

1 A bill to be entitled
2 An act relating to insurance claims payments to health
3 care providers; creating s. 627.4193, F.S.; providing
4 definitions; prohibiting payment adjudicators from
5 downcoding health care services under certain
6 circumstances; providing exceptions; providing
7 requirements for such exceptions; requiring health
8 insurers to ensure that their downcoding policies are
9 updated and to ensure compliance with specified
10 provisions on downcoding; authorizing investigations
11 and actions against noncompliance; providing certain
12 presumption in favor of physicians' determination
13 regarding patients' diagnoses and service orders;
14 providing calculations of interests on health
15 insurers' nonpayment and underpayment due to
16 downcoding; providing causes of action for health care
17 providers; amending s. 627.42392, F.S.; providing and
18 revising definitions; requiring utilization review
19 entities to establish electronic prior authorizations
20 to accept prior authorization requests; providing
21 requirements for such entities and for prior
22 authorization processes; prohibiting such entities
23 from implementing new requirements, restrictions, and
24 changes; providing exceptions; providing reporting
25 requirements; requiring the Office of Insurance

26 Regulation to publish a report based on such entities'
27 reports; providing requirements for adverse
28 determinations made by such entities on health care
29 providers' claims; providing a timeframe for such
30 entities' determination on claims; prohibiting prior
31 authorization requirements under certain
32 circumstances; prohibiting prior authorization
33 revocations, limits, conditions, and restrictions
34 under certain circumstances; providing exceptions;
35 providing validity timeframe of prior authorizations
36 under certain circumstances; providing construction;
37 amending ss. 627.6131 and 641.3155, F.S.; providing
38 and revising definitions; revising requirements and
39 timeframes for responses from health insurers and
40 health maintenance organizations, respectively, to
41 submitted claims; revising interests on overdue
42 payments of claims; authorizing health care providers
43 to refuse to participate in internal dispute
44 resolution processes under certain circumstances;
45 prohibiting health insurers and health maintenance
46 organizations, respectively, from retrospectively,
47 rather than retroactively, denying claims because of
48 insured and enrollee ineligibility beyond a specified
49 timeframe; revising such timeframe; revising
50 applicability; providing construction; prohibiting

health insurers and health maintenance organizations, respectively, from requesting or requiring certain information from health care providers under certain circumstances; providing causes of action for health care providers under certain circumstances; amending s. 395.1065, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 627.4193, Florida Statutes, is created to read:

627.4193 Restrictions on health insurance reimbursement downcoding.—

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

(a) "Downcode" or "downcoding" means the alteration by a payment adjudicator of a 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 insurer" means any entity that offers health insurance coverage, whether through a fully insured plan or self-insured plan or fund, including, as applicable:

1. An authorized health insurer offering health insurance

76 as defined in s. 624.603, as well as any entity that offers a
77 commercial self-insurance fund as defined in s. 624.462(2) or
78 group self-insurance fund as described in s. 624.4621.

79 2. A health insurer that is subject to any of the
80 provisions of this chapter, as well as any entity that offers a
81 self-insurance plan or a group self-insurance plan.

82 3. A managed care plan as defined in s. 409.962.

83 4. A health maintenance organization as defined in s.
84 641.19.

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

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

93 (e) "Payment adjudicator" means a health insurer or any
94 entity that provides, offers to provide, or administers payment
95 on behalf of a health insurer, as well any pharmacy benefit
96 manager as defined in s. 624.490(1), and any other individual or
97 entity that provides, offers to provide, or administers payment
98 for hospital services, outpatient services, medical services,
99 prescription drugs, or other health care services, to a person
100 treated by a health care professional or facility in this state

101 under a policy, plan, or contract.

102 (f) "Provider" means any health care professional,
103 facility, or entity that submits claims for reimbursement for
104 covered health care services.

105 (2) Payment adjudicators are prohibited from downcoding a
106 health care service billed by, or on behalf of, a provider, if
107 the health care service was ordered by a provider that is in-
108 network with the applicable health insurer, unless such
109 downcoding is otherwise expressly permitted under the
110 participation agreement between the health insurer and the
111 provider.

112 (3) If downcoding is expressly permitted under the
113 participation agreement, the payment adjudicator must provide
114 the following information to the provider before making its
115 initial payment or notice of denial of payment:

116 (a) A statement indicating that the service code or
117 modifier billed by the provider or facility is going to be
118 downcoded.

119 (b) An explanation detailing the reasons for downcoding
120 the claim. This explanation must include a clear description of
121 the service codes or modifiers that were altered, added, or
122 removed, if applicable.

123 (c) The payment amount that the payment adjudicator would
124 otherwise make if the service code or modifier is not downcoded.

125 (d) A statement that the provider may contest the

126 downcoding of the applicable service code or modifier by filing
127 a contestation with the payment adjudicator with respect to the
128 downcoding within 15 days after receipt of the notice of
129 downcoding.

130 (e) A statement that by contesting the downcoding of the
131 applicable service code or modifier, the provider does not waive
132 any of its legal rights and claims against the health insurer or
133 payment adjudicator to the fullest extent permissible under law.

134 (4) Even if the participation agreement expressly permits
135 downcoding, a payment adjudicator is prohibited from downcoding
136 a service without first conducting a review of the associated
137 medical record to ensure the accuracy of the coding change.

138 (5) A payment adjudicator is prohibited from downcoding
139 for orders by a licensed nurse.

140 (6) Notwithstanding any provision in this section, a
141 payment adjudicator that proceeds to downcode a service code or
142 modifier, regardless of whether such downcoding is contested by
143 the provider, is solely responsible for any violations of law
144 associated with such downcoding.

145 (7) Payment adjudicators are required to maintain clear
146 and accessible downcoding policies on their official website.
147 These policies must include:

148 (a) An overview of the circumstances under which
149 downcoding may occur.

150 (b) The process and criteria used for conducting reviews

151 of downcoded claims, including the role of medical record
152 review.

153 (c) Information about the internal mechanisms for ensuring
154 consistency and accuracy in downcoding practices.

155 (d) Information regarding the processes for contesting
156 with the payment adjudicator the downcoding of a service code,
157 which processes must offer appeal rights for the provider and
158 the patient, and peer review by a licensed physician before the
159 downcoding.

160 (8) Health insurers shall ensure that their downcoding
161 policies are updated as needed to reflect any changes in
162 regulations, industry standards, or internal procedures.

163 (9) Health insurers shall ensure compliance with this
164 section and shall develop internal procedures to implement and
165 adhere to the requirements outlined in this section.

166 (10) Regulatory authorities, including, but not limited
167 to, the Office of Insurance Regulation, may investigate and take
168 appropriate actions in cases of noncompliance with this section.

169 (11) When a particular health care service is ordered by a
170 licensed physician, there shall be a presumption that the
171 physician determination regarding the diagnosis of the patient
172 and service order by the physician is correct and sufficient,
173 absent a coding error which the health insurer must first verify
174 with the physician before downcoding for such error.

175 (12) If an applicable court, arbitration tribunal, or

other binding legal process determines that a claim was subject to an inappropriate or impermissible downcoding, whether in breach of contract, statute, common law, or otherwise, such that nonpayment or underpayment of the original claim has occurred, then in accordance with s. 627.6131, interest shall be calculated upon the full total amount that should have been paid on the claim as of the applicable time period for payment specified in s. 627.6131.

(13) In the instance of a violation of this section, a provider shall have a private cause of action to proceed against the health insurer or payment adjudicator in the applicable tribunal for the violation.

Section 2. 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 that the health care services rendered, or proposed to be rendered, to a patient are denied, reduced, or terminated. The term does not include a decision to deny, reduce, or terminate services that are determined to have been billed in 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.

201 (c) "Emergency health care service" means medical
202 screening, examination, and evaluation by a physician, or, to
203 the extent permitted by applicable law, by other appropriate
204 personnel under the supervision of a physician, to determine if
205 an emergency medical condition exists and, if it does, the care,
206 treatment, or surgery by a physician necessary to relieve or
207 eliminate the emergency medical condition, within the service
208 capability of the facility.

209 (d) "Emergency medical condition" means a medical
210 condition manifesting itself by acute symptoms of sufficient
211 severity, including severe pain, such that a prudent layperson
212 who possesses an average knowledge of health and medicine could
213 reasonably expect the absence of immediate medical attention to
214 result in any of the conditions listed in s. 395.002(8).

215 (e) "Health insurer" means any entity that offers health
216 insurance coverage, whether through a fully insured plan or
217 self-insured plan or fund, including, as applicable:

218 1. An authorized health insurer offering health insurance
219 as defined in s. 624.603, as well as any entity that offers a
220 commercial self-insurance fund as defined in s. 624.462(2) or a
221 group self-insurance fund as described in s. 624.4621.

222 2. A health insurer that is subject to any of the
223 provisions of this chapter, as well as any entity that offers a
224 self-insurance plan or a group self-insurance plan.

225 3. A managed care plan as defined in s. 409.962.

226 4. A health maintenance organization as defined in s.
227 641.19.

228 (f) "Prior authorization" means the process by which
229 utilization review entities determine the medical necessity or
230 medical appropriateness of otherwise covered health care
231 services before the rendering of such health care services. The
232 term also includes any requirement by a health insurer or
233 utilization review entity that an enrollee or health care
234 provider notify the health insurer or utilization review entity
235 before the provision of a health care service.

236 (g) "Urgent health care service" means a health care
237 service that, if the timeframe for making a nonexpedited prior
238 authorization is applied, could, in the opinion of a physician
239 with knowledge of the patient's medical condition:

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

242 2. Subject the patient to severe pain that cannot be
243 adequately managed without the care, treatment, or prescription
244 drugs that are the subject of the prior authorization request.

245 (h) "Utilization review activity" means any activity
246 prospective to, concurrent with, or retrospective to, the
247 provision of a nonemergency health care service, to determine
248 whether payment shall be made in full or shall be subject to an
249 adverse determination. Utilization review activity is
250 prohibited:

251 1. To the extent restricted or prohibited by an agreement
252 with a health care provider;

253 2. For an emergency health care service; or

254 3. For a service provided to a patient who is experiencing
255 an emergency medical condition.

256 (i) "Utilization review entity" means an entity permitted
257 under the applicable agreement with a health care provider or
258 otherwise permitted by a provider that does not have such an
259 agreement to perform utilization review activities or upon whose
260 behalf utilization review activities are performed, including,
261 as applicable:

262 1. An authorized health insurer offering health insurance
263 as defined in s. 624.603, as well as any entity that offers a
264 commercial self-insurance fund as defined in s. 624.462(2) or
265 group self-insurance fund as described in s. 624.4621.

266 2. A health insurer that is subject to any of the
267 provisions of this chapter, as well as any entity that offers a
268 self-insurance plan or a group self-insurance plan.

269 3. A managed care plan as defined in s. 409.962.

270 4. A health maintenance organization as defined in s.
271 641.19.

272 5. A pharmacy benefit manager as defined in s. 624.490(1).

273 6. Any other individual or entity that provides, offers to
274 provide, or administers payment for hospital services,
275 outpatient services, medical services, prescription drugs, or

276 other health care services to a person treated by a health care
277 professional or facility in this state under a policy, plan,
278 contract, or fund ~~"health insurer" means an authorized insurer~~
279 ~~offering health insurance as defined in s. 624.603, a managed~~
280 ~~care plan as defined in s. 409.962(10), or a health maintenance~~
281 ~~organization as defined in s. 641.19(12).~~

282 (2) Notwithstanding any other provision of law, a
283 utilization review entity that ~~effective January 1, 2017, or six~~
284 ~~(6) months after the effective date of the rule adopting the~~
285 ~~prior authorization form, whichever is later, a health insurer,~~
286 ~~or a pharmacy benefits manager on behalf of the health insurer,~~
287 ~~which~~ does not provide an electronic prior authorization process
288 for use by its contracted providers, shall only use the prior
289 authorization form that has been approved by the Financial
290 Services Commission for granting a prior authorization for a
291 medical procedure, course of treatment, or prescription drug
292 benefit. Such form shall be no longer than ~~may not exceed~~ two
293 pages in length, excluding any instructions or guiding
294 documentation, and must include all clinical documentation
295 necessary for the utilization review entity ~~health insurer~~ to
296 make a decision. At a minimum, the form must include: (1)
297 sufficient patient information to identify the member, date of
298 birth, full name, and Health Plan ID number; (2) provider name,
299 address and phone number; (3) the medical procedure, course of
300 treatment, or prescription drug benefit being requested,

301 including the medical reason therefor, and all services tried
302 and failed; (4) any laboratory documentation required; and (5)
303 an attestation that all information provided is true and
304 accurate.

305 (3) The Financial Services Commission in consultation with
306 the Agency for Health Care Administration shall adopt by rule
307 guidelines for all prior authorization forms which ensure the
308 general uniformity of such forms.

309 (4) A utilization review entity must establish and offer a
310 secure, interactive online electronic prior authorization to
311 accept electronic prior authorization requests. The process of
312 electronic prior authorization must allow a person seeking a
313 prior authorization the ability to upload documentation if such
314 documentation is required by the utilization review entity to
315 adjudicate the prior authorization request. Once a provider
316 grants a health insurer access to a patient's electronic medical
317 record, the provider shall be deemed to have supplied all
318 information necessary for prior authorization of the health care
319 service, including, without limitation, all information that is
320 reasonably required by the health insurer, other than for an
321 emergency health care service or for a service provided to a
322 patient who is experiencing an emergency medical condition, in
323 advance of the provision of service, and the health insurer
324 asserts is missing as of the date of such service. Additional
325 information or documentation, regardless of whether the

utilization review entity requests any additional information,
shall be deemed unnecessary, and deemed not required, for prior
authorization of the health care service, and any request for
additional information or any position of the utilization review
entity or any third party acting on behalf of the utilization
review entity regarding any lack of information from the
provider is prohibited from being used to deny, pend, or delay
prior authorization of the health care service.

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

(6) A utilization review entity's prior authorization
process is prohibited from requiring 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. This information shall be explained in detail and
in clear and ordinary terms.

(8) A utilization review entity is prohibited from
implementing any new requirements or restrictions and from
making changes to existing requirements or restrictions on
obtaining prior authorization unless:

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

354 (b) Policyholders and health care providers who are
355 affected by the new requirements and restrictions or changes to
356 the requirements and restrictions are provided with a written
357 notice of the changes at least 60 days before they are
358 implemented, with such notice being delivered electronically or
359 by other means as agreed to by the policyholder or the health
360 care provider; and

361 (c) All applicable amendments to a provider's agreement
362 with the applicable health insurer or utilization review entity
363 have been obtained and memorialized in a mutually agreed-upon
364 writing before such implementation.

365 (9)(a) Utilization review entities shall, by March 31 of
366 each year, submit a report to the Office of Insurance Regulation
367 with the following data elements for the prior calendar year:

368 1. A list of all items and services requiring prior
369 authorization.

370 2. The percentage of standard prior authorization requests
371 approved by the utilization review entity and aggregated by item
372 or service.

373 3. The percentage of standard prior authorization requests
374 denied by the utilization review entity aggregated by item or
375 service.

376 4. The percentage of standard prior authorization requests
377 approved by the utilization review entity after appeal by item
378 or service.

379 5. The percentage of prior authorization where the
380 timeframe for review was extended and request approved by item
381 or service.

382 6. The percentage of expedited prior authorization
383 requests approved by the utilization review entity by item or
384 service.

385 7. The percentage of expedited prior authorization
386 requests denied by the utilization review entity by item or
387 service.

388 8. The percentage of expedited prior authorization
389 requests approved by the utilization review entity after appeal
390 by item or service.

391 9. The average and median time between submission of a
392 request for prior authorization and the utilization review
393 entity's decision for standard prior authorizations by item or
394 service.

395 10. The average and median time between submission of a
396 request for prior authorization and the utilization review
397 entity's decision for expedited prior authorizations by item or
398 service.

399 (b) The Office of Insurance Regulation shall, by July 1 of
400 each year, publish a report on its website detailing the

401 information in paragraph (a) submitted by utilization review
402 entities.

403 (10) Utilization review entities must ensure that all
404 adverse determinations are made by a physician licensed under
405 chapter 458 or chapter 459. The physician must:

406 (a) Possess a current and valid nonrestricted license to
407 practice medicine in this state;

408 (b) Be of the same specialty as the physician who
409 typically manages the medical condition or disease, or provides
410 the health care service involved in the request;

411 (c) Have at least 5 years of experience treating patients
412 with the medical condition or disease for which the health care
413 service is being requested; and

414 (d) Not have any direct or indirect financial arrangement
415 with the utilization review entity that rewards or incentivizes,
416 financially or otherwise, such physician in any way relating to
417 adverse determinations.

418 (11) Notice of an adverse determination shall be provided
419 by electronic mail to the health care provider that initiated
420 the prior authorization and to the patient. Notice required
421 under this subsection must include:

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

425 (b) The written clinical criteria, if any, and any

426 internal rule, guideline, or protocol on which the utilization
427 review entity relied when making the adverse determination and
428 how those provisions apply to the patient's specific medical
429 circumstance.

430 (c) Information for the patient and the patient's health
431 care provider which describes the procedure through which the
432 patient or health care provider may request a copy of any report
433 developed by personnel performing the review that led to the
434 adverse determination.

435 (d) Information that explains to the patient and the
436 patient's health care provider how to appeal the adverse
437 determination.

438 (12) If a utilization review entity requires prior
439 authorization of a nonurgent health care service, the
440 utilization review entity shall grant a prior authorization or
441 make an adverse determination and notify the patient and the
442 patient's health care provider of the decision within 72 hours
443 after obtaining all necessary information to grant the prior
444 authorization or make the adverse determination. For purposes of
445 this subsection, the term "necessary information" includes the
446 results of any face-to-face clinical evaluation or second
447 opinion that may be required.

448 (13) A utilization review entity shall grant an expedited
449 prior authorization or make an expedited adverse determination
450 concerning an urgent health care service and notify the patient

451 and the patient's health care provider of such expedited prior
452 authorization or adverse determination no later than 24 hours
453 after receiving all information needed to complete the review of
454 the requested urgent health care service.

455 (14) (a) A utilization review entity is prohibited from
456 requiring prior authorization for:

- 457 1. Prehospital transportation;
458 2. Provision of an emergency health care service; or
459 3. Provision of a service to a patient who is experiencing
460 an emergency medical condition.

461 (b) A utilization review entity is prohibited from
462 conducting utilization review activity, and from making any
463 adverse determinations, to the extent restricted or prohibited
464 by an agreement with a health care provider. A utilization
465 review entity is prohibited from performing any utilization
466 review activity, and from making any adverse determinations,
467 with respect to:

- 468 1. An emergency health care service; or
469 2. A service provided to a patient who experiences an
470 emergency medical condition.

471 (15) A utilization review entity is prohibited from
472 requiring prior authorization, and from making any adverse
473 determinations, for the provision of medications for opioid use
474 disorder. For purposes of this subsection, the term "medications
475 for opioid use disorder" means the use of medications, commonly

prescribed in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. 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. Types of behavioral therapies include, but are not limited to, individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities.

(16) A utilization review entity is prohibited from revoking, limiting, conditioning, or restricting a prior authorization if care is provided within 45 business days after the date the health care provider receives the prior authorization. A utilization review entity must pay, or cause payment to be made to, the health care provider, without any prepayment review or prepayment audit before such payment, at the contracted payment rate for a health care service provided by the health care provider per the prior authorization, unless:

(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, and medical necessity did not constitute a basis for such noncovered benefit status, on the day the health care

501 service was provided, and the utilization review entity notified
502 the health care provider in writing of these facts before the
503 health care service being provided;

504 (c) The authorized service was never performed; or

505 (d) The patient was no longer enrolled under the
506 applicable health plan and, on that basis, was not eligible for
507 health care coverage from the applicable health insurer or self-
508 insured plan on the day the care was provided, and the
509 utilization review entity notified the health care provider in
510 writing of these facts before the health care service being
511 provided.

512 (17) If a utilization review entity requires a prior
513 authorization for a health care service for the treatment of a
514 chronic or long-term care condition, the prior authorization
515 shall remain valid for the length of the treatment and the
516 utilization review entity is prohibited from requiring the
517 patient to obtain a prior authorization again for the health
518 care service.

519 (18) A utilization review entity is prohibited from
520 imposing an additional prior authorization requirement with
521 respect to a surgical or otherwise invasive procedure, or any
522 item furnished as part of the surgical or invasive procedure, if
523 the procedure or item is furnished during the perioperative
524 period of another procedure for which prior authorization was
525 granted by the health insurer.

526 (19) If there is a change in coverage or approval criteria
527 for a previously authorized health care service, the change in
528 coverage or approval criteria is prohibited from adversely
529 affecting an enrollee who received prior authorization before
530 the effective date of the change for the remainder of the
531 enrollee's plan year.

532 (20) A utilization review entity shall continue to honor a
533 prior authorization it has granted to an enrollee when the
534 enrollee changes products under the same health insurer.

535 (21) Any failure by a utilization review entity to comply
536 with the deadlines and other requirements specified in this
537 section shall result in any health care services subject to
538 review to be automatically deemed authorized by the utilization
539 review entity.

540 (22) Except as otherwise provided in paragraphs (16)(a)-
541 (d), prior authorization constitutes a conclusive determination
542 of the medical necessity of the authorized health care service
543 and an irrevocable obligation to pay for such authorized health
544 care service.

545 (23)(a) This section prohibits an agreement with a health
546 care provider to restrict, limit, prohibit, or substitute a
547 utilization review activity or prior authorization.

548 (b) Nothing in this section shall be construed to:

549 1. Limit in any way the restrictions or prohibitions on
550 adverse determinations under an agreement with a health care

551 provider, nor to imply permission for, or applicability of,
552 adverse determinations for emergency health care services.

553 2. Restrict, limit, or prohibit in any way prior
554 authorizations under an agreement between a provider and a
555 utilization review entity, nor to restrict, limit, or prohibit a
556 provider's rights to contest, reject, or oppose any prior
557 authorization activities.

558 (24) In the instance of a violation of this section, a
559 provider shall have a private cause of action to proceed against
560 the health insurer or utilization review entity in the
561 applicable tribunal for the violation.

562 **Section 3. Section 627.6131, Florida Statutes, is amended**
563 **to read:**

564 627.6131 Prompt payment of claims.—

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

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

572 (a) "Claim" for a noninstitutional provider means a paper
573 HCFA 1500 claim form, or its successor, or an electronic billing
574 instrument submitted to the health insurer's designated location
575 that consists of the ANSI ASC X12N 837P standard ~~HCFA-1500~~ data

576 set, or its successor, that has all mandatory entries for a
577 physician licensed under chapter 458, chapter 459, chapter 460,
578 chapter 461, or chapter 463, or psychologists licensed under
579 chapter 490 or any appropriate billing instrument as designated
580 by the provider that has all mandatory entries for any other
581 noninstitutional provider. For institutional providers, "claim"
582 means a paper CMS-1450 claim form or its successor, or an
583 electronic billing instrument submitted to the health insurer's
584 designated location that consists of the ANSI ASC X12N 837I
585 standard ~~UB-92 data set~~, or its successor, with entries stated
586 as mandatory by the National Uniform Billing Committee.

587 (b) "Clean claim" means a completed form, or completed
588 electronic billing instrument, containing all information
589 required under the applicable form or electronic billing
590 instrument, as well as information reasonably required by the
591 health insurer, other than for emergency services and care as
592 defined in s. 395.002(9), in advance of the provision of service
593 by the health insurer to substantiate the claim.

594 (c) "Electronic medical record" means the digital record
595 of a patient's information that may be accessed through
596 electronic means, via portal or other method of electronic
597 access, which may include information regarding the patient's
598 medical history, medical condition, medical treatment,
599 laboratory results, diagnostic reports, and clinical notes.

600 (d) "Emergency health care services" has the same meaning

as "emergency services and care" as defined in s. 395.002(9).

(e) "Health insurer" means any entity that offers health insurance coverage, whether through a fully insured plan or a self-insured plan or fund, including, as applicable:

1. An authorized health insurer offering health insurance as defined in s. 624.603, as well as any entity that offers a commercial self-insurance fund as defined in s. 624.462(2) or a group self-insurance fund as described in s. 624.4621.

2. A health insurer that is subject to any of the provisions of this chapter, as well as any entity that offers a self-insurance plan or a group self-insurance plan.

(f) "Insured ineligibility" means that the insured was no longer enrolled in the health plan at the time of receiving the applicable service.

(g) "Overpayment" means payment made upon a claim that is:

1. Billed in error;

2. A duplicate claim; or

3. Billed for a service rendered to a patient in spite of insured ineligibility.

A request for overpayment is limited to a billing error, duplicate bill, or insured ineligibility.

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

(a) Are considered received on the date the claim is

received by the health insurer at its designated claims-receipt location or the date the ~~claim for~~ overpayment claim is received by the provider at its designated location.

(b) As to providers' claims for payment, must be mailed or electronically transferred to the primary health insurer within 6 months after the following have occurred:

1. Discharge for inpatient services or the date of service for outpatient services; and

2. The provider has been furnished with the correct name and address of the patient's health insurer.

All providers' claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to the secondary health insurer within 45 ~~90~~ days after final determination by the primary health insurer. A provider's claim is considered submitted on the date it is electronically transferred or mailed.

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

(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

651 acknowledgment of the receipt of the claim, accompanied by a
652 statement indicating the health insurer's position as to whether
653 the claim is a clean claim or is missing any information that is
654 required under the applicable electronic billing instrument, as
655 described in paragraph (2)(a), or that was reasonably required
656 by the health insurer, other than for emergency health care
657 services, in advance of the provision of service to substantiate
658 ~~to the electronic source submitting~~ the claim, and the health
659 insurer asserts is missing as of the date of service.

660 (b) Within 15 ~~20~~ days after receipt of the claim, pay the
661 claim or notify a provider or designee if a claim is denied or
662 contested. Notice of the health insurer's action on the claim
663 and payment of the claim is considered to be made on the date
664 the notice or payment was received by the provider ~~mailed~~ or
665 electronically transferred.

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

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 30 ~~35~~ days after receipt of the notification of contestation unless, within the 30-day period, the provider notifies the health insurer of the provider's 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 is prohibited from requesting ~~may not request~~ duplicate documents.

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

(e) A claim that was contested by the health insurer must be paid or denied within 30 ~~90~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~120~~ days after receipt of the claim, regardless of whether contested by the health insurer, creates an uncontestable obligation to pay the claim as submitted by the provider.

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

(a) Within 15 days following receipt of the claim ~~Effective November 1, 2003,~~ provide to the provider or its designee:

701 1. An acknowledgment of receipt of the claim, accompanied
702 by a statement indicating the health insurer's position as to
703 whether the claim is a clean claim or the claim is missing any
704 information that is required under the applicable paper billing
705 form, as described in paragraph (2) (a), or that was reasonably
706 required by the health insurer, other than for emergency health
707 care services, in advance of the provision of service to
708 substantiate the claim, and the health insurer asserts is
709 missing as of the date of service; or

710 ~~2. within 15 days after receipt of the claim to the~~
711 ~~provider or provide a provider within 15 days after receipt with~~
712 Electronic access to the status of the a submitted claim, which
713 status must indicate the health insurer's position as to whether
714 the claim is a clean claim or missing any information described
715 in subparagraph 1.

716 (b) Within 30 ~~40~~ days after receipt of the claim, pay the
717 claim or notify a provider or designee if a claim is denied or
718 contested. Notice of the health insurer's action on the claim
719 and payment of the claim is considered to be made on the date
720 the notice or payment was received by the provider ~~mailed~~ or
721 electronically transferred.

722 (c)1. Notification of the health insurer's determination
723 of a contested claim must be accompanied by an itemized list of
724 any additional information that is required under the applicable
725 form or billing instrument, as described in paragraph (2) (a), or

726 that was reasonably required by the health insurer, other than
727 for emergency health care services, in advance of the provision
728 of service to substantiate the claim, and the health insurer
729 asserts is missing as of the date of such service ~~or documents~~
730 ~~the insurer can reasonably determine are necessary to process~~
731 ~~the claim.~~

732 2. A provider must submit the additional information or
733 documentation, as specified on the itemized list, within 30 ~~35~~
734 days after receipt of the notification of contestation unless,
735 within the 30-day period, the provider notifies the health
736 insurer of its position that a clean claim has been submitted.
737 Additional information is considered submitted on the date it is
738 electronically transferred or mailed. The health insurer is
739 prohibited from requesting ~~may not request~~ duplicate documents.

740 (d) For purposes of this subsection, electronic means of
741 transmission of claims, notices, documents, forms, and payments
742 shall be used to the greatest extent possible by the health
743 insurer and the provider.

744 (e) A claim that was contested by the health insurer must
745 be paid or denied within 30 ~~120~~ days after receipt of the
746 additional information requested ~~claim~~. Failure to pay or deny a
747 claim within 90 ~~140~~ days after receipt of the claim, regardless
748 of whether contested by the health insurer, creates an
749 uncontestable obligation to pay the claim as submitted by the
750 provider.

751 (6) Regardless of whether a claim has been submitted
752 electronically or nonelectronically, and notwithstanding any
753 other provision of this section to the contrary:

754 (a) Once a provider grants a health insurer access to a
755 patient's electronic medical record, the provider shall be
756 deemed to have supplied all information necessary to pay the
757 claim, including, without limitation, all information that is
758 required under the applicable billing instrument and that was
759 reasonably required by the health insurer, other than for
760 emergency health care services, in advance of the provision of
761 service to substantiate the claim. Additional information or
762 documentation, regardless of whether the health insurer requests
763 any additional information, shall be deemed unnecessary, and
764 deemed not required for payment of the claim, and any request
765 for additional information, and any position of the health
766 insurer or any third party acting on behalf of the health
767 insurer regarding any lack of information from the provider, is
768 prohibited from being used to deny, reduce, offset, withhold,
769 pend, or delay payment of the claim.

770 (b) For instances in which notice of access to the
771 electronic medical record has been provided to the health
772 insurer, the claim must be paid or denied within 30 days of such
773 notice to the health insurer. Failure to pay or deny a claim,
774 for which the health insurer has been provided notice of access
775 to the electronic medical record within 75 days after receipt of

776 such notice creates an uncontestable obligation to pay the claim
777 as submitted by the provider.

778 ~~(7)-(6)~~ If a health insurer determines that it has made an
779 overpayment to a provider for services rendered to an insured,
780 the health insurer must make an overpayment ~~a claim~~ for such
781 overpayment to the provider's designated location. A health
782 insurer that makes an overpayment ~~a claim for overpayment~~ to a
783 provider under this section shall give the provider a written or
784 electronic statement specifying the basis for the retrospective
785 ~~retroactive~~ denial or payment adjustment. The health insurer
786 must also identify the claim or claims, or portion thereof, as
787 to which the health insurer alleges overpayment claim; and the
788 specific invoice number submitted with or on the claim ~~portion~~
789 ~~thereof, for which a claim for overpayment is submitted.~~ Except
790 as provided in subparagraph (a).3, there shall be no denial,
791 reduction, offset, withholding, pending, or delay of payment, or
792 other negative impact, regardless of whether by the health
793 insurer or any third party acting on behalf of such health
794 insurer, on payment of any other claim of the provider on the
795 basis of the overpayment allegation.

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

- 800 1. All overpayment claims ~~for overpayment~~ must be received

801 by the ~~submitted to a~~ provider within 18 ~~30~~ months after the
802 health insurer's payment of the claim. A provider must pay,
803 deny, or contest the health insurer's ~~claim for~~ overpayment
804 claim within 40 days after the receipt of the overpayment claim.
805 All contested overpayment claims ~~for overpayment~~ must be paid or
806 denied within 120 days after receipt of the overpayment claim.
807 Failure to pay or deny an overpayment ~~and~~ claim within 140 days
808 after receipt creates an uncontestable obligation to pay the
809 overpayment claim.

810 2. A provider that denies or contests a health insurer's
811 overpayment claim ~~for overpayment~~ or any portion of an
812 overpayment ~~a~~ claim shall notify the health insurer, in writing,
813 within 40 ~~35~~ days after the provider receives the overpayment
814 claim that such overpayment ~~the claim for overpayment~~ is
815 contested or denied. The notice that the overpayment claim ~~for~~
816 ~~overpayment~~ is denied or contested must identify the denied or
817 contested portion of the overpayment claim and the specific
818 reason for contesting or denying the overpayment claim and, if
819 contested, must include a request for additional information. If
820 the health insurer submits additional information, the health
821 insurer must, within 35 days after receipt of the request, mail
822 or electronically transfer the information to the provider. The
823 provider shall pay or deny the overpayment claim ~~for overpayment~~
824 within 45 days after receipt of the information. The notice from
825 the provider regarding denial or contestation of the overpayment

claim is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health insurer is prohibited from denying, reducing, offsetting, withholding, pending, or delaying ~~may not reduce~~ payment to the provider for other services unless the provider agrees to the denial, reduction, offset, withholding, pending, or delay of payment 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 an overpayment ~~a claim for an overpayment~~ begins to accrue when the overpayment claim should have been paid, ~~denied, or contested~~.

(b) An overpayment ~~A claim is prohibited for overpayment~~ ~~shall not be permitted~~ beyond 18 ~~30~~ months after the health insurer's payment of a claim, except that overpayment claims ~~for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

~~(8)(7)~~ Payment of a claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 15 ~~12~~ percent per year, to be calculated upon the full total amount that should have been paid on the claim within the applicable time period

851 specified in this section. If an applicable court, arbitration
852 tribunal, or other binding legal process determines that a claim
853 that was paid at a lesser amount should have been paid at a full
854 total amount, whether under a breach of contract legal claim, a
855 legal claim under a statutory private cause of action, or other
856 basis, the 15 percent per year interest shall be calculated upon
857 the full total amount, rather than upon the difference between
858 the full total amount and the amount that was actually paid. If
859 an applicable court, arbitration tribunal, or other binding
860 legal process determines that a claim was subject to an
861 inappropriate or impermissible denial or partial denial, whether
862 in a breach of contract, statute, common law, or otherwise,
863 interest shall be calculated upon the full total amount that
864 should have been paid on the claim within the applicable time
865 period for payment specified in this section, and the act of
866 denial or partial denial shall be deemed not to have in any way
867 tolled the time period for such payment. Interest on the full
868 total amount that should have been paid on the claim within the
869 applicable time period specified in this section ~~an overdue~~
870 ~~payment for a claim or for any portion of a claim~~ begins to
871 accrue when the claim should have been paid, ~~denied, or~~
872 ~~contested~~. The interest must be paid along with, and in addition
873 to, the payment for the satisfaction of the full total amount of
874 the claim, as determined by an applicable court, arbitration
875 tribunal, or other binding legal process ~~is payable with the~~

876 ~~payment of the claim.~~

877 (9)~~(8)~~ For all contracts entered into or renewed on or
878 after October 1, 2002, a health insurer's internal dispute
879 resolution process related to a denied claim not under active
880 review by a mediator, arbitrator, or third-party dispute entity
881 must be finalized within 60 days after the receipt of the
882 provider's request for review or appeal. Notwithstanding any
883 provision of this section to the contrary, when the provider and
884 health insurer disagree as to interpretation of contractual or
885 statutory language, the provider is not required to participate
886 in the health insurer's internal dispute resolution process.

887 (10)~~(9)~~ A provider or any representative of a provider,
888 regardless of whether the provider is under contract with the
889 health insurer, is prohibited from collecting or attempting ~~may~~
890 ~~not collect or attempt~~ to collect money from, maintaining
891 ~~maintain~~ any action at law against, or reporting ~~report~~ to a
892 credit agency an insured for payment of covered services for
893 which the health insurer contested or denied the provider's
894 claim. This prohibition applies during the pendency of any claim
895 for payment made by the provider to the health insurer for
896 payment of the services or internal dispute resolution process
897 to determine whether the health insurer is liable for the
898 services. For a claim, this pendency applies from the date the
899 claim or a portion of the claim is denied to the date of the
900 completion of the health insurer's internal dispute resolution

901 process, not to exceed 60 days. This subsection does not
902 prohibit the collection by the provider of copayments,
903 coinsurance, or deductible amounts due the provider.

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

906 (11) A health insurer is prohibited from retrospectively
907 denying ~~may not retroactively deny~~ a claim because of insured
908 ineligibility more than 90 days ~~1 year~~ after the date of payment
909 of the claim.

910 (12) A health insurer shall pay a contracted primary care
911 or admitting physician, pursuant to such physician's contract,
912 for providing inpatient services in a contracted hospital to an
913 insured if such services are determined by such physician ~~the~~
914 ~~health insurer~~ to be medically necessary and, regardless of the
915 health plan's determination of medical necessity, are otherwise
916 covered services under the health insurer's contract with the
917 contract holder.

918 (13) Upon written notification by an insured, a health an
919 insurer shall investigate any claim of improper billing of the
920 insured by a physician, hospital, or other health care provider
921 for a health care service alleged to not actually have been
922 received. The health insurer shall determine if the insured
923 actually received the applicable service ~~was properly billed for~~
924 ~~only those procedures and services that the insured actually~~
925 ~~received~~. If the health insurer determines that the insured did

926 not actually receive the applicable service ~~has been improperly~~
927 ~~billed,~~ the health insurer shall notify the insured and the
928 provider of its findings and shall reduce the amount of payment
929 to the provider by the amount for the service that was not
930 actually received ~~determined to be improperly billed. If a~~
931 ~~reduction is made due to such notification by the insured, the~~
932 ~~insurer shall pay to the insured 20 percent of the amount of the~~
933 ~~reduction up to \$500.~~

934 (14) A permissible error ratio of 5 percent is established
935 for health insurer's claims payment violations of paragraphs
936 (4) (a), (b), (c), and (e) and (5) (a), (b), (c), and (e). If the
937 error ratio of a particular health insurer does not exceed the
938 permissible error ratio of 5 percent for an audit period, no
939 fine shall be assessed for the noted claims violations for the
940 audit period. The error ratio shall be determined by dividing
941 the number of claims with violations found on a statistically
942 valid sample of claims for the audit period by the total number
943 of claims in the sample. If the error ratio exceeds the
944 permissible error ratio of 5 percent, a fine may be assessed
945 according to s. 624.4211 for those claims payment violations
946 which exceed the error ratio. Notwithstanding the provisions of
947 this section, the office may fine a health insurer for claims
948 payment violations of paragraphs (4) (e) and (5) (e) which create
949 an uncontestable obligation to pay the claim as submitted by the
950 provider. The office shall refrain from imposing a ~~not~~ fine upon

951 a health insurer ~~insurers~~ for violations which the office
952 determines were due to circumstances beyond the health insurer's
953 control.

954 (15) This section is applicable only to a major medical
955 expense health insurance policy as defined in s. 627.643(2)(e)
956 offered by a group or an individual health insurer licensed
957 under ~~pursuant to~~ chapter 624, including a preferred provider
958 policy under s. 627.6471 and an exclusive provider organization
959 under s. 627.6472 or a group or individual insurance contract
960 that only provides direct payments to dentists for enumerated
961 dental services, or other health insurance coverage, policy, or
962 fund, regardless of whether fully insured or self-insured,
963 offered or administered by a health insurer.

964 (16) Notwithstanding paragraph (4)(b), where an electronic
965 pharmacy claim is submitted to a pharmacy benefits manager
966 acting on behalf of a health insurer, the pharmacy benefits
967 manager shall, within 30 days of receipt of the claim, pay the
968 claim or notify a provider or designee if a claim is denied or
969 contested. Notice of the health insurer's action on the claim
970 and payment of the claim is considered to be made on the date
971 the notice or payment was received by the provider ~~mailed~~ or
972 electronically transferred.

973 (17) Notwithstanding paragraph (5)(a), effective November
974 1, 2003, where a nonelectronic pharmacy claim is submitted to a
975 pharmacy benefits manager acting on behalf of a health insurer,

the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(18) Notwithstanding the 18-month ~~30-month~~ period provided in subsection (7) ~~(6)~~, all overpayment claims ~~for overpayment~~ submitted to a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment of the claim. An overpayment ~~A claim to a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 is prohibited~~ ~~for overpayment may not be permitted~~ beyond 12 months after the health insurer's payment of a claim, except that overpayment claims ~~for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(19) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment by a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter

1001 466 is prohibited ~~may not be permitted~~ beyond 12 months after
1002 the health insurer's payment of a claim.

1003 (20) Nothing in this section shall be interpreted to
1004 limit, restrict, or negatively impact any legal claim by a
1005 provider or health insurer for breach of contract, statutory or
1006 regulatory violation, or a common-law cause of action, nor to
1007 shorten or otherwise negatively impact the statute of
1008 limitations timeframe for bringing any such legal claim.

1009 (21) A health insurer is prohibited from requesting
1010 information from a contracted or noncontracted provider which
1011 does not apply to the medical condition at issue for the
1012 purposes of adjudicating a clean claim.

1013 (22) A health insurer is prohibited from requesting a
1014 contracted or noncontracted provider to resubmit claim
1015 information that the contracted or noncontracted provider can
1016 document it has already provided to the health insurer or that
1017 is contained inside the electronic medical record to which the
1018 health insurer has been provided access.

1019 (23) Notwithstanding any other provision of this section
1020 to the contrary, a health insurer is prohibited from requiring
1021 any information from a provider before the provision of
1022 emergency health care services as a condition of payment of a
1023 claim, as a basis for denying, delaying, offsetting,
1024 withholding, or reducing payment of a claim, or in contesting
1025 whether the claim is a clean claim.

1026 (24) In an instance of a violation of this section, a
1027 provider shall have a private cause of action to proceed against
1028 the health insurer in the applicable tribunal for the violation.

1029 (25)~~(20)~~ (a) A contract between a health insurer and a
1030 dentist licensed under chapter 466 for the provision of services
1031 to an insured is prohibited from specifying ~~may not specify~~
1032 credit card payment as the only acceptable method for payments
1033 from the health insurer to the dentist.

1034 (b) When a health insurer employs the method of claims
1035 payment to a dentist through electronic funds transfer,
1036 including, but not limited to, virtual credit card payment, the
1037 health insurer shall notify the dentist as provided in this
1038 paragraph and obtain the dentist's consent before employing the
1039 electronic funds transfer. The dentist's consent described in
1040 this paragraph applies to the dentist's entire practice. For the
1041 purpose of this paragraph, the dentist's consent, which may be
1042 given through e-mail, must bear the signature of the dentist.
1043 Such signature includes an electronic or digital signature if
1044 the form of signature is recognized as a valid signature under
1045 applicable federal law or state contract law or an act that
1046 demonstrates express consent, including, but not limited to,
1047 checking a box indicating consent. The health insurer or dentist
1048 is prohibited from requiring ~~may not require~~ that a dentist's
1049 consent as described in this paragraph be made on a patient-by-
1050 patient basis. The notification provided by the health insurer

to the dentist must include all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health insurer that pays a claim to a dentist through automated clearinghouse transfer is prohibited from charging ~~may not charge~~ a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

~~(26) (21)~~ (a) A health insurer is prohibited from denying ~~may not deny~~ any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

1076 2. The documentation provided by the person submitting the
1077 claim fails to support the claim as originally authorized.

1078 3. Subsequent to the issuance of the prior authorization,
1079 new procedures are provided to the patient or a change in the
1080 condition of the patient occurs such that the prior authorized
1081 procedure would no longer be considered medically necessary,
1082 based on the prevailing standard of care.

1083 4. Subsequent to the issuance of the prior authorization,
1084 new procedures are provided to the patient or a change in the
1085 patient's condition occurs such that the prior authorized
1086 procedure would at that time have required disapproval pursuant
1087 to the terms and conditions for coverage under the patient's
1088 plan in effect at the time the prior authorization was issued.

1089 5. The denial of the claim was due to one of the
1090 following:

1091 a. Another payor is responsible for payment.

1092 b. The dentist has already been paid for the procedures
1093 identified in the claim.

1094 c. The claim was submitted fraudulently, or the prior
1095 authorization was based in whole or material part on erroneous
1096 information provided to the health insurer by the dentist,
1097 patient, or other person not related to the health insurer.

1098 d. The person receiving the procedure was not eligible to
1099 receive the procedure on the date of service.

1100 e. The services were provided during the grace period

established under s. 627.608 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 4. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

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

(a) "Claim" for a noninstitutional provider means a paper HCFA 1500 claim form, or its successor, or an electronic billing instrument submitted to the health maintenance organization's designated location that consists of the ANSI ASC X12N 837P standard ~~HCFA-1500~~ data set, or its successor, 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 as designated by the provider that has all mandatory entries for any other noninstitutional provider. For

1126 institutional providers, "claim" means a paper CMS-1450 claim
1127 form, or its successor, or an electronic billing instrument
1128 submitted to the health maintenance organization's designated
1129 location that consists of the ANSI ASC X12N 837I standard ~~UB-92~~
1130 data set or its successor with entries stated as mandatory by
1131 the National Uniform Billing Committee.

1132 (b) "Clean claim" means a completed form, or completed
1133 electronic billing instrument, containing all information
1134 required under the applicable form or electronic billing
1135 instrument, as well as information reasonably required by the
1136 health maintenance organization, other than for emergency
1137 services and care as defined in s. 641.19, in advance of the
1138 provision of service by the health maintenance organization to
1139 substantiate the claim.

1140 (c) "Electronic medical record" means the digital record
1141 of a patient's information that may be accessed through
1142 electronic means, via portal or other method of electronic
1143 access, which may include information regarding the patient's
1144 medical history, medical condition, medical treatment,
1145 laboratory results, diagnostic reports, and clinical notes.

1146 (d) "Emergency health care service" has the same meaning
1147 as "emergency services and care" as defined in s. 641.19.

1148 (e) "Enrollee ineligibility" means that the enrollee was
1149 no longer enrolled in the health maintenance organization at the
1150 time of receiving the applicable service.

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(f) "Overpayment" means payment made upon a claim that is:
1. Billed in error;
2. A duplicate claim; or
3. Billed for a service rendered to a patient in spite of
enrollee ineligibility.

A request for overpayment is limited to a billing error,
duplicate bill, or enrollee ineligibility.

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

(a) Are considered received on the date the claim is
 received by the health maintenance organization at its
 designated claims-receipt location or the date the overpayment ~~a~~
~~claim for overpayment~~ is received by the provider at its
 designated location.

(b) As to providers' claims for payment, must be mailed or
 electronically transferred to the primary organization within 6
 months after the following have occurred:

1. Discharge for inpatient services or the date of service
 for outpatient services; and

2. The provider has been furnished with the correct name
 and address of the patient's health maintenance organization.

All providers' claims for payment, whether electronic or
 nonelectronic, must be mailed or electronically transferred to

the secondary organization within 45 ~~90~~ days after final determination by the primary organization. A provider's claim is considered submitted on the date it is electronically transferred or mailed.

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

(3) For all electronically submitted claims, a health maintenance organization 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, accompanied by a statement indicating the health maintenance organization's position as to whether the claim is a clean claim or whether the claim is missing any information that is required under the applicable electronic billing instrument described in paragraph (1) (a) or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate ~~to the electronic source submitting the claim,~~ and the health maintenance organization asserts is missing as of the date of service.

(b) Within 15 ~~20~~ days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or

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1201 contested. Notice of the health maintenance organization's
1202 action on the claim and payment of the claim is considered to be
1203 made on the date the notice or payment was received by the
1204 provider ~~mailed~~ or electronically transferred.

1205 (c)1. Notification of the health maintenance
1206 organization's determination of a contested claim must be
1207 accompanied by an itemized list of any ~~additional~~ information
1208 required under the applicable billing instrument described in
1209 paragraph (1)(a) or that was reasonably required by the health
1210 maintenance organization, other than for emergency health care
1211 services, in advance of the provision of service to substantiate
1212 the claim, and the health maintenance organization asserts is
1213 missing as of the date of such service ~~or documents the insurer~~
1214 ~~can reasonably determine are necessary to process the claim.~~

1215 2. A provider must submit the additional information or
1216 documentation, as specified on the itemized list, within 30 ~~35~~
1217 days after receipt of the notification of contestation unless,
1218 within the 30-day period, the provider notifies the health
1219 maintenance organization of the provider's position that a clean
1220 claim has been submitted. Additional information is considered
1221 submitted on the date it is electronically transferred or
1222 mailed. The health maintenance organization is prohibited from
1223 requesting ~~may not request~~ duplicate documents.

1224 (d) For purposes of this subsection, electronic means of
1225 transmission of claims, notices, documents, forms, and payment

shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim that was contested by the health maintenance organization must be paid or denied within 30 ~~90~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~120~~ days after receipt of the claim, regardless of whether contested by the health maintenance organization, creates an uncontestable obligation to pay the claim.

(4) For all nonelectronically submitted claims, a health maintenance organization shall:

(a) Within 15 days following receipt of the claim
~~Effective November 1, 2003, provide to the provider, or~~
designee, who submitted the claim:

1. An acknowledgment of receipt of the claim, accompanied by a statement indicating the health maintenance organization's position as to whether the claim is a clean claim or the claim is missing any information that is required under the applicable paper billing form, as described in paragraph (1)(a), or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health maintenance organization asserts is missing as of the date of service; or

2. within 15 days after receipt of the claim to the

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~~provider or designee or provide a provider or designee within 15~~
~~days after receipt with~~ Electronic access to the status of the a
submitted claim, which status must indicate the health
maintenance organization's position as to whether the claim is a
clean claim or missing any information described in subparagraph
1.

(b) Within 30 ~~40~~ days after receipt of the claim, pay the
claim or notify a provider or designee if a claim is denied or
contested. Notice of the health maintenance organization's
action on the claim and payment of the claim is considered to be
made on the date the notice or payment was received by the
provider ~~mailed~~ or electronically transferred.

(c)1. Notification of the health maintenance
organization's determination of a contested claim must be
accompanied by an itemized list of any ~~additional~~ information
required under the applicable form or billing instrument
described in paragraph (1)(a), or that was reasonably required
by the health maintenance organization, other than for emergency
health care services, in advance of the provision of service to
substantiate the claim, and the health maintenance organization
asserts is missing as of the date of such service ~~or documents~~
~~the organization 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 30 ~~35~~

1276 days after receipt of the notification of contestation unless,
1277 within the 30-day period, the provider notifies the health
1278 maintenance organization of the provider's position that a clean
1279 claim has been submitted. Additional information is considered
1280 submitted on the date it is electronically transferred or
1281 mailed. The health maintenance organization is prohibited from
1282 requesting ~~may not request~~ duplicate documents.

1283 (d) For purposes of this subsection, electronic means of
1284 transmission of claims, notices, documents, forms, and payments
1285 shall be used to the greatest extent possible by the health
1286 maintenance organization and the provider.

1287 (e) A claim that was contested by the health maintenance
1288 organization must be paid or denied within 30 ~~120~~ days after
1289 receipt of the additional information requested ~~claim~~. Failure
1290 to pay or deny a claim within 90 ~~140~~ days after receipt of the
1291 claim, regardless of whether contested by the health maintenance
1292 organization, creates an uncontestable obligation to pay the
1293 claim as submitted by the provider.

1294 (5) Regardless of whether a claim has been submitted
1295 electronically or nonelectronically, and notwithstanding any
1296 other provision of this section to the contrary:

1297 (a) Once a provider grants a health maintenance
1298 organization access to a patient's electronic medical record,
1299 the provider shall be deemed to have supplied all information
1300 necessary to pay the claim, including, without limitation, all

information that is required under the applicable billing instrument and that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim. Additional information or documentation, regardless of whether the health maintenance organization requests any additional information, shall be deemed unnecessary, and deemed not required for payment of the claim, and any request for additional information, and any position of the health maintenance organization or any third party acting on behalf of the health maintenance organization regarding any lack of information from the provider, is prohibited from being used to deny, reduce, offset, withhold, pend, or delay payment of the claim.

(b) For instances in which notice of access to the electronic medical record has been provided to the health maintenance organization, the claim must be paid or denied within 30 days of such notice to the health maintenance organization. Failure to pay or deny a claim, for which the health maintenance organization has been provided notice of access to the electronic medical record within 75 days after receipt of such notice creates an uncontestable obligation to pay the claim as submitted by the provider.

(6)-(5) If a health maintenance organization determines that it has made an overpayment to a provider for services

rendered to an enrollee ~~a subscriber~~, the health maintenance organization must make an overpayment ~~a~~ claim for such overpayment to the provider's designated location. A health maintenance organization that makes an overpayment ~~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 health maintenance organization must also identify the claim or claims, or ~~overpayment claim~~ portion thereof, as to which the health maintenance organization alleges overpayment; and the specific invoice number submitted with or on the claim, as well as the specific line items on the bill that are subject to the overpayment claim for which a claim for overpayment is submitted. Except as provided in subparagraph (a)3., there shall be no denial, reduction, offset, withholding, pending, or delay of payment, or other negative impact, regardless of whether by the health maintenance organization or any third party acting on behalf of such health maintenance organization, on payment of any other claim of the provider on the basis of the overpayment allegation.

(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 maintenance organization shall adhere to the following procedures:

1351 1. All overpayment claims ~~for overpayment~~ must be received
1352 by the ~~submitted to a~~ provider within 18 ~~30~~ months after the
1353 health maintenance organization's payment of the claim. A
1354 provider must pay, deny, or contest the health maintenance
1355 organization's overpayment claim ~~for overpayment~~ within 40 days
1356 after the receipt of the overpayment claim. All contested
1357 overpayment claims ~~for overpayment~~ must be paid or denied within
1358 120 days after receipt of the overpayment claim. Failure to pay
1359 or deny an overpayment ~~and~~ claim within 140 days after receipt
1360 creates an uncontestable obligation to pay the overpayment
1361 claim.

1362 2. A provider that denies or contests a health maintenance
1363 organization's overpayment claim ~~for overpayment~~ or any portion
1364 of an overpayment ~~a~~ claim shall notify the health maintenance
1365 organization, in writing, within 40 ~~35~~ days after the provider
1366 receives the overpayment claim that the overpayment claim ~~for~~
1367 ~~overpayment~~ is contested or denied. The notice that the
1368 overpayment claim ~~for overpayment~~ is denied or contested must
1369 identify the denied or contested portion of the claim and the
1370 specific reason for contesting or denying the overpayment claim
1371 and, if contested, must include a request for additional
1372 information. If the health maintenance organization submits
1373 additional information, the health maintenance organization
1374 must, within 35 days after receipt of the request, mail or
1375 electronically transfer the information to the provider. The

provider shall pay or deny the overpayment claim ~~for overpayment~~ within 45 days after receipt of the information. The notice from the provider regarding denial or contestation of the overpayment claim is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health maintenance organization is prohibited from denying, reducing, offsetting, withholding, pending, or delaying ~~may not reduce~~ payment to the provider for other services unless the provider agrees to the denial, reduction, offset, withholding, pending, or delay of payment 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 an overpayment ~~a claim for an overpayment payment~~ begins to accrue when the overpayment claim should have been paid, ~~denied, or contested~~.

(b) An overpayment ~~A claim is prohibited for overpayment shall not be permitted~~ beyond 18 ~~30~~ months after the health maintenance organization's payment of a claim, except that overpayment ~~claims for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

~~(7)(6)~~ Payment of a claim is considered made on the date

1401 the payment was mailed or electronically transferred to the
1402 provider. An overdue payment of a claim bears simple interest of
1403 15 ~~12~~ percent per year, to be calculated upon the full total
1404 amount that should have been paid on the claim within the
1405 applicable time period specified in this section. If an
1406 applicable court, arbitration tribunal, or other binding legal
1407 process determines that a claim that was paid at a lesser amount
1408 should have been paid at a full total amount, whether under a
1409 breach of contract legal claim, a legal claim under a statutory
1410 private cause of action, or other basis, the 15 percent per year
1411 interest shall be calculated upon the full total amount, rather
1412 than upon the difference between the full total amount and the
1413 amount that was actually paid. If an applicable court,
1414 arbitration tribunal, or other binding legal process determines
1415 that a claim was subject to an inappropriate or impermissible
1416 denial or partial denial, whether in a breach of contract,
1417 statute, common law, or otherwise, interest shall be calculated
1418 upon the full total amount that should have been paid on the
1419 claim within the applicable time period for payment specified in
1420 this section, and the act of denial or partial denial shall be
1421 deemed not to have in any way tolled the time period for such
1422 payment. Interest on the full total amount that should have been
1423 paid on the claim within the applicable time period specified in
1424 this section ~~an overdue payment for a claim or for any portion~~
1425 ~~of a claim~~ begins to accrue when the claim should have been

1426 paid, ~~denied, or contested~~. The interest must be paid along
1427 with, and in addition to, the payment for the satisfaction of
1428 the full total amount of the claim, as determined by an
1429 applicable court, arbitration tribunal, or other binding legal
1430 process ~~is payable with the payment of the claim.~~

1431 (8)(7) For all contracts entered into or renewed on or
1432 after October 1, 2002, a health maintenance organization's
1433 internal dispute resolution process related to a denied claim
1434 not under active review by a mediator, arbitrator, or third-
1435 party dispute entity must be finalized within 60 days after the
1436 receipt of the provider's request for review or appeal.

1437 Notwithstanding any provision of this section to the contrary,
1438 if the provider and health maintenance organization disagree as
1439 to the interpretation of contractual or statutory language, the
1440 provider is not required to participate in the health
1441 maintenance organization's internal dispute resolution process.

1442 (9)(8) A provider or any representative of a provider,
1443 regardless of whether the provider is under contract with the
1444 health maintenance organization, is prohibited from collecting
1445 or attempting ~~may not collect or attempt~~ to collect money from,
1446 maintaining ~~maintain~~ any action at law against, or reporting
1447 ~~report~~ to a credit agency an enrollee ~~a subscriber~~ for payment
1448 of covered services for which the health maintenance
1449 organization contested or denied the provider's claim. This
1450 prohibition applies during the pendency of any claim for payment

made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

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

(10) A health maintenance organization is prohibited from retrospectively denying ~~may not retroactively deny~~ a claim because of enrollee ~~subscriber~~ ineligibility more than 90 days ± ~~year~~ after the date of payment of the claim.

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

(12) A permissible error ratio of 5 percent is established

1476 for health maintenance organizations' claims payment violations
1477 of paragraphs (3)(a), (b), (c), and (e) and (4)(a), (b), (c),
1478 and (e). If the error ratio of a particular health maintenance
1479 organization ~~insurer~~ does not exceed the permissible error ratio
1480 of 5 percent for an audit period, no fine shall be assessed for
1481 the noted claims violations for the audit period. The error
1482 ratio shall be determined by dividing the number of claims with
1483 violations found on a statistically valid sample of claims for
1484 the audit period by the total number of claims in the sample. If
1485 the error ratio exceeds the permissible error ratio of 5
1486 percent, a fine may be assessed according to s. 624.4211 for
1487 those claims payment violations which exceed the error ratio.
1488 Notwithstanding the provisions of this section, the office may
1489 fine a health maintenance organization for claims payment
1490 violations of paragraphs (3)(e) and (4)(e) which create an
1491 uncontestable obligation to pay the claim as submitted by the
1492 provider. The office shall refrain from imposing a ~~not~~ fine upon
1493 a health maintenance organization ~~organizations~~ for violations
1494 which the office determines were due to circumstances beyond the
1495 organization's control.

1496 (13) This section shall apply to all claims or any portion
1497 of a claim submitted for payment for services provided to an
1498 enrollee ~~by a health maintenance organization subscriber~~ under a
1499 health maintenance organization plan, or submitted for payment
1500 for services provided to an enrollee under a self-insured plan

1501 or fund, or fully-insured plan or fund, offered by a person or
1502 entity, when a health maintenance organization is involved in
1503 the administration, or claims-processing activities, relating to
1504 such plan or fund ~~subscriber contract to the organization for~~
1505 ~~payment.~~

1506 (14) Notwithstanding paragraph (3)(b), where an electronic
1507 pharmacy claim is submitted to a pharmacy benefits manager
1508 acting on behalf of a health maintenance organization, the
1509 pharmacy benefits manager shall, within 30 days after ~~of~~ receipt
1510 of the claim, pay the claim or notify a provider or designee if
1511 a claim is denied or contested. Notice of the health maintenance
1512 organization's action on the claim and payment of the claim is
1513 considered to be made on the date the notice or payment was
1514 received by the provider ~~mailed~~ or electronically transferred.

1515 (15) Notwithstanding paragraph (4)(a), effective November
1516 1, 2003, where a nonelectronic pharmacy claim is submitted to a
1517 pharmacy benefits manager acting on behalf of a health
1518 maintenance organization, the pharmacy benefits manager shall
1519 provide acknowledgment of receipt of the claim within 30 days
1520 after receipt of the claim to the provider or provide a provider
1521 within 30 days after receipt with electronic access to the
1522 status of a submitted claim.

1523 (16) Notwithstanding the 18-month ~~30-month~~ period provided
1524 in subsection (6) ~~(5)~~, all claims for overpayment submitted to a
1525 provider licensed under chapter 395, chapter 458, chapter 459,

chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. An overpayment ~~A claim to a provider licensed under chapter 395, 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 is prohibited~~ ~~for overpayment may not be permitted~~ beyond 12 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.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health maintenance organization within 12 months after the health maintenance organization's payment of the claim. A claim for underpayment by a provider licensed under chapter 395, 458, chapter 459, chapter 460, chapter 461, or chapter 466 is prohibited ~~may not be permitted~~ beyond 12 months after the health maintenance organization's payment of a claim.

(18) Nothing in this section shall be interpreted to limit, restrict, or negatively impact any legal claim by a provider or health maintenance organization for breach of contract, statutory or regulatory violation, or a common-law cause of action, nor to shorten or otherwise negatively impact

1551 the statute of limitations timeframe for bringing any such legal
1552 claim.

1553 (19) A health insurer is prohibited from requesting
1554 information from a contracted or noncontracted provider which
1555 does not apply to the medical condition at issue for the
1556 purposes of adjudicating a clean claim.

1557 (20) A health maintenance organization is prohibited from
1558 requesting a contracted or noncontracted provider to resubmit
1559 claim information that the contracted or noncontracted provider
1560 can document it has already provided to the health maintenance
1561 organization or that is contained inside the electronic medical
1562 record to which the health maintenance organization has been
1563 provided access.

1564 (21) Notwithstanding any other provision of this section
1565 to the contrary, a health maintenance organization is prohibited
1566 from requiring any information from a provider before the
1567 provision of emergency health care services as a condition of
1568 payment of a claim, as a basis for denying, delaying,
1569 offsetting, withholding, or reducing payment of a claim, or in
1570 contesting whether the claim is a clean claim.

1571 (22) In an instance of a violation of this section, a
1572 provider shall have a private cause of action to proceed against
1573 the health maintenance organization in the applicable tribunal
1574 for the violation.

1575 **Section 5. Paragraph (c) of subsection (2) of section**

395.1065, Florida Statutes, is amended to read:

395.1065 Criminal and administrative penalties;
moratorium.—

(2)

(c) The agency may impose an administrative fine for the violation of s. 641.3154 or, if sufficient claims due to a provider from a health maintenance organization do not exist to enable the take-back of an overpayment, as provided under s. 641.3155(6) ~~s. 641.3155(5)~~, for the violation of s. 641.3155(5) ~~s. 641.3155(5)~~. The administrative fine for a violation cited in this paragraph shall be in the amounts specified in s. 641.52(5), and the provisions of paragraph (a) do not apply.

Section 6. This act shall take effect July 1, 2026.