

By Senator Fasano

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1 A bill to be entitled
2 An act relating to health services claims; amending s.
3 627.6141, F.S.; authorizing appeals from denials of
4 certain claims for certain services; requiring a
5 health insurer to conduct a retrospective review of
6 the medical necessity of a service under certain
7 circumstances; requiring the health insurer to submit
8 a written justification for a determination that a
9 service was not medically necessary and provide a
10 process for appealing the determination; amending s.
11 641.3156, F.S.; authorizing appeals from denials of
12 certain claims for certain services; requiring a
13 health maintenance organization to conduct a
14 retrospective review of the medical necessity of a
15 service under certain circumstances; requiring the
16 health maintenance organization to submit a written
17 justification for a determination that a service was
18 not medically necessary and provide a process for
19 appealing the determination; providing an effective
20 date.

21
22 Be It Enacted by the Legislature of the State of Florida:

23
24 Section 1. Section 627.6141, Florida Statutes, is amended
25 to read:

26 627.6141 Denial of claims.—Each claimant, or provider
27 acting for a claimant, who has had a claim denied or a portion
28 of a claim denied because the provider failed to obtain the
29 necessary authorization due to an unintentional act or error or

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30 ~~omission as not medically necessary~~ must be provided an
31 opportunity for an appeal to the insurer's licensed physician
32 who is responsible for the medical necessity reviews under the
33 plan ~~or is a member of the plan's peer review group~~. If the
34 provider appeals the denial, the health insurer shall conduct
35 and complete a retrospective review of the medical necessity of
36 the service within 30 business days after the submitted appeal.
37 If the insurer determines upon review that the service was
38 medically necessary, the insurer shall reverse the denial and
39 pay the claim. If the insurer determines that the service was
40 not medically necessary, the insurer shall submit to the
41 provider specific written clinical justification for the
42 determination. The appeal may be by telephone, and the insurer's
43 licensed physician must respond within a reasonable time, not to
44 exceed 15 business days.

45 Section 2. Subsection (3) of section 641.3156, Florida
46 Statutes, is renumbered as subsection (4), and a new subsection
47 (3) is added to that section to read:

48 641.3156 Treatment authorization; payment of claims.—

49 (3) If a provider claim or a portion of a provider claim is
50 denied because the provider, due to an unintentional act of
51 error or omission, failed to obtain the necessary authorization,
52 the provider may appeal the denial to the health maintenance
53 organization's licensed physician who is responsible for medical
54 necessity reviews. The health maintenance organization shall
55 conduct and complete a retrospective review of the medical
56 necessity of the service within 30 business days after the
57 submitted appeal. If the health maintenance organization
58 determines that the service is medically necessary, the health

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59 maintenance organization shall reverse the denial and pay the
60 claim. If the health maintenance organization determines that
61 the service is not medically necessary, the health maintenance
62 organization shall provide the provider with specific written
63 clinical justification for the determination.

64 Section 3. This act shall take effect July 1, 2010.