

By the Council for Healthy Communities and Representatives  
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1                                   A bill to be entitled  
2           An act relating to health care coverage  
3           procedures; amending s. 408.7057, F.S.;  
4           redesignating a program title; revising  
5           definitions; including preferred provider  
6           organizations and health insurers in the claim  
7           dispute resolution program; specifying  
8           timeframes for submission of supporting  
9           documentation necessary for dispute resolution;  
10          providing consequences for failure to comply;  
11          providing an additional responsibility for the  
12          claim dispute resolution organization relating  
13          to patterns of claim disputes; providing  
14          timeframes for review by the resolution  
15          organization; directing the agency to notify  
16          appropriate licensure and certification  
17          entities as part of violation of final orders;  
18          amending s. 626.88, F.S.; revising a  
19          definition; creating s. 627.6131, F.S.;  
20          specifying payment of claims provisions  
21          applicable to certain health insurers;  
22          providing a definition; providing requirements  
23          and procedures for paying, denying, or  
24          contesting claims; providing criteria and  
25          limitations; requiring payment within specified  
26          periods; specifying rate of interest charged on  
27          overdue payments; providing for electronic and  
28          nonelectronic transmission of claims; providing  
29          procedures for overpayment recovery; specifying  
30          timeframes for adjudication of claims,  
31          internally and externally; prohibiting action

1 to collect payment from an insured under  
2 certain circumstances; providing applicability;  
3 prohibiting contractual modification of  
4 provisions of law; specifying circumstances for  
5 retroactive claim denial; specifying claim  
6 payment requirements; providing for billing  
7 review procedures; specifying claim content  
8 requirements; establishing a permissible error  
9 ratio, specifying its applicability, and  
10 providing for fines; creating s. 627.6135,  
11 F.S., relating to treatment authorization;  
12 providing a definition; specifying  
13 circumstances for authorization timeframes;  
14 specifying content for response to  
15 authorization requests; providing for an  
16 obligation for payment, with exception;  
17 providing authorization procedure notice  
18 requirements; amending s. 627.651, F.S.;  
19 correcting a cross reference, to conform;  
20 amending s. 627.662, F.S.; specifying  
21 application of certain additional provisions to  
22 group, blanket, and franchise health insurance;  
23 amending s. 627.638, F.S.; revising  
24 requirements relating to direct payment of  
25 benefits to specified providers under certain  
26 circumstances; amending s. 641.30, F.S.;  
27 conforming a cross reference; amending s.  
28 641.3154, F.S.; modifying the circumstances  
29 under which a provider knows that an  
30 organization is liable for service  
31 reimbursement; amending s. 641.3155, F.S.;

1 revising payment of claims provisions  
2 applicable to certain health maintenance  
3 organizations; providing a definition;  
4 providing requirements and procedures for  
5 paying, denying, or contesting claims;  
6 providing criteria and limitations; requiring  
7 payment within specified periods; revising rate  
8 of interest charged on overdue payments;  
9 providing for electronic and nonelectronic  
10 transmission of claims; providing procedures  
11 for overpayment recovery; specifying timeframes  
12 for adjudication of claims, internally and  
13 externally; prohibiting action to collect  
14 payment from a subscriber under certain  
15 circumstances; prohibiting contractual  
16 modification of provisions of law; specifying  
17 circumstances for retroactive claim denial;  
18 specifying claim payment requirements;  
19 providing for billing review procedures;  
20 specifying claim content requirements;  
21 establishing a permissible error ratio,  
22 specifying its applicability, and providing for  
23 fines; amending s. 641.3156, F.S., relating to  
24 treatment authorization; providing a  
25 definition; specifying circumstances for  
26 authorization timeframes; specifying content  
27 for response to authorization requests;  
28 providing for an obligation for payment, with  
29 exception; providing authorization procedure  
30 notice requirements; providing application;  
31 providing effective dates.

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

2

3 Section 1. Section 408.7057, Florida Statutes, is  
4 amended to read:

5 408.7057 Statewide provider and health plan ~~managed~~  
6 ~~care organization~~ claim dispute resolution program.--

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

8 (a) "Agency" means the Agency for Health Care  
9 Administration.

10 (b)(a) "Health plan Managed care organization" means a  
11 health maintenance organization or a prepaid health clinic  
12 certified under chapter 641, a prepaid health plan authorized  
13 under s. 409.912, or an exclusive provider organization  
14 certified under s. 627.6472, or a major medical expense health  
15 insurance policy, as defined in s. 627.643(2)(e), offered by a  
16 group or an individual health insurer licensed pursuant to  
17 chapter 624, including a preferred provider organization under  
18 s. 627.6471.

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

23 (2)(a) The agency ~~for Health Care Administration~~ shall  
24 establish a program by January 1, 2001, to provide assistance  
25 to contracted and noncontracted providers and health plans  
26 ~~managed care organizations~~ for resolution of claim disputes  
27 that are not resolved by the provider and the health plan  
28 ~~managed care organization~~. The agency shall contract with a  
29 resolution organization to timely review and consider claim  
30 disputes submitted by providers and health plans ~~managed care~~  
31 ~~organizations~~ and recommend to the agency an appropriate

1 resolution of those disputes. The agency shall establish by  
2 rule jurisdictional amounts and methods of aggregation for  
3 claim disputes that may be considered by the resolution  
4 organization.

5 (b) The resolution organization shall review claim  
6 disputes filed by contracted and noncontracted providers and  
7 health plans ~~managed care organizations~~ unless the disputed  
8 claim:

9 1. Is related to interest payment;

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

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

16 4. Is related to a health plan that is not regulated  
17 by the state;

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

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

22 7. Is subject to a binding claim-dispute-resolution  
23 process provided by contract entered into prior to October 1,  
24 2000, between the provider and the managed care organization.

25 (c) Contracts entered into or renewed on or after  
26 October 1, 2000, may require exhaustion of an internal  
27 dispute-resolution process as a prerequisite to the submission  
28 of a claim by a provider or a health plan maintenance  
29 ~~organization~~ to the resolution organization ~~when the~~  
30 ~~dispute-resolution program becomes effective.~~

31

1           (d) A contracted or noncontracted provider or health  
2 plan maintenance organization may not file a claim dispute  
3 with the resolution organization more than 12 months after a  
4 final determination has been made on a claim by a health plan  
5 or provider maintenance organization.

6           (e) The resolution organization shall require the  
7 health plan or provider submitting the claim dispute to submit  
8 any supporting documentation to the resolution organization  
9 within 15 days after receipt by the health plan or provider of  
10 a request from the resolution organization for documentation  
11 in support of the claim dispute. The resolution organization  
12 may extend the time if appropriate. Failure to submit the  
13 supporting documentation within such time period shall result  
14 in the dismissal of the submitted claim dispute.

15           (f) The resolution organization shall require the  
16 respondent in the claim dispute to submit all documentation in  
17 support of its position within 15 days after receiving a  
18 request from the resolution organization for supporting  
19 documentation. The resolution organization may extend the time  
20 if appropriate. Failure to submit the supporting documentation  
21 within such time period shall result in a default against the  
22 health plan or provider. In the event of such a default, the  
23 resolution organization shall issue its written recommendation  
24 to the agency that a default be entered against the defaulting  
25 entity. The written recommendation shall include a  
26 recommendation to the agency that the defaulting entity shall  
27 pay the entity submitting the claim dispute the full amount of  
28 the claim dispute, plus all accrued interest, and shall be  
29 considered a nonprevailing party for the purposes of this  
30 section.

31

1       (g) If, on an ongoing basis, during the preceding  
2 12-month period, the resolution organization has reason to  
3 believe that a pattern exists on the part of a particular  
4 health plan or provider, the resolution organization shall  
5 evaluate the information contained in these cases to determine  
6 whether the information as to the timely processing of claims  
7 evidences a pattern of violation of s. 627.6131 or s. 641.3155  
8 and report its findings, together with substantiating  
9 evidence, to the appropriate licensure or certification entity  
10 for the health plan or provider.

11       (3) The agency shall adopt rules to establish a  
12 process to be used by the resolution organization in  
13 considering claim disputes submitted by a provider or health  
14 plan ~~managed care organization~~ which must include the issuance  
15 by the resolution organization of a written recommendation,  
16 supported by findings of fact, to the agency within 60 days  
17 after the requested information is received by the resolution  
18 organization within the timeframes specified by the resolution  
19 organization. In no event shall the review time exceed 90 days  
20 following receipt of the initial claim dispute submission by  
21 the resolution organization ~~receipt of the claim dispute~~  
22 submission.

23       (4) Within 30 days after receipt of the recommendation  
24 of the resolution organization, the agency shall adopt the  
25 recommendation as a final order.

26       (5) The agency shall notify within 7 days the  
27 appropriate licensure or certification entity whenever there  
28 is a violation of a final order issued by the agency pursuant  
29 to this section.

30       (6)~~(5)~~ The entity that does not prevail in the  
31 agency's order must pay a review cost to the review

1 organization, as determined by agency rule. Such rule must  
2 provide for an apportionment of the review fee in any case in  
3 which both parties prevail in part. If the nonprevailing party  
4 fails to pay the ordered review cost within 35 days after the  
5 agency's order, the nonpaying party is subject to a penalty of  
6 not more than \$500 per day until the penalty is paid.

7 ~~(7)(6)~~ The agency for ~~Health Care Administration~~ may  
8 adopt rules to administer this section.

9 Section 2. Subsection (1) of section 626.88, Florida  
10 Statutes, is amended to read:

11 626.88 Definitions of "administrator" and "insurer".--

12 (1) For the purposes of this part, an "administrator"  
13 is any person who directly or indirectly solicits or effects  
14 coverage of, collects charges or premiums from, or adjusts or  
15 settles claims on residents of this state in connection with  
16 authorized commercial self-insurance funds or with insured or  
17 self-insured programs which provide life or health insurance  
18 coverage or coverage of any other expenses described in s.  
19 624.33(1), or any entity which provides provider billing and  
20 collection services to health insurers and health maintenance  
21 organizations on behalf of health care providers and, for  
22 purposes of this section, such entities shall comply with the  
23 provisions of ss. 627.6131, 641.3155, and 641.51(4), other  
24 than any of the following persons:

25 (a) An employer on behalf of such employer's employees  
26 or the employees of one or more subsidiary or affiliated  
27 corporations of such employer.

28 (b) A union on behalf of its members.

29 (c) An insurance company which is either authorized to  
30 transact insurance in this state or is acting as an insurer  
31 with respect to a policy lawfully issued and delivered by such

1 company in and pursuant to the laws of a state in which the  
2 insurer was authorized to transact an insurance business.

3 (d) A health care services plan, health maintenance  
4 organization, professional service plan corporation, or person  
5 in the business of providing continuing care, possessing a  
6 valid certificate of authority issued by the department, and  
7 the sales representatives thereof, if the activities of such  
8 entity are limited to the activities permitted under the  
9 certificate of authority.

10 (e) An insurance agent licensed in this state whose  
11 activities are limited exclusively to the sale of insurance.

12 (f) An adjuster licensed in this state whose  
13 activities are limited to the adjustment of claims.

14 (g) A creditor on behalf of such creditor's debtors  
15 with respect to insurance covering a debt between the creditor  
16 and its debtors.

17 (h) A trust and its trustees, agents, and employees  
18 acting pursuant to such trust established in conformity with  
19 29 U.S.C. s. 186.

20 (i) A trust exempt from taxation under s. 501(a) of  
21 the Internal Revenue Code, a trust satisfying the requirements  
22 of ss. 624.438 and 624.439, or any governmental trust as  
23 defined in s. 624.33(3), and the trustees and employees acting  
24 pursuant to such trust, or a custodian and its agents and  
25 employees, including individuals representing the trustees in  
26 overseeing the activities of a service company or  
27 administrator, acting pursuant to a custodial account which  
28 meets the requirements of s. 401(f) of the Internal Revenue  
29 Code.

30 (j) A financial institution which is subject to  
31 supervision or examination by federal or state authorities or

1 a mortgage lender licensed under chapter 494 who collects and  
2 remits premiums to licensed insurance agents or authorized  
3 insurers concurrently or in connection with mortgage loan  
4 payments.

5 (k) A credit card issuing company which advances for  
6 and collects premiums or charges from its credit card holders  
7 who have authorized such collection if such company does not  
8 adjust or settle claims.

9 (l) A person who adjusts or settles claims in the  
10 normal course of such person's practice or employment as an  
11 attorney at law and who does not collect charges or premiums  
12 in connection with life or health insurance coverage.

13 (m) A person approved by the Division of Workers'  
14 Compensation of the Department of Labor and Employment  
15 Security who administers only self-insured workers'  
16 compensation plans.

17 (n) A service company or service agent and its  
18 employees, authorized in accordance with ss. 626.895-626.899,  
19 serving only a single employer plan, multiple-employer welfare  
20 arrangements, or a combination thereof.

21 (2) For the purposes of this part, an "insurer"  
22 includes an authorized commercial self-insurance fund and  
23 includes any person undertaking to provide life or health  
24 insurance coverage or coverage of any of the other expenses  
25 described in s. 624.33(1).

26 Section 3. Section 627.6131, Florida Statutes, is  
27 created to read:

28 627.6131 Payment of claims.--

29 (1) The contract shall include the following  
30 provision:

31

1       "Time of Payment of Claims: After receiving  
2       written proof of loss, the insurer will pay  
3       monthly all benefits then due for ... (type of  
4       benefit).... Benefits for any other loss  
5       covered by this policy will be paid as soon as  
6       the insurer receives proper written proof."

7  
8       (2) As used in this section, the term "claim" for a  
9       noninstitutional provider means a paper or electronic billing  
10      instrument submitted to the insurer's designated location that  
11      consists of the HCFA 1500 data set, or its successor, that has  
12      all mandatory entries for a physician licensed under chapter  
13      458, chapter 459, chapter 460, or chapter 461 or other  
14      appropriate billing instrument that has all mandatory entries  
15      for any other noninstitutional provider. For institutional  
16      providers, "claim" means a paper or electronic billing  
17      instrument submitted to the insurer's designated location that  
18      consists of the UB-92 data set or its successor that has all  
19      mandatory entries.

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

22      (a) Are considered received on the date the claim is  
23      received by the insurer at its designated claims receipt  
24      location.

25      (b) Must be mailed or electronically transferred to an  
26      insurer within 9 months after completion of the service and  
27      the provider is furnished with the correct name and address of  
28      the patient's health insurer.

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

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

3           (a) Within 24 hours after the beginning of the next  
4 business day after receipt of the claim, provide electronic  
5 acknowledgment of the receipt of the claim to the electronic  
6 source submitting the claim.

7           (b) Within 20 days after receipt of the claim, pay the  
8 claim or notify a provider or designee if a claim is denied or  
9 contested. Notice of the insurer's action on the claim and  
10 payment of the claim is considered to be made on the date the  
11 notice or payment was mailed or electronically transferred.

12           (c)1. Notification of the health insurer's  
13 determination of a contested claim must be accompanied by an  
14 itemized list of additional information or documents the  
15 insurer can reasonably determine are necessary to process the  
16 claim.

17           2. A provider must submit the additional information  
18 or documentation, as specified on the itemized list, within 35  
19 days after receipt of the notification. Failure of a provider  
20 to submit by mail or electronically the additional information  
21 or documentation requested within 35 days after receipt of the  
22 notification may result in denial of the claim.

23           3. A health insurer may not make more than one request  
24 for documents under this paragraph in connection with a claim,  
25 unless the provider fails to submit all of the requested  
26 documents to process the claim or if documents submitted by  
27 the provider raise new additional issues not included in the  
28 original written itemization, in which case the health insurer  
29 may provide the provider with one additional opportunity to  
30 submit the additional documents needed to process the claim.  
31 In no case may the health insurer request duplicate documents.

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

5       (e) A claim must be paid or denied within 90 days  
6 after receipt of the claim. Failure to pay or deny a claim  
7 within 120 days after receipt of the claim creates an  
8 uncontestable obligation to pay the claim.

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

11       (a) Effective November 1, 2003, provide acknowledgment  
12 of receipt of the claim within 15 days after receipt of the  
13 claim to the provider or provide a provider within 15 days  
14 after receipt with electronic access to the status of a  
15 submitted claim.

16       (b) Within 40 days after receipt of the claim, pay the  
17 claim or notify a provider or designee if a claim is denied or  
18 contested. Notice of the insurer's action on the claim and  
19 payment of the claim is considered to be made on the date the  
20 notice or payment was mailed or electronically transferred.

21       (c)1. Notification of the health insurer's  
22 determination of a contested claim must be accompanied by an  
23 itemized list of additional information or documents the  
24 insurer can reasonably determine are necessary to process the  
25 claim.

26       2. A provider must submit the additional information  
27 or documentation, as specified on the itemized list, within 35  
28 days after receipt of the notification. Failure of a provider  
29 to submit by mail or electronically the additional information  
30 or documentation requested within 35 days after receipt of the  
31 notification may result in denial of the claim.

1           3. A health insurer may not make more than one request  
2 for documents under this paragraph in connection with a claim  
3 unless the provider fails to submit all of the requested  
4 documents to process the claim or if documents submitted by  
5 the provider raise new additional issues not included in the  
6 original written itemization, in which case the health insurer  
7 may provide the provider with one additional opportunity to  
8 submit the additional documents needed to process the claim.  
9 In no case may the health insurer request duplicate documents.

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

14           (e) A claim must be paid or denied within 120 days  
15 after receipt of the claim. Failure to pay or deny a claim  
16 within 140 days after receipt of the claim creates an  
17 uncontestable obligation to pay the claim.

18           (6) Payment of a claim is considered made on the date  
19 the payment was mailed or electronically transferred. An  
20 overdue payment of a claim bears simple interest of 12 percent  
21 per year. Interest on an overdue payment for a claim or for  
22 any portion of a claim begins to accrue when the claim should  
23 have been paid, denied, or contested. The interest is payable  
24 with the payment of the claim.

25           (7) If a health insurer determines that it has made an  
26 overpayment to a provider for services rendered to an insured,  
27 the health insurer must make a claim for such overpayment. A  
28 health insurer that makes a claim for overpayment to a  
29 provider under this section shall give the provider a written  
30 or electronic statement specifying the basis for the  
31 retroactive denial or payment adjustment. The insurer must

1 identify the claim or claims, or overpayment claim portion  
2 thereof, for which a claim for overpayment is submitted.

3 (a) If an overpayment determination is the result of  
4 retroactive review or audit of coverage decisions or payment  
5 levels not related to fraud, a health insurer shall adhere to  
6 the following procedures:

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

16 2. A provider that denies or contests a health  
17 insurer's claim for overpayment or any portion of a claim  
18 shall notify the health insurer, in writing, within 35 days  
19 after the provider receives the claim that the claim for  
20 overpayment is contested or denied. The notice that the claim  
21 for overpayment is denied or contested must identify the  
22 contested portion of the claim and the specific reason for  
23 contesting or denying the claim and, if contested, must  
24 include a request for additional information. If the health  
25 insurer submits additional information, the health insurer  
26 must, within 35 days after receipt of the request, mail or  
27 electronically transfer the information to the provider. The  
28 provider shall pay or deny the claim for overpayment within 45  
29 days after receipt of the information. The notice is  
30 considered made on the date the notice is mailed or  
31 electronically transferred by the provider.

1           3. Failure of a health insurer to respond to a  
2 provider's contesting of claim or request for additional  
3 information regarding the claim within 35 days after receipt  
4 of such notice may result in denial of the claim.

5           4. The health insurer may not reduce payment to the  
6 provider for other services unless the provider agrees to the  
7 reduction in writing or fails to respond to the health  
8 insurer's overpayment claim as required by this paragraph.

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

16           (b) A claim for overpayment shall not be permitted  
17 beyond 30 months after the health insurer's payment of a  
18 claim, except that claims for overpayment may be sought beyond  
19 that time from providers convicted of fraud pursuant to s.  
20 817.234.

21           (8) For all contracts entered into or renewed on or  
22 after October 1, 2002, a health insurer's internal dispute  
23 resolution process related to a denied claim not under active  
24 review by a mediator, arbitrator, or third-party dispute  
25 entity must be finalized within 60 days after the receipt of  
26 the provider's request for review or appeal.

27           (9) A provider or any representative of a provider,  
28 regardless of whether the provider is under contract with the  
29 health insurer, may not collect or attempt to collect money  
30 from, maintain any action at law against, or report to a  
31 credit agency an insured for payment of covered services for

1 which the health insurer contested or denied the provider's  
2 claim. This prohibition applies during the pendency of any  
3 claim for payment made by the provider to the health insurer  
4 for payment of the services or internal dispute resolution  
5 process to determine whether the health insurer is liable for  
6 the services. For a claim, this pendency applies from the  
7 date the claim or a portion of the claim is denied to the date  
8 of the completion of the health insurer's internal dispute  
9 resolution process, not to exceed 60 days.

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

12 (11) A health insurer may not retroactively deny a  
13 claim because of insured ineligibility more than 1 year after  
14 the date of payment of the claim.

15 (12) A health insurer shall pay a contracted primary  
16 care or admitting physician, pursuant to such physician's  
17 contract, for providing inpatient services in a contracted  
18 hospital to an insured if such services are determined by the  
19 health insurer to be medically necessary and covered services  
20 under the health insurer's contract with the contract holder.

21 (13) Upon written notification by an insured, an  
22 insurer shall investigate any claim of improper billing by a  
23 physician, hospital, or other health care provider. The  
24 insurer shall determine if the insured was properly billed for  
25 only those procedures and services that the insured actually  
26 received. If the insurer determines that the insured has been  
27 improperly billed, the insurer shall notify the insured and  
28 the provider of its findings and shall reduce the amount of  
29 payment to the provider by the amount determined to be  
30 improperly billed. If a reduction is made due to such  
31

1 notification by the insured, the insurer shall pay to the  
2 insured 20 percent of the amount of the reduction up to \$500.  
3 (14) A permissible error ratio of 5 percent is  
4 established for insurer's claims payment violations of s.  
5 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and  
6 (e). If the error ratio of a particular insurer does not  
7 exceed the permissible error ratio of 5 percent for an audit  
8 period, no fine shall be assessed for the noted claims  
9 violations for the audit period. The error ratio shall be  
10 determined by dividing the number of claims with violations  
11 found on a statistically valid sample of claims for the audit  
12 period by the total number of claims in the sample. If the  
13 error ratio exceeds the permissible error ratio of 5 percent,  
14 a fine may be assessed according to s. 624.4211 for those  
15 claims payment violations which exceed the error ratio.  
16 Notwithstanding the provisions of this section, the department  
17 may fine a health insurer for claims payment violations of s.  
18 627.6131(4)(e) and (5)(e) which create an uncontestable  
19 obligation to pay the claim. The department shall not fine  
20 insurers for violations which the department determines were  
21 due to circumstances beyond the insurer's control.  
22 (15) This section is applicable only to a major  
23 medical expense health insurance policy as defined in s.  
24 627.643(2)(e) offered by a group or an individual health  
25 insurer licensed pursuant to chapter 624, including a  
26 preferred provider policy under s. 627.6471 and an exclusive  
27 provider organization under s. 627.6472.  
28 Section 4. Section 627.6135, Florida Statutes, is  
29 created to read:  
30 627.6135 Treatment authorization; payment of claims.--  
31

1       (1) For purposes of this section, "authorization"  
2 consists of any requirement of a provider to obtain prior  
3 approval or to provide documentation relating to the necessity  
4 of a covered medical treatment or service as a condition for  
5 reimbursement for the treatment or service prior to the  
6 treatment or service. Each authorization request from a  
7 provider must be assigned an identification number by the  
8 health insurer.

9       (2) Upon receipt of a request from a provider for  
10 authorization, the health insurer shall make a determination  
11 within a reasonable time appropriate to medical circumstance  
12 indicating whether the treatment or services are authorized.  
13 For urgent care requests for which the standard timeframe for  
14 the health insurer to make a determination would seriously  
15 jeopardize the life or health of an insured or would  
16 jeopardize the insured's ability to regain maximum function, a  
17 health insurer must notify the provider as to its  
18 determination as soon as possible taking into account medical  
19 exigencies.

20       (3) Each response to an authorization request must be  
21 assigned an identification number. Each authorization provided  
22 by a health insurer must include the date of request of  
23 authorization, a timeframe of the authorization, length of  
24 stay if applicable, identification number of the  
25 authorization, place of service, and type of service.

26       (4) A claim for treatment may not be denied if a  
27 provider follows the health insurer's authorization procedures  
28 and receives authorization for a covered service for an  
29 eligible insured unless the provider provided information to  
30 the health insurer with the intention to misinform the health  
31 insurer.

1       (5) A health insurer's requirements for authorization  
2 for medical treatment or services and 30-day advance notice of  
3 material change in such requirements must be provided to all  
4 contracted providers and upon request to all noncontracted  
5 providers. A health insurer that makes such requirements and  
6 advance notices accessible to providers and insureds  
7 electronically shall be deemed to be in compliance with this  
8 subsection.

9           Section 5. Subsection (4) of section 627.651, Florida  
10 Statutes, is amended to read:

11           627.651 Group contracts and plans of self-insurance  
12 must meet group requirements.--

13           (4) This section does not apply to any plan which is  
14 established or maintained by an individual employer in  
15 accordance with the Employee Retirement Income Security Act of  
16 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
17 arrangement as defined in s. 624.437(1), except that a  
18 multiple-employer welfare arrangement shall comply with ss.  
19 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,  
20 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(8)(6)~~.  
21 This subsection does not allow an authorized insurer to issue  
22 a group health insurance policy or certificate which does not  
23 comply with this part.

24           Section 6. Section 627.662, Florida Statutes, is  
25 amended to read:

26           627.662 Other provisions applicable.--The following  
27 provisions apply to group health insurance, blanket health  
28 insurance, and franchise health insurance:

29           (1) Section 627.569, relating to use of dividends,  
30 refunds, rate reductions, commissions, and service fees.

31

- 1           (2) Section 627.602(1)(f) and (2), relating to  
2 identification numbers and statement of deductible provisions.  
3           (3) Section 627.635, relating to excess insurance.  
4           (4) Section 627.638, relating to direct payment for  
5 hospital or medical services.  
6           (5) Section 627.640, relating to filing and  
7 classification of rates.  
8           (6) Section 627.613, relating to timely payment of  
9 claims, or s. 627.6131, relating to payment of claims.  
10           (7) Section 627.6135, relating to treatment  
11 authorizations and payment of claims.  
12           ~~(8)(6)~~ Section 627.645(1), relating to denial of  
13 claims.  
14           ~~(9)(7)~~ Section 627.613, relating to time of payment of  
15 claims.  
16           ~~(10)(8)~~ Section 627.6471, relating to preferred  
17 provider organizations.  
18           ~~(11)(9)~~ Section 627.6472, relating to exclusive  
19 provider organizations.  
20           ~~(12)(10)~~ Section 627.6473, relating to combined  
21 preferred provider and exclusive provider policies.  
22           ~~(13)(11)~~ Section 627.6474, relating to provider  
23 contracts.  
24           Section 7. Subsection (2) of section 627.638, Florida  
25 Statutes, is amended to read:  
26           627.638 Direct payment for hospital, medical  
27 services.--  
28           (2) Whenever, in any health insurance claim form, an  
29 insured specifically authorizes payment of benefits directly  
30 to any recognized hospital or physician, the insurer shall  
31 make such payment to the designated provider of such services,

1 unless otherwise provided in the insurance contract. However,  
2 if:

3 (a) The benefit is determined to be covered under the  
4 terms of the policy;

5 (b) The claim is limited to treatment of mental health  
6 or substance abuse, including drug and alcohol abuse; and

7 (c) The insured authorizes the insurer, in writing, as  
8 part of the claim to make direct payment of benefits to a  
9 recognized hospital, physician, or other licensed provider,

10  
11 payments shall be made directly to the recognized hospital,  
12 physician, or other licensed provider, notwithstanding any  
13 contrary provisions in the insurance contract.

14 Section 8. Subsection (1) of section 641.30, Florida  
15 Statutes, is amended to read:

16 641.30 Construction and relationship to other laws.--

17 (1) Every health maintenance organization shall accept  
18 the ~~standard health~~ claim form prescribed pursuant to s.  
19 641.3155 ~~627-647~~.

20 Section 9. Subsection (4) of section 641.3154, Florida  
21 Statutes, is amended to read:

22 641.3154 Organization liability; provider billing  
23 prohibited.--

24 (4) A provider or any representative of a provider,  
25 regardless of whether the provider is under contract with the  
26 health maintenance organization, may not collect or attempt to  
27 collect money from, maintain any action at law against, or  
28 report to a credit agency a subscriber of an organization for  
29 payment of services for which the organization is liable, if  
30 the provider in good faith knows or should know that the  
31 organization is liable. This prohibition applies during the

1 pendency of any claim for payment made by the provider to the  
2 organization for payment of the services and any legal  
3 proceedings or dispute resolution process to determine whether  
4 the organization is liable for the services if the provider is  
5 informed that such proceedings are taking place. It is  
6 presumed that a provider does not know and should not know  
7 that an organization is liable unless:

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

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

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

17 (d) The agency issues a final order that the  
18 organization is required to pay for such services subsequent  
19 to a recommendation made by a resolution organization pursuant  
20 to s. 408.7057.

21 Section 10. Section 641.3155, Florida Statutes, is  
22 amended to read:

23 (Substantial rewording of section. See  
24 s. 641.3155, F.S., for present text.)  
25 641.3155 Prompt payment of claims.--

26 (1) As used in this section, the term "claim" for a  
27 noninstitutional provider means a paper or electronic billing  
28 instrument submitted to the health maintenance organization's  
29 designated location that consists of the HCFA 1500 data set,  
30 or its successor, that has all mandatory entries for a  
31 physician licensed under chapter 458, chapter 459, chapter

1 460, or chapter 461 or other appropriate billing instrument  
2 that has all mandatory entries for any other noninstitutional  
3 provider. For institutional providers, "claim" means a paper  
4 or electronic billing instrument submitted to the health  
5 maintenance organization's designated location that consists  
6 of the UB-92 data set or its successor that has all mandatory  
7 entries.

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

10 (a) Are considered received on the date the claim is  
11 received by the organization at its designated claims receipt  
12 location.

13 (b) Must be mailed or electronically transferred to an  
14 organization within 9 months after completion of the service  
15 and the provider is furnished with the correct name and  
16 address of the patient's health insurer.

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

20 (3) For all electronically submitted claims, a health  
21 maintenance organization shall:

22 (a) Within 24 hours after the beginning of the next  
23 business day after receipt of the claim, provide electronic  
24 acknowledgment of the receipt of the claim to the electronic  
25 source submitting the claim.

26 (b) Within 20 days after receipt of the claim, pay the  
27 claim or notify a provider or designee if a claim is denied or  
28 contested. Notice of the organization's action on the claim  
29 and payment of the claim is considered to be made on the date  
30 the notice or payment was mailed or electronically  
31 transferred.

1           (c)1. Notification of the health maintenance  
2 organization's determination of a contested claim must be  
3 accompanied by an itemized list of additional information or  
4 documents the insurer can reasonably determine are necessary  
5 to process the claim.

6           2. A provider must submit the additional information  
7 or documentation, as specified on the itemized list, within 35  
8 days after receipt of the notification. Failure of a provider  
9 to submit by mail or electronically the additional information  
10 or documentation requested within 35 days after receipt of the  
11 notification may result in denial of the claim.

12           3. A health maintenance organization may not make more  
13 than one request for documents under this paragraph in  
14 connection with a claim, unless the provider fails to submit  
15 all of the requested documents to process the claim or if  
16 documents submitted by the provider raise new additional  
17 issues not included in the original written itemization, in  
18 which case the health maintenance organization may provide the  
19 provider with one additional opportunity to submit the  
20 additional documents needed to process the claim. In no case  
21 may the health maintenance organization request duplicate  
22 documents.

23           (d) For purposes of this subsection, electronic means  
24 of transmission of claims, notices, documents, forms, and  
25 payment shall be used to the greatest extent possible by the  
26 health maintenance organization and the provider.

27           (e) A claim must be paid or denied within 90 days  
28 after receipt of the claim. Failure to pay or deny a claim  
29 within 120 days after receipt of the claim creates an  
30 uncontestable obligation to pay the claim.

31

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

3       (a) Effective November 1, 2003, provide  
4 acknowledgement of receipt of the claim within 15 days after  
5 receipt of the claim to the provider or designee or provide a  
6 provider or designee within 15 days after receipt with  
7 electronic access to the status of a submitted claim.

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

14       (c)1. Notification of the health maintenance  
15 organization's determination of a contested claim must be  
16 accompanied by an itemized list of additional information or  
17 documents the organization can reasonably determine are  
18 necessary to process the claim.

19       2. A provider must submit the additional information  
20 or documentation, as specified on the itemized list, within 35  
21 days after receipt of the notification. Failure of a provider  
22 to submit by mail or electronically the additional information  
23 or documentation requested within 35 days after receipt of the  
24 notification may result in denial of the claim.

25       3. A health maintenance organization may not make more  
26 than one request for documents under this paragraph in  
27 connection with a claim unless the provider fails to submit  
28 all of the requested documents to process the claim or if  
29 documents submitted by the provider raise new additional  
30 issues not included in the original written itemization, in  
31 which case the health maintenance organization may provide the

1 provider with one additional opportunity to submit the  
2 additional documents needed to process the claim. In no case  
3 may the health maintenance organization request duplicate  
4 documents.

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

9 (e) A claim must be paid or denied within 120 days  
10 after receipt of the claim. Failure to pay or deny a claim  
11 within 140 days after receipt of the claim creates an  
12 uncontestable obligation to pay the claim.

13 (5) Payment of a claim is considered made on the date  
14 the payment was mailed or electronically transferred. An  
15 overdue payment of a claim bears simple interest of 12 percent  
16 per year. Interest on an overdue payment for a claim or for  
17 any portion of a claim begins to accrue when the claim should  
18 have been paid, denied, or contested. The interest is payable  
19 with the payment of the claim.

20 (6) If a health maintenance organization determines  
21 that it has made an overpayment to a provider for services  
22 rendered to a subscriber, the health maintenance organization  
23 must make a claim for such overpayment. A health maintenance  
24 organization that makes a claim for overpayment to a provider  
25 under this section shall give the provider a written or  
26 electronic statement specifying the basis for the retroactive  
27 denial or payment adjustment. The health maintenance  
28 organization must identify the claim or claims, or overpayment  
29 claim portion thereof, for which a claim for overpayment is  
30 submitted.

31

1        (a) If an overpayment determination is the result of  
2 retroactive review or audit of coverage decisions or payment  
3 levels not related to fraud, a health maintenance organization  
4 shall adhere to the following procedures:

5            1. All claims for overpayment must be submitted to a  
6 provider within 30 months after the health maintenance  
7 organization's payment of the claim. A provider must pay,  
8 deny, or contest the health maintenance organization's claim  
9 for overpayment within 40 days after the receipt of the claim.  
10 All contested claims for overpayment must be paid or denied  
11 within 120 days after receipt of the claim. Failure to pay or  
12 deny overpayment and claim within 140 days after receipt  
13 creates an uncontestable obligation to pay the claim.

14            2. A provider that denies or contests a health  
15 maintenance organization's claim for overpayment or any  
16 portion of a claim shall notify the organization, in writing,  
17 within 35 days after the provider receives the claim that the  
18 claim for overpayment is contested or denied. The notice that  
19 the claim for overpayment is denied or contested must identify  
20 the contested portion of the claim and the specific reason for  
21 contesting or denying the claim and, if contested, must  
22 include a request for additional information. If the  
23 organization submits additional information, the organization  
24 must, within 35 days after receipt of the request, mail or  
25 electronically transfer the information to the provider. The  
26 provider shall pay or deny the claim for overpayment within 45  
27 days after receipt of the information. The notice is  
28 considered made on the date the notice is mailed or  
29 electronically transferred by the provider.

30            3. Failure of a health maintenance organization to  
31 respond to a provider's contestment of claim or request for

1 additional information regarding the claim within 35 days  
2 after receipt of such notice may result in denial of the  
3 claim.

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

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

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

21 (7)(a) For all contracts entered into or renewed on or  
22 after October 1, 2002, a health maintenance organization's  
23 internal dispute resolution process related to a denied claim  
24 not under active review by a mediator, arbitrator, or  
25 third-party dispute entity must be finalized within 60 days  
26 after the receipt of the provider's request for review or  
27 appeal.

28 (b) All claims to a health maintenance organization  
29 begun after October 1, 2000, not under active review by a  
30 mediator, arbitrator, or third-party dispute entity, shall  
31 result in a final decision on the claim by the health

1 maintenance organization by January 2, 2003, for the purpose  
2 of the statewide provider and managed care organization claim  
3 dispute resolution program pursuant to s. 408.7057.

4 (8) A provider or any representative of a provider,  
5 regardless of whether the provider is under contract with the  
6 health maintenance organization, may not collect or attempt to  
7 collect money from, maintain any action at law against, or  
8 report to a credit agency a subscriber for payment of covered  
9 services for which the health maintenance organization  
10 contested or denied the provider's claim. This prohibition  
11 applies during the pendency of any claim for payment made by  
12 the provider to the health maintenance organization for  
13 payment of the services or internal dispute resolution process  
14 to determine whether the health maintenance organization is  
15 liable for the services. For a claim, this pendency applies  
16 from the date the claim or a portion of the claim is denied to  
17 the date of the completion of the health maintenance  
18 organization's internal dispute resolution process, not to  
19 exceed 60 days.

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

22 (10) A health maintenance organization may not  
23 retroactively deny a claim because of subscriber ineligibility  
24 more than 1 year after the date of payment of the claim.

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

1       (12) Upon written notification by a subscriber, a  
2 health maintenance organization shall investigate any claim of  
3 improper billing by a physician, hospital, or other health  
4 care provider. The organization shall determine if the  
5 subscriber was properly billed for only those procedures and  
6 services that the subscriber actually received. If the  
7 organization determines that the subscriber has been  
8 improperly billed, the organization shall notify the  
9 subscriber and the provider of its findings and shall reduce  
10 the amount of payment to the provider by the amount determined  
11 to be improperly billed. If a reduction is made due to such  
12 notification by the insured, the insurer shall pay to the  
13 insured 20 percent of the amount of the reduction up to \$500.

14       (13) A permissible error ratio of 5 percent is  
15 established for health maintenance organizations' claims  
16 payment violations of s. 641.3155(3)(a), (b), (c), and (e) and  
17 (4)(a), (b), (c), and (e). If the error ratio of a particular  
18 insurer does not exceed the permissible error ratio of 5  
19 percent for an audit period, no fine shall be assessed for the  
20 noted claims violations for the audit period. The error ratio  
21 shall be determined by dividing the number of claims with  
22 violations found on a statistically valid sample of claims for  
23 the audit period by the total number of claims in the sample.  
24 If the error ratio exceeds the permissible error ratio of 5  
25 percent, a fine may be assessed according to s. 624.4211 for  
26 those claims payment violations which exceed the error ratio.  
27 Notwithstanding the provisions of this section, the department  
28 may fine a health maintenance organization for claims payment  
29 violations of s. 641.3155(3)(e) and (4)(e) which create an  
30 uncontestable obligation to pay the claim. The department  
31 shall not fine organizations for violations which the

1 department determines were due to circumstances beyond the  
2 organization's control.  
3       Section 11. Section 641.3156, Florida Statutes, is  
4 amended to read:  
5       641.3156 Treatment authorization; payment of claims.--  
6       (1) For purposes of this section, "authorization"  
7 consists of any requirement of a provider to obtain prior  
8 approval or to provide documentation relating to the necessity  
9 of a covered medical treatment or service as a condition for  
10 reimbursement for the treatment or service prior to the  
11 treatment or service. Each authorization request from a  
12 provider must be assigned an identification number by the  
13 health maintenance organization ~~A health maintenance~~  
14 ~~organization must pay any hospital service or referral service~~  
15 ~~claim for treatment for an eligible subscriber which was~~  
16 ~~authorized by a provider empowered by contract with the health~~  
17 ~~maintenance organization to authorize or direct the patient's~~  
18 ~~utilization of health care services and which was also~~  
19 ~~authorized in accordance with the health maintenance~~  
20 ~~organization's current and communicated procedures, unless the~~  
21 ~~provider provided information to the health maintenance~~  
22 ~~organization with the willful intention to misinform the~~  
23 ~~health maintenance organization.~~  
24       (2) A claim for treatment may not be denied if a  
25 provider follows the health maintenance organization's  
26 authorization procedures and receives authorization for a  
27 covered service for an eligible subscriber, unless the  
28 provider provided information to the health maintenance  
29 organization with the ~~willful~~ intention to misinform the  
30 health maintenance organization.  
31

1       (3) Upon receipt of a request from a provider for  
2 authorization, the health maintenance organization shall make  
3 a determination within a reasonable time appropriate to  
4 medical circumstance indicating whether the treatment or  
5 services are authorized. For urgent care requests for which  
6 the standard timeframe for the health maintenance organization  
7 to make a determination would seriously jeopardize the life or  
8 health of a subscriber or would jeopardize the subscriber's  
9 ability to regain maximum function, a health maintenance  
10 organization must notify the provider as to its determination  
11 as soon as possible taking into account medical exigencies.

12       (4) Each response to an authorization request must be  
13 assigned an identification number. Each authorization provided  
14 by a health maintenance organization must include the date of  
15 request of authorization, timeframe of the authorization,  
16 length of stay if applicable, identification number of the  
17 authorization, place of service, and type of service.

18       (5) A health maintenance organization's requirements  
19 for authorization for medical treatment or services and 30-day  
20 advance notice of material change in such requirements must be  
21 provided to all contracted providers and upon request to all  
22 noncontracted providers. A health maintenance organization  
23 that makes such requirements and advance notices accessible to  
24 providers and subscribers electronically shall be deemed to be  
25 in compliance with this paragraph.

26       (6)~~(3)~~ Emergency services are subject to the  
27 provisions of s. 641.513 and are not subject to the provisions  
28 of this section.

29       Section 12. Except as otherwise provided herein, this  
30 act shall take effect October 1, 2002, and shall apply to  
31 claims for services rendered after such date.