**By** Senator Saunders

25-299-02 See HB 293

A bill to be entitled

An act relating to health insurance; amending s. 408.7057, F.S.; redefining the term "managed care organization"; providing for filing certain claim disputes with a dispute-resolution organization under certain circumstances; amending s. 627.4235, F.S.; providing a definition; including prepaid health plans under coordination of benefits provisions; providing for coordination of benefits under multiple health insurance policies regardless of time periods under certain circumstances; amending s. 627.613, F.S.; revising time of payment of claims provisions; requiring the Department of Insurance to adopt rules consistent with federal standards; providing requirements and procedures for payment or denial of claims; providing criteria and limitations; amending s. 627.614, F.S.; entitling insureds to prompt insurer payments of claims for covered services; requiring payment within specified periods; providing payment procedures; providing penalties; creating s. 627.6142, F.S.; providing a definition; requiring health insurers to provide lists of medical care and health care services that require authorization; prohibiting denial of certain claims; providing procedural requirements for determination and issuance of authorizations of services; amending s. 627.6471, F.S.; revising

limitations on policies providing differing schedules of payments for preferred provider services and nonpreferred provider services; amending s. 627.662, F.S.; specifying application of certain additional provisions to group, blanket, and franchise health insurance; amending s. 641.185, F.S.; entitling health maintenance organization subscribers to prompt payment by the organization for covered services by an out-of-network provider; requiring payment within specified periods; providing payment procedures; providing penalties; amending s. 641.30, F.S.; conforming a cross-reference; amending s. 641.3155, F.S.; providing a definition; requiring the Department of Insurance to adopt rules consistent with federal claim-filing standards; providing requirements and procedures for payment of claims; requiring payment within specified periods; requiring the payment of interest on overdue payments; requiring coordination of benefits; providing remedies for certain violations; providing for attorney's fees and costs under certain circumstances; amending s. 641.3156, F.S.; providing a definition; requiring health maintenance organizations to provide lists of medical care and health care services that require authorization; prohibiting denial of certain claims; providing procedural requirements for determination and issuance of

authorizations of services; amending s. 627.651, F.S.; conforming a cross-reference; repealing s. 627.647, F.S., relating to standard health claim forms; providing effective dates.

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

Section 1. Paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of section 408.7057, Florida Statutes, are amended 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, or a preferred provider organization.

(2)

(c) Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or health maintenance organization to the resolution organization when the dispute-resolution program becomes effective; provided that, if the internal dispute-resolution process is not completed within 60 calendar days after the filing of the claim dispute with the managed care maintenance organization, the provider may file a claim dispute with a dispute-resolution organization.

Section 2. Section 627.4235, Florida Statutes, is amended to read:

627.4235 Coordination of benefits.--

(1) For purposes of this section, the term "coordination of benefits" or "coordinating benefits" means establishing an order, or operating pursuant to an established order, under which primary plans pay claims and secondary plans are permitted to reduce benefits paid so that the combined benefits paid under all plans do not exceed covered charges.

(2)~~(1)~~ A group hospital, medical, or surgical expense policy, group health care services plan, prepaid health plan licensed pursuant to chapter 641, or group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses delivered or issued for delivery in this state must contain a provision for coordinating its benefits with any similar benefits provided by any other group hospital, medical, or surgical expense policy, any group health care services plan, prepaid health plan licensed pursuant to chapter 641, or any group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses for the same loss.

(3)~~(2)~~ A hospital, medical, or surgical expense policy, health care services plan, prepaid health plan licensed pursuant to chapter 641, or self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses issued in this state or issued for delivery in this state shall ~~may~~ contain a provision whereby the insurer may reduce or refuse to pay benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under insurance policies issued by the same

or another insurer, health care services plan, prepaid health plan licensed pursuant to chapter 641, or self-insurance plan which provides protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, the insurers together pay 100 percent of the total covered charges for ~~reasonable expenses actually incurred of the type of expense within the~~ benefits described in the policies and presented to the insurer for payment.

(4)~~(3)~~ The standards provided in subsection(3)~~(2)~~ apply to coordination of benefits payable under Medicare, Title XVIII of the Social Security Act.

(5)~~(4)~~ If a claim is submitted in accordance with any group hospital, medical, or surgical expense policy, or in accordance with any group health care service plan or group-type self-insurance plan, that provides protection, insurance, or indemnity against hospital, medical, or surgical expenses, and the policy or any other document that provides coverage includes a coordination-of-benefits provision and the claim involves another policy or plan which has a coordination-of-benefits provision, the following rules determine the order in which benefits under the respective health policies or plans will be determined:

(a)1. The benefits of a policy or plan which covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.

2. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to

the plan covering the person as a dependent of an active employee, the order of benefit determination is:

a. First, benefits of a plan covering a person as an employee, member, or subscriber.

b. Second, benefits of a plan of an active worker covering a person as a dependent.

c. Third, Medicare benefits.

(b) Except as stated in paragraph (c), if two or more policies or plans cover the same child as a dependent of different parents:

1. The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before the benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but

2. If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

However, if a policy or plan subject to the rule based on the birthdays of the parents coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan determine the order of benefits.

(c) If two or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the policy or plan of the parent with custody of the child.

2. Second, the policy or plan of the spouse of the parent with custody of the child.

3. Third, the policy or plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first, except with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before the entity has the actual knowledge.

(d) The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as the employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph does not apply.

(e) If none of the rules in paragraph (a), paragraph (b), paragraph (c), or paragraph (d) determine the order of benefits, the benefits of the policy or plan which covered an employee, member, or subscriber for a longer period of time

are determined before those of the policy or plan which covered the person for the shorter period of time.

(6)~~(5)~~ Coordination of benefits is not permitted against an indemnity-type policy, an excess insurance policy as defined in s. 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

(7)~~(6)~~ If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272), and also under another group plan, the following order of benefits applies:

(a) First, the plan covering the person as an employee, or as the employee's dependent.

(b) Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

(8) If the insured fails to furnish the provider with the correct name and address of the insured's primary insurer, and the claim is submitted to a secondary insurer or prepaid health plan licensed pursuant to chapter 641 and the claim is subsequently rejected, the provider has 60 calendar days from the date the provider obtains the correct billing information to submit a claim to either the primary or secondary insurer, regardless of any time periods for filing of claims established by any applicable contract.

Section 3. Effective October 16, 2002, section 627.613, Florida Statutes, is amended to read:

(Substantial rewording of section.
See s. 627.613, F.S., for present text.)

627.613 Time of payment of claims.--

(1)(a) As used in this section, for a noninstitutional provider, the term "claim" means a paper or electronic billing instrument that consists of the HCFA 1500 data set that has all mandatory entries completed for a physician licensed under chapter 458 or chapter 459 or other appropriate form for any other noninstitutional provider, or its successor. For institutional providers, "claim" means a paper or electronic billing instrument that consists of the UB-92 data set or its successor that has all mandatory entries completed.

(b) The department shall adopt rules to establish claim forms consistent with federal claim-filing standards for health insurers required by the Secretary of the United States Department of Health and Human Services. The department shall adopt rules to require code sets consistent with code sets adopted by the Secretary of the United States Department of Health and Human Services. The code sets shall apply to electronic claims. A code set, as defined by the secretary, includes both the codes and the descriptors of the codes and shall include, but not be limited to:

1. Medical data code sets, including the International Classification of Diseases, the HCFA Common Procedure Coding System and current procedure terminology, and the HCFA Common Procedure Coding System for supplies and other health care items.

2. Health care claims or equivalent encounter information for professional health care claims and institutional health care claims.

3. Eligibility for a health plan standard.

4. Referral certification and authorization standard.

5. Health care claim status standard.

6. Enrollment and disenrollment in a health plan standard.

7. Health care payment and remittance advice standard.

8. Coordination of benefits standard.

9. Revenue codes used by Medicare for processing claims.

10. National Correct Coding Initiative edits used by Medicare.

(c) All providers and payors shall use only the standard code sets defined for their area of operation by the Secretary of the United States Department of Health and Human Services for the filing and adjudication of electronic claims. The version of the code set shall be the version that is valid at the time the health care is furnished, defined as the date of discharge for inpatient services and date of service for health care provided in an outpatient or ambulatory setting.

(2)(a) A health insurer shall pay any claim or any portion of a claim made by a contract provider for services or goods provided under a contract with the health insurer or a claim made by a noncontracted provider, which the insurer does not contest or deny, within 15 calendar days after receipt of the claim by the health insurer that is electronically submitted by the provider, or within 35 calendar days after receipt of the claim by the health insurer that is submitted by the provider using either hand delivery, the United States mail, or a reputable overnight delivery service. The investigation and determination of eligibility for payment, including any coordination of any other payments, does not extend the time periods specified in this paragraph.

(b) A health insurer that denies or contests a provider's claim or any portion of a claim shall notify the

provider within 35 calendar days after the health insurer receives the claim, if submitted by hand delivery, United States mail, or overnight delivery service, or within 15 calendar days after the health insurer receives the claim if submitted by electronic means, that the claim is contested or denied. The notice that the claim is contested or denied shall identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, shall give the provider a written itemization of any additional information or additional documents needed to process the claim or any portion of the claim that is not being paid. The health insurer shall pay or deny the claim or portion of the claim within 35 calendar days after receipt of the information. A health insurer may not make more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information to process the claim, in which case the health insurer may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim.

(c) If a health insurer requests additional information or additional documents from a person other than the provider who submitted the claim, the health insurer shall provide a copy of the request to the provider who submitted the claim. The health insurer may not withhold payment pending receipt of information or documents requested under this paragraph. A health insurer may not deny or withhold payment on a claim because the insured has not paid a required deductible or copayment.

(3) Payment of a claim is considered made on the date the payment is received, electronically transferred, or

otherwise delivered. An insurer that does not pay a claim when payment is due as provided in subsection (4) shall pay the provider submitting the claim the provider's billed charges submitted on the claim.

(4) A health insurer shall pay or deny any claim no later than 50 calendar days after receiving the claim if the claim is submitted electronically, or no later than 70 calendar days if the claim is submitted by hand delivery, United States mail, or a reputable overnight delivery service. Failure to pay or deny a claim within such time periods creates an uncontestable obligation of the health insurer to pay the claim to the provider. The running of the time specified in this subsection shall be tolled by the number of days taken by the provider who submitted the claim to submit the additional information requested by the insurer pursuant to paragraph (2)(b).

(5) If, as a result of retroactive review of coverage decisions or payment levels, a health insurer determines that the insurer has made an overpayment to a provider for services rendered to an insured, the insurer may not reduce payment to that provider for other services. The look-back or audit review period may not exceed 1 year from the date of discharge or 1 year from the date the health service was provided.

(6) A provider claim for payment shall be considered received by the health insurer, if the claim has been electronically transmitted to the health insurer, when receipt is verified electronically; if the claim is mailed by United States mail to the address disclosed by the insurer, on the date indicated on the return receipt; or, if the claim is hand delivered, on the date the delivery receipt is signed by the health insurer. A health insurer shall not require a provider

to resubmit a claim for payment if the claim has been received by the insurer. A provider shall wait 35 calendar days following receipt of a claim before submitting a duplicate claim.

(7) A health insurer shall provide a provider or the provider's designee, who bills electronically, electronic acknowledgment of the receipt of a claim within 24 hours after receipt.

(8) A health insurer may not retroactively deny a claim because of subscriber ineligibility.

(9)(a) Without regard to any other remedy or relief to which a provider is entitled, any provider aggrieved by a violation of this section by a health insurer may bring an action to enjoin a person who has violated, or is violating, this section. In any such action, the provider who has suffered a loss as a result of the violation may recover any amounts due the provider by the health insurer, including accrued interest, plus attorney's fees and costs as provided in paragraph (b).

(b) In any action arising out of a violation of this section by a health insurer where the health insurer is found to have violated this section, the provider, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her reasonable attorney's fees and costs from the health insurer.

(10) The provisions of this section apply to contracts entered into pursuant to ss. 627.6471 and 627.6472.

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

Section 4. Subsection (3) is added to section 627.614, Florida Statutes, to read:

627.614 Payment of claims.--

(3) An insured is entitled to prompt payment from an insurer for claims submitted for a covered service. If the claim is submitted electronically by the insured or on the insured's behalf, the claim shall be paid to the insured within 15 days or the insurer shall advise the insured of what additional information is required to adjudicate the claim. After receipt of the additional information, the insurer shall pay the claim within 10 days. If the claim is submitted by electronic facsimile, United States mail, or overnight delivery service, the insurer shall pay the claim within 30 days or the insurer shall advise the insured of what additional information is required to adjudicate the claim. After receipt of the additional information, the insurer shall pay the claim within 10 days. If the insurer fails to pay a claim submitted by an insured within the time periods specified in this subsection, the insurer shall pay the insured twice the amount of the claim. Failure to pay claims and penalties, if applicable, within the time periods specified in this subsection is a violation of the insurance code and each occurrence shall be considered a separate violation.

Section 5. Section 627.6142, Florida Statutes, is created to read:

627.6142 Treatment authorization; payment of claims.--

(1) For purposes of this section, "authorization" includes any requirement of a provider to notify an insurer in advance of providing a covered service, regardless of whether the actual terminology used by the insurer includes, but is not limited to, preauthorization, precertification, notification, or any other similar terminology.

(2) A health insurer that requires authorization for medical care or health care services shall provide to each provider with whom the health insurer has contracted pursuant to s. 627.6471 or s. 627.6472 a list of the medical care and health care services that require authorization and the authorization procedures used by the health insurer at the time a contract becomes effective. A health insurer that requires authorization for medical care or health care services shall provide to all other providers, not later than 10 working days after a request is made, a list of the medical care and health care services that require authorization and the authorization procedures established by the insurer. The medical care or health care services that require authorization and the authorization procedures used by the insurer shall not be modified unless written notice is provided at least 30 days in advance of any changes to all affected insureds as well as to all contracted providers and all other providers that had previously requested in writing a list of medical care or health care services that require authorization.

(3) Any claim for treatment that does not require authorization that is ordered by a physician and entered on the medical record may not be denied.

(4)(a) Any claim for treatment may not be denied if a provider follows the health insurer's published authorization procedures and receives authorization, unless the provider submits information to the health insurer with the willful intention to misinform the health insurer.

(b) Upon receipt of a request from a provider for authorization, the health insurer shall issue a determination indicating whether the service or services are authorized. The

determination shall be transmitted to the provider making the request in writing no later than 8 hours after the request is made by the provider. If the health insurer denies the request for authorization, the health insurer shall notify the insured at the same time the insurer notifies the provider requesting the authorization. A health insurer that fails to respond to a request for an authorization pursuant to this paragraph within 8 hours is considered to have authorized the requested medical care or health care service and payment shall not be denied.

(5) If the proposed medical care or health care service or services involve an inpatient admission and the health insurer requires an authorization as a condition of payment, the health insurer shall review and issue a written or electronic authorization for the total estimated length of stay for the admission, based on the recommendation of the patient's physician. If the proposed medical care or health care service or services are to be provided to an insured who is an inpatient in a health care facility and authorization is required, the health insurer shall issue a written determination indicating whether the proposed services are authorized or denied no later than 1 hour after the request is made by the provider. A health insurer who fails to respond to such request within 1 hour is considered to have authorized the requested medical service or health care service and payment shall not be denied.

(6) Emergency services and care are subject to the provisions of s. 641.513 and are not subject to the provisions of this section, including any inpatient admission required in order to stabilize the patient pursuant to federal and state law.

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

(8) The provisions of this section apply to contracts entered into pursuant to ss. 627.6471 and 627.6472.

Section 6. Paragraph (h) of subsection (4) of section 627.6471, Florida Statutes, is amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(4) Any policy that provides schedules of payments for services provided by preferred providers that differ from the schedules of payments for services provided by nonpreferred providers is subject to the following limitations:

(h) Each preferred provider shall be given a list of all payors with whom the insurer has entered into agreements to use the services of the preferred provider and no additional payors shall be added to the agreement unless approved by the preferred provider. Neither the insurer nor the insurer's claims administrator shall disclose contract rate information without the written approval of the preferred provider.~~If any service or treatment is not within the scope of services provided by the network of preferred providers, but is within the scope of services or treatment covered by the policy, the service or treatment shall be reimbursed at a rate not less than 10 percentage points lower than the percentage rate paid to preferred providers. The reimbursement rate must be applied to the usual and customary charges in the area.~~

Section 7. Section 627.662, Florida Statutes, is amended to read:

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

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

(2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions.

(3) Section 627.635, relating to excess insurance.

(4) Section 627.638, relating to direct payment for hospital or medical services.

(5) Section 627.640, relating to filing and classification of rates.

(6) Section 627.4235, relating to coordination of benefits.

(7) Section 627.614, relating to payment of claims.

(8) Section 627.6142, relating to treatment authorizations.

(9)~~(6)~~ Section 627.645(1), relating to denial of claims.

(10)~~(7)~~ Section 627.613, relating to time of payment of claims.

(11)~~(8)~~ Section 627.6471, relating to preferred provider organizations.

(12)~~(9)~~ Section 627.6472, relating to exclusive provider organizations.

(13)~~(10)~~ Section 627.6473, relating to combined preferred provider and exclusive provider policies.

(14)~~(11)~~ Section 627.6474, relating to provider contracts.

Section 8. Paragraph (m) is added to subsection (1) of section 641.185, Florida Statutes, to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(m) A health maintenance organization subscriber is entitled to prompt payment from the organization whenever a subscriber pays an out-of-network provider for a covered service and then submits a claim to the organization. If the claim is submitted electronically by the subscriber or on the subscriber's behalf by the out-of-network provider, the claim shall be paid to the subscriber within 15 days or the organization shall advise the subscriber of what additional information is required to adjudicate the claim. After receipt of the additional information, the organization shall pay the claim within 10 days. If the claim is submitted by United States mail or overnight delivery service, the organization shall pay the claim within 30 days or the organization shall advise the subscriber of what additional information is required to adjudicate the claim. After receipt of the additional information, the organization shall pay the claim within 10 days. If the organization fails to pay claims submitted by subscribers within the time periods specified in this paragraph, the organization shall pay the subscriber twice the amount of the claim. Failure to pay claims and penalties, if applicable, within the time periods specified in

this paragraph, is a violation of the insurance code and each occurrence shall be considered a separate violation.

Section 9. Effective October 16, 2002, subsection (1) of section 641.30, Florida Statutes, is amended to read:

641.30 Construction and relationship to other laws.--

(1) Every health maintenance organization shall accept the ~~standard health~~ claim form prescribed pursuant to s. 641.3155 ~~627.647~~.

Section 10. Effective October 16, 2002, section 641.3155, Florida Statutes, is amended to read:

641.3155 Payment of claims.--

(1)(a) As used in this section, the term "~~clean~~ claim" for a noninstitutional provider means a paper or electronic billing instrument that consists of the HCFA 1500 data set that has all mandatory entries for a physician licensed under chapter 458 or chapter 459 or other appropriate form for any other noninstitutional provider, or its successor. For institutional providers, "claim" means a paper or electronic billing instrument that consists of the UB-92 data set or its successor that has all mandatory entries.~~claim submitted on a HCFA 1500 form which has no defect or impropriety, including lack of required substantiating documentation for noncontracted 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. This definition of "clean claim" is repealed on the effective date of rules adopted by the department which define the term "clean claim."~~

~~(b) Absent a written definition that is agreed upon through contract, the term "clean claim" for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.~~

(b)~~(c)~~ The department shall adopt rules to establish claim forms consistent with federal claim-filing standards for health maintenance organizations required by the Secretary of the United States Department of Health and Human Services ~~federal Health Care Financing Administration~~. The department shall ~~may~~ adopt rules to require code sets consistent with code sets adopted by the Secretary of the United States Department of Health and Human Services. The code sets shall apply to electronic claims. A code set, as defined by the secretary, shall include both the codes and the descriptors of the codes and shall also include, but not be limited to:

1. Medical data code sets, including the International Classification of Diseases, the HCFA Common Procedure Coding System and current procedure terminology, and the HCFA Common Procedure Coding System for supplies or other items used in health care services.

2. Health care claims or equivalent encounter information for professional and institutional health care claims.

3. Eligibility for a health plan standard.

4. Referral certification and authorization standard.

5. Health care claim status standard.

6. Health care payment and remittance advice standard.

7. Enrollment and disenrollment in a health plan standard.

8. Coordination of benefits standard.

9. Revenue codes used by Medicare for processing claims.

10. National Correct Coding Initiative edits used by Medicare ~~relating to coding standards consistent with Medicare coding standards adopted by the federal Health Care Financing Administration~~.

(c) All providers and payors shall use the standard code sets defined for their area of operation by the Secretary of the United States Department of Health and Human Services for the filing and adjudication of electronic claims. The version of the code set shall be the version that is valid at the time the health care is furnished, defined as the date of discharge for inpatient services and date of service for health care provided in an outpatient or ambulatory setting.

(2)(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 15 ~~35~~ days after receipt of the claim by the health maintenance organization which is ~~mailed or~~ electronically submitted ~~transferred~~ by the provider, or within 35 calendar days after receipt of the claim by the health maintenance organization that is submitted by the provider using either hand delivery, the United States mail, or a reputable overnight delivery service. The investigation and determination of eligibility for payment, including any

coordination of any other payments, does not extend the time periods contained in this paragraph.

(b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall notify the provider~~, in writing,~~ within 35 calendar days after the health maintenance organization receives the claim, if submitted by hand delivery, United States mail, or overnight delivery service, or within 15 calendar days after the health maintenance organization receives the claim if submitted by electronic means, 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 give the provider a written itemization of any ~~include a request for~~ additional information or additional documents needed to process the claim or any portion of the claim that is not being paid. ~~If the provider submits additional information, the provider must, within 35 days after receipt of the 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 35 calendar ~~45~~ days after receipt of the information from the provider. A health maintenance organization may not make more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information to process the claim, in which case the health maintenance organization may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim.

(c) If a health maintenance organization requests additional information or additional documents from a person other than the provider who submitted the claim, the health maintenance organization shall provide a copy of the request to the provider who submitted the claim. The health maintenance organization shall not withhold payment pending receipt of information or documents requested under this paragraph. If, upon receiving information or documents requested under this paragraph, the health maintenance organization determines the existence of an error in payment of the claim, the health maintenance organization may recover the payment under subsection (5).

(d) A health maintenance organization shall not deny or withhold payment on a claim because the insured has not paid a requested deductible or copayment.

(3) Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An insurer that does not pay a claim when payment is due as provided in subsection (4) shall pay the provider submitting the claim the full amount of the provider's billed charges submitted on the claim or twice the provider's contracted rate, whichever is less.~~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) A health maintenance organization shall pay or deny any claim no later than 50 calendar ~~120~~ days after receiving the claim if the claim is submitted electronically or no later than 70 calendar days if the claim is submitted by

hand delivery, United States mail, or a reputable overnight delivery service. Failure to pay or deny a claim within such time periods ~~do so~~ creates an uncontestable obligation for the health maintenance organization to pay the claim to the provider. The running of the time specified in this subsection shall be tolled by the number of days taken by the provider who submitted the claim to submit the additional information requested by the health maintenance organization pursuant to paragraph (2)(b).

(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 in writing after receipt of the claim for overpayment from the health maintenance organization 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 15 calendar ~~35~~ days after receipt of the claim that is ~~mailed or~~ electronically transferred to the provider, or within 35 calendar days after receipt of the claim that is submitted to the provider using either United States mail or a reputable overnight delivery service.

(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 calendar days after the provider receives the claim if the claim is

submitted by United States mail or overnight delivery service, or within 15 calendar days after the provider receives the claim if the claim is electronically transferred to the provider, 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 21 calendar ~~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 30 calendar ~~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 18 ~~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 71 calendar ~~120~~ days after receiving the claim if submitted electronically or no later than 91 calendar days if the claim for overpayment is submitted by United States mail or overnight delivery service. Failure to do so creates an uncontestable obligation for the provider to pay the claim to the organization.

(6) 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 or audit review period shall not exceed 1 year ~~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 when receipt is verified electronically~~,~~ if the claim has been electronically transmitted to the health maintenance organization, on the date indicated on the return receipt ~~when receipt is verified electronically or,~~ if the claim is mailed by United States mail to the address disclosed by the organization, or on the date the delivery receipt is signed by the health maintenance organization if the claim is hand delivered ~~on the date indicated on the return receipt~~. A health maintenance organization shall not require a provider to resubmit a claim for payment if the claim has been received by the organization.A provider must wait 45 calendar days following 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. A provider shall not require a health maintenance organization to resubmit a claim for payment if the claim for overpayment has been received by the provider.An organization must wait 45 calendar days following the provider's receipt of a claim for overpayment before submitting a duplicate claim.

~~(c) This section does not preclude the health maintenance organization and provider from agreeing to other methods of transmission and receipt of claims.~~

(8) A health maintenance organization shall provide a provider, or the provider's designee who bills electronically, electronic acknowledgment of the receipt of a claim within 24 hours after receipt.~~A provider, or the provider's designee, who bills electronically is entitled to electronic acknowledgment of the receipt of a claim within 72 hours.~~

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

(10) 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 a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

(11)(a) Each policy issued by a health maintenance organization shall contain a provision for coordinating benefits under the policy with any similar benefits provided by any other health maintenance organization, group hospital, medical, or surgical expense policy; any group health care services plan; any auto medical policy; any governmental

medical expense policy; or any group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses for the same loss.

(b) A policy issued by a health maintenance organization shall contain a provision whereby the health maintenance organization may reduce or refuse to pay benefits otherwise payable under the policy solely due to the existence of similar benefits provided under insurance policies issued by the same or another health maintenance organization, insurer, health care services plan, or self-insurance plan if the similar benefits provide protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, 100 percent of the total covered changes described in the policies and presented for payment are paid.

(c) If a subscriber fails to furnish the provider with the correct name and address of the subscriber's primary prepaid health plan, group hospital, medical, or surgical expense policy, group health care services plan, or group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses delivered or issued for delivery in this state, and the claim is submitted to a secondary prepaid health plan or insurer and is subsequently rejected, the provider has 60 calendar days from the date the provider obtains the correct billing information for the primary or secondary insurer or prepaid health plan to submit the claim, regardless of any time periods for submission of claims established by any applicable contract. For the purposes of this subsection, "insurer" includes persons contracting with preferred provider networks pursuant

to s. 627.6471 and exclusive provider networks pursuant to s. 627.6472.

(12)(a) Without regard to any other remedy or relief to which a provider is entitled, any provider aggrieved by a violation of this section by a health maintenance organization may bring an action to enjoin a person who has violated, or is violating, this section. In any such action, the provider who has suffered a loss as a result of the violation may recover any amounts due the provider by the health maintenance organization, including accrued interest, plus attorney's fees and costs as provided in paragraph (b).

(b) In any action arising out of a violation of this section by a health maintenance organization in which the health maintenance organization is found to have violated this section, the provider, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her reasonable attorney's fees and costs from the health maintenance organization.

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

Section 11. Section 641.3156, Florida Statutes, is amended to read:

641.3156 Treatment authorization; payment of claims.--

(1) For purposes of this section, "authorization" includes any requirement of a provider to notify a health maintenance organization in advance of providing a covered service, regardless of whether the actual terminology used by the organization includes, but is not limited to, preauthorization, precertification, notification, or any other similar terminology.

(2) A health maintenance organization that requires authorization for medical care and health care services shall provide to each contracted provider at the time a contract is signed a list of the medical care and health care services that require authorization and the authorization procedures used by the organization. A health maintenance organization that requires authorization for medical care and health care services shall provide to each noncontracted provider, not later than 10 working days after a request is made, a list of the medical care and health care services that require authorization and the authorization procedures used by the organization. The list of medical care or health care services that require authorization and the authorization procedures used by the organization shall not be modified unless written notice is provided at least 30 days in advance of any changes to all subscribers, contracted providers, and noncontracted providers who had previously requested a list of medical care or health care services that require authorization.

(3) Any claim for treatment that does not require an authorization for a covered service that is ordered by a contracted physician may not be denied.~~A health maintenance organization must pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a provider 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 provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.~~

(4)(a)~~(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 provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

(b) On receipt of a request from a provider for authorization pursuant to this section, the health maintenance organization shall issue a determination indicating whether the service or services are authorized. The determination must be transmitted to the provider making the request in writing no later than 8 hours after the request is made by the provider. If the organization denies the request for an authorization, the health maintenance organization must notify the subscriber at the same time when notifying the provider requesting the authorization. A health maintenance organization that fails to respond to a request for an authorization from a provider pursuant to this paragraph is considered to have authorized the requested medical care or health care service and payment may not be denied.

(5) If the proposed medical care or health care service or services involve an inpatient admission and the health maintenance organization requires authorization as a condition of payment, the health maintenance organization shall issue a written or electronic authorization for the total estimated length of stay for the admission. If the proposed medical care or health care service or services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed and the medical care or health care service requires an authorization,

the health maintenance organization shall issue a determination indicating whether the proposed services are authorized no later than 1 hour after the request by the health care provider. A health maintenance organization that fails to respond to such request within 1 hour is considered to have authorized the requested medical care or health care service and payment may not be denied.

(6)~~(3)~~ Emergency services are subject to the provisions of s. 641.513 and are not subject to the provisions of this section, including any inpatient admission required in order to stabilize the patient pursuant to federal and state law.

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

Section 12. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

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

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(9)~~(6)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 13. Effective October 16, 2002, section 627.647, Florida Statutes, is repealed.

Section 14. Except as otherwise provided in this act, this act shall take effect October 1, 2002.

**********

LEGISLATIVE SUMMARY

Includes preferred provider organizations within the definition of managed care organization and provides for filing unresolved internal dispute-resolution processes with a dispute-resolution organization. Provides for coordination of benefits under multiple health insurance policies regardless of time periods. Revises time of payment of claims provisions. Requires the Department of Insurance to adopt insurance claim-filing rules consistent with federal standards and provides requirements and procedures for payment or denial of claims. Entitles insureds and health maintenance organization subscribers to prompt payment of claims for covered services. Requires health insurers and health maintenance organizations to provide lists of medical care and health care services that require authorization and provides procedural requirements for determination and issuance of authorizations for services. Revises limitations on policies providing differing schedules of payments for preferred provider services and nonpreferred provider services. Applies coordination of benefits, payment of claims, and treatment authorizations provisions to group, blanket, and franchise health insurance. (See bill for details.)