

By Senator Massullo

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30 managers' or health insurers' requirement to use a
31 specified prior authorization form; requiring
32 utilization review entities to establish and offer a
33 specified electronic prior authorization process;
34 specifying requirements for such process; specifying
35 that the provider is deemed to have supplied all
36 information necessary for prior authorization under
37 certain circumstances; specifying that additional
38 information is deemed unnecessary under certain
39 circumstances; prohibiting utilization review
40 entities' prior authorization process from requiring
41 information that is not needed; requiring utilization
42 review entities to disclose all prior authorization
43 requirements and restrictions; requiring such
44 requirements and restrictions to be explained in a
45 specified manner; prohibiting utilization review
46 entities from implementing certain new requirements or
47 restrictions; providing exceptions; providing
48 reporting requirements; requiring the Office of
49 Insurance Regulation to publish on its website a
50 report based on such entities' reports; providing
51 requirements for adverse determinations made by such
52 entities on health care providers' claims; providing a
53 timeframe for such entities' determination on claims;
54 prohibiting prior authorization requirements under
55 certain circumstances; prohibiting prior authorization
56 revocations, limits, conditions, and restrictions
57 under certain circumstances; providing exceptions;
58 providing a timeframe for the validity of prior

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59 authorizations under certain circumstances; providing
60 construction; amending ss. 627.6131 and 641.3155,
61 F.S.; defining terms; revising the definition of the
62 term "claim"; revising requirements and timeframes for
63 responses from health insurers and health maintenance
64 organizations, respectively, to submitted claims;
65 revising the interest rate on overdue payments of
66 claims; authorizing health care providers to refuse to
67 participate in internal dispute resolution processes
68 under certain circumstances; prohibiting health
69 insurers and health maintenance organizations,
70 respectively, from retrospectively, rather than
71 retroactively, denying claims because of insured and
72 enrollee ineligibility beyond a specified timeframe;
73 revising such timeframe; revising applicability;
74 providing construction; prohibiting health insurers
75 and health maintenance organizations, respectively,
76 from requesting or requiring certain information from
77 health care providers under certain circumstances;
78 providing causes of action for health care providers
79 under certain circumstances; amending s. 395.1065,
80 F.S.; conforming cross-references; providing an
81 effective date.

82
83 Be It Enacted by the Legislature of the State of Florida:

84
85 Section 1. Section 627.4193, Florida Statutes, is created
86 to read:

87 627.4193 Restrictions on health insurance reimbursement

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88 downcoding.—89 (1) As used in this section, the term:90 (a) "Downcode" or "downcoding" means the alteration by a
91 payment adjudicator of a service code to another service code or
92 the alteration, addition, or deletion by a payment adjudicator
93 of a modifier, when the changed code or modifier is associated
94 with a lower payment amount than the service code or modifier
95 billed by the provider or facility.96 (b) "Health insurer" means any entity that offers health
97 insurance coverage, whether through a fully insured plan or
98 self-insured plan or fund, including, as applicable:99 1. An authorized health insurer offering health insurance
100 as defined in s. 624.603, as well as any entity that offers a
101 commercial self-insurance fund as defined in s. 624.462(2) or
102 group self-insurance fund as described in s. 624.4621.103 2. A health insurer that is subject to any provision of
104 this chapter, as well as any entity that offers a self-insurance
105 plan or a group self-insurance plan.106 3. A managed care plan as defined in s. 409.962.107 4. A health maintenance organization as defined in s.
108 641.19.109 (c) "Medical record" means the comprehensive collection of
110 documentation, including clinical notes, diagnostic reports, and
111 other relevant information, which supports the health care
112 services provided.113 (d) "Participation agreement" means a written contract or
114 agreement between a health insurer and a provider which outlines
115 the terms and conditions of participation, reimbursement rates,
116 and other relevant details.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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204 as of the applicable time period for payment specified in s.
205 627.6131.

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

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

212 627.42392 Prior authorization.—

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

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

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

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

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

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

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

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

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

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

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

249 641.19.

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

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

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262 1. Seriously jeopardize the life or health of the patient
263 or the ability of the patient to regain maximum function; or
264 2. Subject the patient to severe pain that cannot be
265 adequately managed without the care, treatment, or prescription
266 drugs that are the subject of the prior authorization request.

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

272 1. To the extent restricted or prohibited by an agreement
273 with a health care provider;
274 2. For an emergency health care service; or
275 3. For a service provided to a patient experiencing an
276 emergency medical condition.

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

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

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

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

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

292 641.19.

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

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

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

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

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

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

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

355 (5) (4) Electronic prior authorization approvals do not
356 preclude benefit verification or medical review by the health
357 insurer under either the medical or pharmacy benefits.

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

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

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

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

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

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378 changes at least 60 days before they are implemented, with such
379 notice being delivered electronically or by other means as
380 agreed to by the policyholder or the health care provider; and
381 (c) All applicable amendments to a provider's agreement
382 with the applicable health insurer or utilization review entity
383 have been obtained and memorialized in a mutually agreed-upon
384 writing before such implementation.

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

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

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

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

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

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

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

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

406 8. The percentage of expedited prior authorization requests

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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465 opinion that may be required.

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

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

475 1. Prehospital transportation;
476 2. Provision of an emergency health care service; or
477 3. Provision of a service to a patient who is experiencing
478 an emergency medical condition.

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

486 1. An emergency health care service; or
487 2. A service provided to a patient who experiences an
488 emergency medical condition.

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

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

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

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

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

522 (c) The authorized service was never performed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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581 627.6131 Prompt payment of claims.—

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

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

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

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

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

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

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

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

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

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

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

633 (g) "Overpayment" means payment made upon a claim that is:
634 1. Billed in error;
635 2. A duplicate claim; or
636 3. Billed for a service rendered to a patient despite
637 insured ineligibility.

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

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

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

647 (b) As to providers' claims for payment, must be mailed or
648 electronically transferred to the primary health insurer within
649 6 months after the following have occurred:

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

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

654
655 All providers' claims for payment, whether electronic or
656 nonelectronic, must be mailed or electronically transferred to
657 the secondary health insurer within 45 90 days after final
658 determination by the primary health insurer. A provider's claim
659 is considered submitted on the date it is electronically
660 transferred or mailed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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726 missing as of the date of service; or

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

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

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

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

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

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

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

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

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

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

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

795 (7)-(6) If a health insurer determines that it has made an
796 overpayment to a provider for services rendered to an insured,
797 the health insurer must make an overpayment a claim for such
798 overpayment to the provider's designated location. A health
799 insurer that makes an overpayment a claim for overpayment to a
800 provider under this section shall give the provider a written or
801 electronic statement specifying the basis for the retrospective
802 retroactive denial or payment adjustment. The health insurer
803 must also identify the claim or claims, or portion thereof, as
804 to which the health insurer alleges overpayment claim, and the
805 specific invoice number submitted with or on the claim portion
806 thereof, for which a claim for overpayment is submitted. Except
807 as provided in subparagraph (a)3., there may be no denial,
808 reduction, offset, withholding, pending, or delay of payment, or
809 other negative impact, regardless of whether by the health
810 insurer or any third party acting on behalf of such health
811 insurer, on payment of any other claim of the provider on the
812 basis of the overpayment allegation.

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

817 1. All overpayment claims ~~for overpayment~~ must be received
818 ~~by the submitted to a~~ provider within 18 30 months after the
819 health insurer's payment of the claim. A provider must pay,
820 deny, or contest the health insurer's ~~claim for~~ overpayment
821 claim within 40 days after the receipt of the overpayment claim.
822 All contested overpayment claims ~~for overpayment~~ must be paid or
823 denied within 120 days after receipt of the overpayment claim.
824 Failure to pay or deny an overpayment ~~and~~ claim within 140 days
825 after receipt creates an uncontestable obligation to pay the
826 overpayment claim.

827 2. A provider that denies or contests a health insurer's
828 overpayment claim ~~for overpayment~~ or any portion of an
829 overpayment ~~a~~ claim shall notify the health insurer, in writing,
830 within 40 35 days after the provider receives the overpayment
831 claim that such overpayment ~~the~~ claim ~~for overpayment~~ is
832 contested or denied. The notice that the overpayment claim ~~for~~
833 ~~overpayment~~ is denied or contested must identify the denied or
834 contested portion of the overpayment claim and the specific
835 reason for contesting or denying the overpayment claim and, if
836 contested, must include a request for additional information. If
837 the health insurer submits additional information, the health
838 insurer must, within 35 days after receipt of the request, mail
839 or electronically transfer the information to the provider. The
840 provider shall pay or deny the overpayment claim ~~for overpayment~~
841 within 45 days after receipt of the information. The notice from

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

845 3. The health insurer is prohibited from denying, reducing,
846 offsetting, withholding, pending, or delaying ~~may not reduce~~
847 payment to the provider for other services unless the provider
848 agrees to the denial, reduction, offset, withholding, pending,
849 or delay of payment in writing or fails to respond to the health
850 insurer's overpayment claim as required by this paragraph.

851 4. Payment of an overpayment claim is considered made on
852 the date the payment was mailed or electronically transferred.
853 An overdue payment of a claim bears simple interest at the rate
854 of 12 percent per year. Interest on an overdue payment for an
855 overpayment ~~a claim for an overpayment~~ begins to accrue when the
856 overpayment claim should have been paid, ~~denied, or contested~~.
857 (b) An overpayment ~~A claim is prohibited for overpayment~~
858 ~~shall not be permitted~~ beyond 18 30 months after the health
859 insurer's payment of a claim, except that overpayment claims ~~for~~
860 ~~overpayment~~ may be sought beyond that time from providers
861 convicted of fraud pursuant to s. 817.234.

862 (8)-(7) Payment of a claim is considered made on the date
863 the payment was mailed or electronically transferred. An overdue
864 payment of a claim bears simple interest of 15 12 percent per
865 year, to be calculated on the full total amount that should have
866 been paid on the claim within the applicable time period
867 specified in this section. If an applicable court, arbitration
868 tribunal, or other binding legal process determines that a claim
869 that was paid at a lesser amount should have been paid at a full
870 total amount, whether under a breach of contract legal claim, a

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

893 (9)-(8) For all contracts entered into or renewed on or
894 after October 1, 2002, a health insurer's internal dispute
895 resolution process related to a denied claim not under active
896 review by a mediator, arbitrator, or third-party dispute entity
897 must be finalized within 60 days after the receipt of the
898 provider's request for review or appeal. Notwithstanding any
899 provision of this section, when the provider and health insurer

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

903 (10) ~~(9)~~ A provider or any representative of a provider,
904 regardless of whether the provider is under contract with the
905 health insurer, is prohibited from collecting or attempting ~~may~~
906 ~~not collect or attempt~~ to collect money from, maintaining
907 maintain any action at law against, or reporting ~~report~~ to a
908 credit agency an insured for payment of covered services for
909 which the health insurer contested or denied the provider's
910 claim. This prohibition applies during the pendency of any claim
911 for payment made by the provider to the health insurer for
912 payment of the services or internal dispute resolution process
913 to determine whether the health insurer is liable for the
914 services. For a claim, this pendency applies from the date the
915 claim or a portion of the claim is denied to the date of the
916 completion of the health insurer's internal dispute resolution
917 process, not to exceed 60 days. This subsection does not
918 prohibit the collection by the provider of copayments,
919 coinsurance, or deductible amounts due the provider.

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

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

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

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

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

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

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

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

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

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

989 (17) Notwithstanding paragraph (5)(a), effective November
990 1, 2003, where a nonelectronic pharmacy claim is submitted to a
991 pharmacy benefits manager acting on behalf of a health insurer,
992 the pharmacy benefits manager shall provide acknowledgment of
993 receipt of the claim within 30 days after receipt of the claim
994 to the provider or provide a provider within 30 days after
995 receipt with electronic access to the status of a submitted
996 claim.

997 (18) Notwithstanding the 18-month ~~30-month~~ period provided
998 in subsection (7) ~~(6)~~, all overpayment claims ~~for overpayment~~
999 submitted to a provider licensed under chapter 395, chapter 458,
1000 chapter 459, chapter 460, chapter 461, chapter 463, chapter 466,
1001 or chapter 490 must be submitted to the provider within 12
1002 months after the health insurer's payment of the claim. An
1003 overpayment ~~A~~ claim to a provider licensed under chapter 395,
1004 chapter 458, chapter 459, chapter 460, chapter 461, chapter 463,
1005 chapter 466, or chapter 490 is prohibited ~~for overpayment~~ may
1006 ~~not be permitted~~ beyond 12 months after the health insurer's
1007 payment of a claim, except that overpayment claims ~~for~~
1008 ~~overpayment~~ may be sought beyond that time from providers
1009 convicted of fraud pursuant to s. 817.234.

1010 (19) Notwithstanding any other provision of this section,
1011 all claims for underpayment from a provider licensed under
1012 chapter 395, chapter 458, chapter 459, chapter 460, chapter 461,
1013 or chapter 466 must be submitted to the health insurer within 12
1014 months after the health insurer's payment of the claim. A claim
1015 for underpayment by a provider licensed under chapter 395,

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1016 chapter 458, chapter 459, chapter 460, chapter 461, or chapter
1017 466 is prohibited ~~may not be permitted~~ beyond 12 months after
1018 the health insurer's payment of a claim.

1019 (20) Nothing in this section shall be interpreted to limit,
1020 restrict, or negatively impact any legal claim by a provider or
1021 health insurer for breach of contract, statutory or regulatory
1022 violation, or a common-law cause of action, nor to shorten or
1023 otherwise negatively impact the statute of limitations timeframe
1024 for bringing any such legal claim.

1025 (21) A health insurer is prohibited from requesting
1026 information from a contracted or noncontracted provider which
1027 does not apply to the medical condition at issue for the
1028 purposes of adjudicating a clean claim.

1029 (22) A health insurer is prohibited from requesting a
1030 contracted or noncontracted provider to resubmit claim
1031 information that the contracted or noncontracted provider can
1032 document it has already provided to the health insurer or that
1033 is contained inside the electronic medical record to which the
1034 health insurer has been provided access.

1035 (23) Notwithstanding any other provision of this section, a
1036 health insurer is prohibited from requiring any information from
1037 a provider before the provision of emergency health care
1038 services as a condition of payment of a claim, as a basis for
1039 denying, delaying, offsetting, withholding, or reducing payment
1040 of a claim, or in contesting whether the claim is a clean claim.

1041 (24) For a violation of this section, a provider shall have
1042 a private cause of action to proceed against the health insurer
1043 in the applicable tribunal for the violation.

1044 (25) (20) (a) A contract between a health insurer and a

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1045 dentist licensed under chapter 466 for the provision of services
1046 to an insured is prohibited from specifying ~~may not specify~~
1047 credit card payment as the only acceptable method for payments
1048 from the health insurer to the dentist.

1049 (b) When a health insurer employs the method of claims
1050 payment to a dentist through electronic funds transfer,
1051 including, but not limited to, virtual credit card payment, the
1052 health insurer shall notify the dentist as provided in this
1053 paragraph and obtain the dentist's consent before employing the
1054 electronic funds transfer. The dentist's consent described in
1055 this paragraph applies to the dentist's entire practice. For the
1056 purpose of this paragraph, the dentist's consent, which may be
1057 given through e-mail, must bear the signature of the dentist.
1058 Such signature includes an electronic or digital signature if
1059 the form of signature is recognized as a valid signature under
1060 applicable federal law or state contract law or an act that
1061 demonstrates express consent, including, but not limited to,
1062 checking a box indicating consent. The health insurer or dentist
1063 is prohibited from requiring ~~may not require~~ that a dentist's
1064 consent as described in this paragraph be made on a patient-by-
1065 patient basis. The notification provided by the health insurer
1066 to the dentist must include all of the following:

1067 1. The fees, if any, associated with the electronic funds
1068 transfer.

1069 2. The available methods of payment of claims by the health
1070 insurer, with clear instructions to the dentist on how to select
1071 an alternative payment method.

1072 (c) A health insurer that pays a claim to a dentist through
1073 automated clearinghouse transfer is prohibited from charging ~~may~~

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1074 ~~not charge~~ a fee solely to transmit the payment to the dentist
1075 unless the dentist has consented to the fee.

1076 (d) This subsection applies to contracts delivered, issued,
1077 or renewed on or after January 1, 2025.

1078 (e) The office has all rights and powers to enforce this
1079 subsection as provided by s. 624.307.

1080 (f) The commission may adopt rules to implement this
1081 subsection.

1082 (26) ~~(21)~~(a) A health insurer is prohibited from denying ~~may~~
1083 ~~not deny~~ any claim subsequently submitted by a dentist licensed
1084 under chapter 466 for procedures specifically included in a
1085 prior authorization unless at least one of the following
1086 circumstances applies for each procedure denied:

1087 1. Benefit limitations, such as annual maximums and
1088 frequency limitations not applicable at the time of the prior
1089 authorization, are reached subsequent to issuance of the prior
1090 authorization.

1091 2. The documentation provided by the person submitting the
1092 claim fails to support the claim as originally authorized.

1093 3. Subsequent to the issuance of the prior authorization,
1094 new procedures are provided to the patient or a change in the
1095 condition of the patient occurs such that the prior authorized
1096 procedure would no longer be considered medically necessary,
1097 based on the prevailing standard of care.

1098 4. Subsequent to the issuance of the prior authorization,
1099 new procedures are provided to the patient or a change in the
1100 patient's condition occurs such that the prior authorized
1101 procedure would at that time have required disapproval pursuant
1102 to the terms and conditions for coverage under the patient's

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1103 plan in effect at the time the prior authorization was issued.

1104 5. The denial of the claim was due to one of the following:

1105 a. Another payor is responsible for payment.

1106 b. The dentist has already been paid for the procedures
1107 identified in the claim.

1108 c. The claim was submitted fraudulently, or the prior
1109 authorization was based in whole or material part on erroneous
1110 information provided to the health insurer by the dentist,
1111 patient, or other person not related to the health insurer.

1112 d. The person receiving the procedure was not eligible to
1113 receive the procedure on the date of service.

1114 e. The services were provided during the grace period
1115 established under s. 627.608 or applicable federal regulations,
1116 and the dental insurer notified the provider that the patient
1117 was in the grace period when the provider requested eligibility
1118 or enrollment verification from the dental insurer, if such
1119 request was made.

1120 (b) This subsection applies to all contracts delivered,
1121 issued, or renewed on or after January 1, 2025.

1122 (c) The office has all rights and powers to enforce this
1123 subsection as provided by s. 624.307.

1124 (d) The commission may adopt rules to implement this
1125 subsection.

1126 Section 4. Section 641.3155, Florida Statutes, is amended
1127 to read:

1128 641.3155 Prompt payment of claims.—

1129 (1) As used in this section, the term:

1130 (a) "Claim" for a noninstitutional provider means a paper
1131 HCFA 1500 claim form, or its successor, or an electronic billing

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1132 instrument submitted to the health maintenance organization's
1133 designated location that consists of the ANSI ASC X12N 837P
1134 standard HCFA 1500 data set, or its successor, that has all
1135 mandatory entries for a physician licensed under chapter 458,
1136 chapter 459, chapter 460, chapter 461, or chapter 463, or
1137 psychologists licensed under chapter 490 or any appropriate
1138 billing instrument as designated by the provider that has all
1139 mandatory entries for any other noninstitutional provider. For
1140 institutional providers, "claim" means a paper CMS-1450 claim
1141 form, or its successor, or an electronic billing instrument
1142 submitted to the health maintenance organization's designated
1143 location that consists of the ANSI ASC X12N 837I standard UB-92
1144 data set or its successor with entries stated as mandatory by
1145 the National Uniform Billing Committee.

1146 (b) "Clean claim" means a completed form, or completed
1147 electronic billing instrument, containing all information
1148 required under the applicable form or electronic billing
1149 instrument, as well as information reasonably required by the
1150 health maintenance organization, other than for emergency
1151 services and care as defined in s. 641.19, in advance of the
1152 provision of service by the health maintenance organization to
1153 substantiate the claim.

1154 (c) "Electronic medical record" means the digital record of
1155 a patient's information that may be accessed through electronic
1156 means, via portal or other method of electronic access, which
1157 may include information regarding the patient's medical history,
1158 medical condition, medical treatment, laboratory results,
1159 diagnostic reports, and clinical notes.

1160 (d) "Emergency health care service" has the same meaning as

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1161 "emergency services and care" as defined in s. 641.19.

1162 (e) "Enrollee ineligibility" means that the enrollee was no
1163 longer enrolled in the health maintenance organization at the
1164 time of receiving the applicable service.

1165 (f) "Overpayment" means payment made upon a claim that is:

1166 1. Billed in error;

1167 2. A duplicate claim; or

1168 3. Billed for a service rendered to a patient despite
1169 enrollee ineligibility.

1170

1171 A request for overpayment is limited to a billing error,
1172 duplicate bill, or enrollee ineligibility.

1173 (2) All claims for payment or overpayment, whether
1174 electronic or nonelectronic:

1175 (a) Are considered received on the date the claim is
1176 received by the health maintenance organization at its
1177 designated claims-receipt location or the date the overpayment a
1178 claim for overpayment is received by the provider at its
1179 designated location.

1180 (b) As to providers' claims for payment, must be mailed or
1181 electronically transferred to the primary organization within 6
1182 months after the following have occurred:

1183 1. Discharge for inpatient services or the date of service
1184 for outpatient services; and

1185 2. The provider has been furnished with the correct name
1186 and address of the patient's health maintenance organization.

1188 All providers' claims for payment, whether electronic or
1189 nonelectronic, must be mailed or electronically transferred to

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1190 the secondary organization within 45 ~~90~~ days after final
1191 determination by the primary organization. A provider's claim is
1192 considered submitted on the date it is electronically
1193 transferred or mailed.

1194 (c) Must not duplicate a claim previously submitted unless
1195 it is determined that the original claim was not received or is
1196 otherwise lost.

1197 (3) For all electronically submitted claims, a health
1198 maintenance organization shall:

1199 (a) Within 24 hours after the beginning of the next
1200 business day after receipt of the claim, provide to the
1201 electronic source submitting the claim an electronic
1202 acknowledgment of the receipt of the claim, accompanied by a
1203 statement indicating the health maintenance organization's
1204 position as to whether the claim is a clean claim or whether the
1205 claim is missing any information that is required under the
1206 applicable electronic billing instrument described in paragraph
1207 (1) (a) or that was reasonably required by the health maintenance
1208 organization, other than for emergency health care services, in
1209 advance of the provision of service to substantiate ~~to the~~
1210 electronic source submitting the claim, and the health
1211 maintenance organization asserts is missing as of the date of
1212 service.

1213 (b) Within 15 ~~20~~ days after receipt of the claim, pay the
1214 claim or notify a provider or designee if a claim is denied or
1215 contested. Notice of the health maintenance organization's
1216 action on the claim and payment of the claim is considered to be
1217 made on the date the notice or payment was received by the
1218 provider mailed or electronically transferred.

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(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

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1248 claim.

1249 (4) For all nonelectronically submitted claims, a health
1250 maintenance organization shall:1251 (a) Within 15 days following receipt of the claim Effective
1252 ~~November 1, 2003, provide to the provider, or designee, who~~
1253 submitted the claim:1254 1. An acknowledgment of receipt of the claim, accompanied
1255 by a statement indicating the health maintenance organization's
1256 position as to whether the claim is a clean claim or the claim
1257 is missing any information that is required under the applicable
1258 paper billing form, as described in paragraph (1) (a), or that
1259 was reasonably required by the health maintenance organization,
1260 other than for emergency health care services, in advance of the
1261 provision of service to substantiate the claim, and the health
1262 maintenance organization asserts is missing as of the date of
1263 service; or1264 ~~2. within 15 days after receipt of the claim to the~~
1265 ~~provider or designee or provide a provider or designee within 15~~
1266 ~~days after receipt with~~ Electronic access to the status of the a
1267 submitted claim, which status must indicate the health
1268 maintenance organization's position as to whether the claim is a
1269 clean claim or missing any information described in subparagraph
1270 1.1271 (b) Within 30 40 days after receipt of the claim, pay the
1272 claim or notify a provider or designee if a claim is denied or
1273 contested. Notice of the health maintenance organization's
1274 action on the claim and payment of the claim is considered to be
1275 made on the date the notice or payment was received by the
1276 provider mailed or electronically transferred.

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(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

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1306 organization, creates an uncontestable obligation to pay the
1307 claim as submitted by the provider.

1308 (5) Regardless of whether a claim has been submitted
1309 electronically or nonelectronically, and notwithstanding any
1310 other provision of this section:

1311 (a) Once a provider grants a health maintenance
1312 organization access to a patient's electronic medical record,
1313 the provider is deemed to have supplied all information
1314 necessary to pay the claim, including, without limitation, all
1315 information that is required under the applicable billing
1316 instrument and that was reasonably required by the health
1317 maintenance organization, other than for emergency health care
1318 services, in advance of the provision of service to substantiate
1319 the claim. Additional information or documentation, regardless
1320 of whether the health maintenance organization requests any
1321 additional information, is deemed unnecessary and deemed not
1322 required for payment of the claim, and any request for
1323 additional information, and any position of the health
1324 maintenance organization or any third party acting on behalf of
1325 the health maintenance organization regarding any lack of
1326 information from the provider, is prohibited from being used to
1327 deny, reduce, offset, withhold, pend, or delay payment of the
1328 claim.

1329 (b) If notice of access to the electronic medical record
1330 has been provided to the health maintenance organization, the
1331 claim must be paid or denied within 30 days of such notice to
1332 the health maintenance organization. Failure to pay or deny a
1333 claim, for which the health maintenance organization has been
1334 provided notice of access to the electronic medical record

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1335 within 75 days after receipt of such notice, creates an
1336 uncontestable obligation to pay the claim as submitted by the
1337 provider.

1338 (6)-(5) If a health maintenance organization determines that
1339 it has made an overpayment to a provider for services rendered
1340 to an enrollee a subscriber, the health maintenance organization
1341 must make an overpayment a claim for such overpayment to the
1342 provider's designated location. A health maintenance
1343 organization that makes an overpayment a claim for overpayment
1344 to a provider under this section shall give the provider a
1345 written or electronic statement specifying the basis for the
1346 retrospective retroactive denial or payment adjustment. The
1347 health maintenance organization must also identify the claim or
1348 claims, or overpayment claim portion thereof, as to which the
1349 health maintenance organization alleges overpayment, and the
1350 specific invoice number submitted with or on the claim, as well
1351 as the specific line items on the bill that are subject to the
1352 overpayment claim for which a claim for overpayment is
1353 submitted. Except as provided in subparagraph (a)3., there may
1354 be no denial, reduction, offset, withholding, pending, or delay
1355 of payment, or other negative impact, regardless of whether by
1356 the health maintenance organization or any third party acting on
1357 behalf of such health maintenance organization, on payment of
1358 any other claim of the provider on the basis of the overpayment
1359 allegation.

1360 (a) If an overpayment determination is the result of
1361 retrospective retroactive review or retrospective audit of
1362 coverage decisions or payment levels not related to fraud, a
1363 health maintenance organization must shall adhere to the

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1364 following procedures:

1365 1. All overpayment claims ~~for overpayment~~ must be received
1366 ~~by the~~ submitted to a provider within 18 30 months after the
1367 health maintenance organization's payment of the claim. A
1368 provider must pay, deny, or contest the health maintenance
1369 organization's overpayment claim ~~for overpayment~~ within 40 days
1370 after the receipt of the overpayment claim. All contested
1371 overpayment claims ~~for overpayment~~ must be paid or denied within
1372 120 days after receipt of the overpayment claim. Failure to pay
1373 or deny an overpayment ~~and~~ claim within 140 days after receipt
1374 creates an uncontestable obligation to pay the overpayment
1375 claim.

1376 2. A provider that denies or contests a health maintenance
1377 organization's overpayment claim ~~for overpayment~~ or any portion
1378 of an overpayment a claim shall notify the health maintenance
1379 organization, in writing, within 40 35 days after the provider
1380 receives the overpayment claim that the overpayment claim ~~for~~
1381 ~~overpayment~~ is contested or denied. The notice that the
1382 overpayment claim ~~for overpayment~~ is denied or contested must
1383 identify the denied or contested portion of the claim and the
1384 specific reason for contesting or denying the overpayment claim
1385 and, if contested, must include a request for additional
1386 information. If the health maintenance organization submits
1387 additional information, the health maintenance organization
1388 must, within 35 days after receipt of the request, mail or
1389 electronically transfer the information to the provider. The
1390 provider shall pay or deny the overpayment claim ~~for overpayment~~
1391 within 45 days after receipt of the information. The notice from
1392 the provider regarding denial or contestation of the overpayment

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1393 claim is considered made on the date the notice is mailed or
1394 electronically transferred by the provider.

1395 3. The health maintenance organization is prohibited from
1396 denying, reducing, offsetting, withholding, pending, or delaying
1397 ~~may not reduce~~ payment to the provider for other services unless
1398 the provider agrees to the denial, reduction, offset,
1399 withholding, pending, or delay of payment in writing or fails to
1400 respond to the health maintenance organization's overpayment
1401 claim as required by this paragraph.

1402 4. Payment of an overpayment claim is considered made on
1403 the date the payment was mailed or electronically transferred.
1404 An overdue payment of a claim bears simple interest at the rate
1405 of 12 percent per year. Interest on an overdue payment for an
1406 overpayment ~~a claim for an overpayment payment~~ begins to accrue
1407 when the overpayment claim should have been paid, ~~denied, or~~
1408 ~~contested~~.

1409 (b) An overpayment ~~A claim is prohibited for overpayment~~
1410 ~~shall not be permitted beyond 18~~ 30 months after the health
1411 maintenance organization's payment of a claim, except that
1412 overpayment claims ~~for overpayment~~ may be sought beyond that
1413 time from providers convicted of fraud pursuant to s. 817.234.

1414 (7)-(6) Payment of a claim is considered made on the date
1415 the payment was mailed or electronically transferred to the
1416 provider. An overdue payment of a claim bears simple interest of
1417 15 ~~12~~ percent per year, to be calculated on the full total
1418 amount that should have been paid on the claim within the
1419 applicable time period specified in this section. If an
1420 applicable court, arbitration tribunal, or other binding legal
1421 process determines that a claim that was paid at a lesser amount

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1422 should have been paid at a full total amount, whether under a
1423 breach of contract legal claim, a legal claim under a statutory
1424 private cause of action, or other basis, the 15 percent per year
1425 interest must be calculated on the full total amount, rather
1426 than upon the difference between the full total amount and the
1427 amount that was actually paid. If an applicable court,
1428 arbitration tribunal, or other binding legal process determines
1429 that a claim was subject to an inappropriate or impermissible
1430 denial or partial denial, whether in a breach of contract,
1431 statute, common law, or otherwise, interest must be calculated
1432 on the full total amount that should have been paid on the claim
1433 within the applicable time period for payment specified in this
1434 section, and the act of denial or partial denial is deemed not
1435 to have in any way tolled the time period for such payment.
1436 Interest on the full total amount that should have been paid on
1437 the claim within the applicable time period specified in this
1438 section ~~an overdue payment for a claim or for any portion of a~~
1439 ~~claim~~ begins to accrue when the claim should have been paid,
1440 ~~denied, or contested~~. The interest must be paid along with, and
1441 in addition to, the payment for the satisfaction of the full
1442 total amount of the claim, as determined by an applicable court,
1443 arbitration tribunal, or other binding legal process is payable
1444 ~~with the payment of the claim.~~

1445 (8)(7) For all contracts entered into or renewed on or
1446 after October 1, 2002, a health maintenance organization's
1447 internal dispute resolution process related to a denied claim
1448 not under active review by a mediator, arbitrator, or third-
1449 party dispute entity must be finalized within 60 days after the
1450 receipt of the provider's request for review or appeal.

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1451 Notwithstanding any provision of this section, if the provider
1452 and health maintenance organization disagree as to the
1453 interpretation of contractual or statutory language, the
1454 provider is not required to participate in the health
1455 maintenance organization's internal dispute resolution process.

1456 (9) (8) A provider or any representative of a provider,
1457 regardless of whether the provider is under contract with the
1458 health maintenance organization, is prohibited from collecting
1459 or attempting may not collect or attempt to collect money from,
1460 maintaining maintain any action at law against, or reporting
1461 report to a credit agency an enrollee a subscriber for payment
1462 of covered services for which the health maintenance
1463 organization contested or denied the provider's claim. This
1464 prohibition applies during the pendency of any claim for payment
1465 made by the provider to the health maintenance organization for
1466 payment of the services or internal dispute resolution process
1467 to determine whether the health maintenance organization is
1468 liable for the services. For a claim, this pendency applies from
1469 the date the claim or a portion of the claim is denied to the
1470 date of the completion of the health maintenance organization's
1471 internal dispute resolution process, not to exceed 60 days. This
1472 subsection does not prohibit collection by the provider of
1473 copayments, coinsurance, or deductible amounts due the provider.

1474 (9) ~~The provisions of this section may not be waived,~~
1475 ~~voided, or nullified by contract.~~

1476 (10) A health maintenance organization is prohibited from
1477 retrospectively denying may not retroactively deny a claim
1478 because of enrollee subscriber ineligibility more than 90 days +
1479 year after the date of payment of the claim.

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(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 net fine upon a health maintenance organization organizations for violations which the office determines were due to circumstances beyond the

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1509 organization's control.

1510 (13) This section applies shall apply to all claims or any
1511 portion of a claim submitted for payment for services provided
1512 to an enrollee by a health maintenance organization subscriber
1513 under a health maintenance organization plan, or submitted for
1514 payment for services provided to an enrollee under a self-
1515 insured plan or fund, or fully-insured plan or fund, offered by
1516 a person or an entity, when a health maintenance organization is
1517 involved in the administration, or claims-processing activities,
1518 relating to such plan or fund subscriber contract to the
1519 organization for payment.

1520 (14) Notwithstanding paragraph (3) (b), where an electronic
1521 pharmacy claim is submitted to a pharmacy benefits manager
1522 acting on behalf of a health maintenance organization, the
1523 pharmacy benefits manager must shall, within 30 days after ~~of~~
1524 receipt of the claim, pay the claim or notify a provider or
1525 designee if a claim is denied or contested. Notice of the health
1526 maintenance organization's action on the claim and payment of
1527 the claim is considered to be made on the date the notice or
1528 payment was received by the provider mailed or electronically
1529 transferred.

1530 (15) Notwithstanding paragraph (4) (a), effective November
1531 1, 2003, where a nonelectronic pharmacy claim is submitted to a
1532 pharmacy benefits manager acting on behalf of a health
1533 maintenance organization, the pharmacy benefits manager shall
1534 provide acknowledgment of receipt of the claim within 30 days
1535 after receipt of the claim to the provider or provide a provider
1536 within 30 days after receipt with electronic access to the
1537 status of a submitted claim.

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1538 (16) Notwithstanding the 18-month ~~30-month~~ period provided
1539 in subsection (6) ~~(5)~~, all claims for overpayment submitted to a
1540 provider licensed under chapter 395, chapter 458, chapter 459,
1541 chapter 460, chapter 461, chapter 463, chapter 466, or chapter
1542 490 must be submitted to the provider within 12 months after the
1543 health maintenance organization's payment of the claim. An
1544 overpayment A claim to a provider licensed under chapter 395,
1545 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter
1546 466, or chapter 490 is prohibited for overpayment may not be
1547 permitted beyond 12 months after the health maintenance
1548 organization's payment of a claim, except that claims for
1549 overpayment may be sought beyond that time from providers
1550 convicted of fraud pursuant to s. 817.234.

1551 (17) Notwithstanding any other provision of this section,
1552 all claims for underpayment from a provider licensed under
1553 chapter 395, chapter 458, chapter 459, chapter 460, chapter 461,
1554 or chapter 466 must be submitted to the health maintenance
1555 organization within 12 months after the health maintenance
1556 organization's payment of the claim. A claim for underpayment by
1557 a provider licensed under chapter 395, chapter 458, chapter 459,
1558 chapter 460, chapter 461, or chapter 466 is prohibited may not
1559 be permitted beyond 12 months after the health maintenance
1560 organization's payment of a claim.

1561 (18) Nothing in this section may be interpreted to limit,
1562 restrict, or negatively impact any legal claim by a provider or
1563 health maintenance organization for breach of contract,
1564 statutory or regulatory violation, or a common-law cause of
1565 action, nor to shorten or otherwise negatively impact the
1566 statute of limitations timeframe for bringing any such legal

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1567 claim.

1568 (19) A health insurer is prohibited from requesting
1569 information from a contracted or noncontracted provider which
1570 does not apply to the medical condition at issue for the
1571 purposes of adjudicating a clean claim.

1572 (20) A health maintenance organization is prohibited from
1573 requesting a contracted or noncontracted provider to resubmit
1574 claim information that the contracted or noncontracted provider
1575 can document it has already provided to the health maintenance
1576 organization or that is contained inside the electronic medical
1577 record to which the health maintenance organization has been
1578 provided access.

1579 (21) Notwithstanding any other provision of this section, a
1580 health maintenance organization is prohibited from requiring any
1581 information from a provider before the provision of emergency
1582 health care services as a condition of payment of a claim, as a
1583 basis for denying, delaying, offsetting, withholding, or
1584 reducing payment of a claim, or in contesting whether the claim
1585 is a clean claim.

1586 (22) For a violation of this section, a provider shall have
1587 a private cause of action to proceed against the health
1588 maintenance organization in the applicable tribunal for the
1589 violation.

1590 Section 5. Paragraph (c) of subsection (2) of section
1591 395.1065, Florida Statutes, is amended to read:

1592 395.1065 Criminal and administrative penalties;
1593 moratorium.—

1594 (2)

1595 (c) The agency may impose an administrative fine for the

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1596 violation of s. 641.3154 or, if sufficient claims due to a
1597 provider from a health maintenance organization do not exist to
1598 enable the take-back of an overpayment, as provided under s.
1599 641.3155(6) ~~s. 641.3155(5)~~, for the violation of s. 641.3155(6)
1600 ~~s. 641.3155(5)~~. The administrative fine for a violation cited in
1601 this paragraph shall be in the amounts specified in s.
1602 641.52(5), and the provisions of paragraph (a) do not apply.
1603

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