By the Committees on Health, Aging and Long-Term Care; Banking and Insurance; and Senator Brown-Waite

317-2038-00

A bill to be entitled

An act relating to managed care organizations; amending s. 641.315, F.S.; deleting provisions relating to provider billings; revising provisions relating to provider contracts; providing for certain disclosures and requiring notice; requiring procedures for requesting and granting authorization for utilization of services; creating s. 641.3154, F.S.; providing for health maintenance organization liability for payment for services rendered to subscribers; prohibiting provider billing of subscribers under specified circumstances; amending s. 641.3155, F.S.; defining the term "clean claim"; specifying the basis for determining when a claim is to be considered clean or not clean; requiring the Department of Insurance to adopt rules to establish a claim form; providing requirements; providing the Department of Insurance with discretionary rulemaking authority for coding standards; providing requirements; providing for payment of clean claims; providing requirements for denying or contesting a portion of a claim; providing for interest accrual and payment of interest; providing an uncontestable obligation to pay a claim; requiring a health maintenance organization to make a claim for overpayment; prohibiting an organization from reducing payment for other services; providing exceptions; requiring a provider to pay a claim

for overpayment within a specified timeframe; providing a procedure and timeframes for a provider to notify a health maintenance organization that it is denying or contesting a claim for overpayment; specifying when a provider payment of a claim for overpayment is to be considered made; providing for assessment of simple interest against overdue payment of a claim; specifying when interest on overdue payments of claims for overpayment begins to accrue; specifying a timeframe for a provider to deny or contest a claim for overpayment; providing an uncontestable obligation to pay a claim; specifying when a provider claim that is electronically transmitted or mailed is considered received; specifying when a health maintenance organization claim for overpayment is considered received; mandating acknowledgment of receipts for electronically submitted provider claims; prescribing a timeframe for a health maintenance organization to retroactively deny a claim for services provided to an ineligible subscriber; creating s. 641.3156, F.S.; providing for treatment authorization and payment of claims by a health maintenance organization; clarifying that treatment authorization and payment of a claim for emergency services is subject to another provision of law; providing a cross-reference; amending s. 641.495, F.S.; revising provisions relating to treatment-authorization

capabilities; requiring agreement to pending authorizations and tracking numbers as a precondition to such an authorization; creating s. 408.7057, F.S.; providing for the establishment of a statewide provider and managed-care-organization claim-dispute resolution program; providing rulemaking authority to the Agency for Health Care Administration; amending s. 395.1065, F.S., relating to criminal and administrative penalties for health care providers; authorizing administrative sanctions against a hospital's license for improper subscriber billing and violations of requirements relating to claims payment; amending s. 817.50, F.S., relating to fraud against hospitals; expanding applicability to health care providers; providing a cross-reference; providing applicability; providing an effective date.

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

Section 1. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

~~(1) Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.~~

~~(2) No subscriber of an HMO shall be liable to any provider of health care services for any services covered by the HMO.~~

~~(3) No provider of services or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.~~

(1)~~(4)~~ Each ~~Every~~ contract between a health maintenance organization ~~an HMO~~ and a provider of health care services must ~~shall~~ be in writing and ~~shall~~ contain a provision that the subscriber is ~~shall~~ not ~~be~~ liable to the provider for any services for which the health maintenance organization is liable, as specified in s. 641.3154 ~~covered by the subscriber's contract with the HMO~~.

~~(5) The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.~~

(2)~~(6)~~(a) For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:

1. The contracts must require ~~provide that~~ the provider to give ~~shall provide~~ 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason; and

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

(b) For all provider contracts executed after October 1, 1996, and within 180 days after October 1, 1996, for contracts in existence as of October 1, 1996, the contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(3)~~(7)~~ Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.

(4) Whenever a contract exists between a health maintenance organization and a provider, the health maintenance organization shall disclose to the provider:

(a) The mailing address or electronic address where claims should be sent for processing;

(b) The telephone number that a provider may call to have questions and concerns regarding claims addressed; and

(c) The address of any separate claims-processing centers for specific types of services.

A health maintenance organization shall provide to its contracted providers in no less than 30 calendar days, prior written notice of any changes in the information required in this subsection.

(5)~~(8)~~ A contract between a health maintenance organization and a provider of health care services may ~~shall~~ not restrict ~~contain any provision restricting~~ the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(6)~~(9)~~ A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(7)~~(10)~~ A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required by ~~in~~ this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466.

(8) A contract between a health maintenance organization and a provider must establish procedures for a provider to request and the health maintenance organization to grant authorization for utilization of health care services. The health maintenance organization must give written notice to the provider prior to any changes in these procedures.

Section 2. Section 641.3154, Florida Statutes, is created to read:

641.3154 Organization liability; provider billing prohibited.--

(1) If a health maintenance organization is liable for services rendered to a subscriber by a provider, whether a contract exists between the organization and the provider or not, the organization is liable for payment of fees to the provider, and the subscriber is not liable for payment of fees to the provider.

(2) For purposes of this section, a health maintenance organization is liable for services rendered to a subscriber by a provider if the subscriber contract or applicable law establishes such liability.

(3) The liability of an organization for payment of fees for services is not affected by any contract the organization has with a third party for the functions of authorizing, processing, or paying claims.

(4) A provider, whether under contract with the health maintenance organization or not, or any representative of such provider, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable.

This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute-resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It shall be conclusively presumed that a physician does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; or

(c) The department or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056.

(5) An organization and the department shall report any suspected violation of this section by a health care practitioner to the Department of Health and by a facility to the agency which shall take such actions as authorized by law.

Section 3. Section 641.3155, Florida Statutes, is amended to read:

641.3155 ~~Provider contracts;~~Payment of claims.--

(1)(a) As used in this section, the term "clean claim" means a claim that has no defect or impropriety, including lack of required substantiating documentation for noncontracting providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because a health maintenance

organization refers the claim to a medical specialist within the health maintenance organization for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from a source outside the health maintenance organization, the claim is considered not clean.

(b) The department shall adopt rules to establish claim forms consistent with federal claim-filing standards for health maintenance organizations required by the federal Health Care Financing Administration. The department may adopt rules relating to coding standards consistent with Medicare coding standards adopted by the federal Health Care Financing Administration.

(2)~~(1)~~(a) A health maintenance organization shall pay any clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with the health maintenance organization or a clean claim made by a noncontract provider which the organization does not contest or deny within 35 days after receipt of the claim by the health maintenance organization which is mailed or electronically transferred by the provider.

(b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall notify the ~~contract~~ provider, in writing, within 35 days after ~~receipt of the claim by~~ the health maintenance organization receives the claim that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must ~~may~~ include a request for additional information. If the provider submits ~~health maintenance organization requests~~ additional

information, the provider must ~~shall~~, within 35 days after receipt of the ~~such~~ request, mail or electronically transfer the information to the health maintenance organization. The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(3)~~(2)~~ Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year. Interest on an overdue payment for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received. The interest is payable with the payment of the claim.

(4)~~(3)~~ A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the health maintenance organization to pay the claim.

(5)(a) If, as a result of retroactive review of coverage decisions or payment levels, a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the organization must make a claim for such overpayment. The organization may not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to the organization's claim as required in this subsection.

(b) A provider shall pay a claim for an overpayment made by a health maintenance organization which the provider does not contest or deny within 35 days after receipt of the

claim that is mailed or electronically transferred to the provider.

(c) A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information.

(d) Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of 10 percent a year. Interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

(e) A provider shall pay or deny any claim for overpayment no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the provider to pay the claim.

(6)~~(4)~~ Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

(7)(a) A provider claim for payment shall be considered received by the health maintenance organization, if the claim has been electronically transmitted to the health maintenance organization, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization, on the date indicated on the return receipt. A provider must wait 45 days from receipt of a claim before submitting a duplicate claim.

(b) A health maintenance organization claim for overpayment shall be considered received by a provider, if the claim has been electronically transmitted to the provider, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the provider, on the date indicated on the return receipt. An organization must wait 45 days from the provider's receipt of a claim for overpayment before submitting a duplicate claim.

(8) A provider who bills electronically is entitled to electronic acknowledgement of the receipt of a claim within 72 hours.

(9) A health maintenance organization may not retroactively deny a claim more than 1 year after the date of service because of subscriber ineligibility.

Section 4. Section 641.3156, Florida Statutes, is created to read:

641.3156 Treatment authorization; payment of claims.--

(1) A health maintenance organization must pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a physician empowered by contract with the health maintenance organization to authorize or direct the patient's utilization of health care services and which was also authorized in accordance with the health maintenance organization's current and communicated procedures, unless the physician provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

(2) A claim for treatment may not be denied if a provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the physician provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

(3) Emergency services are subject to the provisions of s. 641.513 and are not subject to the provisions of this section.

Section 5. Subsection (4) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(4) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(13)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs. The health maintenance organization must have the capability of providing treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.

Section 6. Effective January 1, 2001, section 408.7057, Florida Statutes, is created to read:

408.7057 Statewide provider and managed care organization claim dispute resolution program.--

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

(a) "Managed care organization" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(b) "Resolution organization" means a qualified independent third-party claims dispute resolution entity selected by and contracted with the Agency for Health Care Administration.

(2)(a) The Agency for Health Care Administration shall establish a program to provide assistance to contracting and noncontracting providers and managed care organizations for claim disputes that are not resolved by the provider and the

managed care organization. The program must include the agency contracting with a resolution organization to timely review and consider claims disputes submitted by providers and managed care organizations and to recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claims disputes that may be considered by the resolution organization.

(b) The resolution organization shall review claim disputes filed by contracting and noncontracting providers and managed care organizations unless the disputed claim:

1. Is related to interest payment;

2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided in paragraph (a);

3. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;

4. Is related to a health plan that is not regulated by the state, such as an administrative services organization, a third-party administrator, or a federal employee health benefit program;

5. Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

6. Is the basis for an action pending in state or federal court;

7. Is subject to a binding claims dispute resolution process provided by contract entered into prior to July 1, 2000, between the provider and the managed care organization; or

8. Is subject to a binding claims dispute resolution process provided by a contract entered into or renewed on or after July 1, 2000, in which the provider has elected to arbitrate the claim. All contracts entered into after the effective date of this act which provide for a binding claims dispute resolution process shall allow providers the option of pursuing either the contracted dispute resolution process or bringing the claim before the resolution organization created by this section.

(3) The agency shall adopt rules to establish a process for the consideration by the resolution organization of claims disputes submitted by either a provider or managed care organization which shall include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after receipt of the claims dispute submission.

(4) Within 30 days after receipt of the recommendation of the resolution organization the agency shall issue a final order subject to the provisions of chapter 120.

(5) The entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule, which shall include an apportionment of the review fee in those cases where both parties may prevail in part. The failure of the nonprevailing party to pay the ordered review cost within 35 days after the agency's order will subject the nonpaying party to a penalty of no more than $500 per day until the penalty is paid.

(6) The Agency for Health Care Administration may adopt rules necessary to administer this section.

Section 7. Paragraph (a) of subsection (2) of section 395.1065, Florida Statutes, is amended to read:

395.1065 Criminal and administrative penalties; injunctions; emergency orders; moratorium.--

(2)(a) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $1,000 per violation, per day, for the violation of any provision of this part or rules adopted under this part or s. 641.3154 ~~promulgated hereunder~~. Each day of violation constitutes a separate violation and is subject to a separate fine. The agency may impose an administrative fine for the violation of s. 641.3155 in amounts specified in s. 641.52.

Section 8. Section 817.50, Florida Statutes, is amended to read:

817.50 Fraudulently obtaining goods, services, etc., from a health care provider ~~hospital~~.--

(1) Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any health care provider, as "provider" is defined in s. 641.19(15), ~~hospital~~ in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) If any person gives to any provider ~~hospital~~ in this state a false or fictitious name or a false or fictitious address or assigns to any provider ~~hospital~~ the proceeds of any health maintenance contract or insurance contract, then knowing that such contract is no longer in force, is invalid, or is void for any reason, such action shall be prima facie evidence of the intent of such person to defraud the provider ~~such hospital~~.

Section 9. Except as otherwise provided, this act shall take effect October 1, 2000, and shall apply to claims for services rendered after such date and to all requests for

claim-dispute resolution which are submitted by a provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS for Senate Bill 1508

Amends and moves current law relating to provider balance billing of subscribers, revises current law relating to provider contracts, requires certain contractual disclosures of addresses and a telephone number, and requires procedures for requesting and granting authorization for utilizing health care services.

Prohibits balance billing during the pendency of a claim submitted by a provider for payment to an HMO. As relates to balance billing, creates a conclusive presumption, based on the absence of three specified circumstances, that a physician does not know and should not know that an organization is liable for payment for services rendered to a subscriber.

Defines the term "clean claim." Prescribes when a claim may be considered clean or not clean. Requires the Department of Insurance to adopt rules to establish a claim form and provides the department with discretionary rulemaking authority for establishing coding standards both of which must be consistent with certain federal standards. Provides requirements and timeframes for payment of a portion of a clean claim. Specifies timeframes for: denying and contesting a claim and provides for an uncontestable obligation to pay a claim, submitting requested information, and submitting duplicate claims. Provides a timeframe for accruing of interest and payment of an overdue payment of a clean claim or an uncontested portion of a claim.

Requires a health maintenance organization to make a claim for overpayment to a provider based on retroactive review. Prohibits a health maintenance organization from retroactively reducing payment for other services as adjustment for overpayment, unless the provider agrees or does not respond to the claim for overpayment. Requires a provider to pay an uncontested claim for overpayment by a health maintenance organization within a specified timeframe. Provides a procedure and timeframes for a provider to notify a health maintenance organization that it is denying or contesting a claim for overpayment. Specifies when a provider payment of a claim for overpayment is to be considered made to a health maintenance organization. Provides for assessment of simple interest against overdue payment of a claim. Specifies when interest on overdue payments of claims for overpayment begins to accrue. Specifies a timeframe for a provider to deny or contest a claim for overpayment. Provides a timeframe for a provider to pay or deny a claim for overpayment and provides an uncontestable obligation for payment of such a claim.

Specifies when a provider claim that is electronically transmitted or mailed is considered received. Specifies when a health maintenance organization claim for overpayment that is electronically transmitted or mailed is considered received. Requires a provider or health maintenance organization to wait a specified amount of time before submitting a duplicate claim. Mandates acknowledgment of receipts for electronically submitted provider claims. Prescribes a timeframe after which

a health maintenance organization is prohibited from denying a claim for services provided to an ineligible subscriber. Provides for treatment authorization and payment of claims. Provides for payment of claims for emergency services treatment. Revises provisions of current law relating to treatment authorization capabilities.

Applies current law relating to criminal and administrative penalties that may be assessed against a hospital or ambulatory surgical center for regulatory violations of licensure regulations to certain prohibited subscriber billing practices. Subjects a hospital or ambulatory surgical center to administrative fines that the Agency for Health Care Administration may assess against health maintenance organizations when a hospital violates certain requirements relating to payment of claims. Expands the applicability of a current provision of law relating to fraud against hospitals to health care providers, including hospitals.

Excludes from consideration by the claim dispute resolution organization, authorized by the bill to hear claim disputes between HMOs and providers, those disputes that are subject to a contractually binding claims dispute resolution process that is provided for in a contract entered into prior to July 1, 2000, and excludes those claim disputes that the provider has elected to arbitrate in accordance with a contract entered into or renewed on or after July 1, 2000. Requires that all contracts between providers and HMOs entered into after the bill's effective date allow providers the option of either a contracted dispute resolution process or bringing claims before the resolution organization.