the insured's health care provider of the appeals process for an adverse determination.

(12) If a utilization review entity requires prior authorization of a nonemergency health care service, the utilization review entity must make an authorization or adverse determination and notify the insured and the insured's provider of such service of the decision within 2 business days after obtaining all necessary information to make the authorization or adverse determination. For purposes of this subsection, necessary information includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(13) A utilization review entity shall render an expedited authorization or adverse determination concerning an emergency health care service and notify the insured and the insured's provider of such service of the expedited prior authorization or adverse determination no later than 1 business day after receiving all information needed to complete the review of the requested urgent health care service.

(14) A utilization review entity may not require prior authorization for prehospital transportation or for provision of an emergency health care service. A utilization review entity may not conduct any utilization review activity, nor render any adverse determinations, to the extent restricted or prohibited by an agreement with a health care provider. A utilization review entity may not perform any utilization review activity,

nor render any adverse determinations, with respect to emergency health care services beyond verification of the presenting emergency medical condition.

(15) A utilization review entity may not require prior authorization for the provision of medications for opioid use disorder. As used in this subsection, the term "medications for opioid use disorder" means the use of medications approved by the United States Food and Drug Administration (FDA), commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. Such FDA-approved medications used to treat opioid addiction include, but are not limited to, methadone; buprenorphine, alone or in combination with naloxone; and extended-release injectable naltrexone. Such types of behavioral therapies include, but are not limited to, individual therapy, group counseling, family therapy, motivational incentives, and other modalities.

(16) A utilization review entity may not revoke, limit, condition, or restrict a prior authorization if care is provided within 45 business days after the date the health care provider received the prior authorization. A utilization review entity shall pay the health care provider at the contracted payment rate for a health care service provided by the health care provider under a prior authorization unless any of the following is true:

(a) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity.

(b) The health care service was no longer a covered benefit on the day it was provided, and the utilization review entity notified the health care provider in writing of this fact before the health care service was provided.

(c) The authorized service was never performed.

(d) The insured was no longer eligible for health care coverage on the day the care was provided, and the utilization review entity notified the health care provider in writing of this fact before the health care service was provided.

(17) If a utilization review entity required a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization remains valid for the length of the treatment and the utilization review entity may not require the insured to obtain a prior authorization again for the health care service.

(18) A utilization review entity may not impose an additional prior authorization requirement with respect to a surgical or otherwise invasive procedure, or any item furnished as part of such a procedure, if the procedure or item is furnished during the perioperative period of another procedure for which prior authorization was granted by the utilization review entity.

(19) Any change in coverage or approval criteria for a previously authorized health care service may not affect an insured who received prior authorization before the effective date of the change for the remainder of the insured's plan year.

(20) A utilization review entity shall continue to honor a prior authorization it has granted to an insured when the insured changes coverage under the same insurance company.

(21) Any health care services subject to review are automatically deemed authorized by the utilization review entity if it fails to comply with the deadlines and other requirements specified in this section.

(22) Except as otherwise provided in subsection (16), a prior authorization constitutes a conclusive determination of the medical necessity of the authorized health care service and an irrevocable obligation to pay for such authorized health care service.

(23) The requirements of this section cannot be waived by contract. Any contractual arrangement or action taken in conflict with this section, or which purports to waive any requirement of this section, is void.

(24) This section does not prohibit an agreement with a health care provider to restrict, limit, prohibit, or substitute utilization review activity or prior authorization.

Section 2. Section 627.4262, Florida Statutes, is created to read:

627.4262 Payment adjudication.—

(1) For the purposes of this section, the term:

(a) "Downcode" or "downcoding" means the alteration by a payment adjudicator of the service code to another service code or the alteration, addition, or removal by a payment adjudicator of a modifier, when the changed code or modifier is associated with a lower payment amount than the service code or modifier billed by the provider or facility.

(b) "Health plan" means any entity that offers health insurance coverage, whether through a fully insured plan or a self-insured plan or fund, including an authorized insurer

offering health insurance as defined in s. 624.603, any entity that offers a self-insured fund as described in s. 624.462, or group self-insurance funds as described in 624.4621, a health insurer subject to chapter 627, a managed care plan as defined in s. 409.962, or a health maintenance organization as defined in s. 641.19.

(c) "Medical record" means the comprehensive collection of documentation, including clinical notes, diagnostic reports, and other relevant information, which supports the health care services provided.

(d) "Participation agreement" means a written contract or agreement between a health plan and a provider which outlines the terms and conditions of participation, reimbursement rates, and other relevant details.

(e) "Payment adjudicator" means a health plan or any entity that provides, offers to provide, or administers payment on behalf of a health plan, as well any pharmacy benefit manager as defined in s. 626.88, and any other individual or entity that provides, offers to provide, or administers payment for hospital services, outpatient services, medical services, prescription drugs, or other health care services to a person treated by a health care professional or facility in this state under a policy, plan, or contract.

(f) "Provider" includes any health care professional, facility, or entity that submits claims for reimbursement for covered health care services provided to individuals covered under a health plan.

(2)(a) Payment adjudicators are prohibited from downcoding a health care service billed by, or on behalf of, a provider, if

the health care service was ordered by a provider in-network with the applicable health plan, unless such downcoding is otherwise expressly allowed under the participation agreement between the health plan and such provider.

(b) If downcoding is expressly allowed under the participation agreement, the payment adjudicator must first conduct a review of the associated medical record to ensure the accuracy of the coding change, and then provide the following information to the provider before making its initial payment or notice of denial of payment:

1. A statement indicating that the service code or modifier billed by the provider or facility is going to be downcoded.

2. An explanation detailing the reasons for downcoding the claim. This explanation must include a clear description of the service codes or modifiers that were altered, added, or removed, if applicable.

3. The payment amount that the payment adjudicator would otherwise make if the service code or modifier was not downcoded.

4. A statement that the provider may contest the downcoding of the applicable service code or modifier by filing a contestation with the payment adjudicator with respect to the downcoding within 15 days after receipt of the statements required under this paragraph.

5. A statement that, by contesting the downcoding of the applicable service code or modifier, the provider does not waive any of its legal rights to pursue claims against the health plan or payment adjudicator.

(c) A payment adjudicator may not downcode a service code

or modifier for services provided pursuant to orders issued by a licensed nurse.

(d) Notwithstanding this section, a payment adjudicator that downcodes a service code or modifier, regardless of whether such downcoding is contested by the provider, is solely responsible for any violations of law associated with such downcoding.

(3)(a) Payment adjudicators shall maintain clear and accessible downcoding policies on their official websites. These policies must include all of the following:

1. An overview of the circumstances under which downcoding may occur.

2. The process and criteria used for conducting reviews of downcoded claims, including the role of medical record review.

3. Information about the internal mechanisms for ensuring consistency and accuracy in downcoding practices.

4. Information regarding the processes for contesting the downcode of a service code with the payment adjudicator.

(b) Health plans shall ensure that their downcoding policies are updated, as needed, to reflect any changes in regulations, industry standards, or internal procedures.

(4)(a) Payment adjudicators are responsible for ensuring compliance with this section and shall develop internal procedures to implement and adhere to the requirements thereof.

(b) The office may investigate and take appropriate actions in cases of noncompliance with this section.

(5) If any provision of this section or its application to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of this section

which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(6) A provider may bring a private cause of action against the payment adjudicator for a violation of this section.

Section 3. Present subsections (18) and (19) of section 627.6131, Florida Statutes, are redesignated as subsections (22) and (23), respectively, new subsections (18) and (19) and subsections (20) and (21) are added to that section, and subsections (1) and (2), paragraphs (a) and (c) of subsection (4), paragraphs (a) and (c) of subsection (5), and subsections (6), (10), (11), and (13) of that section are amended, to read:

627.6131 Payment of claims.—

(1) The contract must ~~shall~~ include the following provision: "Time of Payment of Claims: After receiving written proof of loss, the insurer will pay monthly all claims ~~benefits then due for ...(type of benefit)...~~. Claims ~~Benefits~~ for any other loss covered by this policy will be paid as soon as the insurer receives proper written proof."

(2) As used in this section, the term:

(a) "Claim," for a noninstitutional provider, means a paper, Centers for Medicare and Medicaid Services (CMS) 1500 form, or its successor, or electronic billing instrument submitted to the insurer's designated location which ~~that~~ consists of the ANSI ASC X12N 837P standard ~~HCFA 1500~~ data set, or its successor, which ~~that~~ has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all

mandatory entries for any other noninstitutional provider. For institutional providers, the term ~~"claim"~~ means a paper or electronic billing instrument submitted to the insurer's designated location which ~~that~~ consists of the ANSI ASC X12N 837P standard ~~UB-92~~ data set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee.

(b) "Clean claim" means a completed form or completed electronic billing instrument referenced in paragraph (a) which contains all of the following information:

1. All information required under the applicable form or electronic billing instrument.

2. Information reasonably required by the insurer to substantiate the claim, which, except for emergency services and care as defined in s. 641.47, is submitted in advance of the provision of service.

(c) "Insured ineligibility" means a circumstance in which an insured is no longer enrolled in the health plan at the time of receiving the applicable service.

(d) "Overpayment" means a payment that is billed in error, a duplicate claim, or a payment for a service rendered to a patient for a service because of insured ineligibility.

(4) For all electronically submitted claims, a health insurer shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide, to the electronic source submitting the claim, an electronic acknowledgment of the receipt of the claim along with its position as to whether the claim is a clean claim or whether the claim is missing any information required under the applicable

electronic billing instrument provided in paragraph (2)(a) or that was reasonably required by the insurer in advance of the provision of service, other than emergency services and care as defined in s. 641.47, to substantiate the claim ~~to the electronic source submitting the claim~~.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information required under the applicable billing instrument specified in paragraph (2)(a) or which was reasonably required by the insurer and the health insurer asserts is still missing as of the date of such service, other than for emergency services and care as defined in s. 641.47 ~~or documents the insurer can reasonably determine are necessary to process the claim~~.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification unless within such 35-day period the provider notifies the insurer of its position that a clean claim has been submitted. Additional information is considered submitted on the date it is electronically transferred or mailed. The health insurer may not request duplicate documents.

(5) For all nonelectronically submitted claims, a health insurer shall:

(a) ~~Effective November 1, 2003,~~ Provide to the provider submitting the claim an acknowledgment of receipt of the claim along with its position as to whether the claim is a clean claim or whether the claim is missing any information required under the applicable paper billing form described in paragraph (2)(a)

which was reasonably required by the insurer to substantiate the claim in advance of the provision of service, other than for emergency services and care as defined in s. 641.47, within 15 days after receipt of the claim ~~to the provider~~ or provide a provider within 15 days after receipt with electronic access to the status of a submitted claim.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information required under the applicable billing instrument described in paragraph (2)(a) or which was reasonably required by the insurer to substantiate the claim in advance of the provision of service, other than for emergency services and care as defined in s. 641.47, which the health insurer asserts is still missing as of the date of such service ~~or documents the insurer can reasonably determine are necessary to process the claim~~.

2. A provider must submit the ~~additional~~ information ~~or documentation~~, as specified on the itemized list, within 35 days after receipt of the notification unless, within such 35-day period, the provider notifies the insurer of its position that a clean claim has been submitted. ~~Additional~~ Information is considered submitted on the date it is electronically transferred or mailed. The health insurer may not request duplicate documents.

(6) If a health insurer determines that it has made an overpayment to a provider for services rendered to an insured, the health insurer must make a claim for such overpayment to the provider's designated location. A health insurer that makes a claim for overpayment to a provider under this section shall

give the provider a written or electronic statement specifying the basis for the retrospective ~~retroactive~~ denial or payment adjustment. The insurer must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retrospective ~~retroactive~~ review or retrospective audit ~~of coverage decisions or payment levels not related to fraud~~, a health insurer must ~~shall~~ adhere to all of the following procedures:

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

2. A provider that denies or contests a health insurer's claim for overpayment or any portion of a claim shall notify the health insurer, in writing, within 35 days after the provider receives the claim that the 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 health insurer submits additional information, the health insurer 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 insurer 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 insurer'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 begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 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.

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

(10)~~(11)~~ A health insurer may not retrospectively ~~retroactively~~ deny a claim because of insured ineligibility more than 90 days ~~1 year~~ after the date of payment of the claim.

(12)~~(13)~~ Upon written notification by an insured, an insurer shall investigate any claim of improper billing of the insured by a physician, hospital, or other health care provider for a health care service alleged not to have been received. The insurer shall determine if the insured received such service ~~was properly billed for only those procedures and services that the~~

~~insured actually received~~. If the insurer determines that the insured did not receive the service ~~has been improperly billed~~, the insurer must ~~shall~~ notify the insured and the provider of its findings and ~~shall~~ reduce the amount of payment to the provider by the amount charged for the service that was not received ~~determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500~~.

(18) This section may not be interpreted to limit, restrict, or negatively impact any legal claim by a provider or insurer for breach of contract, statutory or regulatory violation, or under a common law cause of action, or shorten or otherwise negatively impact the statute of limitations timeframe for bringing any such legal claim.

(19) A health insurer may not request information from a contracted or noncontracted provider which does not apply to the medical condition at issue for the purposes of making a determination of a clean claim.

(20) A health insurer may not request a contracted or noncontracted provider to resubmit claim information that the contracted or noncontracted provider can document it has already provided to the health insurer.

(21) Notwithstanding any law to the contrary, an insurer may not require any information from a provider before the provision of emergency services and care as defined in s. 641.47 as a condition of payment of a claim, as a basis for denying or reducing payment of a claim, or in contesting whether the claim is a clean claim.

639 Section 4. This act shall take effect July 1, 2024.