A bill to be entitled

An act relating to health services claims; amending s. 627.6141, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health insurer to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health insurer to submit a written justification for a determination that a service was not medically necessary and provide a process for appealing the determination; amending s. 641.3156, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health maintenance organization to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health maintenance organization to submit a written justification for a determination that a service was not medically necessary and provide a process for appealing the determination; providing an effective date.

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

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

627.6141 Denial of claims.—Each claimant, or provider acting for a claimant, who has had a claim denied or a portion of a claim denied because the provider failed to obtain the necessary authorization due to an unintentional act or error or omission ~~as not medically necessary~~ must be provided an

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

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

641.3156 Treatment authorization; payment of claims.—

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

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

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