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CHAMBER ACTION

Senate	.	House
Comm: WD 4/1/2008	.	
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The Committee on Health Policy (Dockery) recommended the following **substitute for amendment (457874):**

Senate Amendment (with title amendment)

Between line(s) 33 and 34,

insert:

Section 1. Subsections (3) and (6) of section 627.6131, Florida Statutes, are amended to read:

627.6131 Payment of claims.--

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

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

(b) Must be mailed or electronically transferred to the primary insurer within 60 days ~~6 months~~ after the following have occurred:

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

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

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

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

(6) If a health insurer determines that it has made an overpayment to a provider for services rendered to an insured, the health insurer must make a claim for such overpayment to the provider's designated location. A health insurer that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The insurer must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

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

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

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

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

4. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of

12 percent per year. Interest on an overdue payment for a claim for an overpayment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for an underpayment by a provider or overpayment by a health insurer may ~~shall~~ not be made ~~permitted~~ beyond 18 ~~30~~ months after the health insurer's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234 or where fraud or abuse is suspected.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

On line(s) 2, after the semicolon,

insert:

amending s. 627.6131, F.S.; reducing the period for a health insurer to submit a claim to a provider for underpayment or overpayment; reducing the amount of time in which a claim for an underpayment by a provider or overpayment by a health insurer is permitted; providing an exception;