By Senator Massullo

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A bill to be entitled

An act relating to insurance claims payments to health care providers; creating s. 627.4193, F.S.; defining terms; prohibiting payment adjudicators from downcoding health care services under certain circumstances; providing exceptions; requiring payment adjudicators to provide certain information to the provider; prohibiting payment adjudicators from downcoding a service under certain circumstances; prohibiting payment adjudicators for downcoding orders by a licensed nurse; specifying that payment adjudicators are solely responsible for certain violations of law; requiring payment adjudicators to maintain downcoding policies on their websites; specifying requirements for such policies; requiring health insurers to ensure that their downcoding policies are updated and to ensure compliance with specified provisions on downcoding; authorizing investigations and actions against noncompliance; providing certain presumption in favor of physicians' determinations regarding diagnoses of patients and service orders; providing the calculation of interest on health insurers' nonpayment or underpayment due to downcoding; providing a cause of action for health care providers; amending s. 627.42392, F.S.; defining terms; revising the definition of the term "health insurer"; requiring certain utilization review entities to only use a certain prior authorization form; deleting provisions related to pharmacy benefits

managers' or health insurers' requirement to use a specified prior authorization form; requiring utilization review entities to establish and offer a specified electronic prior authorization process; specifying requirements for such process; specifying that the provider is deemed to have supplied all information necessary for prior authorization under certain circumstances; specifying that additional information is deemed unnecessary under certain circumstances; prohibiting utilization review entities' prior authorization process from requiring information that is not needed; requiring utilization review entities to disclose all prior authorization requirements and restrictions; requiring such requirements and restrictions to be explained in a specified manner; prohibiting utilization review entities from implementing certain new requirements or restrictions; providing exceptions; providing reporting requirements; requiring the Office of Insurance Regulation to publish on its website a report based on such entities' reports; providing requirements for adverse determinations made by such entities on health care providers' claims; providing a timeframe for such entities' determination on claims; prohibiting prior authorization requirements under certain circumstances; prohibiting prior authorization revocations, limits, conditions, and restrictions under certain circumstances; providing exceptions; providing a timeframe for the validity of prior

authorizations under certain circumstances; providing construction; amending ss. 627.6131 and 641.3155, F.S.; defining terms; revising the definition of the term "claim"; revising requirements and timeframes for responses from health insurers and health maintenance organizations, respectively, to submitted claims; revising the interest rate on overdue payments of claims; authorizing health care providers to refuse to participate in internal dispute resolution processes under certain circumstances; prohibiting health insurers and health maintenance organizations, respectively, from retrospectively, rather than retroactively, denying claims because of insured and enrollee ineligibility beyond a specified timeframe; revising such timeframe; revising applicability; providing construction; prohibiting health insurers and health maintenance organizations, respectively, from requesting or requiring certain information from health care providers under certain circumstances; providing causes of action for health care providers under certain circumstances; amending s. 395.1065, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 627.4193, Florida Statutes, is created to read:

627.4193 Restrictions on health insurance reimbursement

downcoding.—

(1) As used in this section, the term:

(a) "Downcode" or "downcoding" means the alteration by a payment adjudicator of a service code to another service code or the alteration, addition, or deletion by a payment adjudicator of a modifier, when the changed code or modifier is associated with a lower payment amount than the service code or modifier billed by the provider or facility.

(b) "Health insurer" means any entity that offers health insurance coverage, whether through a fully insured plan or self-insured plan or fund, including, as applicable:

1. An authorized health insurer offering health insurance as defined in s. 624.603, as well as any entity that offers a commercial self-insurance fund as defined in s. 624.462(2) or group self-insurance fund as described in s. 624.4621.

2. A health insurer that is subject to any provision of this chapter, as well as any entity that offers a self-insurance plan or a group self-insurance plan.

3. A managed care plan as defined in s. 409.962.

4. A health maintenance organization as defined in s. 641.19.

(c) "Medical record" means the comprehensive collection of documentation, including clinical notes, diagnostic reports, and other relevant information, which supports the health care services provided.

(d) "Participation agreement" means a written contract or agreement between a health insurer and a provider which outlines the terms and conditions of participation, reimbursement rates, and other relevant details.

(e) "Payment adjudicator" means a health insurer or any entity that provides, offers to provide, or administers payment on behalf of a health insurer, as well any pharmacy benefit manager as defined in s. 624.490(1), and any other individual or entity that provides, offers to provide, or administers payment for hospital services, outpatient services, medical services, prescription drugs, or other health care services to a person treated by a health care professional or facility in this state under a policy, plan, or contract.

(f) "Provider" means any health care professional, facility, or entity that submits claims for reimbursement for covered health care services.

(2) Payment adjudicators are prohibited from downcoding a health care service billed by, or on behalf of, a provider, if the health care service was ordered by a provider that is in-network with the applicable health insurer, unless such downcoding is otherwise expressly permitted under the participation agreement between the health insurer and the provider.

(3) If downcoding is expressly permitted under the participation agreement, the payment adjudicator must provide the following information to the provider before making its initial payment or notice of denial of payment:

(a) A statement indicating that the service code or modifier billed by the provider or facility will be downcoded.

(b) An explanation detailing the reasons for downcoding the claim. This explanation must include a clear description of the service codes or modifiers that were altered, added, or deleted, if applicable.

(c) The payment amount that the payment adjudicator would otherwise make if the service code or modifier is not downcoded.

(d) A statement that the provider may contest the downcoding of the applicable service code or modifier by filing a contestation with the payment adjudicator with respect to the downcoding within 15 days after receipt of the notice of downcoding.

(e) A statement that by contesting the downcoding of the applicable service code or modifier, the provider does not waive any of its legal rights and claims against the health insurer or payment adjudicator to the fullest extent permissible under law.

(4) Even if the participation agreement expressly permits downcoding, a payment adjudicator is prohibited from downcoding a service without first conducting a review of the associated medical record to ensure the accuracy of the coding change.

(5) A payment adjudicator is prohibited from downcoding for orders by a licensed nurse.

(6) Notwithstanding any provision in this section, a payment adjudicator that proceeds to downcode a service code or modifier, regardless of whether such downcoding is contested by the provider, is solely responsible for any violations of law associated with such downcoding.

(7) Payment adjudicators are required to maintain clear and accessible downcoding policies on their official website. These policies must include:

(a) An overview of the circumstances under which downcoding may occur.

(b) The process and criteria used for conducting reviews of downcoded claims, including the role of medical record review.

(c) Information about the internal mechanisms for ensuring consistency and accuracy in downcoding practices.

(d) Information regarding the processes for contesting with the payment adjudicator the downcoding of a service code, which processes must offer appeal rights for the provider and the patient, and peer review by a licensed physician before the downcoding.

(8) Health insurers shall ensure that their downcoding policies are updated as needed to reflect any changes in regulations, industry standards, or internal procedures.

(9) Health insurers shall ensure compliance with this section and shall develop internal procedures to implement and adhere to the requirements outlined in this section.

(10) Regulatory authorities, including, but not limited to, the Office of Insurance Regulation, may investigate and take appropriate actions in cases of noncompliance with this section.

(11) When a particular health care service is ordered by a licensed physician, there is a presumption that the physician's determination regarding the diagnosis of the patient and any service order by the physician is correct and sufficient, absent a coding error which the health insurer must first verify with the physician before downcoding for such error.

(12) If an applicable court, arbitration tribunal, or other binding legal process determines that a claim was subject to an inappropriate or impermissible downcoding, whether in breach of contract, statute, common law, or otherwise, such that nonpayment or underpayment of the original claim has occurred, then in accordance with s. 627.6131, interest must be calculated on the full total amount that should have been paid on the claim

as of the applicable time period for payment specified in s. 627.6131.

(13) For a violation of this section, a provider shall have a private cause of action to proceed against the health insurer or payment adjudicator in the applicable tribunal for the violation.

Section 2. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term:

(a) "Adverse determination" means a decision by a health insurer or utilization review entity that the health care services rendered, or proposed to be rendered, to a patient are denied, reduced, or terminated. The term does not include a decision to deny, reduce, or terminate services that are determined to have been billed in duplicate bills or that are confirmed with the provider to have been billed in error.

(b) "Electronic prior authorization process" does not include transmissions through a facsimile machine.

(c) "Emergency health care service" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(d) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity,

including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the conditions listed in s. 395.002(8).

(e) "Health insurer" means any entity that offers health insurance coverage, whether through a fully insured plan or self-insured plan or fund, including, as applicable:

1. An authorized health insurer offering health insurance as defined in s. 624.603, as well as any entity that offers a commercial self-insurance fund as defined in s. 624.462(2) or a group self-insurance fund as described in s. 624.4621.

2. A health insurer that is subject to any provision of this chapter, as well as any entity that offers a self-insurance plan or a group self-insurance plan.

3. A managed care plan as defined in s. 409.962.

4. A health maintenance organization as defined in s. 641.19.

(f) "Prior authorization" means the process by which utilization review entities determine the medical necessity or medical appropriateness of otherwise covered health care services before the rendering of such health care services. The term also includes any requirement by a health insurer or utilization review entity that an enrollee or a health care provider notify the health insurer or utilization review entity before the provision of a health care service.

(g) "Urgent health care service" means a health care service that, if the timeframe for making a nonexpedited prior authorization is applied, could, in the opinion of a physician with knowledge of the patient's medical condition:

1. Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

2. Subject the patient to severe pain that cannot be adequately managed without the care, treatment, or prescription drugs that are the subject of the prior authorization request.

(h) "Utilization review activity" means any activity prospective to, concurrent with, or retrospective to the provision of a nonemergency health care service, to determine whether payment must be made in full or is subject to an adverse determination. Utilization review activity is prohibited:

1. To the extent restricted or prohibited by an agreement with a health care provider;

2. For an emergency health care service; or

3. For a service provided to a patient experiencing an emergency medical condition.

(i) "Utilization review entity" means an entity permitted under the applicable agreement with a health care provider or otherwise permitted by a provider that does not have such an agreement to perform utilization review activities or upon whose behalf utilization review activities are performed, including, as applicable:

1. An authorized health insurer offering health insurance as defined in s. 624.603, as well as any entity that offers a commercial self-insurance fund as defined in s. 624.462(2) or group self-insurance fund as described in s. 624.4621.

2. A health insurer that is subject to any provision of this chapter, as well as any entity that offers a self-insurance plan or a group self-insurance plan.

3. A managed care plan as defined in s. 409.962.

4. A health maintenance organization as defined in s. 641.19.

5. A pharmacy benefit manager as defined in s. 624.490(1).

6. Any other individual or entity that provides, offers to provide, or administers payment for hospital services, outpatient services, medical services, prescription drugs, or other health care services to a person treated by a health care professional or facility in this state under a policy, plan, contract, or fund ~~"health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962(10), or a health maintenance organization as defined in s. 641.19(12)~~.

(2) Notwithstanding any other provision of law, a utilization review entity that ~~effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which~~ does not provide an electronic prior authorization process for use by its contracted providers may~~, shall~~ only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form must be no longer than ~~may not exceed~~ two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the utilization review entity ~~health insurer~~ to make a decision. At a minimum, the form must include~~: (1)~~ sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; ~~(2)~~ provider name,

address and phone number; ~~(3)~~ the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; ~~(4)~~ any laboratory documentation required; and ~~(5)~~ an attestation that all information provided is true and accurate.

(3) The Financial Services Commission, in consultation with the Agency for Health Care Administration, shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(4) A utilization review entity shall establish and offer a secure, interactive online electronic prior authorization process to accept electronic prior authorization requests. The electronic prior authorization process must allow a person seeking a prior authorization the ability to upload documentation if such documentation is required by the utilization review entity to adjudicate the prior authorization request. Once a provider grants a health insurer access to a patient's electronic medical record, the provider is deemed to have supplied all information necessary for prior authorization of the health care service, including, without limitation, all information that is reasonably required by the health insurer, other than for an emergency health care service or for a service provided to a patient who is experiencing an emergency medical condition, in advance of the provision of service, and the health insurer asserts is missing as of the date of such service. Additional information or documentation, regardless of whether the utilization review entity requests any additional information, is deemed unnecessary, and deemed not required, for

prior authorization of the health care service, and any request for additional information or any position of the utilization review entity or any third party acting on behalf of the utilization review entity regarding any lack of information from the provider is prohibited from being used to deny, pend, or delay prior authorization of the health care service.

(5) ~~(4)~~ Electronic prior authorization approvals do not preclude benefit verification or medical review by the health insurer under either the medical or pharmacy benefits.

(6) A utilization review entity's prior authorization process is prohibited from requiring information that is not needed to make a determination or facilitate a determination of medical necessity of the requested medical procedure, course of treatment, or prescription drug benefit.

(7) A utilization review entity shall disclose all of its prior authorization requirements and restrictions, including any written clinical criteria, in a publicly accessible manner on its website. These requirements and restrictions must be explained in detail and in clear and ordinary terms.

(8) A utilization review entity is prohibited from implementing any new requirements or restrictions and from making changes to existing requirements or restrictions on obtaining prior authorization unless:

(a) The changes have been available on a publicly accessible website for at least 60 days before they are implemented;

(b) Policyholders and health care providers affected by the new requirements and restrictions or changes to the requirements and restrictions are provided with a written notice of the

changes at least 60 days before they are implemented, with such notice being delivered electronically or by other means as agreed to by the policyholder or the health care provider; and

(c) All applicable amendments to a provider's agreement with the applicable health insurer or utilization review entity have been obtained and memorialized in a mutually agreed-upon writing before such implementation.

(9)(a) Utilization review entities shall, by March 31 of each year, submit a report to the Office of Insurance Regulation with the following data elements for the prior calendar year:

1. A list of all items and services requiring prior authorization.

2. The percentage of standard prior authorization requests approved by the utilization review entity, aggregated by item or service.

3. The percentage of standard prior authorization requests denied by the utilization review entity, aggregated by item or service.

4. The percentage of standard prior authorization requests approved by the utilization review entity after appeal, aggregated by item or service.

5. The percentage of prior authorizations when the timeframe for review was extended and request approved, by item or service.

6. The percentage of expedited prior authorization requests approved by the utilization review entity, by item or service.

7. The percentage of expedited prior authorization requests denied by the utilization review entity, by item or service.

8. The percentage of expedited prior authorization requests

approved by the utilization review entity after appeal, by item or service.

9. The average and median time between submission of a request for prior authorization and the utilization review entity's decision for standard prior authorizations, by item or service.

10. The average and median time between submission of a request for prior authorization and the utilization review entity's decision for expedited prior authorizations, by item or service.

(b) The Office of Insurance Regulation shall, by July 1 of each year, publish a report on its website detailing the information in paragraph (a) submitted by utilization review entities.

(10) Utilization review entities shall ensure that all adverse determinations are made by a physician licensed under chapter 458 or chapter 459. The physician:

(a) Must possess a current and valid nonrestricted license to practice medicine in this state;

(b) Must be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request;

(c) Must have at least 5 years of experience treating patients with the medical condition or disease for which the health care service is being requested; and

(d) May not have any direct or indirect financial arrangement with the utilization review entity that rewards or incentivizes, financially or otherwise, such physician in any way relating to adverse determinations.

(11) Notice of an adverse determination must be provided by e-mail to the health care provider that initiated the prior authorization and to the patient. Notice required under this subsection must include:

(a) The name, title, e-mail address, and telephone number of the physician responsible for making the adverse determination.

(b) Any written clinical criteria and any internal rule, guideline, or protocol on which the utilization review entity relied when making the adverse determination and the reasons those provisions apply to the patient's specific medical circumstance.

(c) Information for the patient and the patient's health care provider which describes the procedure through which the patient or health care provider may request a copy of any report developed by personnel performing the review that led to the adverse determination.

(d) Information that explains to the patient and the patient's health care provider the manner in which to appeal the adverse determination.

(12) If a utilization review entity requires prior authorization of a nonurgent health care service, the utilization review entity must grant a prior authorization or make an adverse determination and notify the patient and the patient's health care provider of the decision within 72 hours after obtaining all necessary information to grant the prior authorization or make the adverse determination. For purposes of this subsection, the term "necessary information" includes the results of any face-to-face clinical evaluation or second

opinion that may be required.

(13) A utilization review entity shall grant an expedited prior authorization or make an expedited adverse determination concerning an urgent health care service and notify the patient and the patient's health care provider of such expedited prior authorization or adverse determination no later than 24 hours after receiving all information needed to complete the review of the requested urgent health care service.

(14)(a) A utilization review entity is prohibited from requiring prior authorization for:

1. Prehospital transportation;

2. Provision of an emergency health care service; or

3. Provision of a service to a patient who is experiencing an emergency medical condition.

(b) A utilization review entity is prohibited from conducting utilization review activity, and from making any adverse determinations, to the extent restricted or prohibited by an agreement with a health care provider. A utilization review entity is prohibited from performing any utilization review activity, and from making any adverse determinations, with respect to:

1. An emergency health care service; or

2. A service provided to a patient who experiences an emergency medical condition.

(15) A utilization review entity is prohibited from requiring prior authorization, and from making any adverse determinations, for the provision of medications for opioid use disorder. For purposes of this subsection, the term "medications for opioid use disorder" means the use of medications, commonly

prescribed in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. FDA-approved medications used to treat opioid addiction include, but are not limited to, methadone, buprenorphine, alone or in combination with naloxone, and extended-release injectable naltrexone. Types of behavioral therapies include, but are not limited to, individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities.

(16) A utilization review entity is prohibited from revoking, limiting, conditioning, or restricting a prior authorization if care is provided within 45 business days after the date the health care provider receives the prior authorization. A utilization review entity must pay, or cause payment to be made to, the health care provider, without any prepayment review or prepayment audit before such payment, at the contracted payment rate for a health care service provided by the health care provider per the prior authorization, unless:

(a) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity;

(b) The health care service was no longer a covered benefit, and medical necessity did not constitute a basis for such noncovered benefit status, on the day the health care service was provided, and the utilization review entity notified the health care provider in writing of these facts before the health care service was provided;

(c) The authorized service was never performed; or

(d) The patient was no longer enrolled under the applicable health plan and, on that basis, was not eligible for health care coverage from the applicable health insurer or self-insured plan on the day the care was provided, and the utilization review entity notified the health care provider in writing of these facts before the health care service was provided.

(17) If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization must remain valid for the length of the treatment, and the utilization review entity is prohibited from requiring the patient to obtain a prior authorization again for the health care service.

(18) A utilization review entity is prohibited from imposing an additional prior authorization requirement with respect to a surgical or otherwise invasive procedure, or any item furnished as part of the surgical or invasive procedure, if the procedure or item is furnished during the perioperative period of another procedure for which prior authorization was granted by the health insurer.

(19) If there is a change in coverage or approval criteria for a previously authorized health care service, the change in coverage or approval criteria is prohibited from adversely affecting an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee’s plan year.

(20) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurer.

(21) Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this section will result in any health care services subject to review being automatically deemed authorized by the utilization review entity.

(22) Except as otherwise provided in paragraphs (16)(a)-(d), prior authorization constitutes a conclusive determination of the medical necessity of the authorized health care service and an irrevocable obligation to pay for such authorized health care service.

(23)(a) This section prohibits an agreement with a health care provider to restrict, limit, prohibit, or substitute a utilization review activity or prior authorization.

(b) Nothing in this section may be construed to:

1. Limit in any way the restrictions or prohibitions on adverse determinations under an agreement with a health care provider, nor to imply permission for, or applicability of, adverse determinations for emergency health care services.

2. Restrict, limit, or prohibit in any way prior authorizations under an agreement between a provider and a utilization review entity, nor to restrict, limit, or prohibit a provider's rights to contest, reject, or oppose any prior authorization activities.

(24) For a violation of this section, a provider shall have a private cause of action to proceed against the health insurer or utilization review entity in the applicable tribunal for the violation.

Section 3. Section 627.6131, Florida Statutes, is amended to read:

627.6131 Prompt payment of claims.—

(1) The contract must ~~shall~~ include the following provision: "Time of Payment of Claims: After receiving written proof of loss, the health insurer shall ~~will~~ pay monthly all claims. Claims ~~benefits then due for ...(type of benefit).... Benefits~~ for any other loss covered by this policy shall ~~will~~ be paid as soon as the health insurer receives proper written proof."

(2) As used in this section, the term:

(a) "Claim" for a noninstitutional provider means a paper HCFA 1500 claim form, or its successor, or an electronic billing instrument submitted to the health insurer's designated location that consists of the ANSI ASC X12N 837P standard ~~HCFA 1500~~ data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument as designated by the provider that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper CMS-1450 claim form, or its successor, or an electronic billing instrument submitted to the health insurer's designated location that consists of the ANSI ASC X12N 837I standard ~~UB-92 data~~ set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee.

(b) "Clean claim" means a completed form, or completed electronic billing instrument, containing all information required under the applicable form or electronic billing instrument, as well as information reasonably required by the health insurer, other than for emergency services and care as

defined in s. 395.002, in advance of the provision of service by the health insurer to substantiate the claim.

(c) "Electronic medical record" means the digital record of a patient's information that may be accessed through electronic means, via portal or other method of electronic access, which may include information regarding the patient's medical history, medical condition, medical treatment, laboratory results, diagnostic reports, and clinical notes.

(d) "Emergency health care services" has the same meaning as "emergency services and care" as defined in s. 395.002.

(e) "Health insurer" means any entity that offers health insurance coverage, whether through a fully insured plan or a self-insured plan or fund, including, as applicable:

1. An authorized health insurer offering health insurance as defined in s. 624.603, as well as any entity that offers a commercial self-insurance fund as defined in s. 624.462(2) or a group self-insurance fund as described in s. 624.4621.

2. A health insurer that is subject to any provision of this chapter, as well as any entity that offers a self-insurance plan or a group self-insurance plan.

(f) "Insured ineligibility" means that the insured was no longer enrolled in the health plan at the time of receiving the applicable service.

(g) "Overpayment" means payment made upon a claim that is:

1. Billed in error;

2. A duplicate claim; or

3. Billed for a service rendered to a patient despite insured ineligibility.

A request for overpayment is limited to a billing error, duplicate bill, or insured ineligibility.

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

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

(b) As to providers' claims for payment, must be mailed or electronically transferred to the primary health insurer within 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 providers' claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to the secondary health insurer within 45 ~~90~~ days after final determination by the primary health 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.

(4) For all electronically submitted claims, a health insurer shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide to the

electronic source submitting the claim an electronic acknowledgment of the receipt of the claim, accompanied by a statement indicating the health insurer's position as to whether the claim is a clean claim or is missing any information that is required under the applicable electronic billing instrument, as described in paragraph (2)(a), or that was reasonably required by the health insurer, other than for emergency health care services, in advance of the provision of service to substantiate ~~to the electronic source submitting~~ the claim, and the health insurer asserts is missing as of the date of service.

(b) Within 15 ~~20~~ days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health- insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information that is required under the applicable billing instrument, as described in paragraph (2)(a), or that was reasonably required by the health insurer, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health insurer asserts is missing as of the date of such service ~~or documents the insurer can reasonably determine are necessary to process the claim~~.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 30 ~~35~~ days after receipt of the notification of contestation unless,

within the 30-day period, the provider notifies the health insurer of the provider's position that a clean claim has been submitted. Additional information is considered submitted on the date it is electronically transferred or mailed. The health insurer is prohibited from requesting ~~may not request~~ duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments shall be used to the greatest extent possible by the health insurer and the provider.

(e) A claim contested by the health insurer must be paid or denied within 30 ~~90~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~120~~ days after receipt of the claim, regardless of whether contested by the health insurer, creates an uncontestable obligation to pay the claim as submitted by the provider.

(5) For all nonelectronically submitted claims, a health insurer shall:

(a) Within 15 days following receipt of the claim ~~Effective November 1, 2003~~, provide to the provider or its designee:

1. An acknowledgment of receipt of the claim, accompanied by a statement indicating the health insurer's position as to whether the claim is a clean claim or the claim is missing any information that is required under the applicable paper billing form, as described in paragraph (2)(a), or that was reasonably required by the health insurer, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health insurer asserts is

missing as of the date of service; or

2. ~~within 15 days after receipt of the claim to the provider or provide a provider within 15 days after receipt with~~ Electronic access to the status of the ~~a~~ submitted claim, which status must indicate the health insurer's position as to whether the claim is a clean claim or missing any information described in subparagraph 1.

(b) Within 30 ~~40~~ days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information that is required under the applicable form or billing instrument, as described in paragraph (2)(a), or that was reasonably required by the health insurer, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health insurer asserts is missing as of the date of such service ~~or documents the insurer can reasonably determine are necessary to process the claim~~.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 30 ~~35~~ days after receipt of the notification of contestation unless, within the 30-day period, the provider notifies the health insurer of its position that a clean claim has been submitted. Additional information is considered submitted on the date it is

electronically transferred or mailed. The health insurer is prohibited from requesting ~~may not request~~ duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments must ~~shall~~ be used to the greatest extent possible by the health insurer and the provider.

(e) A claim contested by the health insurer must be paid or denied within 30 ~~120~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~140~~ days after receipt of the claim, regardless of whether contested by the health insurer, creates an uncontestable obligation to pay the claim as submitted by the provider.

(6) Regardless of whether a claim has been submitted electronically or nonelectronically, and notwithstanding any other provision of this section:

(a) Once a provider grants a health insurer access to a patient's electronic medical record, the provider is deemed to have supplied all information necessary to pay the claim, including, without limitation, all information that is required under the applicable billing instrument and that was reasonably required by the health insurer, other than for emergency health care services, in advance of the provision of service to substantiate the claim. Additional information or documentation, regardless of whether the health insurer requests any additional information, is deemed unnecessary, and deemed not required for payment of the claim, and any request for additional information, and any position of the health insurer or any third party acting on behalf of the health insurer regarding any lack

of information from the provider, is prohibited from being used to deny, reduce, offset, withhold, pend, or delay payment of the claim.

(b) If notice of access to the electronic medical record has been provided to the health insurer, the claim must be paid or denied within 30 days of such notice to the health insurer. Failure to pay or deny a claim for which the health insurer has been provided notice of access to the electronic medical record within 75 days after receipt of such notice creates an uncontestable obligation to pay the claim as submitted by the provider.

(7) ~~(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 an overpayment ~~a~~ claim for such overpayment to the provider's designated location. A health insurer that makes an overpayment ~~a~~ claim ~~for overpayment~~ to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retrospective ~~retroactive~~ denial or payment adjustment. The health insurer must also identify the claim or claims, or portion thereof, as to which the health insurer alleges overpayment ~~claim~~, and the specific invoice number submitted with or on the claim ~~portion thereof, for which a claim for overpayment is submitted~~. Except as provided in subparagraph (a)3., there may be no denial, reduction, offset, withholding, pending, or delay of payment, or other negative impact, regardless of whether by the health insurer or any third party acting on behalf of such health insurer, on payment of any other claim of the provider on the basis of the overpayment allegation.

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

1. All overpayment claims ~~for overpayment~~ must be received by the ~~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 claim within 40 days after the receipt of the overpayment claim. All contested overpayment claims ~~for overpayment~~ must be paid or denied within 120 days after receipt of the overpayment claim. Failure to pay or deny an overpayment ~~and~~ claim within 140 days after receipt creates an uncontestable obligation to pay the overpayment claim.

2. A provider that denies or contests a health insurer's overpayment claim ~~for overpayment~~ or any portion of an overpayment ~~a~~ claim shall notify the health insurer, in writing, within 40 ~~35~~ days after the provider receives the overpayment claim that such overpayment ~~the~~ claim ~~for overpayment~~ is contested or denied. The notice that the overpayment claim ~~for overpayment~~ is denied or contested must identify the denied or contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment 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 overpayment claim ~~for overpayment~~ within 45 days after receipt of the information. The notice from

the provider regarding denial or contestation of the overpayment claim is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health insurer is prohibited from denying, reducing, offsetting, withholding, pending, or delaying ~~may not reduce~~ payment to the provider for other services unless the provider agrees to the denial, reduction, offset, withholding, pending, or delay of payment 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 an overpayment ~~a~~ claim ~~for an overpayment~~ begins to accrue when the overpayment claim should have been paid~~, denied, or contested~~.

(b) An overpayment ~~A~~ claim is prohibited ~~for overpayment shall not be permitted~~ beyond 18 ~~30~~ months after the health insurer's payment of a claim, except that overpayment claims ~~for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(8)~~(7)~~ Payment of a claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 15 ~~12~~ percent per year, to be calculated on the full total amount that should have been paid on the claim within the applicable time period specified in this section. If an applicable court, arbitration tribunal, or other binding legal process determines that a claim that was paid at a lesser amount should have been paid at a full total amount, whether under a breach of contract legal claim, a

legal claim under a statutory private cause of action, or other basis, the 15 percent per year interest must be calculated on the full total amount, rather than upon the difference between the full total amount and the amount that was actually paid. If an applicable court, arbitration tribunal, or other binding legal process determines that a claim was subject to an inappropriate or impermissible denial or partial denial, whether in a breach of contract, statute, common law, or otherwise, interest must be calculated on the full total amount that should have been paid on the claim within the applicable time period for payment specified in this section, and the act of denial or partial denial is deemed not to have in any way tolled the time period for such payment. Interest on the full total amount that should have been paid on the claim within the applicable time period specified in this section ~~an overdue payment for a claim or for any portion of a claim~~ begins to accrue when the claim should have been paid~~, denied, or contested~~. The interest must be paid along with, and in addition to, the payment for the satisfaction of the full total amount of the claim, as determined by an applicable court, arbitration tribunal, or other binding legal process ~~is payable with the payment of the claim~~.

(9)~~(8)~~ For all contracts entered into or renewed on or after October 1, 2002, a health insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal. Notwithstanding any provision of this section, when the provider and health insurer

disagree as to interpretation of contractual or statutory language, the provider is not required to participate in the health insurer's internal dispute resolution process.

(10) ~~(9)~~ A provider or any representative of a provider, regardless of whether the provider is under contract with the health insurer, is prohibited from collecting or attempting ~~may not collect or attempt~~ to collect money from, maintaining ~~maintain~~ any action at law against, or reporting ~~report~~ to a credit agency an insured for payment of covered services for which the health insurer contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health insurer for payment of the services or internal dispute resolution process to determine whether the health insurer is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health insurer's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit the collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

~~(10) The provisions of this section may not be waived, voided, or nullified by contract.~~

(11) A health insurer is prohibited from retrospectively denying ~~may not retroactively deny~~ a claim because of insured ineligibility more than 90 days ~~1 year~~ after the date of payment of the claim.

(12) A health insurer must ~~shall~~ pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted

hospital to an insured if such services are determined by such physician ~~the health insurer~~ to be medically necessary and, regardless of the health plan's determination of medical necessity, are otherwise covered services under the health insurer's contract with the contract holder.

(13) Upon written notification by an insured, a health ~~an~~ insurer shall investigate any claim of improper billing of the insured by a physician, hospital, or other health care provider for a health care service alleged to not actually have been received. The health insurer shall determine whether ~~if~~ the insured actually received the applicable service ~~was properly billed for only those procedures and services that the insured actually received~~. If the health insurer determines that the insured did not actually receive the applicable service ~~has been improperly billed~~, the health insurer must ~~shall~~ notify the insured and the provider of its findings and must ~~shall~~ reduce the amount of payment to the provider by the amount for the service that was not actually received ~~determined to be improperly billed~~. ~~If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500~~.

(14) A permissible error ratio of 5 percent is established for health insurer's claims payment violations of paragraphs (4)(a), (b), (c), and (e) and (5)(a), (b), (c), and (e). If the error ratio of a particular health insurer does not exceed the permissible error ratio of 5 percent for an audit period, no fine may ~~shall~~ be assessed for the noted claims violations for the audit period. The error ratio is ~~shall be~~ determined by dividing the number of claims with violations found on a

statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the office may fine a health insurer for claims payment violations of paragraphs (4)(e) and (5)(e) which create an uncontestable obligation to pay the claim as submitted by the provider. The office shall refrain from imposing a ~~not~~ fine upon a health insurer ~~insurers~~ for violations which the office determines were due to circumstances beyond the health insurer's control.

(15) This section is applicable only to a major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual health insurer licensed under ~~pursuant to~~ chapter 624, including a preferred provider policy under s. 627.6471 and an exclusive provider organization under s. 627.6472 or a group or individual insurance contract that only provides direct payments to dentists for enumerated dental services, or other health insurance coverage, policy, or fund, regardless of whether fully insured or self-insured, offered or administered by a health insurer.

(16) Notwithstanding paragraph (4)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health insurer, the pharmacy benefits manager shall, within 30 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health insurer's action on the claim and payment of the claim is considered to be made on the date

the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(17) Notwithstanding paragraph (5)(a), effective November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health insurer, the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(18) Notwithstanding the 18-month ~~30-month~~ period provided in subsection (7) ~~(6)~~, all overpayment claims ~~for overpayment~~ submitted to a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment of the claim. An overpayment ~~A~~ claim to a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 is prohibited ~~for overpayment may not be permitted~~ beyond 12 months after the health insurer's payment of a claim, except that overpayment claims ~~for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(19) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment by a provider licensed under chapter 395,

chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 is prohibited ~~may not be permitted~~ beyond 12 months after the health insurer's payment of a claim.

(20) Nothing in this section shall be interpreted to limit, restrict, or negatively impact any legal claim by a provider or health insurer for breach of contract, statutory or regulatory violation, or a common-law cause of action, nor to shorten or otherwise negatively impact the statute of limitations timeframe for bringing any such legal claim.

(21) A health insurer is prohibited from requesting information from a contracted or noncontracted provider which does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.

(22) A health insurer is prohibited from requesting a contracted or noncontracted provider to resubmit claim information that the contracted or noncontracted provider can document it has already provided to the health insurer or that is contained inside the electronic medical record to which the health insurer has been provided access.

(23) Notwithstanding any other provision of this section, a health insurer is prohibited from requiring any information from a provider before the provision of emergency health care services as a condition of payment of a claim, as a basis for denying, delaying, offsetting, withholding, or reducing payment of a claim, or in contesting whether the claim is a clean claim.

(24) For a violation of this section, a provider shall have a private cause of action to proceed against the health insurer in the applicable tribunal for the violation.

(25) ~~(20)~~ (a) A contract between a health insurer and a

dentist licensed under chapter 466 for the provision of services to an insured is prohibited from specifying ~~may not specify~~ credit card payment as the only acceptable method for payments from the health insurer to the dentist.

(b) When a health insurer employs the method of claims payment to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payment, the health insurer shall notify the dentist as provided in this paragraph and obtain the dentist's consent before employing the electronic funds transfer. The dentist's consent described in this paragraph applies to the dentist's entire practice. For the purpose of this paragraph, the dentist's consent, which may be given through e-mail, must bear the signature of the dentist. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not limited to, checking a box indicating consent. The health insurer or dentist is prohibited from requiring ~~may not require~~ that a dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health insurer to the dentist must include all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health insurer that pays a claim to a dentist through automated clearinghouse transfer is prohibited from charging ~~may~~

~~not charge~~ a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(e) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(f) The commission may adopt rules to implement this subsection.

(26)~~(21)~~(a) A health insurer is prohibited from denying ~~may not deny~~ any claim subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached subsequent to issuance of the prior authorization.

2. The documentation provided by the person submitting the claim fails to support the claim as originally authorized.

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient’s condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient’s

plan in effect at the time the prior authorization was issued.

5. The denial of the claim was due to one of the following:

a. Another payor is responsible for payment.

b. The dentist has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health insurer by the dentist, patient, or other person not related to the health insurer.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service.

e. The services were provided during the grace period established under s. 627.608 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(c) The office has all rights and powers to enforce this subsection as provided by s. 624.307.

(d) The commission may adopt rules to implement this subsection.

Section 4. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(1) As used in this section, the term:

(a) "Claim" for a noninstitutional provider means a paper HCFA 1500 claim form, or its successor, or an electronic billing

instrument submitted to the health maintenance organization's designated location that consists of the ANSI ASC X12N 837P standard ~~HCFA 1500~~ data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument as designated by the provider that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper CMS-1450 claim form, or its successor, or an electronic billing instrument submitted to the health maintenance organization's designated location that consists of the ANSI ASC X12N 837I standard ~~UB-92~~ data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(b) "Clean claim" means a completed form, or completed electronic billing instrument, containing all information required under the applicable form or electronic billing instrument, as well as information reasonably required by the health maintenance organization, other than for emergency services and care as defined in s. 641.19, in advance of the provision of service by the health maintenance organization to substantiate the claim.

(c) "Electronic medical record" means the digital record of a patient's information that may be accessed through electronic means, via portal or other method of electronic access, which may include information regarding the patient's medical history, medical condition, medical treatment, laboratory results, diagnostic reports, and clinical notes.

(d) "Emergency health care service" has the same meaning as

"emergency services and care" as defined in s. 641.19.

(e) "Enrollee ineligibility" means that the enrollee was no longer enrolled in the health maintenance organization at the time of receiving the applicable service.

(f) "Overpayment" means payment made upon a claim that is:

1. Billed in error;

2. A duplicate claim; or

3. Billed for a service rendered to a patient despite enrollee ineligibility.

A request for overpayment is limited to a billing error, duplicate bill, or enrollee ineligibility.

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

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

(b) As to providers' claims for payment, must be mailed or electronically transferred to the primary organization within 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 maintenance organization.

All providers' claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to

the secondary organization within 45 ~~90~~ days after final determination by the primary organization. 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.

(3) For all electronically submitted claims, a health maintenance organization shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide to the electronic source submitting the claim an electronic acknowledgment of the receipt of the claim, accompanied by a statement indicating the health maintenance organization's position as to whether the claim is a clean claim or whether the claim is missing any information that is required under the applicable electronic billing instrument described in paragraph (1)(a) or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate ~~to the electronic source submitting~~ the claim, and the health maintenance organization asserts is missing as of the date of service.

(b) Within 15 ~~20~~ days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(c)1. Notification of the health maintenance organization's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information required under the applicable billing instrument described in paragraph (1)(a) or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health maintenance organization asserts is missing as of the date of such service ~~or documents the insurer can reasonably determine are necessary to process the claim~~.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 30 ~~35~~ days after receipt of the notification of contestation unless, within the 30-day period, the provider notifies the health maintenance organization of the provider's position that a clean claim has been submitted. Additional information is considered submitted on the date it is electronically transferred or mailed. The health maintenance organization is prohibited from requesting ~~may not request~~ duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim contested by the health maintenance organization must be paid or denied within 30 ~~90~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~120~~ days after receipt of the claim, regardless of whether contested by the health maintenance organization, creates an uncontestable obligation to pay the

claim.

(4) For all nonelectronically submitted claims, a health maintenance organization shall:

(a) Within 15 days following receipt of the claim ~~Effective November 1, 2003~~, provide to the provider, or designee, who submitted the claim:

1. An acknowledgment of receipt of the claim, accompanied by a statement indicating the health maintenance organization's position as to whether the claim is a clean claim or the claim is missing any information that is required under the applicable paper billing form, as described in paragraph (1)(a), or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health maintenance organization asserts is missing as of the date of service; or

2. ~~within 15 days after receipt of the claim to the provider or designee or provide a provider or designee within 15 days after receipt with~~ Electronic access to the status of the ~~a~~ submitted claim, which status must indicate the health maintenance organization's position as to whether the claim is a clean claim or missing any information described in subparagraph 1.

(b) Within 30 ~~40~~ days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(c)1. Notification of the health maintenance organization's determination of a contested claim must be accompanied by an itemized list of any ~~additional~~ information required under the applicable form or billing instrument described in paragraph (1)(a), or that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim, and the health maintenance organization asserts is missing as of the date of such service ~~or documents the organization can reasonably determine are necessary to process the claim~~.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 30 ~~35~~ days after receipt of the notification of contestation unless, within the 30-day period, the provider notifies the health maintenance organization of the provider's position that a clean claim has been submitted. Additional information is considered submitted on the date it is electronically transferred or mailed. The health maintenance organization is prohibited from requesting ~~may not request~~ duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments must ~~shall~~ be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim contested by the health maintenance organization must be paid or denied within 30 ~~120~~ days after receipt of the additional information requested ~~claim~~. Failure to pay or deny a claim within 90 ~~140~~ days after receipt of the claim, regardless of whether contested by the health maintenance

organization, creates an uncontestable obligation to pay the claim as submitted by the provider.

(5) Regardless of whether a claim has been submitted electronically or nonelectronically, and notwithstanding any other provision of this section:

(a) Once a provider grants a health maintenance organization access to a patient's electronic medical record, the provider is deemed to have supplied all information necessary to pay the claim, including, without limitation, all information that is required under the applicable billing instrument and that was reasonably required by the health maintenance organization, other than for emergency health care services, in advance of the provision of service to substantiate the claim. Additional information or documentation, regardless of whether the health maintenance organization requests any additional information, is deemed unnecessary and deemed not required for payment of the claim, and any request for additional information, and any position of the health maintenance organization or any third party acting on behalf of the health maintenance organization regarding any lack of information from the provider, is prohibited from being used to deny, reduce, offset, withhold, pend, or delay payment of the claim.

(b) If notice of access to the electronic medical record has been provided to the health maintenance organization, the claim must be paid or denied within 30 days of such notice to the health maintenance organization. Failure to pay or deny a claim, for which the health maintenance organization has been provided notice of access to the electronic medical record

within 75 days after receipt of such notice, creates an uncontestable obligation to pay the claim as submitted by the provider.

(6)~~(5)~~ If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to an enrollee ~~a subscriber~~, the health maintenance organization must make an overpayment ~~a~~ claim for such overpayment to the provider's designated location. A health maintenance organization that makes an overpayment ~~a~~ claim ~~for overpayment~~ to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retrospective ~~retroactive~~ denial or payment adjustment. The health maintenance organization must also identify the claim or claims, or ~~overpayment claim~~ portion thereof, as to which the health maintenance organization alleges overpayment, and the specific invoice number submitted with or on the claim, as well as the specific line items on the bill that are subject to the overpayment claim ~~for which a claim for overpayment is submitted~~. Except as provided in subparagraph (a)3., there may be no denial, reduction, offset, withholding, pending, or delay of payment, or other negative impact, regardless of whether by the health maintenance organization or any third party acting on behalf of such health maintenance organization, on payment of any other claim of the provider on the basis of the overpayment allegation.

(a) If an overpayment determination is the result of retrospective ~~retroactive~~ review or retrospective audit ~~of coverage decisions or payment levels not related to fraud~~, a health maintenance organization must ~~shall~~ adhere to the

following procedures:

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

2. A provider that denies or contests a health maintenance organization's overpayment claim ~~for overpayment~~ or any portion of an overpayment ~~a~~ claim shall notify the health maintenance organization, in writing, within 40 ~~35~~ days after the provider receives the overpayment claim that the overpayment claim ~~for overpayment~~ is contested or denied. The notice that the overpayment claim ~~for overpayment~~ is denied or contested must identify the denied or contested portion of the claim and the specific reason for contesting or denying the overpayment claim and, if contested, must include a request for additional information. If the health maintenance organization submits additional information, the health maintenance organization 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 overpayment claim ~~for overpayment~~ within 45 days after receipt of the information. The notice from the provider regarding denial or contestation of the overpayment

claim is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health maintenance organization is prohibited from denying, reducing, offsetting, withholding, pending, or delaying ~~may not reduce~~ payment to the provider for other services unless the provider agrees to the denial, reduction, offset, withholding, pending, or delay of payment in writing or fails to respond to the health maintenance organization'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 an overpayment ~~a~~ claim ~~for an overpayment payment~~ begins to accrue when the overpayment claim should have been paid~~, denied, or contested~~.

(b) An overpayment ~~A~~ claim is prohibited ~~for overpayment shall not be permitted~~ beyond 18 ~~30~~ months after the health maintenance organization's payment of a claim, except that overpayment claims ~~for overpayment~~ may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(7)~~(6)~~ Payment of a claim is considered made on the date the payment was mailed or electronically transferred to the provider. An overdue payment of a claim bears simple interest of 15 ~~12~~ percent per year, to be calculated on the full total amount that should have been paid on the claim within the applicable time period specified in this section. If an applicable court, arbitration tribunal, or other binding legal process determines that a claim that was paid at a lesser amount

should have been paid at a full total amount, whether under a breach of contract legal claim, a legal claim under a statutory private cause of action, or other basis, the 15 percent per year interest must be calculated on the full total amount, rather than upon the difference between the full total amount and the amount that was actually paid. If an applicable court, arbitration tribunal, or other binding legal process determines that a claim was subject to an inappropriate or impermissible denial or partial denial, whether in a breach of contract, statute, common law, or otherwise, interest must be calculated on the full total amount that should have been paid on the claim within the applicable time period for payment specified in this section, and the act of denial or partial denial is deemed not to have in any way tolled the time period for such payment. Interest on the full total amount that should have been paid on the claim within the applicable time period specified in this section ~~an overdue payment for a claim or for any portion of a claim~~ begins to accrue when the claim should have been paid~~, denied, or contested~~. The interest must be paid along with, and in addition to, the payment for the satisfaction of the full total amount of the claim, as determined by an applicable court, arbitration tribunal, or other binding legal process ~~is payable with the payment of the claim~~.

(8)~~(7)~~ For all contracts entered into or renewed on or after October 1, 2002, a health maintenance organization's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

Notwithstanding any provision of this section, if the provider and health maintenance organization disagree as to the interpretation of contractual or statutory language, the provider is not required to participate in the health maintenance organization's internal dispute resolution process.

(9)~~(8)~~ A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, is prohibited from collecting or attempting ~~may not collect or attempt~~ to collect money from, maintaining ~~maintain~~ any action at law against, or reporting ~~report~~ to a credit agency an enrollee ~~a subscriber~~ for payment of covered services for which the health maintenance organization contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

~~(9) The provisions of this section may not be waived, voided, or nullified by contract.~~

(10) A health maintenance organization is prohibited from retrospectively denying ~~may not retroactively deny~~ a claim because of enrollee ~~subscriber~~ ineligibility more than 90 days ~~1 year~~ after the date of payment of the claim.

(11) A health maintenance organization must ~~shall~~ pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to an enrollee ~~a subscriber~~ if such services are determined by the primary care physician or admitting physician ~~health maintenance organization~~ to be medically necessary and such services are covered services under the health maintenance organization's contract with the contract holder.

(12) A permissible error ratio of 5 percent is established for health maintenance organizations' claims payment violations of paragraphs (3)(a), (b), (c), and (e) and (4)(a), (b), (c), and (e). If the error ratio of a particular health maintenance organization ~~insurer~~ does not exceed the permissible error ratio of 5 percent for an audit period, no fine may ~~shall~~ be assessed for the noted claims violations for the audit period. The error ratio is ~~shall be~~ determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the office may fine a health maintenance organization for claims payment violations of paragraphs (3)(e) and (4)(e) which create an uncontestable obligation to pay the claim as submitted by the provider. The office shall refrain from imposing a ~~not~~ fine upon a health maintenance organization ~~organizations~~ for violations which the office determines were due to circumstances beyond the

organization's control.

(13) This section applies ~~shall apply~~ to all claims or any portion of a claim submitted for payment for services provided to an enrollee ~~by~~ a ~~health maintenance organization subscriber~~ under a health maintenance organization plan, or submitted for payment for services provided to an enrollee under a self-insured plan or fund, or fully-insured plan or fund, offered by a person or an entity, when a health maintenance organization is involved in the administration, or claims-processing activities, relating to such plan or fund ~~subscriber contract to the organization for payment~~.

(14) Notwithstanding paragraph (3)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization, the pharmacy benefits manager must ~~shall~~, within 30 days after ~~of~~ receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was received by the provider ~~mailed~~ or electronically transferred.

(15) Notwithstanding paragraph (4)(a), effective November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization, the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(16) Notwithstanding the 18-month ~~30-month~~ period provided in subsection (6) ~~(5)~~, all claims for overpayment submitted to a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. An overpayment ~~A~~ claim to a provider licensed under chapter 395, 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 466, or chapter 490 is prohibited ~~for overpayment may not be permitted~~ beyond 12 months after the health maintenance organization'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.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health maintenance organization within 12 months after the health maintenance organization's payment of the claim. A claim for underpayment by a provider licensed under chapter 395, chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 is prohibited ~~may not be permitted~~ beyond 12 months after the health maintenance organization's payment of a claim.

(18) Nothing in this section may be interpreted to limit, restrict, or negatively impact any legal claim by a provider or health maintenance organization for breach of contract, statutory or regulatory violation, or a common-law cause of action, nor to shorten or otherwise negatively impact the statute of limitations timeframe for bringing any such legal

claim.

(19) A health insurer is prohibited from requesting information from a contracted or noncontracted provider which does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.

(20) A health maintenance organization is prohibited from requesting a contracted or noncontracted provider to resubmit claim information that the contracted or noncontracted provider can document it has already provided to the health maintenance organization or that is contained inside the electronic medical record to which the health maintenance organization has been provided access.

(21) Notwithstanding any other provision of this section, a health maintenance organization is prohibited from requiring any information from a provider before the provision of emergency health care services as a condition of payment of a claim, as a basis for denying, delaying, offsetting, withholding, or reducing payment of a claim, or in contesting whether the claim is a clean claim.

(22) For a violation of this section, a provider shall have a private cause of action to proceed against the health maintenance organization in the applicable tribunal for the violation.

Section 5. Paragraph (c) of subsection (2) of section 395.1065, Florida Statutes, is amended to read:

395.1065 Criminal and administrative penalties; moratorium.—

(2)

(c) The agency may impose an administrative fine for the

violation of s. 641.3154 or, if sufficient claims due to a provider from a health maintenance organization do not exist to enable the take-back of an overpayment, as provided under s. 641.3155(6) ~~s. 641.3155(5)~~, for the violation of s. 641.3155(6) ~~s. 641.3155(5)~~. The administrative fine for a violation cited in this paragraph shall be in the amounts specified in s. 641.52(5), and the provisions of paragraph (a) do not apply.

Section 6. This act shall take effect July 1, 2026.