Florida Senate - 2002

By the Committees on Health, Aging and Long-Term Care; Banking and Insurance; and Senators Saunders, Campbell, Peaden and Cowin

i	317-1937-02
1	A bill to be entitled
2	An act relating to health insurance; amending
3	s. 408.7057, F.S.; redefining "managed care
4	organization"; including preferred provider
5	organization and health insurers in the claim
6	dispute resolution program; specifying
7	timeframes for submission of supporting
8	documentation necessary for dispute resolution;
9	providing consequences for failure to comply;
10	authorizing the agency to impose fines and
11	sanctions as part of final orders; amending s.
12	627.613, F.S.; revising time of payment of
13	claims provisions; providing requirements and
14	procedures for payment or denial of claims;
15	providing criteria and limitations; revising
16	rate of interest charged on overdue payments;
17	providing for electronic transmission of
18	claims; providing a penalty; providing for
19	attorney's fees and costs; prohibiting
20	contractual modification of provisions of law;
21	creating s. 627.6142, F.S.; defining the term
22	"authorization"; requiring health insurers to
23	provide lists of medical care and health care
24	services that require authorization;
25	prohibiting denial of certain claims; providing
26	procedural requirements for determination and
27	issuance of authorizations of services;
28	amending s. 627.638, F.S.; providing for direct
29	payment for services in treatment of a
30	psychological disorder or substance abuse;
31	amending s. 627.651, F.S.; conforming a
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1	cross-reference; amending s. 627.662, F.S.;
2	specifying application of certain additional
3	provisions to group, blanket, and franchise
4	health insurance; amending s. 641.185, F.S.;
5	entitling health maintenance organization
6	subscribers to prompt payment when appropriate;
7	amending s. 641.30, F.S.; conforming a
8	cross-reference; amending s. 641.3155, F.S.;
9	revising definitions; eliminating provisions
10	that require the Department of Insurance to
11	adopt rules consistent with federal
12	claim-filing standards; providing requirements
13	and procedures for payment of claims; requiring
14	payment within specified periods; revising rate
15	of interest charged on overdue payments;
16	requiring employers to provide notice of
17	changes in eligibility status within a
18	specified time period; providing a penalty;
19	entitling health maintenance organization
20	subscribers to prompt payment by the
21	organization for covered services by an
22	out-of-network provider; requiring payment
23	within specified periods; providing payment
24	procedures; providing penalties; amending s.
25	641.3156, F.S.; defining the term
26	"authorization"; requiring health maintenance
27	organizations to provide lists of medical care
28	and health care services that require
29	authorization; prohibiting denial of certain
30	claims; providing procedural requirements for
31	determination and issuance of authorizations of

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1 services; amending ss. 626.9541, 641.3903, 2 F.S.; providing that untruthfully notifying a 3 provider that a filed claim has not been received constitutes an unfair claim-settlement 4 5 practice by insurers and health maintenance б organizations; providing penalties; providing 7 an effective date. 8 9 Be It Enacted by the Legislature of the State of Florida: 10 11 Section 1. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsection (4) of section 408.7057, 12 Florida Statutes, are amended, and paragraphs (e) and (f) are 13 added to subsection (2) of that section, to read: 14 408.7057 Statewide provider and managed care 15 organization claim dispute resolution program .--16 17 (1) As used in this section, the term: 18 (a) "Managed care organization" means a health 19 maintenance organization or a prepaid health clinic certified 20 under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under 21 22 s. 627.6472, a preferred provider organization under s. 627.6471, or a health insurer licensed pursuant to chapter 23 24 627. 25 (2) (c) Contracts entered into or renewed on or after 26 27 October 1, 2000, may require exhaustion of an internal 28 dispute-resolution process as a prerequisite to the submission 29 of a claim by a provider, or health maintenance organization, or health insurer to the resolution organization when the 30 31 dispute-resolution program becomes effective. 3

1	(e) The resolution organization shall require the
2	managed care organization or provider submitting the claim
3	dispute to submit any supporting documentation to the
4	resolution organization within 15 days after receipt by the
5	managed care organization or provider of a request from the
6	resolution organization for documentation in support of the
7	claim dispute. Failure to submit the supporting documentation
8	within such time period shall result in the dismissal of the
9	submitted claim dispute.
10	(f) The resolution organization shall require the
11	respondent in the claim dispute to submit all documentation in
12	support of its position within 15 days after receiving a
13	request from the resolution organization for supporting
14	documentation. Failure to submit the supporting documentation
15	within such time period shall result in a default against the
16	managed care organization or provider. In the event of such a
17	default, the resolution organization shall issue its written
18	recommendation to the agency that a default be entered against
19	the defaulting entity. The written recommendation shall
20	include a recommendation to the agency that the defaulting
21	entity shall pay the entity submitting the claim dispute the
22	full amount of the claim dispute, plus all accrued interest.
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. The agency may issue a final
26	order imposing fines or sanctions, including those contained
27	in s. 641.52. All fines collected under this subsection shall
28	be deposited into the Health Care Trust Fund.
29	Section 2. Section 627.613, Florida Statutes, is
30	amended to read:
31	627.613 Time of payment of claims
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1 (1) The contract shall include the following provision: 2 3 "Time of Payment of Claims: After receiving written 4 5 proof of loss, the insurer will pay monthly all benefits then б due for (type of benefit). Benefits for any other loss covered 7 by this policy will be paid as soon as the insurer receives 8 proper written proof." 9 10 (2) Health insurers shall reimburse all claims or any 11 portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 12 13 35 + 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health 14 insurer, the insured or the insured's assignees shall be 15 notified, in writing, that the claim is contested or denied, 16 17 within 35 45 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify 18 19 the contested portion of the claim, and the specific reasons for contesting the claim, and written itemization of any 20 21 additional information or additional documents needed to process the claim or the contested portion of the claim. A 22 health insurer may not make more than one request under this 23 24 subsection in connection with a claim unless the provider 25 fails to submit all of the requested information to process the claim or if information submitted by the provider raises 26 27 new, additional issues not included in the original written 28 itemization, in which case the health insurer may provide the 29 health care provider with one additional opportunity to submit 30 the additional information needed to process the claim. In no 31 case may the health insurer request duplicate information.

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1	(3) A health insurer, upon receipt of the additional
2	information requested from the insured or the insured's
3	assignees shall pay or deny the contested claim or portion of
4	the contested claim, within $35 + 60$ days.
5	(4) <u>A health</u> An insurer shall pay or deny any claim no
6	later than 120 days after receiving the claim. <u>Failure to do</u>
7	so creates an uncontestable obligation for the health insurer
8	to pay the claim to the provider.
9	(5) Payment <u>of a claim is considered</u> shall be treated
10	as being made on the date the payment was electronically
11	transferred or otherwise delivered a draft or other valid
12	instrument which is equivalent to payment was placed in the
13	United States mail in a properly addressed, postpaid envelope
14	or, if not so posted, on the date of delivery.
15	(6) All overdue payments shall bear simple interest at
16	the rate of $\underline{12}$ $\underline{10}$ percent per year. Interest on a late payment
17	of a claim or uncontested portion of a claim begins to accrue
18	on the 36th day after the claim has been received. Interest
19	due is payable with the payment of the claim.
20	(7) Upon written notification by an insured, an
21	insurer shall investigate any claim of improper billing by a
22	physician, hospital, or other health care provider. The
23	insurer shall determine if the insured was properly billed for
24	only those procedures and services that the insured actually
25	received. If the insurer determines that the insured has been
26	improperly billed, the insurer shall notify the insured and
27	the provider of its findings and shall reduce the amount of
28	payment to the provider by the amount determined to be
29	improperly billed. If a reduction is made due to such
30	notification by the insured, the insurer shall pay to the
31	insured 20 percent of the amount of the reduction up to $$500$.
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1	(8) A provider claim for payment shall be considered
2	received by the health insurer, if the claim has been
3	electronically transmitted to the health insurer, when receipt
4	is verified electronically or, if the claim is mailed to the
5	address disclosed by the health insurer, on the date indicated
6	on the return receipt. A provider must wait 35 days following
7	receipt of a claim before submitting a duplicate claim.
8	(9)(a) If, as a result of retroactive review of
9	coverage decisions or payment levels, a health insurer
10	determines that it has made an overpayment to a provider for
11	services rendered to an insured, the health insurer must make
12	a claim for such overpayment. The health insurer may not
13	reduce payment to that provider for other services unless the
14	provider agrees to the reduction or fails to respond to the
15	health insurer's claim as required in this subsection.
16	(b) A provider shall pay a claim for an overpayment
17	made by a health insurer that the provider does not contest or
18	deny within 35 days after receipt of the claim that is mailed
19	or electronically transferred to the provider.
20	(c) A provider that denies or contests a health
21	insurer's claim for overpayment or any portion of a claim
22	shall notify the health insurer, in writing, within 35 days
23	after the provider receives the claim that the claim for
24	overpayment is contested or denied. The notice that the claim
25	for overpayment is contested or denied must identify the
26	contested portion of the claim and the specific reason for
27	contesting or denying the claim, and, if contested, must
28	include a request for additional information. The provider
29	shall pay or deny the claim for overpayment within 35 days
30	after receipt of the information.
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1	(d) Payment of a claim for overpayment is considered
2	made on the date payment was electronically transferred or
3	otherwise delivered to the health insurer or on the date that
4	the provider receives a payment from the health insurer that
5	reduces or deducts the overpayment. An overdue payment of a
б	claim bears simple interest at the rate of 12 percent per
7	year. Interest on an overdue payment of a claim for
8	overpayment or for any uncontested portion of a claim for
9	overpayment begins to accrue on the 36th day after the claim
10	for overpayment has been received.
11	(e) A provider shall pay or deny any claim for
12	overpayment no later than 120 days after receiving the claim.
13	Failure to do so creates an uncontestable obligation for the
14	provider to pay the claim to the health insurer.
15	(f) A health insurer's claim for overpayment shall be
16	considered received by a provider, if the claim has been
17	electronically transmitted to the provider, when receipt is
18	verified electronically, or, if the claim is mailed to the
19	address disclosed by the provider, on the date indicated on
20	the return receipt. A health insurer must wait 35 days
21	following the provider's receipt of a claim for overpayment
22	before submitting a duplicate claim.
23	(10) Any retroactive reductions of payments or demands
24	for refund of previous overpayments that are due to
25	retroactive review of coverage decisions or payment levels
26	must be reconciled to specific claims. Any retroactive demands
27	by providers for payment due to underpayments or nonpayments
28	for covered services must be reconciled to specific claims.
29	The look-back or audit-review period shall not exceed 2 years
30	after the date the claim was paid by the health insurer,
31	unless fraud in billing is involved.

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1	(11) A health insurer may not deny a claim because of
2	the insured's ineligibility if the provider can document
3	receipt of the insured's eligibility confirmation by the
4	health insurer prior to the date or time covered services were
5	provided. Any person who knowingly and willfully misinforms a
6	provider prior to receipt of services as to his or her
7	coverage eligibility commits insurance fraud, punishable as
8	provided in s. 817.50.
9	(12)(a) Without regard to any other remedy or relief
10	to which a person is entitled, or obligated to under contract,
11	anyone aggrieved by a violation of this section may bring an
12	action to obtain a declaratory judgment that an act or
13	practice violates this section and to enjoin a person who has
14	violated, is violating, or is otherwise likely to violate this
15	section.
16	(b) In any action brought by a person who has suffered
17	a loss as a result of a violation of this section, such person
18	may recover any amounts due the person under this section,
19	including accrued interest, plus attorney's fees and court
20	costs as provided in paragraph (c).
21	(c) In any civil litigation resulting from an act or
22	practice involving a violation of this section by a health
23	insurer in which the health insurer is found to have violated
24	this section, the provider, after judgment in the trial court
25	and after exhausting all appeals, if any, shall receive his or
26	her attorney's fees and costs from the insurer; however, such
27	fees shall not exceed three times the amount in controversy or
28	\$5,000, whichever is greater. In any such civil litigation, if
29	the insurer is found not to have violated this section, the
30	insurer, after judgment in the trial court and exhaustion of
31	all appeals, if any, may receive its reasonable attorney's

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1 fees and costs from the provider on any claim or defense that the court finds the provider knew or should have known was not 2 3 supported by the material facts necessary to establish the claim or defense or would not be supported by the application 4 5 of then-existing law as to those material facts. б (d) The attorney for the prevailing party shall submit 7 a sworn affidavit of his or her time spent on the case and his 8 or her costs incurred for all the motions, hearings, and appeals to the trial judge who presided over the civil case. 9 10 (e) Any award of attorney's fees or costs shall become 11 a part of the judgment and subject to execution as the law 12 allows. 13 (13) The provisions of this section may not be waived, 14 voided, or nullified by contracts. Section 3. Section 627.6142, Florida Statutes, is 15 16 created to read: 17 627.6142 Treatment authorization; payment of claims.--(1) For purposes of this section, "authorization" 18 19 includes any requirement of a provider to notify an insurer in advance of providing a covered service, regardless of whether 20 the actual terminology used by the insurer includes, but is 21 not limited to, preauthorization, precertification, 22 notification, or any other similar terminology. 23 24 (2) A health insurer that requires authorization for 25 medical care or health care services shall provide to each provider with whom the health insurer has contracted pursuant 26 27 to s. 627.6471 or s. 627.6472 a list of the medical care and health care services that require authorization and the 28 29 authorization procedures used by the health insurer at the time a contract becomes effective. A health insurer that 30 31 requires authorization for medical care or health care

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1 services shall provide to all other providers, not later than 10 working days after a request is made, a list of the medical 2 3 care and health care services that require authorization and the authorization procedures established by the insurer. The 4 5 medical care or health care services that require б authorization and the authorization procedures used by the 7 insurer shall not be modified unless written notice is 8 provided at least 30 days in advance of any changes to all affected insureds as well as to all contracted providers and 9 all other providers that had previously requested in writing a 10 11 list of medical care or health care services that require authorization. An insurer that makes such list and procedures 12 accessible to providers and insureds electronically is in 13 compliance with this section so long as notice is provided at 14 least 30 days in advance of any changes in such list or 15 procedures to all insureds, contracted providers, and 16 17 noncontracted providers who had previously requested a list of medical care or health care services that require 18 19 authorization. (3) Any claim for a covered service that does not 20 require authorization that is ordered by a contracted 21 physician and entered on the medical record may not be denied. 22 If the health insurer determines that an overpayment has been 23 24 made, then a claim for overpayment should be submitted to the 25 provider pursuant to s. 627.613. (4)(a) Any claim for treatment may not be denied if a 26 27 provider follows the health insurer's published authorization procedures and receives authorization, unless the provider 28 29 submits information to the health insurer with the willful 30 intention to misinform the health insurer. 31

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1	(b) Upon receipt of a request from a provider for
2	authorization, the health insurer shall issue a written
3	determination indicating whether the service or services are
4	authorized. If the request for an authorization is for an
5	inpatient admission, the determination shall be transmitted to
6	the provider making the request in writing no later than 24
7	hours after the request is made by the provider. If the health
8	insurer denies the request for authorization, the health
9	insurer shall notify the insured at the same time the insurer
10	notifies the provider requesting the authorization. A health
11	insurer that fails to respond to a request for an
12	authorization pursuant to this paragraph within 24 hours is
13	considered to have authorized the inpatient admission and
14	payment shall not be denied.
15	(5) If the proposed medical care or health care
16	service or services involve an inpatient admission and the
17	health insurer requires an authorization as a condition of
18	payment, the health insurer shall review and issue a written
19	or electronic authorization for the total estimated length of
20	stay for the admission, based on the recommendation of the
21	patient's physician. If the proposed medical care or health
22	care service or services are to be provided to an insured who
23	is an inpatient in a health care facility and authorization is
24	required, the health insurer shall issue a written
25	determination indicating whether the proposed services are
26	authorized or denied no later than 4 hours after the request
27	is made by the provider. A health insurer who fails to respond
28	to such request within 4 hours is considered to have
29	authorized the requested medical care or health care service
30	and payment shall not be denied.
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1 (6) Authorization may not be required for emergency services and care or emergency medical services as provided 2 3 pursuant to ss. 395.002, 395.1041, 401.45, and 401.252. Such emergency services and care shall extend through any inpatient 4 5 admission required in order to provide for stabilization of an б emergency medical condition pursuant to state and federal law. 7 The provisions of this section may not be waived, (7) 8 voided, or nullified by contract. 9 Section 4. Subsection (3) is added to section 627.638, 10 Florida Statutes, to read: 11 627.638 Direct payment for hospital, medical services.--12 13 (3) Under any health insurance policy insuring against loss or expense due to hospital confinement or to medical and 14 related services, payment of benefits shall be made directly 15 to any recognized hospital, doctor, or other person who 16 17 provided services for the treatment of a psychological disorder or treatment for substance abuse, including drug and 18 19 alcohol abuse, when the treatment is in accordance with the provisions of the policy and the insured specifically 20 authorizes direct payment of benefits. Payments shall be made 21 under this section, notwithstanding any contrary provisions in 22 the health insurance contract. This subsection applies to all 23 24 health insurance policies now or hereafter in force as of the 25 effective date of this act. Section 5. Subsection (4) of section 627.651, Florida 26 27 Statutes, is amended to read: 28 627.651 Group contracts and plans of self-insurance 29 must meet group requirements. --(4) This section does not apply to any plan which is 30 31 established or maintained by an individual employer in 13

1 accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare 2 3 arrangement as defined in s. 624.437(1), except that a 4 multiple-employer welfare arrangement shall comply with ss. 5 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, б 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)(6). 7 This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not 8 9 comply with this part. 10 Section 6. Section 627.662, Florida Statutes, is 11 amended to read: 627.662 Other provisions applicable. -- The following 12 13 provisions apply to group health insurance, blanket health insurance, and franchise health insurance: 14 (1) Section 627.569, relating to use of dividends, 15 refunds, rate reductions, commissions, and service fees. 16 17 (2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions. 18 19 (3) Section 627.635, relating to excess insurance. 20 Section 627.638, relating to direct payment for (4) 21 hospital or medical services. (5) Section 627.640, relating to filing and 22 classification of rates. 23 (6) Section 627.6142, relating to treatment 24 25 authorizations. 26 (7) (6) Section 627.645(1), relating to denial of 27 claims. 28 (8) (7) Section 627.613, relating to time of payment of 29 claims. 30 (9)(8) Section 627.6471, relating to preferred 31 provider organizations.

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1 (10)(9) Section 627.6472, relating to exclusive 2 provider organizations. 3 (11)(10) Section 627.6473, relating to combined 4 preferred provider and exclusive provider policies. 5 (12)(11) Section 627.6474, relating to provider б contracts. 7 Section 7. Paragraph (e) of subsection (1) of section 8 641.185, Florida Statutes, is amended to read: 9 641.185 Health maintenance organization subscriber 10 protections. --11 (1) With respect to the provisions of this part and part III, the principles expressed in the following statements 12 13 shall serve as standards to be followed by the Department of 14 Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising 15 administrative discretion, in administrative interpretations 16 17 of the law, in enforcing its provisions, and in adopting 18 rules: 19 (e) A health maintenance organization subscriber should receive timely, concise information regarding the 20 health maintenance organization's reimbursement to providers 21 22 and services pursuant to ss. 641.31 and 641.31015 and is 23 entitled to prompt payment from the organization when 24 appropriate pursuant to s. 641.3155. 25 Section 8. Subsection (1) of section 641.30, Florida Statutes, is amended to read: 26 27 641.30 Construction and relationship to other laws.--28 (1) Every health maintenance organization shall accept 29 the standard health claim form prescribed pursuant to s. 641.3155 627.647. 30 31

1 Section 9. Section 641.3155, Florida Statutes, is 2 amended to read: 3 641.3155 Payment of claims.--(1)(a) As used in this section, the term "clean claim" 4 5 for a noninstitutional provider means a paper or electronic б billing instrument that consists of the HCFA 1500 data set that has all mandatory entries for a physician licensed under 7 8 chapter 458, chapter 459, chapter 460, chapter 461, or chapter 490 or other appropriate form for any other noninstitutional 9 10 provider, or its successor. For institutional providers, 11 "claim" means a paper or electronic billing instrument that consists of the UB-92 data set or its successor that has all 12 mandatory entries. claim submitted on a HCFA 1500 form which 13 14 has no defect or impropriety, including lack of required substantiating documentation for noncontracted providers and 15 16 suppliers, or particular circumstances requiring special 17 treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because 18 19 a health maintenance organization refers the claim to a medical specialist within the health maintenance organization 20 21 for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from 22 a source outside the health maintenance organization, the 23 24 claim is considered not clean. This definition of "clean claim" is repealed on the effective date of rules adopted by 25 the department which define the term "clean claim." 26 27 (b) Absent a written definition that is agreed upon through contract, the term "clean claim" for an institutional 28 claim is a properly and accurately completed paper or 29 30 electronic billing instrument that consists of the UB-92 data 31

1 set or its successor with entries stated as mandatory by the 2 National Uniform Billing Committee. 3 (c) The department shall adopt rules to establish 4 claim forms consistent with federal claim-filing standards for 5 health maintenance organizations required by the federal б Health Care Financing Administration. The department may adopt 7 rules relating to coding standards consistent with Medicare 8 coding standards adopted by the federal Health Care Financing Administration. 9 10 (2)(a) A health maintenance organization shall pay any 11 clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with 12 13 the health maintenance organization or a clean claim made by a noncontract provider which the organization does not contest 14 15 or deny within 35 days after receipt of the claim by the health maintenance organization which is submitted mailed or 16 17 electronically transferred by the provider, either electronically or using hand delivery, the United States mail, 18 19 or a reputable overnight delivery service. 20 (b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall 21 notify the provider, in writing, within 35 days after the 22 health maintenance organization receives the claim that the 23 24 claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the 25 claim and the specific reason for contesting or denying the 26 claim, and, if contested, must give the provider a written 27 28 itemization of any include a request for additional 29 information or additional documents needed to process the claim or any portion of the claim that is not being paid. If 30 31 the provider submits additional information, the provider 17

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1	must, within 35 days after receipt of the request, mail or
2	electronically transfer the information to the health
3	maintenance organization. The health maintenance organization
4	shall pay or deny the claim or portion of the claim within $\underline{35}$
5	45 days after receipt of the information. A health maintenance
6	organization may not make more than one request under this
7	paragraph in connection with a claim, unless the provider
8	fails to submit all of the requested information to process
9	the claim or if information submitted by the provider raises
10	new, additional issues not included in the original written
11	itemization, in which case the health maintenance organization
12	may provide the health care provider with one additional
13	opportunity to submit the additional information needed to
14	process the claim. In no case may the health insurer request
15	duplicate information.
16	(c) A health maintenance organization shall not deny
17	or withhold payment on a claim because the insured has not
18	paid a required deductible or copayment.
19	(3) Payment of a claim is considered made on the date
20	the payment was received or electronically transferred or
21	otherwise delivered. An overdue payment of a claim bears
22	simple interest at the rate of $\frac{12}{10}$ percent per year.
23	Interest on an overdue payment for a clean claim or for any
24	uncontested portion of a clean claim begins to accrue on the
25	36th day after the claim has been received. The interest is
26	payable with the payment of the claim.
27	(4) A health maintenance organization shall pay or
28	deny any claim no later than 120 days after receiving the
29	claim. Failure to do so creates an uncontestable obligation
30	for the health maintenance organization to pay the claim to
31	the provider.

1 (5)(a) If, as a result of retroactive review of 2 coverage decisions or payment levels, a health maintenance 3 organization determines that it has made an overpayment to a 4 provider for services rendered to a subscriber, the 5 organization must make a claim for such overpayment. The 6 organization may not reduce payment to that provider for other services unless the provider agrees to the reduction in 7 8 writing after receipt of the claim for overpayment from the 9 health maintenance organization or fails to respond to the 10 organization's claim as required in this subsection. 11 (b) A provider shall pay a claim for an overpayment made by a health maintenance organization which the provider 12 13 does not contest or deny within 35 days after receipt of the claim that is mailed or electronically transferred to the 14 provider. 15 (c) A provider that denies or contests an 16 17 organization's claim for overpayment or any portion of a claim 18 shall notify the organization, in writing, within 35 days 19 after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim 20 for overpayment is denied or contested must identify the 21 contested portion of the claim and the specific reason for 22 contesting or denying the claim, and, if contested, must 23 24 include a request for additional information. If the organization submits additional information, the organization 25 must, within 35 days after receipt of the request, mail or 26 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. 30 (d) Payment of a claim for overpayment is considered 31 made on the date payment was received or electronically

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1 transferred or otherwise delivered to the organization, or the 2 date that the provider receives a payment from the 3 organization that reduces or deducts the overpayment. An 4 overdue payment of a claim bears simple interest at the rate 5 of 12 10 percent a year. Interest on an overdue payment of a б claim for overpayment or for any uncontested portion of a 7 claim for overpayment begins to accrue on the 36th day after 8 the claim for overpayment has been received.

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

13 (6) Any retroactive reductions of payments or demands 14 for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels 15 must be reconciled to specific claims unless the parties agree 16 to other reconciliation methods and terms. Any retroactive 17 18 demands by providers for payment due to underpayments or 19 nonpayments for covered services must be reconciled to 20 specific claims unless the parties agree to other reconciliation methods and terms. The look-back or 21 audit-review period shall not exceed 2 years after the date 22 the claim was paid by the health maintenance organization, 23 24 unless fraud in billing is involved. The look-back period may 25 be specified by the terms of the contract. (7)(a) A provider claim for payment shall be 26 27 considered received by the health maintenance organization, if 28 the claim has been electronically transmitted to the health 29 maintenance organization, when receipt is verified electronically or, if the claim is mailed to the address 30 31 disclosed by the organization, on the date indicated on the 20

1 return receipt, or on the date the delivery receipt is signed by the health maintenance organization if the claim is hand 2 3 delivered. A provider must wait 45 days following receipt of a claim before submitting a duplicate claim. 4 5 (b) A health maintenance organization claim for 6 overpayment shall be considered received by a provider, if the 7 claim has been electronically transmitted to the provider, when receipt is verified electronically or, if the claim is 8 mailed to the address disclosed by the provider, on the date 9 10 indicated on the return receipt. An organization must wait 45 11 days following the provider's receipt of a claim for overpayment before submitting a duplicate claim. 12 (c) This section does not preclude the health 13 maintenance organization and provider from agreeing to other 14 methods of submission transmission and receipt of claims. 15 (8) A provider, or the provider's designee, who bills 16 17 electronically is entitled to electronic acknowledgment of the 18 receipt of a claim within 72 hours. 19 (9) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility 20 21 if the provider can document receipt of subscriber eligibility confirmation by the organization prior to the date or time 22 covered services were provided. Every health maintenance 23 24 organization contract with an employer shall include a 25 provision that requires the employer to notify the health maintenance organization of changes in eligibility status 26 within 30 days more than 1 year after the date of payment of 27 28 the clean claim. Any person who knowingly misinforms a 29 provider prior to the receipt of services as to his or her 30 coverage eligibility commits insurance fraud punishable as provided in s. 817.50. 31

1	(10) A health maintenance organization shall pay a
2	contracted primary care or admitting physician, pursuant to
3	such physician's contract, for providing inpatient services in
4	a contracted hospital to a subscriber, if such services are
5	determined by the organization to be medically necessary and
6	covered services under the organization's contract with the
7	contract holder.
8	(11)(a) Without regard to any other remedy or relief
9	to which a person is entitled, or obligated to under contract,
10	anyone aggrieved by a violation of this section may bring an
11	action to obtain a declaratory judgment that an act or
12	practice violates this section and to enjoin a person who has
13	violated, is violating, or is otherwise likely to violate this
14	section.
15	(b) In any action brought by a person who has suffered
16	a loss as a result of a violation of this section, such person
17	may recover any amounts due the person under this section,
18	including accrued interest, plus attorney's fees and court
19	costs as provided in paragraph (c).
20	(c) In any civil litigation resulting from an act or
21	practice involving a violation of this section by a health
22	maintenance organization in which the organization is found to
23	have violated this section, the provider, after judgment in
24	the trial court and after exhausting all appeals, if any,
25	shall receive his or her attorney's fees and costs from the
26	organization; however, such fees shall not exceed three times
27	the amount in controversy or \$5,000, whichever is greater. In
28	any such civil litigation, if the organization is found not to
29	have violated this section, the organization, after judgment
30	in the trial court and exhaustion of all appeals, if any, may
31	receive its reasonable attorney's fees and costs from the
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1 provider on any claim or defense that the court finds the provider knew or should have known was not supported by the 2 3 material facts necessary to establish the claim or defense or would not be supported by the application of then-existing law 4 5 as to those material facts. (d) The attorney for the prevailing party shall submit б a sworn affidavit of his or her time spent on the case and his 7 8 or her costs incurred for all the motions, hearings, and appeals to the trial judge who presided over the civil case. 9 10 (e) Any award of attorney's fees or costs shall become 11 a part of the judgment and subject to execution as the law 12 allows. (12) A health maintenance organization subscriber is 13 entitled to prompt payment from the organization whenever a 14 subscriber pays an out-of-network provider for a covered 15 service and then submits a claim to the organization. The 16 17 organization shall pay the claim within 35 days after receipt or the organization shall advise the subscriber of what 18 19 additional information is required to adjudicate the claim. After receipt of the additional information, the organization 20 shall pay the claim within 10 days. If the organization fails 21 to pay claims submitted by subscribers within the time periods 22 specified in this subsection, the organization shall pay the 23 24 subscriber interest on the unpaid claim at the rate of 12 25 percent per year. Failure to pay claims and interest, if applicable, within the time periods specified in this 26 27 subsection is a violation of the insurance code and each 28 occurrence shall be considered a separate violation. 29 The provisions of this section may not be waived, (13) 30 voided, or nullified by contract. 31

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1 Section 10. Section 641.3156, Florida Statutes, is 2 amended to read: 3 641.3156 Treatment authorization; payment of claims.--4 (1) For purposes of this section, "authorization" 5 includes any requirement of a provider to notify a health б maintenance organization in advance of providing a covered 7 service, regardless of whether the actual terminology used by 8 the organization includes, but is not limited to, preauthorization, precertification, notification, or any other 9 10 similar terminology. 11 (2) A health maintenance organization that requires authorization for medical care and health care services shall 12 provide to each contracted provider at the time a contract is 13 signed a list of the medical care and health care services 14 that require authorization and the authorization procedures 15 used by the organization. A health maintenance organization 16 17 that requires authorization for medical care and health care services shall provide to each noncontracted provider, not 18 19 later than 10 working days after a request is made, a list of 20 the medical care and health care services that require authorization and the authorization procedures used by the 21 organization. The list of medical care or health care services 22 that require authorization and the authorization procedures 23 24 used by the organization shall not be modified unless written 25 notice is provided at least 30 days in advance of any changes to all subscribers, contracted providers, and noncontracted 26 providers who had previously requested a list of medical care 27 or health care services that require authorization. An 28 29 organization that makes such list and procedures accessible to providers and subscribers electronically is in compliance with 30 31 this section so long as notice is provided at least 30 days in

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1 advance of any changes in such list or procedures to all subscribers, contracted providers, and noncontracted providers 2 3 who had previously requested a list of medical care or health care services that require authorization. 4 5 (3) Any claim for a covered service that does not б require an authorization that is ordered by a contracted physician may not be denied. If an organization determines 7 8 that an overpayment has been made, then a claim for 9 overpayment should be submitted pursuant to s. 641.3155.A 10 health maintenance organization must pay any hospital-service 11 or referral-service claim for treatment for an eligible subscriber which was authorized by a provider empowered by 12 contract with the health maintenance organization to authorize 13 or direct the patient's utilization of health care services 14 and which was also authorized in accordance with the health 15 16 maintenance organization's current and communicated 17 procedures, unless the provider provided information to the 18 health maintenance organization with the willful intention to 19 misinform the health maintenance organization. 20 (4)(a) (2) A claim for treatment may not be denied if a 21 provider follows the health maintenance organization's authorization procedures and receives authorization for a 22 covered service for an eligible subscriber, unless the 23 24 provider provided information to the health maintenance organization with the willful intention to misinform the 25 health maintenance organization. 26 27 (b) On receipt of a request from a provider for 28 authorization pursuant to this section, the health maintenance 29 organization shall issue a written determination indicating 30 whether the service or services are authorized. If the request 31 for an authorization is for an inpatient admission, the

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1 determination must be transmitted to the provider making the request in writing no later than 24 hours after the request is 2 3 made by the provider. If the organization denies the request for an authorization, the health maintenance organization must 4 5 notify the subscriber at the same time when notifying the б provider requesting the authorization. A health maintenance organization that fails to respond to a request for an 7 8 authorization from a provider pursuant to this paragraph is considered to have authorized the inpatient admission within 9 10 24 hours and payment may not be denied. 11 (5) If the proposed medical care or health care service or services involve an inpatient admission and the 12 health maintenance organization requires authorization as a 13 condition of payment, the health maintenance organization 14 shall issue a written or electronic authorization for the 15 total estimated length of stay for the admission. If the 16 17 proposed medical care or health care service or services are to be provided to a patient who is an inpatient in a health 18 19 care facility at the time the services are proposed and the medical care or health care service requires an authorization, 20 the health maintenance organization shall issue a 21 determination indicating whether the proposed services are 22 authorized no later than 4 hours after the request by the 23 health care provider. A health maintenance organization that 24 25 fails to respond to such request within 4 hours is considered to have authorized the requested medical care or health care 26 27 service and payment may not be denied. 28 (6) (3) Emergency services are subject to the provisions of s. 641.513 and are not subject to the provisions 29 of this section. Such emergency services and care shall extend 30 31 through any inpatient admission required in order to provide 26

1 for stabilization of an emergency medical condition pursuant 2 to state and federal law. 3 (7) The provisions of this section may not be waived, voided, or nullified by contract. 4 5 Section 11. Paragraph (i) of subsection (1) of section б 626.9541, Florida Statutes, is amended to read: 7 626.9541 Unfair methods of competition and unfair or 8 deceptive acts or practices defined. --(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR 9 10 DECEPTIVE ACTS. -- The following are defined as unfair methods 11 of competition and unfair or deceptive acts or practices: (i) Unfair claim settlement practices.--12 13 1. Attempting to settle claims on the basis of an 14 application, when serving as a binder or intended to become a 15 part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the 16 17 insured; 2. A material misrepresentation made to an insured or 18 19 any other person having an interest in the proceeds payable 20 under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage 21 under such contract or policy on less favorable terms than 22 those provided in, and contemplated by, such contract or 23 24 policy; or 25 3. Committing or performing with such frequency as to indicate a general business practice any of the following: 26 27 Failing to adopt and implement standards for the a. 28 proper investigation of claims; 29 Misrepresenting pertinent facts or insurance policy b. 30 provisions relating to coverages at issue; 31

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1	c. Failing to acknowledge and act promptly upon
2	communications with respect to claims;
3	d. Denying claims without conducting reasonable
4	investigations based upon available information;
5	e. Failing to affirm or deny full or partial coverage
6	of claims, and, as to partial coverage, the dollar amount or
7	extent of coverage, or failing to provide a written statement
8	that the claim is being investigated, upon the written request
9	of the insured within 30 days after proof-of-loss statements
10	have been completed;
11	f. Failing to promptly provide a reasonable
12	explanation in writing to the insured of the basis in the
13	insurance policy, in relation to the facts or applicable law,
14	for denial of a claim or for the offer of a compromise
15	settlement;
16	g. Failing to promptly notify the insured of any
17	additional information necessary for the processing of a
18	claim; or
19	h. Failing to clearly explain the nature of the
20	requested information and the reasons why such information is
21	necessary; or.
22	(i) Notifying providers that claims filed under s.
23	627.613 have not been received when, in fact, the claims have
24	been received.
25	Section 12. Subsection (5) of section 641.3903,
26	Florida Statutes, is amended to read:
27	641.3903 Unfair methods of competition and unfair or
28	deceptive acts or practices definedThe following are
29	defined as unfair methods of competition and unfair or
30	deceptive acts or practices:
31	(5) UNFAIR CLAIM SETTLEMENT PRACTICES
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1	(a) Attempting to settle claims on the basis of an
1 2	application or any other material document which was altered
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	without notice to, or knowledge or consent of, the subscriber
4	or group of subscribers to a health maintenance organization;
5	(b) Making a material misrepresentation to the
6	subscriber for the purpose and with the intent of effecting
7	settlement of claims, loss, or damage under a health
8	maintenance contract on less favorable terms than those
9	provided in, and contemplated by, the contract; or
10	(c) Committing or performing with such frequency as to
11	indicate a general business practice any of the following:
12	1. Failing to adopt and implement standards for the
13	proper investigation of claims;
14	2. Misrepresenting pertinent facts or contract
15	provisions relating to coverage at issue;
16	3. Failing to acknowledge and act promptly upon
17	communications with respect to claims;
18	4. Denying of claims without conducting reasonable
19	investigations based upon available information;
20	5. Failing to affirm or deny coverage of claims upon
21	written request of the subscriber within a reasonable time not
22	to exceed 30 days after a claim or proof-of-loss statements
23	have been completed and documents pertinent to the claim have
24	been requested in a timely manner and received by the health
25	maintenance organization;
26	6. Failing to promptly provide a reasonable
27	explanation in writing to the subscriber of the basis in the
28	health maintenance contract in relation to the facts or
29	applicable law for denial of a claim or for the offer of a
30	compromise settlement;
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1 7. Failing to provide, upon written request of a 2 subscriber, itemized statements verifying that services and 3 supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual 4 5 specified disease or limited benefit policies, provided that б the organization may receive from the subscriber a reasonable 7 administrative charge for the cost of preparing such 8 statement;

9 8. Failing to provide any subscriber with services, 10 care, or treatment contracted for pursuant to any health 11 maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such 12 13 services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any 14 other emergency or similar event not within the control of the 15 health maintenance organization results in the inability of 16 17 the facilities, personnel, or financial resources of the 18 health maintenance organization to provide or arrange for 19 provision of a health service in accordance with requirements 20 of this part, the health maintenance organization is required only to make a good faith effort to provide or arrange for 21 provision of the service, taking into account the impact of 22 the event. For the purposes of this paragraph, an event is 23 24 not within the control of the health maintenance organization if the health maintenance organization cannot exercise 25 influence or dominion over its occurrence; or 26 27 Systematic downcoding with the intent to deny 9. 28 reimbursement otherwise due; or. 29 10. Notifying providers that claims filed under s. 30 641.3155 have not been received when, in fact, the claims have 31 been received.

1	Section 13. This act shall take effect October 1,
2	2002.
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4	STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
5	COMMITTEE SUBSTITUTE FOR <u>CS/SB 362</u>
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7	The Committee Substitute for CS/SB 362 differs from CS/SB 362 in the following ways.
8	It sets a maximum amount for attorney's fees and court costs
9	that a provider may receive from a health insurer or health maintenance organization that violates the prompt pay
10	provisions of the bill. The maximum amount will be three times the amount in controversy or \$5,000 which ever is greater.
11	If a health insurer or health maintenance organization is
12	found not to have violated the prompt pay provisions of the law, it may receive attorney's fees and costs from any claim
13	or defense that the court finds the provider should have known was not supported by the material facts.
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