2000

Session Law 00-252

Florida Senate & House of Representatives

STORAGE NAME: h2427z.hcs **"AS PASSED BY THE LEGISLATURE"**
DATE: June 9, 2000 **CHAPTER #: 2000-252, Laws of Florida**

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: HB 2427 (PCB HCS 00-09) (Passed as CS/CS/CS/SB 1508 & CS/SB's 706 & 2234

RELATING TO: Managed Care Organizations

SPONSOR(S): Committee on Health Care Services, Reps. Peaden and Casey

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 13 NAYS 1

I. SUMMARY:

Passed by the Legislature as CS/CS/CS/SB 1508 & CS/SB's 706 & 2234. On June 8, 2000, CS/CS/CS/SB 1508 & CS/SB's 706 & 2234 became Ch. 2000-252, Laws of Florida, with the Governor's signature.

This bill addresses a variety of issues relating to managed care and prompt payment of provider claims The bill deletes provisions relating to provider billings, revises provisions relating to provider contracts, provides for disclosure and notice, requires procedures for requesting and granting authorization for utilization of services, provides for HMO liability for payment for services rendered to subscribers; and prohibits certain provider billing of subscribers

The bill defines the term "clean claim" in the institutional and non-institutional setting, and specifies the basis for determining when a claim is to be considered clean or not clean, requires the Department of Insurance to adopt rules to establish a claim form and requirements for the form, grants the department discretionary rulemaking authority for coding standards; provides for payment, denial, and contesting of clean claims or portions of clean claims, and provides for interest accrual, payment of interest, and an incontestable obligation to pay a claim

The bill requires an HMO to make a claim for overpayment, prohibits an organization from reducing payment for other services, and provides exceptions, requires a provider to pay a claim for overpayment within a specified time frame, specifies procedures and time frames regarding provider overpayments, and provides an incontestable obligation to pay a claim for overpayment

The bill specifies when an electronically transmitted or mailed provider claim is considered received, mandates acknowledgment of receipts for electronically submitted provider claims; prescribes a time frame for an HMO to retroactively deny a claim for services provided to an eligible subscriber; provides for treatment authorization and payment of claims by an HMO; and clarifies that treatment authorization and payment of a claim for emergency services is subject to specified provisions of law.

The bill provides that down coding with intent to deny reimbursement by an HMO is an unfair method of competition and an unfair or deceptive act or practice; authorizes the department to issue a cease and desist order for a payment-of-claims violation, and revises provisions relating to treatment-authorization capabilities

The bill establishes a statewide claim dispute resolution program for providers and managed care organizations, provides rulemaking authority to the Agency for Health Care Administration; authorizes administrative sanctions against a hospital's license for improper subscriber billing and violations of requirements relating to claims payments; provides that certain actions by a provider are punishable, and expands the provision of law relating to fraud against hospitals to include health care providers

The bill provides an appropriation of $38,928 from the Health Care Trust Fund and one position to the agency for the purposes of carrying out the provisions of this act during fiscal year 2000-2001

Subject to the Governor's veto powers, the effective date of this bill is October 1, 2000. The bill applies to claims for services rendered after such date and to all requests for claim-dispute resolution which are submitted by a provider for managed care organization 60 days after the effective date of the contract between the resolution organization and the agency

II. SUBSTANTIVE ANALYSIS

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

Department of Insurance: The bill requires the Department of Insurance (department) to do the following: adopt rules which define "clean claim" and adopt rules to establish claim forms consistent with specified federal claim-filing standards. The bill authorizes the department to adopt rules relating to coding standards consistent with certain Medicare coding standards. The bill adds "systematic down coding with the intent to deny reimbursement otherwise not due" as an unfair claim settlement practice subject to action by the department The bill adds violation of s 641.3155, F.S., relating to payment of claims, as subject to a cease and desist and penalty order issued by the department. The bill adds "systematic upcoding with intent to obtain reimbursement otherwise not due" as a false and fraudulent insurance claim. The bill expands language defining fraudulently obtaining goods and services to include health care providers.

Agency for Health Care Administration: The bill requires the Agency for Health Care Administration (agency) to do the following: establish a statewide provider and managed care organization claim dispute resolution program; establish, by rule, jurisdictional amounts and methods of aggregation of claim disputes; adopt rules to establish a process of consideration by resolution organizations; issue final orders based on resolution organization recommendations; adopt rules regulating resolution organization review fees and apportionment of review fees; and imposition of administrative fines for nonpayment of resolution organization review fees.

B. PRESENT SITUATION:

HMO "Prompt Payment" Statute (s. 641.3155, F.S.)

In 1998, the Legislature adopted ch. 98-79, L.O.F., CS/SB 1584, enacting s. 641.3155, F.S., requiring health maintenance organizations (HMOs) to pay claims within certain time frames. This statute (referred to as the "prompt payment" law), requires an HMO to reimburse any claim or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim. If the claim is contested by the HMO, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, and identify the contested portion of the claim and the specific reason for contesting or denying the claim. This notice may also include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request Within 45 days after receipt of the information

requested, the HMO must pay or deny the contested claim or portion of the contested claim In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

In 1999, the Legislature amended s. 641.3155(4), F.S., to address the issue of HMOs deducting past overpayments from a provider's claim, commonly referred to as "take backs " As amended, this subsection requires any retroactive reduction of payments or demands for refund of previous overpayments to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. This also applies to providers who make retroactive demands for payment due to under payments or nonpayment. The look-back period may be specified by the terms of the contract.

Balanced Billing Prohibition (s. 641.315, F.S.)

In 1988, the Legislature amended s. 641 315, F.S., which provides that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO This law also prohibits a provider of services from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO. This statute is interpreted by the Department of Insurance (department), and the Agency for Health Care Administration (agency), as applying to both contract and non-contract providers in those cases where services are covered by the HMO. For example, if a subscriber obtains a covered service at a contract hospital from a non-contract physician, the HMO is liable and the physician may not bill the subscriber. However, some providers argue that the statute is limited to balanced billing by contract providers, due to the directory language of the section that reads, "Provider contracts " There are no appellate court decisions on this point.

The Statewide Provider and Subscriber Assistance Program

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., and is administered by the agency. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to panels that hold hearings on the grievance and issue recommendations to the agency or to the department for a final order. The program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. The program does not provide assistance for a grievance for "unpaid balances." The program does not typically provide assistance for grievances related to provider disputes for late payments or under payments.

HMO Claims for Emergency Care and Treatment

HMOs are required to provide coverage for emergency services and care without prior authorization or referral pursuant to ss. 641.31(12), 641.47(7) and (8), and 641.513, F.S. This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers. "Emergency medical condition" is defined in s. 641.19(7), F.S., as a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

When a subscriber seeks emergency services at a hospital, a determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination. Compensation must be made even if the provider determines that an emergency medical condition does not exist. If the provider determines that an emergency medical condition does exist, the HMO must also compensate the provider for emergency services and care. Emergency services and care include the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition and within the service capability of a hospital.

The hospital must make a reasonable attempt to notify the subscriber's primary care physician or HMO, if known, within a prescribed amount of time; however, an HMO may not deny payment for emergency services and care simply based on a hospital's failure to comply with the notice requirements. A subscriber may be charged a reasonable copayment, up to $100, for the use of an emergency room. Net of this copayment, an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; or the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

Department of Insurance Bulletin 99-901

On September 3, 1999, the Florida Department of Insurance issued Bulletin 99-901, relating to all health maintenance organizations and payments of claims of contract providers. The purpose of the bulletin was to remind all HMOs of the requirements of ss 641.3155 and 641.3903(5), F.S., which govern the payment of claims filed with HMOs by contract medical providers. In the bulletin, the department reminded the HMOs that they are required by law to pay, contest, or deny a claim within 35 days after receipt of the claim from a contracted medical provider under the terms of the contract between the provider and the HMO; and that evidence of the date of receipt of the claim by the HMO is the starting point of the 35-day period.

According to the bulletin, the department had received complaints regarding a variety of claim payment practices by HMOs which had resulted in systematic, automatic denials of claims, such as emergency room claims and others that fall into particular categories. In addition, the department had evidence that some HMOs would automatically "pend" or deny particular types of claims or employ the practice of "down coding" or "right coding" without investigation, changing the billing, and reducing the amount due on claims without discussion.

Federal HIPAA Requirements for "Clean Claims" and Electronic Billing

The federal Health Insurance Portability and Accountability Act (HIPAA), requires the Health Care Financing Administration (HCFA), to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility, and payment. However, there have been problems and delays with the implementation of HIPAA. The National Uniform Billing Committee (NUBC), an industry group working on the implementation, recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC), is expected to agree on an equivalent definition of a practitioner clean claim. Both of these committee recommendations, and other administrative simplification recommendations, will be

submitted to the federal Secretary of Health and Human Services for adoption and implementation. The U.S. Department of Health and Human Services (DHHS) is planning to begin issuing HIPAA regulations on administrative simplification requirements in June 2000. This will be an on-going matter addressing a variety of topics over time.

The Agency for Health Care Administration and the Department of Insurance HMOs Review

The agency conducted a focused claims review of emergency room services of Medicaid and commercial health maintenance organizations (HMOs). The purposes of the reviews were: to determine compliance related to statutory and contractual requirements, address concerns of the provider community, and substantiate or refute anecdotal information. On-site surveys began in March and were completed in November, 1999. A random sample of 75 Medicaid claims and 75 commercial claims was pulled from each HMO for each of the reviews. These claims covered dates of service from April 1, 1998, through June 30, 1998. Each claim included a hospital emergency room claim, and all related claims (physician, laboratory, x-ray, etc.) for that date of service. Medicaid claims were reviewed for compliance related to timeliness of payment, appropriateness of payment amount, and evidence of inappropriately denied claims. Commercial claims were reviewed for compliance related to appropriateness of payment amount and evidence of inappropriately denied claims.

Fourteen Medicaid HMOs were reviewed. The agency found that 4 plans were found in full compliance for payment amount, and one for timely payment. A total of 2,819 claims were reviewed, of which 687, or 25 percent, exceeded 35 days to pay without an acceptable explanation. Of the total claims, 234, or 8 percent, were paid at inappropriate amounts. Thirteen Medicaid HMOs were fined a combined total of $211,000 (subject to change based on appeals); 13 HMOs were required to submit corrective action plans; and 6 were required to reprocess all emergency room claims from July 1997 to present.

Twenty-six commercial HMOs were reviewed. A total of 4,924 claims were reviewed (an average of 190 claims per HMO). Fourteen, or 54 percent, of HMOs were found in compliance, and 32, or 0.65 percent of claims were denied or paid improperly. Twelve HMOs were fined a combined total of $16,000; 12 HMOs were required to submit corrective action plans; and one HMO was required to reprocess all emergency room claims from July 1997 to present.

Since HMOs are dually regulated by the agency and the department and timeliness of payment for commercial claims falls within the jurisdiction of the department, the agency documented commercial timeliness deficiencies and forwarded the information to the department for review. The department accompanied the agency on eight joint audits and then decided to perform its own in-depth analysis of the HMO claims payment systems.

On March 30, 2000, the department issued a Notice and Order to Show Cause ("Order") to each of two HMOs, resulting from a targeted examination of their claims payment practices. Each of the Orders finds that the HMO failed to pay, contest, or deny claims within the 35 days, as required by s. 641.3155, F.S., and failed to pay the 10 percent penalty for late payments as required under that section, among other allegations. The Orders include notice that the department intends to impose administrative penalties of $100,000 against one HMO and $75,000 against the other HMO. This is a preliminary agency order, and is subject to challenge or denial by the HMOs.

Advisory Group on the Submission and Payment of Health Claims

The health care provider community has voiced concerns about delays in payment of HMO claims, underpayment of claims, and difficulty in obtaining authorization for treatment from HMOs. Providers assert that the current prompt payment law is not being observed. Estimates generated by the Florida Hospital Association show that as of May 1999, 16.1 percent of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital and Healthcare Association found that the average age of HMO receivables in the hospitals in question were over 70 days old, with about 30 percent of the receivables being over 60 days old.

The managed care community disputes the magnitude of this problem and maintains that most delays in payment are caused by providers' failure to include essential and accurate information with their claims. In response to these concerns and divided opinions, the Florida Legislature in 1999 authorized the Director of the agency, pursuant to ch. 99-393, L.O.F.; CS/HBs 1927 and 961, to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The advisory group issued its report and recommendations on February 1, 2000 ("Advisory Group Report").

The following is a committee staff summary of the recommendations of the Advisory Group Report, with the page number of the report where the recommendation is contained. The staff summary uses the term "HMO," rather than "MCOs" or managed care organizations, as used in the report, which are, for current purposes, synonymous terms (as stated on page 1 of the report).

Issues and Recommendations: Non-Emergent Treatments

A) Authorization to Treat

1. 24-Hour Service -- HMOs should have the capability to provide authorization 24 hours a day, 7 days a week for all services for which pre-authorization is required. (p. 16)

2. Binding Authorization of Services – If a provider follows authorization procedures and applicable laws, and receives authorization for a covered service for an eligible employee (subscriber), then the plan is bound by its authorization to pay and the service is deemed medically necessary. (p. 16)

3. Pend Numbers – It is inappropriate for HMOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number. (p.16)

B) Electronic Billing and Clean Claims

1. Definition of Clean Claim -- Recommend adoption of the recently adopted National Uniform Billing Committee (NUBC) definition of institutional clean claim. However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them. (p. 17)

2. HIPAA Standards (Federal Health Insurance Portability and Accountability Act) – The federal HIPAA law includes requirements for electronic filing of claims, but these provisions have not yet been implemented. It is believed that implementation will take place within the next 3 years. Recommendation that Florida adopt the expected federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be

applied to all HMOs and providers. Agency staff estimate the costs of HIPAA implementation in Florida to average between $24,000 and $30,000 per office practice. (p. 17)

C) Late Payments

1. Interest Payments -- Section 641.3155, F S., should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, that is, 35 days after the receipt of a clean claim. The statute should also clarify that the accrued interest must automatically be included with any late payment of a claim. This revised statute should apply equally to payment to contracted and non-contracted providers. (p. 18)

2. Venue for Complaints and Dispute Resolution -- Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. The scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmented appeals. (p. 18)

3. Sub-Contractor Processing and Payment of Claims -- In instances where an HMO delegates authority for issuing authorization or processing or paying claims to a third-party subcontractor, the current policy of the department is to hold the licensed HMO financially and legally responsible for all actions or failures to act of the third-party subcontractor. The Advisory Group and the agency support this policy. (p. 19)

D) Claims Review

1. Eligibility Determination -- Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days (p. 19)

2. Receipts -- Providers who submit claims electronically should be entitled to electronic acknowledgment of receipts of claims. Providers who receive acknowledgment of receipts of claims should be prohibited from sending a duplicate bill for 45 days. (p. 19)

3. Take Backs -- Take backs should be treated as claims made by an HMO to a provider. Insurers should provide written notice to providers of all over-payments, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments. (p. 19)

E) Balance and Duplicate Billing

1. Enforcement of Balance Billing Prohibition -- The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. The agency, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards. Balance billing by facilities shall be referred to the agency in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered services. Providers may not balance bill patients while billing disputes are going through any future state supervised dispute resolution process. (p. 20)

2. Medical Necessity -- Except in emergency situations, if an HMO denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not

covered by the HMO, and the provider is entitled to bill the patient for the service. It is important to educate the subscriber that he or she will be responsible for payment of services under these conditions. (p. 20)

3. Non-Covered Services -- Providers have a right to bill patients for non-covered services. (p. 20)

4. Non-Participating Providers -- Current s. 641.315, F.S., is ambiguous because the heading refers to provider contracts, but the language says no provider is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing the heading of the statute. Non-participating providers should not bill patients (beyond HMO copayments) if they are billing the HMO, going through a dispute resolution process to secure payment from an HMO, or have accepted HMO payment for this specific service. (p. 20)

5. Restriction on Referral to Credit Agencies -- It is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations. (p. 21)

F) Non-Participating Providers

Recommends that when a physician empowered by an HMO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the HMO is obligated to reimburse that other provider for the authorized services. (p. 21)

G) Fraud and Abuse

1. Automated Recoding of Claims -- Systematic down coding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The department has already issued a statement to that effect. (p. 22)

2. Incentives for Billing Agent to Submit Fraudulent Claims -- Florida should follow the same policies as Medicare. Under current Medicare regulations, billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised, or enforced more stringently by the Health Care Financing Administration in the near future. Similarly, if Medicare implements a policy against percentage incentives for HMO audit or credit collection firms, the Advisory Group recommends that Florida do likewise. (p. 22)

3. Reporting Liability of Additional Payors -- The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial HMOs. (p. 22)

4. Auditing of Claims -- Providers should not charge HMOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the HMO, but still should not add an extra charge for HMO staff reviewing provider records. (p. 22)

5. Civil Liability of Whistleblowers -- Requested the department to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud. (p. 22)

Issues and Recommendations: Emergency Treatments

1. Hospital Code System -- The Advisory Group acknowledges the agency's review of Medicaid standards concerning the coding of hospital emergency department treatments. The group recommends that the agency look into redoing the Florida Medical Quality Assurance, Inc. (FMQAI) study of hospital emergency room coding in light of the objections to that study that have been presented to the group. (p. 26)

2. Availability of Specialized Physicians for Emergency Treatment -- In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific HMO, the hospital should notify the HMO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the agency's Bureau of Managed Care, which assesses HMO network adequacy. Access to emergency care is addressed in s. 395.1041, F.S. This law gives the agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need. (p. 26)

In addition to the above, the Advisory Group heard testimony on the reimbursement/prompt payment for emergency room claims. Currently, subsection (5) of s. 641.513, F.S., calls for the "lesser of:

(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided, or
(c) The charge mutually agreed to by the HMO and the provider within 60 days of the submittal of the claim."

Fraudulently Obtaining Goods, Services, etc. from Hospitals

Subsection (1) of s. 817.50, F.S., provides that any person who, willfully and with intent to defraud, obtains or attempts to obtain goods, products, merchandise, or services from any hospital is guilty of a second degree misdemeanor.

Subsection (2) of s. 817.50, F.S., provides that giving a hospital a false or fictitious name or a false or fictitious address or assigns to any hospital the proceeds of any insurance contract knowing that such contract is no longer in force, invalid, or void for any reason, is prima facie (a fact presumed to be true unless disproved by some evidence to the contrary) evidence of the intent of such person to defraud the hospital.

C. EFFECT OF PROPOSED CHANGES:

The bill:

- Revises requirements relating to provider contracts, as follows: requires written contracts between HMOs and providers, with provisions relating to HMO and subscriber liability for payment for services; deletes certain requirement; requires certain disclosures by the HMO to providers; requires written procedures for request and authorization for health care services; and mandates certain notice requirements for changes to the request and authorization procedures for health care services procedures.

- Creates provisions related to HMO liability and prohibits provider billing, as follows: specifies HMO liability for services rendered to a subscriber; clarifies that the subscriber is not liable for payment of fees to the provider; specifies HMO liability for services rendered to a subscriber by a provider if the provider follows the HMO's authorization procedures and receives authorization; creates an exemption for information provided to the HMO with willful intent to misinform; prohibits collection attempts by providers from subscribers; provides a presumption regarding provider knowledge and specific exemptions; and mandates reporting of violations to the appropriate regulatory authority.

- Amends provisions relating to provider contracts and payment of claims, as follows: defines "clean claim" for non-institutional providers; prohibits classification of claim as not clean solely on the basis of HMO referral to medical specialist for review; provides for repeal of definition upon effective date of department's rule defining clean claim; defines "clean claim" for institutions absent a contract definition; requires the Department of Insurance to adopt rules to establish claim forms subject to specified requirements; and authorizes the department to adopt rules for coding standards consistent with Medicare standards.

- Expands requirements for payment of claims to include clean claims and portions of clean claims and to include those claims made by noncontract providers; expands requirements relating to denial or contest of claims to require request for additional information within specified time frames, clarifies the date interest begins to accrue on overdue payments of clean claims and uncontested portions of clean claims; specifies when payment is due; and creates incontestable obligation to pay a claim for claims not paid or denied within 120 days.

- Requires an HMO to make a claim for overpayments; prohibits reduction of payments for other services to cover claim for overpayment, subject to certain exceptions; requires providers to pay nondenied and noncontested claims for overpayment within 35 days of receipt; provides interest rate for overdue claim for overpayment; specifies when payment for overdue claim for overpayment accrues interest; and creates incontestable obligation to pay claim for overpayment for claims not paid or denied within 120 days.

- Provides time frames for payment of claim to be considered received and prohibits submission of duplicate claims within 45 days of initial claim receipt; provides time frames for payments of claim for overpayment to be considered received and prohibits submission of duplicate claim for overpayment within 45 days of initial claim for overpayment receipt; provides that nothing in the section precludes an HMO and provider from agreeing to other methods of transmission and receipt of claims.

- Provides that a provider or his or her designee, who bills electronically is entitled to electronic acknowledgment of receipt within 72 hours; and prohibits retroactively denying a claim of more than 1 year after date of service due to subscriber ineligibility.

- Creates requirements for treatment authorization and payment of claims; provides exceptions for willful intention to misinform; and excludes provision of emergency services from the provisions of s. 641.3156, F.S.

- Expands unfair claim settlement practices to include systematic down coding with intent to deny reimbursement.

- Authorizes the Department of Insurance to issue specified cease and desist and penalty orders relating to payment of claims submitted by providers.

- Requires HMOs to provide treatment authorization 24-hours a day, 7-days-a-week; and provides that requests for treatment authorization may not be pended, except as contractually agreed.

- Creates a statewide provider and managed care organization claim dispute resolution program established by the Agency for Health Care Administration; defines terms; requires the agency to contract with organizations to conduct timely review and consider claim disputes; grants the agency rulemaking authority to establish jurisdictional amounts, and methods of aggregation for claims; provides exclusions of specified claims from resolution organization claim dispute resolution program; and provides that claims subject to certain contract requirements may be required to exhaust an internal resolution dispute process as a prerequisite to submitting the claim to the dispute resolution organization.

- Requires the agency to adopt rules to establish a process of consideration to be used by the resolution organization, including a requirement that the resolution organization issue a written recommendation, supported by findings of fact to the agency within 60 days after the receipt of the claims dispute submission; and requires the agency to adopt the recommendation as a final order within 30 days after receipt.

- Requires the nonprevailing entity in a resolution organization claim dispute process to pay a review fee; requires the agency to adopt a rule for determining review fees; requires the agency to include determination of apportionment of review fee in rule; provides for penalty of nonprevailing party failing to pay review fee within 35 days after the agency's adoption of the final order; limits the penalty to no more than $500 per day until penalty is paid; and authorizes the agency to adopt rules necessary to implement the claim dispute resolution program

- Amends statute relating to administrative penalties to update statutory language; and to authorize the agency, under specified circumstances, to impose an administrative fine for violation of the requirements relating to HMO liability and prohibiting provider billing, provider contracts, and payment of claims, in amounts authorized for administrative fines, excluding reporting requirements relating to specified licensed physicians.

- Provides statutory cross-reference to newly created s. 641.3154, F.S., relating to HMO liability and the prohibition on provider billing, in s. 631.818, F.S., relating to powers and duties of the plan, and in s. 641.31, F.S., relating to HMO plans.

- Provides that systematic upcoding by a provider with intent to obtain reimbursement not otherwise due is a false and fraudulent insurance claim subject to specified administrative fines.

- Updates statutory language replacing "hospital" with "health care provider", "hospital" with "provider" and adding "health maintenance contract" to s. 817.50, F.S., relating to fraudulently obtaining goods, services, etc., from a hospital.

- Provides for an appropriation from the Health Care Trust Fund in the amount of $38,928 for the purposes of carrying out the provisions of the act during fiscal year 2000-2001 and authorizes one position in the agency for that purpose.

- Provides for application of the act to claims for services rendered after October 1, 2000, which request claim-dispute services from a claim-dispute resolution organization which are submitted by the provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 641.315, F.S., relating to provider contracts.

Subsections (1), (2), and (3), relating to provider contracts, are deleted.

Subsection (4) is renumbered as subsection (1) and is amended to require that each contract between an HMO and a provider of health care services must be in writing and contain a provision that the subscriber is not liable to the provider for services for which the HMO is liable, as specified in s. 641.3154, F.S., relating to HMO liability for payment for services rendered to subscribers.

Subsection (5), relating to deductibles and co-payments, is deleted.

Subsection (6), paragraph (a), relating to provider contracts executed after October 1, 1991, is renumbered as subsection (2), paragraph (a), and is amended as follows:

Subparagraph 1. is amended to clarify that contracts must require the provider to give 60 days prior written notice to the HMO and the Department of Insurance (department) before canceling the contract with the HMO for any reason; and

Subparagraph 2. is amended to clarify that nonpayment for goods and services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day requirement. Obsolete dates are deleted.

Subsection (7) is renumbered as subsection (3).

A new subsection (4) is created to require that whenever a contract exists between an HMO and a provider, the HMO must disclose to the provider the following.

- The mailing address or electronic address where claims should be sent for processing;
- The telephone number a provider may call to have questions and concerns addressed regarding claims; and
- The address of any separate claims processing centers for specific types of services.

Provides that an HMO must provide, in no less than 30 calendar days, prior written notice of any changes in this required information to contract providers

Subsections (8), (9), and (10) are renumbered as subsections (5), (6), and (7).

A new subsection (8) is created to require that the contract between an HMO and a provider must establish written procedures for the provider to request and the HMO to provide authorization for utilization of health care services. Requires the HMO to give written notice to the provider prior to making any changes in these procedures.

Section 2. Creates s. 641.3154, F.S., relating to HMO liability and prohibiting provider billing.

Subsection (1) provides that if the HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the HMO and the provider, the HMO is liable for the payment of fees to the provider, and the subscriber is not liable for the payment of fees to the provider.

Subsection (2) provides that, for the purposes of this section, an HMO is liable for services rendered to an eligible subscriber by a provider if the provider follows the HMO's authorization procedures and receives authorization for covered service for an eligible subscriber, unless the provider provided information to the HMO with willful intent to misinform.

Subsection (3) provides that the liability of an HMO for payment of fees for services is not affected by any contract the HMO has with a third party for the functions of authorizing, processing, or paying claims.

Subsection (4) specifies that a provider, regardless of whether under contract with the HMO or not, or any representative of the provider, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency, a subscriber of an HMO for payment of services for which the HMO is liable, if the provider, in good faith knows or should know, that the HMO is liable. Provides that this prohibition applies during the pendency of any claim for payment made by the provider to the HMO for payment of services and any legal proceedings or dispute resolution process to determine whether the HMO is liable for services if the provider is informed that such proceedings are taking place. Provides a presumption that a provider does not know and should not know the HMO is liable unless:

- The provider is informed by the HMO that it accepts liability;
- A court of competent jurisdiction determines that the organization is liable; or
- The department or the agency makes a final determination that the organization is required to pay for such service in accordance with a recommendation by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056, F.S.

Subsection (5) requires an HMO and the department to report any suspected violation of this section by a health care practitioner to the Department of Health and by a facility to the agency which must take such actions as authorized by law.

Section 3. Amends s. 641.3155, F.S., relating to provider contracts and payment of claims. The section is retitled "payment of claims."

A new subsection (1) is created as follows:

Paragraph (a) defines "clean claim" for a non-institutional provider as a claim submitted on a HCFA 1500 form that has no defect or impropriety. Such clean claim must also have the required substantiating documentation for noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. Provides that a claim may not be considered *not clean* solely because an HMO refers the claim to a medical specialist within the HMO for examination. Provides that if additional substantiating documentation is required from a source outside the HMO, the claim

is considered *not clean*. Provides for repeal for this definition of "clean claim" upon the effective date of rules adopted by the department which define "clean claim."

Paragraph (b) provides that absent a contractually agreed upon written definition of "clean claim," the term "clean claim" for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

Paragraph (c) requires the department to adopt rules to establish claim forms consistent with federal claim-filing standards for HMOs required by the federal Health Care Financing Administration (HCFA). Permits the department to adopt rules relating to coding standards consistent with Medicare coding standards adopted by HCFA.

Existing subsection (1) is renumbered as subsection (2).

Paragraph (a) is amended to include as a requirement for claim payment that such requirements are applicable to a *clean* claim or portion of a *clean* claim made by a contracted or *noncontracted* provider which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO which was mailed or electronically transferred by the provider.

Paragraph (b) is amended to make grammatical corrections and to provide that an HMO which denies or contests a provider's claim or any portion of a claim must provide written notice to the provider within 35 days after the receipt of the claim by the HMO of the contesting or denying of the claim. Provides that if the claim is contested, the notice must include a request for additional information. Provides that if the provider submits additional information, the provider must, within 35 days after the receipt of the request, mail or electronically transmit the information to the HMO.

Subsection (2) is renumbered as subsection (3) and amended to provide that interest on an overdue payment for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received. Provides that the interest is payable with the payment of the claim.

Subsection (3) is renumbered as subsection (4) and amended to provide that an HMO which fails to pay or deny a claim later than 120 days after receiving the claim creates an incontestable obligation for the HMO to pay the claim to the provider.

Creates subsection (5), relating to HMO overpayments.

Creates paragraph (a) to provide that if, as a result of retroactive review of coverage decisions or payment levels, an HMO determines that it has made an overpayment to a provider for services rendered to a subscriber, the HMO must make a claim for such overpayment. Prohibits an HMO from reducing payment to that provider for other services, unless the provider agrees to the reduction or fails to respond to the HMO's claim, as required in this subsection.

Creates paragraph (b) to require a provider to pay a claim for an HMO overpayment, which is not contested or denied by the provider, within 35 days after the receipt of a claim which is mailed or electronically transferred to the provider.

Creates paragraph © to require a provider that denies or contests an HMO's claim for overpayment or any portion of the claim for overpayment, to notify the HMO in writing, within 35 days after receiving the claim. Provides that the written notice of denial or contest must identify the contested portion of the claim and the specific reason for the denial or contest and, if contested, must include a request for additional information. Provides that if the HMO submits additional information, the HMO must, within 35 days after the receipt of the request, mail or electronically transmit the information to the provider. Requires the provider to pay or deny the claim for overpayment within 45 days after the receipt of the information.

Creates paragraph (d) to provide that payment of a claim for overpayment is considered made on the date the payment was received or electronically transmitted or otherwise delivered to the HMO, or the date that the provider receives a payment from the HMO that reduces or deducts the overpayment. Provides that an overdue payment of a claim bears simple interest at the rate of 10 percent per year. Provides that the interest on any overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

Creates paragraph (e) to require a provider to pay or deny any claim for overpayment no later than 120 days after receiving the claim. Provides that failure to pay a claim for overpayment within 120 days creates an incontestable obligation for the provider to pay the claim to the organization.

Subsection (4) is renumbered as subsection (6).

Creates subsection (7), relating to a provider's claim for payment.

Creates paragraph (a) to specify that a provider claim for payment is considered received by the HMO, if the claim has been electronically transmitted to the HMO, when the receipt is verified electronically or, if the claim was mailed to the address disclosed by the HMO, on the date indicated on the return receipt. Requires a provider to wait 45 days from receipt of a claim before submitting a duplicate claim.

Creates paragraph (b) to provide that an HMO claim for overpayment is considered received by a provider, if the claim has been electronically transmitted to the provider, when the receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization, on the date indicated on the return receipt. Requires an HMO to wait 45 days from the provider's receipt of claim for overpayment before submitting a duplicate claim.

Creates paragraph (c) to provide that nothing in this section precludes an HMO and provider from agreeing to other methods of transmission and receipt of claims.

Creates subsection (8) to specify that a provider, or the provider's designee, who bills electronically, is entitled to an electronic acknowledgment of the receipt of a claim within 72 hours.

Creates subsection (9) to prohibit an HMO from retroactively denying a claim because of subscriber ineligibility more than 1 year after the date of payment of the clean claim.

Section 4. Creates s. 641.3156, F.S., relating to treatment authorization and payment of claims.

Creates subsection (1) to require an HMO to pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a provider that is authorized by contract with the HMO to authorize or direct the patient's utilization of health care services and which was also authorized in accordance with the HMO's current and communicated procedures, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Creates subsection (2) to prohibit the denial of a claim if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Creates subsection (3) to provide that emergency services are subject to the provisions of s. 641.513, F.S., relating to requirements for providing emergency services and care, and are not subject to the provisions of this section.

Section 5. Creates subparagraph 9. of paragraph (c) of subsection (5) of s. 641.3903, F.S., relating to unfair claim settlement practices, to include systematic down coding with the intent to deny reimbursement otherwise due.

Section 6. Amends s. 641.3909, F.S., relating to cease and desist and penalty orders, to include violation of s. 641.3155, F.S., relating to payment of claims, authorizing the department to order specified cease and desist and penalty orders.

Section 7. Amends subsection (4) of s. 641.495, F.S., relating to requirements for issuance and maintenance of HMO certificates, to require the HMO to provide treatment authorization 24 hours a day, 7-days-per-week. Provides that requests for treatment authorization may not be pended, unless the requesting provider contractually agrees to take a pending or tracking number.

Section 8. Creates s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program.

Subsection (1) provides definitions for the following terms:

- "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under ch. 641, F.S., a prepaid health plan authorized under s. 409.912, F.S., or an exclusive provider organization certified under s. 627.6472, F.S.; and
- "Resolution organization" means a qualified independent third-party claims dispute resolution entity selected by and contracted with the Agency for Health Care Administration

Creates subsection (2), relating to the claim dispute resolution organization program.

Creates paragraph (a) to direct the agency to establish a program, by January 1, 2001, to provide assistance to contracted and noncontracted providers and managed care entities for claim disputes that are not resolved by the provider and the managed care organization. Requires the agency to contract with a resolution organization to timely review and consider claims disputes submitted by providers and managed care organizations and to recommend to the agency an appropriate resolution of those disputes. Requires the agency to establish by rule jurisdictional

amounts and methods of aggregation for claims disputes that may be considered by the resolution organization.

Creates paragraph (b) to specify that the resolution organization must review claim disputes filed by contracted and noncontracted providers and managed care organizations unless the disputed claim:

- Is related to interest payment;
- Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule;
- Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;
- Is related to a health plan not regulated by the state;
- Is part of a Medicaid fair hearing pursued under 42. C.F.R. ss. 431.220 et seq.;
- Is the basis for an action pending in state or federal court; or
- Is subject to a binding claim dispute resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization.

Creates paragraph (c) to provide that contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal resolution dispute process as a prerequisite to submitting a claim by a provider or HMO to the dispute resolution organization.

Creates paragraph (d) to specify that a contracted or noncontracted provider or health maintenance organization may not file a claim dispute with the resolution organization more than 12 months after a final determination on a claim by an HMO has occurred.

Creates subsection (3) to require the agency to adopt rules to establish a process for the consideration by the resolution organization of claims disputes submitted by either a provider or managed care organization which must include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after the receipt of the claims dispute submission.

Creates subsection (4) to require the agency to adopt the recommendation as a final order within 30 days after the receipt of the recommendation of the resolution organization.

Creates subsection (5) to provide that the entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. Requires the agency rule to include an apportionment of the review fee in those cases where both parties may prevail in part. Provides that the failure of the nonprevailing party to pay the ordered review cost within 35 days after the agency's order will subject the nonpaying party to a penalty of no more than $500 per day until the penalty is paid.

Creates subsection (6) to authorize the agency to adopt rules necessary to administer this section.

Section 9. Amends subsection (2) of s. 395.1065, F.S., relating to criminal and administrative penalties.

Amends paragraph (a) to update statutory language

Creates paragraph (d) to provide that if sufficient claims due to a provider from an HMO do not exist to enable the take back of an overpayment as provided under s. 641.3155, F.S., relating to payment of claims, the agency may impose an administrative fine for the violation of s. 641.3154, F.S., (HMO liability and prohibiting provider billing) or s. 641.3155, F.S., (payment of claims) in amounts specified in s. 641.52(5), F.S., (administrative fine) and the provisions of paragraph (a) do not apply.

Section 10. Amends paragraph (c) of subsection (1) of section 631.818, F.S., relating to powers and duties of the plan regarding insolvent HMOs, adding to claims that the plan must defend and judgments paid, those claims filed contrary to the provisions of newly created s. 641.3154, F.S. (HMO liability for payment of services rendered to subscribers)

Section 11. Amends subsection (2) of s. 817.234, F.S., relating to false and fraudulent insurance claims, and republishes subsection (11).

Renumbers subsection (2) as paragraph (a) of subsection (2).

Creates paragraph (b) to provide that in addition to any other provision of law, systematic upcoding by a provider, as defined in s. 641.19(15), F S., relating to definitions, with the intent to obtain reimbursement which was otherwise not due from an insurer is punishable as provided in s. 641.52(5), F.S , relating to administrative fines.

Section 12. Amends s. 817.50, F.S., relating to fraudulently obtaining goods, services, etc., to replace "hospital" with "health care provider "

Subsection (1) is amended to replace "hospital" with "health care provider," as provider is defined in s. 641.19(15), F.S., relating to definitions, providing for a criminal penalty for fraudulently obtaining of goods, services, etc , from a health care provider.

Subsection (2) is amended to provide prima facie evidence of intent to defraud a provider when a person provides a false or fictitious name, address, or the assignment of health maintenance contract proceeds when knowing that such a contract is no longer in force.

Section 13. Amends paragraph (d) of subsection (38) of section 641.31, F.S., relating to HMO contracts, to include reference to newly created s. 641.3154 (HMO liability for payment of services rendered to subscribers), providing that this section does not apply to a point-of-service rider authorized under this subsection.

Section 14. Provides that the sum of $38,928 is appropriated from the Health Care Trust Fund and one position to the agency for the purposes of carrying out the provisions of this act during the 2000-2001 fiscal year.

Section 15. Provides that except as otherwise provided, this act will take effect on October 1, 2000, and shall apply to all claims for services rendered after that date, and apply to all requests for claim dispute resolution which are submitted by a provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

HMOs would be expected to incur additional expenses due to the following provisions of the bill:

- Prohibition of retroactive denial of a claim more than 1 year after payment of a clean claim because of subscriber ineligibility;
- Requirement for requesting additional information prior to denying or contesting a claim;
- Requirement to provide treatment authorization 24 hours per day, 7 days per week; and
- Limitation of pending requests for treatment authorization.

Such additional costs to HMOs would be expected to be passed on in higher premiums to subscribers, or reduce profits to shareholders and administrators.

HMOs would be expected to benefit due the following provisions of the bill:

- Overpayment claims payment deadlines;
- Timely determination of claim disputes by resolution organization and issuance of final agency order; and
- Prohibition of systematic upcoding by providers.

Providers would be expected to incur additional expenses due to the requirement of timely review and payment of HMO overpayment claims.

Providers would be expected to benefit due to the following provisions of the bill:

- Requirement of notice of HMO billing mailing address, billing electronic address, telephone number for questions and concerns regarding claims, and address of any separate claims processing centers for specific types of services;

- Requirement of HMOs to provide written procedures for requesting and obtaining authorization of health care services;
- Timely determination of claims disputes by the resolution organization and issuance of final agency order; and
- Prohibition of systematic down coding by HMOs.

The bill may also benefit subscribers by expediting the payment of claims and ensuring prompt treatment authorization, and by clarifying balance billing situations. Subscribers should no longer be balanced billed nor sued by non-contract providers when providers have performed HMO authorized and covered services.

D. FISCAL COMMENTS:

Information is not available at this time on the costs associated with the claim dispute resolution organization process.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The bill grants rulemaking authority to the Department of Insurance, as follows: to adopt rules which define "clean claim" for non-institutional providers; to adopt rules to establish claim forms consistent with specified federal claim-filing standards; and to adopt rules relating to coding standards consistent with certain Medicare coding standards.

The bill grants rulemaking authority to the Agency for Health Care Administration, as follows: for determining jurisdictional amounts and methods of aggregation of claim disputes for the statewide provider and managed care organization claim dispute resolution program; for establishing a process of consideration by resolution organizations; for regulating resolution organization review fees; and for rules relating to apportioning of review fees.

C. OTHER COMMENTS:

Section 8 of the bill requires the Agency for Health Care Administration to establish a statewide provider and managed care organization claim dispute resolution program. The agency is required to contract with resolution organizations to timely review and consider claim disputes submitted by providers and managed care organizations. The bill provides that the nonprevailing entity (either a provider or managed care organization) will be responsible for the review fee as determined by agency rule but charged by the resolution organization. After receiving a recommended order, supported by a finding of fact, the agency has 30 days to adopt the recommendation as a final order. The bill is silent on whether the agency can issue a final order which differs from the recommended order. Failure of an entity to pay the fee within the prescribed time period results in the agency imposing a penalty of up to $500 per day until the reviewing fee is paid. This process raises several concerns:

1. Because the resolution organization has a contract with the agency, failure of an entity to pay a review fee could result in the resolution organization seeking reimbursement from the agency.

2. Because the agency has to issue the final order resolving the dispute, if appealed by the nonprevailing entity, the agency is obligated to defend this final order. Therefore, the agency would be defending an order which included no agency involvement but was a dispute between private entities, where the agency had no role in creating the record which is now being appealed. Should the order be overturned by the court, the agency could be subjected to additional litigation from the previously prevailing party.

3. The bill is silent regarding the fine revenue. It is unclear whether this penalty is to be provided to the resolution organization or kept by the agency, and if by the agency, for what purpose the money is to be used.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

HB 2427 was proposed by the Health Care Services Committee as PCB HCS 00-09. PCB HCS 00-09 addressed a variety of issues relating to managed care organizations including, in part the following: created a private claims dispute process; deleted provisions relating to provider billing; required specified disclosures and notices as part of HMO contracts; defined "clean claim;" revised procedures for provider payments; provided 24-hour, on-line or telephone service for service authorization; revised criteria for false statements, entries, and unfair claim settlement practices; and expanded fraudulently obtained good, services, etc., to include health care providers. When heard by the Health Care Services Committee on April 17, 2000, the committee adopted a "strike-everything" amendment which made numerous technical changes including the following: clarified time frames for interest payments on overdue claims and overpayments; specified time frame for retroactive denial of services for an ineligible subscriber; provided that authorization and claim for emergency services were subject to another provision of law; and revised provisions relating to treatment-authorization capabilities and pending authorizations. On May 2, 2000, the House of Representatives passed HB 2427. On May 5, 2000, the House passed CS/CS/CS/SB 1508 & CS/SB's 706 & 2234. Relevant differences between HB 2427 and CS/CS/CS/SB 1508 & CS/SB 706 & CS/SB 2234 include the following: minor drafting differences; technical differences in statutory cross-references and an appropriation of $38,928 from the Health Care Trust Fund and one position to the agency for the purposes of carrying out the provisions of this act for FY 2000-2001.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Tonya Sue Chavis, Esq. Phil E. Williams

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Tonya Sue Chavis, Esq. Phil E. Williams

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1508

SPONSOR: Health, Aging and Long-Term Care Committee, Banking and Insurance Committee, and Senator Brown-Waite

SUBJECT: Health Maintenance Organizations; Claims Payment

DATE: April 12, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.	Carter	Wilson	HC	Favorable/CS
3.				
4				
5				

I. **Summary:**

The 1999 Florida Legislature authorized the Director of the Agency for Health Care Administration (AHCA or agency) to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The Advisory Group issued its report and recommendations on February 1, 2000.[1] The Committee Substitute for Committee Substitute for Senate Bill 1508 makes the following changes, based on these recommendations *and subsequent dialogue between the parties*:

- Requires health maintenance organizations (HMOs) to pay a hospital-service claim or referral-service claim for treatment that was authorized by a physician empowered by contract with the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, if the provider follows the HMO's authorization procedures and applicable laws and receives authorization for a covered service for an eligible subscriber, unless information was provided with the willful intention to misinform the HMO.

- Creates the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The agency must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and providers with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, F.S., subject to a final agency order.

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[1] *"Florida Advisory Group on The Submission and Payment of Health Claims: Report to the Legislature and the Governor,"* February 1, 2000.

- Requires HMOs to have the capability to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

- Transfers to a newly created section of law and strengthens the "balance billing" prohibitions currently in s. 641.315, F.S., by prohibiting a provider from collecting or attempting to collect from a subscriber any money for services covered by an HMO; specifying that the statute applies to noncontract providers rendering covered services; prohibiting a provider from billing the subscriber during the pendency of any claim for payment and during any legal or dispute resolution process; prohibiting a provider from reporting a subscriber to a credit agency for unpaid claims due from an HMO; and requiring referral of violations by physicians and facilities to the appropriate regulatory agency for final disciplinary action.

- Limits the requirement for an HMO to pay claims within 35 days of receipt, to a "clean claim" or any portion of a "clean claim" filed by a contract provider. The term "clean claim" is defined.

- Clarifies that the current 10 percent annual simple interest penalty on an HMO's claim for overpayment or an overdue payment of a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received, and requires that the interest be payable with the payment of the claim.

- Entitles providers who bill electronically to electronic acknowledgment of receipts of claims within 72 hours.

- Provides a 1 year time limit for a health maintenance organization to retroactively deny a claim for services provided to an ineligible subscriber

This bill substantially amends the following sections of the *Florida Statutes* (F.S.): 395.1065, 641.315, 641.3155, 641.495, and 817.50. The bill creates ss. 408.7057, 641.3154, and 641.3156, F.S

II. **Present Situation:**

Health Maintenance Organization "Prompt Payment" Statute (s. 641.3155, F.S.)

In 1998, the Legislature enacted s. 641.3155, F.S., requiring HMOs to pay claims within certain time frames.[1] This statute (referred to as the "prompt payment" law) requires an HMO to reimburse any claim or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim. If the claim is contested by the HMO, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, identify the contested portion of the claim and the specific reason for contesting or denying the claim. This notice may also include a request for additional information

[1]Ch. 98-79, *Laws of Florida* (L O F), Committee Substitute for Senate Bill 1584 (1998)

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim.

In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

In 1999, the prompt payment statute was amended to address the issue of HMOs deducting past overpayments from a provider's claim, commonly referred to as "take backs."[1] Section 641 3155(4), F.S., requires any retroactive reduction of payments or demands for refund of previous overpayments to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. This also applies to providers who make retroactive demands for payment due to underpayments or nonpayment. The look-back period may be specified by the terms of the contract.

Balance Billing Prohibition (s. 641.315, F.S.)

In 1988, the Legislature enacted amendments to s 641.315, F.S., which provide that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. This law also prohibits a provider of services from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO. This statute is interpreted by the Department of Insurance and the Agency for Health Care Administration as applying to both contract and non-contract providers in those cases where services are covered by the HMO. For example, if a subscriber obtains a covered service at a contract hospital from a non-contract physician, the HMO is liable and the physician may not bill the subscriber. However, some providers argue that the statute is limited to balance billing by contract providers, due to the heading of the statute that reads, "Provider contracts." There are no appellate court decisions on this point.

The Statewide Provider and Subscriber Assistance Program

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., under the administration of AHCA. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to panels that hold hearings on the grievance and issue recommendations to the agency or to the Department of Insurance for a final order. However, the program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. Also, the program does not provide assistance for a grievance for "unpaid balances." Therefore, the program does not typically provide assistance for grievances related to provider disputes for late payments or underpayments

[1]Ch. 99-393, L O F , Committee Substitute for House Bills 1927 and 961 (1999)

HMO Claims for Emergency Care and Treatment

Committee Substitute for Committee Substitute for Senate Bill 1508 does not specifically address claims filed with HMOs for emergency care and treatment, but problems in this area led to the enactment of legislation that is relevant to the issue of prompt payment. Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral. This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers.[1]

In summary, an *emergency medical condition* is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part

When a subscriber is present at a hospital seeking emergency services and care, the determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination (even if the provider determines that an emergency medical condition does not exist). If the provider determines that an emergency medical condition does exist, the HMO must also compensate the provider for *emergency services and care*, which are defined to include the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

Further language in the current law requires the hospital to make a reasonable attempt to notify the subscriber's primary care physician or HMO, if known, and prescribes certain time frames for such notice, but the law provides that an HMO may not deny payment for emergency services and care based on a hospital's failure to comply with the notice requirements.

A subscriber may be charged a reasonable copayment, up to $100, for the use of an emergency room. Net of this copayment, an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

[1]Sections 641.31(12), 641.47(7)-(8), and 641.513, F.S.

Federal HIPAA Requirements for "Clean Claims" and Electronic Billing

The federal Health Insurance Portability and Accountability Act (HIPAA) requires the Health Care Financing Administration (HCFA) to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility and payment. There have been problems and delays with the implementation of HIPAA. An industry group working on the implementation, the National Uniform Billing Committee (NUBC) recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC) is expected to agree to an equivalent definition of a practitioner clean claim. Both of these committee recommendations, and other administrative simplification recommendations, will be submitted to the federal Secretary of Health and Human Services for adoption and implementation.

Florida Advisory Group on the Submission and Payment of Health Claims

The health care provider community has voiced concerns about delays in payment of HMO claims, underpayment of claims, and difficulty in obtaining authorization for treatment from HMOs. The providers assert that the current prompt payment law is not being observed. Estimates generated by the Florida Hospital Association show that as of May 1999, 16.1 percent of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital and Healthcare Association found that the average age of HMO receivables in the hospitals in question were over 70 days old, with about 30 percent of the receivables being over 60 days old. However, none of this information has been independently verified or assessed for accuracy.

The Agency for Health Care Administration performed an emergency room claims payment survey The summary of its survey indicates that 4924 emergency room claims (commercial claims; not Medicaid) from 26 HMOs were reviewed and that 32 claims were improperly denied or not paid. (AHCA Emergency Room Claims Payment Survey Summary, March 23, 2000)

On March 30, 2000, the Department of Insurance issued a Notice and Order to Show Cause ("Order") to each of two HMOs, resulting from a target examination of their claims payment practices. Each of the Orders finds that the HMO failed to pay, contest, or deny claims within the 35 days, as required by s. 641.3155, F.S., and failed to pay the 10 percent penalty for late payments as required under that section, among other allegations. The Orders include notice that the department intends to impose administrative penalties of $100,000 against one HMO and $75,000 against the other HMO.

The managed care community disputes the magnitude of this problem and maintains that most delays in payment are caused by a provider's failure to include essential and accurate information with their claims.

In response to these concerns and divided opinions, the Florida Legislature in 1999 authorized the Director of AHCA to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. (Ch. 99-393, L O.F.; CS/HB's 927 and 961) The Advisory Group issued its report and recommendations on February 1, 2000 ("Advisory Group Report").

Summary of Advisory Group Report

The following is a committee staff summary of the recommendations of the Advisory Group Report, with the page number of the report where the recommendation is contained. The staff summary uses the term "HMO," rather than "MCOs" or managed care organizations, as used in the report, which are synonymous terms (as stated on page 1 of the report).

Issues and Recommendations: Non-Emergent Treatments

A) Authorization to Treat

1. *24-Hour Service* -- HMOs should have the capability to provide authorization 24 hours a day, 7 days a week for all services for which pre-authorization is required. (p. 16)

2. *Binding Authorization of Services* -- If a provider follows authorization procedures and applicable laws, and receives authorization for a covered service for an eligible employee, then the plan is bound by its authorization to pay and the service is deemed medically necessary. (p. 16)

3. *Pend Numbers* -- It is inappropriate for HMOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number. (p.16)

B) Electronic Billing and Clean Claims

1. *Definition of Clean Claim* -- Recommend adoption of the recently adopted National Uniform Billing Committee (NUBC) definition of institutional clean claim. However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them. (p. 17)

2. *HIPAA Standards* (Federal Health Insurance Portability and Accountability Act) -- The federal HIPAA law includes requirements for electronic filing of claims, but these provisions have not yet been implemented. It is believed that implementation will take place within the next 3 years. Recommend that Florida adopt the expected federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be applied to all HMOs and providers. AHCA staff estimate the costs of HIPAA implementation in Florida to average between $24,000 and $30,000 per office practice. (p. 17)

C) Late Payments

1 *Interest Payments* -- Section 641.3155 should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, i.e., 35 days after the receipt of a clean claim. The statute should also clarify that the accrued interest must automatically be included with any late payment of a claim. This revised statute should apply equally to payment to contracted and non-contracted providers. (p 18)

2. *Venue for Complaints and Dispute Resolution* -- Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. The scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmerited appeals. (p. 18)

3. *Sub-Contractor Processing and Payment of Claims* -- In instances where an HMO delegates authority for issuing authorization or processing or paying claims to a third-party subcontractor, the current policy of the Department of Insurance is to hold the licensed HMO financially and legally responsible for all actions or failures to act of the third-party subcontractor. The Advisory Group and the agency support this policy. (p. 19)

D) Claims Review

1 *Eligibility Determination* -- Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days. (p. 19)

2 *Receipts* -- Providers who submit claims electronically should be entitled to electronic acknowledgment of receipts of claims. Providers who receive acknowledgment of receipts of claims should be prohibited from sending a duplicate bill for 45 days (p 19)

3. *Take Backs* -- Take backs should be treated as claims made by an HMO to a provider. Insurers should provide written notice to providers of all over-payments, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments. (p. 19)

E) Balance and Duplicate Billing

1. *Enforcement of Balance Billing Prohibition* -- The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. AHCA, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards. Balance billing by facilities shall be referred to AHCA in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered services. Providers may not balance bill patients while billing disputes are going through any future state supervised dispute resolution process. (p. 20)

2. *Medical Necessity* -- Except in emergency situations, if an HMO denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not covered by the HMO, and the provider is entitled to bill the patient for the service. It is important to

educate the subscriber that he or she will be responsible for payment of services under these conditions. (p. 20)

3. *Non-Covered Services* -- Providers have a right to bill patients for non-covered services (p. 20)

4. *Non-Participating Providers* -- Current s. 641.315, F S., is ambiguous because the heading refers to provider contracts, but the language says no provider is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing the heading of the statute. Non-participating providers should not bill patients (beyond HMO copayments) if they are billing the HMO, going through a dispute resolution process to secure payment from an HMO or have accepted HMO payment for the specific service. (p. 20)

5. *Restriction on Referral to Credit Agencies* -- It is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations.

F) Non-Participating Providers

Recommends that when a physician empowered by an HMO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the HMO is obligated to reimburse that other provider for the authorized services. (p 21)

G) Fraud and Abuse

1. *Automated Recoding of Claims* -- Systematic downcoding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The Department of Insurance has already issued a Statement to that effect. (p. 22)

2. *Incentives for Billing Agent to Submit Fraudulent Claims* -- Florida should follow the same policies as Medicare. Under current Medicare regulations, billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised or enforced more stringently by the Health Care Financing Administration in the near future. Similarly, if Medicare implements a policy against percentage incentives for HMO audit or credit collection firms, the Advisory Group recommends that Florida do likewise. (p 22)

3. *Reporting Liability of Additional Payors* -- The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial HMOs. (p. 22)

4 *Auditing of Claims* -- Providers should not charge HMOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the HMO, but still should not add an extra charge for HMO staff reviewing provider records. (p. 22)

5. *Civil Liability of Whistleblowers* -- Requested the Department of Insurance to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud. (p. 22)

Issues and Recommendations: Emergency Treatments

1. *Hospital Code System* -- The Advisory Group acknowledges AHCA's review of Medicaid standards concerning the coding of hospital emergency department treatments. The group recommends that AHCA look into redoing the Florida Medical Quality Assurance Inc. (FMQAI) study of hospital emergency room coding in light of the objections to that study that have been presented to the group. (p 26)

2. *Availability of Specialized Physicians for Emergency Treatment* -- In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific HMO, the hospital should notify the HMO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the AHCA Bureau of Managed Care, which assesses HMO network adequacy Access to emergency care is addressed in s. 395.1041. This law gives the agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need (p. 26)

III. Effect of Proposed Changes:

Section 1. Amends s. 641.315, F.S., relating to provider contracts, to delete subsections (1)-(3) and (5), relating to payment of provider claims for health care services, and revises current law relating to statutory guidelines for contracts between HMOs and providers. Required contract language relating to subscriber liability for the provision of health care services is revised to require contract wording to the effect that the subscriber is not liable to the provider for any services for which the HMO is liable as specified in a new section of law created in section 2 of the bill that provides for HMO liability for payment of claims and prohibits a provider from balance billing a subscriber.

Two new provisions are added to this section. New subsection (4) requires an HMO to disclose to contract providers: (a) the mailing address or electronic address where claims should be sent for processing; (b) the telephone number a provider may call to have questions addressed; and (c) the address of any separate claims processing centers for specific types of services. The HMO must, also, provide written notice to contract providers at least 30 days prior to any change in this information. New subsection (8) requires that a contract between an HMO and a provider must establish procedures for a provider to request and the HMO to grant authorization for utilization of health care services. The HMO is required to give providers written notice prior to any changes in such procedures.

Section 2. Creates s. 641.3154, F.S., relating to liability of HMOs for the payment of claims for health care services provided to their subscribers, to provide that:

- if an HMO is liable for services rendered to a subscriber by a provider, irrespective of whether a contract between the provider and the HMO exists, the HMO is liable for payment

of fees to the provider and the subscriber is not liable for payment of fees to the provider [this language was moved from s 641.315, F.S., and modified];

- for purposes of this section, an HMO is liable for services rendered to a subscriber by a provider if the subscriber contract or applicable law establishes such liability;

- an HMO's liability for payment of fees for services is not affected by a contract with third parties to perform authorizing, processing, or claims payment functions;

- a provider, whether the provider is a party to a contract with the HMO or not, may not collect or attempt to collect money from, maintain a legal action against, or report to a credit agency, a subscriber of an HMO when a provider, or a representative of such provider, in good faith knows or should know that the HMO is liable for payment of fees for services nor during the pendency of any claim for payment made by the provider to the organization for payment of the services or any legal proceeding or dispute resolution to determine whether an HMO is liable, if the provider is informed of such proceedings;

- a conclusive presumption is created that a physician does not know and should not know that an organization is liable, *unless* one of the following three conditions exists. (1) the provider is informed by the organization that it accepts liability; (2) a court of competent jurisdiction determines that the organization is liable; or (3) the Department of Insurance or AHCA makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel; and

- an HMO and the Department of Insurance must report to the Department of Health, for violations by health care practitioners, and AHCA, for violations by facilities it regulates, any suspected violation of the prohibition against providers collecting or attempting to collect money from, maintain a legal action against, or report to a credit agency a subscriber of an HMO that is liable for the payment for services rendered to the subscriber. The regulatory agencies are required to take actions against violators as authorized by law.

Section 3. Amends s. 641.3155, F.S., relating to payment of claims, to define the term "clean claim" as *a claim that has no defect or impropriety, including lack of required substantiating documentation for noncontracting providers and suppliers, or particular circumstances requiring special treatment that prevent a timely payment from being made on the claim* Additional language provides clarification that a claim may not be considered not clean solely because an HMO refers the claim to a medical specialist within the HMO for examination, but may be considered not clean if additional substantiating documentation, such as a medical record or encounter data, is required from a source outside the HMO.

The Department of Insurance is required to adopt rules to establish claim forms that are consistent with federal claim filing standards for HMOs required by the federal Health Care Financing Administration (HCFA) The department is authorized to adopt rules to establish coding standards that are consistent with Medicare coding standards adopted by HCFA

Health maintenance organizations are required to pay any clean claim or portion of a clean claim made by a contract or noncontract provider An HMO's denial or contesting of a portion of a claim is made subject to the statutory processing timeframes applicable to whole claims.

The bill does not impose additional penalties for late payments of claims by HMOs, but clarifies when the interest begins to accrue. Interest on overdue payments for a clean claim or for any uncontested portion of a clean claim would begin to accrue on the 36th day after the claim has been received. Interest is payable with the payment of the claim. As relates to the current law requirement that an HMO pay or deny a claim within 120 days after receiving the claim, an uncontestable obligation is imposed, in the bill, for failure to do so.

An HMO is required to make a claim for an overpayment that it determines that it has made as a result of retroactive review of coverage decisions or payment levels and is prohibited from reducing payment to the provider for other services unless the provider agrees to the reduction or fails to respond to the organization's claim. Providers are required to pay an uncontested or undenied claim for overpayment within 35 days after receipt of a mailed or electronically transferred claim Providers are required to notify, in writing, an HMO within 35 days after the claim for overpayment is received that the claim is contested or denied. Such notice must identify the contested portion of the claim, specify the reason for contesting or denying the claim, and must include a request for additional information When submitting requested additional information, an HMO must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider is required to pay or deny the claim for overpayment within 45 days after receipt of the additional information.

Payment of a claim for overpayment is considered made, as provided in the bill, on the date payment was received or electronically transferred or otherwise delivered to the HMO, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. Providers are made subject to a 10 percent *per annum* simple interest penalty applied to overdue payment of a claim The interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment was received. Providers are required to pay or deny a claim for overpayment within 120 days after receiving such a claim. Failure to pay or deny a claim for overpayment within 120 days creates an uncontestable obligation to the provider to pay the claim. [HMOs are subject to the same interest sanctions and timeframes under s. 641.3155(2)-(4), F.S., as provided in the bill].

Both provider claims and HMO claims for overpayment are deemed, under subsection (7), to be *received* when receipt is verified electronically, if the claim is electronically transmitted, or, if the claim is mailed, to the address disclosed by the HMO on the date indicated on the return receipt. Providers and HMOs are required to wait 45 days after receipt of a claim, by the other party, before submitting a duplicate claim. Providers that bill electronically are entitled to electronic acknowledgement of receipt of a claim within 72 hours. A health maintenance organization may not retroactively deny a claim for payment because of subscriber ineligibility more than 1 year after the date of service.

Section 4. Creates section 641.3156, F.S , relating to treatment authorization and payment of claims. The bill requires HMOs to pay a hospital-service claim or referral-service claim for

treatment that was authorized by a physician empowered by contract with the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, unless the physician provided information to the HMO with the willful intention to misinform the HMO. An HMO could not deny such authorized claims for treatment if the provider follows the HMO's authorization procedures and applicable laws and receives authorization for a covered service for an eligible subscriber, unless the physician provided information to the HMO with the willful intention to misinform the HMO. Emergency services are excluded from the provisions of this section and explicitly made solely subject to the provisions of s. 641.513, F.S., providing statutory requirements for emergency services and care for subscribers of HMOs.

Section 5. Amends s. 641.495, F.S., providing requirements for the issuance and maintenance of an HMO certificate of authority. The bill requires HMOs to have the *capability* to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

Section 6. Effective January 1, 2001, creates s. 408.7057, F S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program, to define the terms "managed care organization" and "resolution organization" and to require AHCA to establish such a program, by contract with a qualified independent third-party claims dispute resolution organization, to provide assistance to contracting and noncontracting providers and managed care organizations in resolving those claim disputes arising under the prompt payment statute, s. 641.3155, F S., and that are not resolved by the provider and the managed care organization. The resolution organization would be required to timely review and consider claims disputes and recommend to AHCA an appropriate resolution of the disputes. The agency is required to establish, by rule, jurisdictional amounts and methods of aggregations for claims disputes that may be considered by the resolution organization.

Certain exclusions from the panel's jurisdiction are enumerated in the bill. These exclusions prohibit the panel from hearing any claim that is subject to a binding claims dispute resolution process provided by contract entered into prior to July 1, 2000, between the provider and the managed care organization or a claim that is subject to a binding claims dispute resolution process provided by a contract entered into or renewed on or after July 1, 2000, in which the provider has elected to arbitrate the claim. On a related matter, the bill provides that all contracts entered into after the effective date of the bill that provide for a binding claims dispute resolution process must allow providers the option of pursuing either the contracted dispute resolution process or bringing the claim before the resolution organization created by this section. Other exclusions include claims related to interest payments, claims that do not meet the jurisdictional thresholds established by AHCA rule, disputes based on any action that is pending in state or federal court, and claims related to Medicare and Medicaid.

The agency would be required to adopt rules to establish a process for the consideration by the resolution organization of claims disputes, which must include the issuance of a written recommendation, supported by findings of fact, to AHCA within 60 days after receipt of the claims dispute submission. Within 30 days after receipt of the recommendation of the resolution organization, AHCA must issue a final order subject to the provisions of chapter 120. The bill

does not specify the allowable scope of the recommendations by the review organization, other than to recommend "an appropriate resolution of the dispute." The bill also does not specify what actions or penalties may be ordered by AHCA against either the managed care entity or the provider. In addition to penalties authorized under current law for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims, but this is not clear.

The entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule with must include an apportionment of the fee in those cases where both parties may prevail in part. The failure of the nonprevailing party to pay the ordered review cost within 35 days of the agency's order subjects the nonpaying party to a penalty of not more than $500 per day until the penalty is paid.

Section 7. Amends s. 395.1065, F.S., providing criminal and administrative penalties for purposes of hospital regulation, to add a cross reference to s. 641.3154, F.S., as created in the bill, providing for HMO liability for payment of fees for services rendered to their subscribers and prohibiting providers from billing subscribers for services for which the HMO is liable, having the effect of making improper hospital claims to subscribers, as provided under that section, subject to sanctions by AHCA. This provision is also amended to subject hospitals to administrative fines that AHCA may impose against HMOs for violations of law relating to provider payment of claims, as provided for under s. 641.3155, F S.

Section 8. Amends s. 817.50, F.S., relating to fraudulently obtaining goods, services, etc , from a hospital, to expand the protections of this current criminal law provision from covering only hospitals to other providers, as that term is defined for purposes of Department of Insurance regulation of HMOs under part I of chapter 641, F S As amended, this provision of law provides for criminal sanctions against anyone who willfully and with the intent to defraud, obtains or attempts to obtain goods, products, merchandise, or services from any provider Furthermore, it is deemed to be *prima facie* evidence of the intent to defraud when a person gives a provider a false or fictitious name or a false or fictitious address or assigns to a provider the proceeds of a health maintenance contract or an insurance contract, knowing that such contract is no longer in force, is invalid, or is void A person determined to have committed any of these acts is guilty of a second degree misdemeanor punishable under chapter 775, F S.

Section 9. Except as provided under section 6 of the bill, provides an effective date of October 1, 2000, and applies to claims for services rendered after the effective date and to all requests for claim dispute resolution which are submitted by a provider or managed care organization 60 days after the effective date of the contract between the resolution organization and the agency.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. **Economic Impact and Fiscal Note:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill creates additional protections for all parties to an HMO contract, including providers, subscribers, and HMOs which should help alleviate claims disputes and clarify legal requirements

Managed care entities and providers will incur fees to fund the activities of the claims dispute resolution organization. The provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. AHCA would also be authorized to issue a final order subsequent to the recommendation of the review organization, but the bill does not specify the allowable scope of the order. In addition to penalties authorized under current law for statutory penalties for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims Hospitals may be sanctioned for balance billing of subscribers under the provisions of the bill.

Health maintenance organizations would incur costs from the requirement to be able to provide treatment authorization 24 hours a day, 7 days a week.

The grounds for imposing administrative sanctions against hospital providers are expanded to include violations relating to balance billing of HMO subscribers and violations relating to HMO claims for overpayment. Consequently, hospitals may incur additional costs.

C. Government Sector Impact:

The Agency for Health Care Administration would incur costs in contracting with independent claims dispute resolution organizations, but the bill provides that the provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. So, it is unknown to what extent this cost would be apportioned between AHCA and private parties, but it could possibly be borne entirely by the private parties The Agency for Health Care Administration would incur costs

related to issuing orders following receipt of recommendations by the resolution organization, which costs have not been estimated. [Previous estimates by AHCA for operating an agency (in-house) claims dispute panel was $895,474 for the first year and $773,239 annually thereafter, based on an estimated 13.5 new FTE positions and an estimated 40 hearings per month.]

VI. **Technical Deficiencies:**

None.

VII. **Related Issues:**

None.

VIII. **Amendments:**

None.

2000-152

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1508

SPONSOR: Banking and Insurance Committee and Senator Brown-Waite

SUBJECT: Health maintenance organizations

DATE: April 4, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2			HC	
3.				
4.				
5.				

I. Summary:

The Florida Legislature in 1999 authorized the Executive Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The Advisory Group issued its report and recommendation on February 1, 2000. The bill makes the following changes, based on these recommendations:

Leg. Affairs

Toni Smith

AHCA

922-5584

Wayne

- Requires HMOs to pay a hospital service claim or referral service claim for treatment that was authorized by a physician empowered by the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, unless the service is not covered, the subscriber was ineligible at the time of service, or the physician provided information to the HMO with the willful intention to misinform.

- Creates the Statewide Provider and Managed Care Organizations Claim Dispute Mediation Panel. AHCA must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and providers with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, subject to a final agency order.

- Requires HMOs to have the capability to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

- Strengthens the "balance billing" prohibitions in s. 641.315, F.S., by prohibiting a provider from collecting or attempting to collect from a subscriber any money for services covered by an HMO; specifying that the statute applies to non-contract providers providing covered services; prohibiting a provider from billing the subscriber during any ongoing dispute

Florida Advisory Group On

The Submission and Payment of Health Claims

Report to The Legislature and The Governor

February 1, 2000

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Chapter 1 – The Advisory Group

A. Legislative Mandate

The 1999 Florida Legislature authorized the Executive Director of AHCA to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The statutory language is included in Appendix A to this report. In additions to studying trends and issues relating to the submission and payment of claims, the group was explicitly enjoined to study the development of electronic billing and claims processing, the form and content of claims and measures to reduce fraud and abuse.

The group consisted of eight members, three of whom represented Florida Health Maintenance Organizations (HMOs, also referred to as Managed Care Organizations – MCOs), 1 from a non-profit hospital, 1 from a for-profit hospital, 1 licensed physician, 1 representative of the Florida Department of Insurance and the Executive Director of the Agency for Health Care Administration (AHCA), who served as the chair.

Panel Members

Mr. Ruben J. King-Shaw, Jr., Chair, Agency for Health Care Administration
Mr. John Benz, Memorial Regional Hospital of Broward County
Mr. Joe Berding, Humana Medical Plan, Inc.
Mr. Bruce Carpenter, Physicians Healthcare Plans, Inc.
Arthur Diskin, M.D., Representative of the Florida Medical Association
Mr. Fred Dunlap, United HealthCare of Florida, Inc
Ms. Susanne Murphy, Department of Insurance
Ms. Kathryn Torres, Columbia/HCA Healthcare Corporation

B. Proceedings of the Advisory Group

The entire group met 7 times in person, approximately once a month for a period of seven months. Four of the meetings were held in Tallahassee, with one each in Orlando, Miami and Tampa. The first meeting was held on June 29, 1999 in Tallahassee; it was primarily organizational in nature. The second meeting was held August 3 in Tallahassee; it was largely devoted to discussing the issues and forming sub-groups The group formed 4 sub-groups, one on trends and issues, one on electronic billing, one on emergency room issues, and one on fraud and abuse.

The third meeting was held September 2 in Tallahassee; it was mostly devoted to hearing reports from the 4 sub-groups, each of which had met the previous week. The fourth meeting was a public hearing held on October 1 in Orlando; besides hearing public testimony, the group received updates from the 4 sub-groups and several presentations. These presentations

covered the federal Health Insurance Portability and Accountability Act (HIPAA), and the use of automated recoding systems by MCOs

The fifth meeting was held November 15, 1999 in Tallahassee; the group heard updates from the sub-groups and a presentation on the federal Emergency Treatment and Active Labor Act (EMTALA). The sixth meeting was a public hearing held on December 3 in Miami. The group found that the complexity of the issues and the very large amounts of money at stake made it difficult to achieve consensus rapidly. The group unanimously decided to hold a seventh meeting in January strictly for the purpose of going through all the outstanding issues and settling on final group recommendations.

After group members reviewed a preliminary draft final report, the seventh meeting was held on January 21, 2000, in Tampa. The group went through all the major issues that had been raised, discussed and analyzed over the previous seven months. The deliberations and recommendations of the group are included in Chapters four and five of this final report

Chapter 2 – Background Analysis

The submission and payment of health insurance claims is an integral process in our health care economy. This process applies both to private insurance and to most government health care programs, including Medicare and Medicaid. However, this report is primarily focused upon issues relating to private health insurance claims. Payments of private health insurance claims amounted to an estimated $375 billion nationwide and at least $15 billion in Florida in 1998, and a large percentage of these amounts were paid by managed care organizations (MCOs). Moreover the institutional arrangements for making these payments are diverse, complex and continuing to evolve.[1]

The Florida Legislature has taken the initiative in addressing major issues in MCO claims payment by authorizing the Executive Director of the Agency for Health Care Administration (AHCA) to establish this Advisory Group. The deliberations, analysis, findings and recommendations of the Advisory Group are contained in this report.

In recent years, the health care provider community in Florida and throughout the nation has voiced discontent with the evolution of claims payment systems. It has charged that payments are subject to unreasonable delays, that the amounts paid are below those required by contract and by law, and that insurers fail to respond to providers' requests for authorization and information or to provider's complaints about slow and low payments. MCOs are the subject of most of the dissatisfaction.

The managed care community disputes the alleged magnitude of payment problems. They believe that a few MCOs in financial distress or facing transitory problems with electronic data processing have delayed payments, but they maintain that the overwhelming majority of claims have been paid on time according to contract. The most substantial delays, they maintain, have been caused by providers' failure to include essential and accurate information with their claims (the "clean claim" issue). They also maintain that providers have misused the billing process through bills for excessive amounts, multiple billing for the same claim and balance billing, which is the practice of billing patients the remaining charges of a paid claim in contravention of state law.

The Florida Legislature has moved to address this complex and contentious issue. A 1998 law specified that uncontested claims must be paid within 35 days of receipt, with full resolution of all claims required within 120 days. However, providers and other observers charge that this law was not being observed. Continued disagreement over this and other aspects of the claims payment process generated requests for further consideration by state government, hence the creation of this advisory group. The authorizing legislation specifically required that the group address the issue of electronic billing and claims processing.

[1] To cite just one plausible example, an insurer's payment to a physician might be initially processed by a fiscal intermediary, which would signal the insurer to make a payment to an independent practice association (IPA), which would pass the payment on to a medical "group without walls," which would actually pay the physician

This introduction provides the background for the advisory group's work and the rest of the report. It discusses and classifies some of the major billing and payment scenarios that have engendered the controversy. Chapter 3 summarizes actions and activities of other states and of the federal government. Chapter 4 presents the issues considered and recommendations made by the group concerning non-emergent treatments (i.e. the majority of all medical treatments provided by physicians, hospitals and other providers). Chapter 5 presents issues and recommendations for emergency treatments Chapter 6 offers brief conclusions. Additional materials are included in the Appendices A-C.

Major Issues in Claims Billing and Payment

Most claims disputes arise in one of three contexts of provider-insurer relationships: contractual, emergency and non-participating In the first context, the provider and the insurer (usually an MCO) have a contract stipulating that the process by which the provider is authorized to treat the MCO's enrollees and describing the amounts of reimbursement the provider is entitled to. The second context arises when MCO enrollees receive emergency treatment from providers, including hospital emergency departments, who do not have contracts with the MCO. The third context concerns non-emergency treatment of MCO subscribers by providers who do not have contracts with the MCO; such providers are often referred to as non-participating providers.

Contracted Services

It is believed that the majority of MCO claims payments in Florida go to contracted providers. Based on published MCO premium and enrollment data, payments by commercial MCOs to contracted providers are conservatively estimated at over $4 billion per year. The smooth execution of contracts between providers and MCOs is marred by providers' allegations of inordinate delays of treatment authorizations, late payments, inadequate payments and failure to respond to provider inquiries. For their part, the MCOs charge that providers frequently fail to submit clean claims, do not promptly and consistently respond to requests for documentation and medical records, fail to accurately record receivables, and balance bill MCO subscribers.

From the perspective of the provider community, particularly the physician providers, MCO contract issues are marked by uneven bargaining power between the parties. Physician providers feel they have little recourse unless state laws and enforcement serve to implement appropriate public policies.

There are no systematic estimates available of what percentage of MCO contractual payments are viewed as late, low or otherwise problematic by the billing provider. Estimates generated by the Florida Hospital Association (FHA) show that as of May 1999, 16.1% of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital & Healthcare Association (SFHHA) found that the average age of MCO receivables in the hospitals in question were more than seventy (70) days old, with

about 30% of the receivables being more than sixty (60) days old None of this information in either report was independently verified or assessed for accuracy by the Advisory Group.

Representatives of the managed care industry contend that MCOs pay claims on time. Medicare HMOs are required to pay 95% of clean claims within 30 days, and the Florida Association of HMOs (FAHMO) has recommended that this and other Medicare standards be applied to State of Florida regulation of commercial HMOs.

There is strong evidence (Health Data Management, October 1999, p. 106) that problems and costs of billing and payment of contracted medical service would be reduced by the universal adoption of electronic claims processing. Unfortunately the conceptual and physical infrastructures needed to implement universal electronic billing and payment are not fully in place. Currently, many rural providers and many small providers, those with 5 or fewer clinicians, lack the computer hardware and software necessary to submit claims electronically.

However, industry committees (including representatives of providers and of MCOs) are working to develop federal standards for identification numbers, claims codes, privacy protection and other data elements.

Non-Contracted Emergency Services

Both Florida statutes and the federal Medicare Code, as well as EMTALA, define emergency medical conditions (see Chapter 5 for the text of the definitions). The two definitions are similar because they both specify that emergency medical conditions threaten serious jeopardy to overall health, bodily functions or a bodily organ The definitions differ because the Medicare definition applies the prudent layperson standard while the Florida definition does not.

Under current state and federal law, hospitals must provide emergency services to a broad range of patients, and MCOs and other insurers must reimburse for those services. However, the exact specification of mandated emergency services and the correct level of reimbursement for those services have been the subject of hot dispute.

Emergency services are only a small part of overall hospital services. It is not known what percentage of emergency service expenses are accrued by hospitals treating the enrollees of MCOs that do not contract with the hospital. However, because of the medical, economic and legal circumstances surrounding emergency care, MCO payments for emergency services have become a controversial issue across the country.

Current Florida law states that MCOs must pay for emergency department services to commercially insured patients the lower of three reimbursement levels: 1) the amount specified in a contract or other agreement with the provider, 2) the usual and customary charge or 3) the full charged amount. Paying the Medicaid fee for Medicaid members and paying the Medicare fee for Medicare members are additional options when the service is for a Medicaid or Medicare beneficiary. Part of the dispute between hospitals and MCOs revolves around the determination of the usual and customary charge. MCOs often determine the usual and customary charge according to formulas of their own choosing.

Hospitals, on the other hand, tend to maintain that the usual and customary charge concept was only developed with reference to physician's fees and does not apply to hospital services. They contend that, for emergency services, MCOs must either pay the hospital its full charges or secure the hospital's agreement to any lower rate of payment. One potential answer was to develop mutually acceptable usual and customary levels for the commercial population for non-participating providers.

The provider and managed care communities also disagree on the appropriate scope of emergency services. The managed care organizations (MCOs) maintain that for non-emergent conditions, they should only have to reimburse the providers for the screening, evaluation and examination that is reasonably calculated to assist the provider in arriving at a determination as to whether the patient's condition is an emergency medical condition.

The provider community believes that a broader definition of emergency treatment is needed and is justified under the law They believe that they are responsible for a broad range of medically necessary treatments, as determined by the ED physician. This includes extensive testing to determine the nature and genesis of the patient's condition, even if it is not "an immediate significant threat to life or physiologic function." As a practical matter, patients may never present for follow-up testing or other treatment if it is not delivered in the ED.

MCO payments for emergency physician services and other emergency medical services are also a serious issue. Many of the issues being debated concerning hospital ED reimbursement apply, or have close analogies, to emergency physician services. Emergency physician groups, notably the Florida College of Emergency Physicians, have played a major role in the discussion of these issues and have participated extensively in the proceedings of the advisory group, as have the managed care plans.

The hospital community believes that usual and customary charges is a better defined and better understood concept when applied to physician fees. Additionally, there is a distinction between the role of emergency physicians and the role of other physicians, usually specialists, who are occasionally called into an emergency department to treat a specific patient.

Non-Participating Providers

MCOs maintain that their contracts do not provide coverage for out-of-network services. In theory, non-participating providers would rarely treat an MCO's patients, but it happens enough to be an issue. Publicly owned or publicly funded hospitals and other institutions often have some degree of obligation to treat all patients who meet certain criteria regardless of their health insurance status. Sometimes subscribers receive treatment at non-participating hospitals because of emergencies, admission by a physician who participates in the MCO network, or because of the patient's or physicians' preference. In these situations, providers may feel that they are entitled to some reimbursement and that state regulation or statute is necessary to clarify MCO obligations.

Even if there were agreement (or law) that non-emergency, non-contracted providers must be reimbursed under certain conditions, the amount of their reimbursement would still need to be determined. Conceivably, a standard non-contracted provider fee schedule can be developed

and implemented. However, currently the principles behind such a fee schedule and the means of developing, maintaining and enforcing it have not been agreed upon and would need to address unusual and unique situations.

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Chapter 3 – Actions of Other States and the Federal Government

The essential issues under consideration by the Advisory Group have arisen in most states of the nation. While there are differences in conditions arising from differing laws and institutional arrangements, policies initiated by other states may be worth consideration as background or options for the State of Florida. Similarly, policies of the federal government are important, both as background and as instructive example, for our state policy process.

A. State Actions

Thirty-three states, including Florida have enacted or toughened prompt payment legislation in the past 3 years. Many of these laws require payment of clean claims within 30 or 45 days. Some of them mandate inclusion of interest payments when bills are paid late, and some provide for fines to be levied by the state department of insurance or other agency.

New York has been one of the most aggressive states in dealing with the issue. For the past 2 years, the New York Department of Insurance has maintained a toll free hotline solely for providers to complain about delayed, denied or inadequate payments. Each patient for whom the provider has not received payment is logged as a separate complaint. In about 2 years of operations, New York State has received complaints concerning 36,000 patient accounts. Complaining physicians are requested to submit a HCFA X-1500 form for unpaid claims, and the department attempts to expedite payment.

The New York Department of Insurance established a policy of fining managed care organizations $100 for repeated confirmed violations The fines are announced quarterly. In 1999, they levied about $345,000 in fines; over $100,000 was assessed against one very large insurer that had experienced very serious financial and managerial problems. In October of 1999, the Greater New York Hospital Association asked the state Attorney General to investigate the practice of day carve-outs, wherein MCOs reimburse hospitals for part of a patient's stay but deny coverage for one or more of the hospitalized days. The MCOs on the committee maintained that such action would drastically reduce their ability to properly manage utilization.

Last year (1999) the State of Pennsylvania assessed a fine of $150,000 against a moderately large MCO. In New Jersey, state officials gave 2 large MCOs 3 weeks to respond to serious allegations, or else face fines of up to $10,000 per day per violation. Although these firms were able to avoid immediate fines, the New Jersey Hospital Association (NJHA) launched a statewide newspaper advertising campaign denouncing payment practices.

The State of Texas is using a different tactic, namely posting complaint summaries on the Internet, to encourage faster payment of providers' claims. The web site www.tdi.state.tx.us/company/cihmo97.html shows the total number of complaints and the

number of justified complaints of all kinds against the state's 51 health maintenance organizations. A separate table on the same website shows that, for 1997, over 45% of complaints against MCOs were made by providers dissatisfied with delay or denial of payment.

In California, where managed care first became popular, a number of specialized physicians refuse to attend to emergency cases for fear that MCO reimbursement will be inadequate.

This policy has apparently been adopted by hundreds of physicians. It has led to an intense debate over who is responsible for reimbursing specialists who work in emergency rooms. Is it hospitals, MCOs, the state or is it the professional responsibility of physicians to provide the services for little or no reimbursement?

Recently, a task force formed by the California Medical Association (CMA) and the American College of Emergency Physicians recommended that more funding be made available to reimburse specialist emergency services. However, MCOs and hospitals have declined to endorse the recommendations of the task force. A ballot initiative currently under consideration would apply funding from the state's tobacco settlement to reimbursing specialists providing emergency services.

In Washington state, Insurance Commissioner Deborah Senn has issued a set of modified rules governing the payment of provider claims. These rules, which partially apply Medicare regulations to commercial insurers, require that 95% of all clean claims be paid within 30 days. Additionally, 95% of all submitted claims, clean or not, must be paid or denied within 60 days of receipt, except for claims that both parties explicitly agree to keep working on. If an insurer does not meet these standards, they are required to pay interest of 1% per month on all claims more than 61 days old.

The Washington state rules also require that insurers who apply alternative dispute resolution processes (ADRs) must give providers at least 30 days to invoke the ADR. Preliminary indications are that Washington State insurers are accepting this new version of the prompt payment rules.

All states that have MCO laws begin with the premise that services provided by an MCO are provided through a network of contracted providers where available. The majority of states, including Florida, have existing laws and regulations that require MCOs to meet sufficient network adequacy standards and have sufficient ratios of participating providers for treatment and services to their members.

B. Federal Actions

Several areas of federal statute and regulations are most relevant to commercial MCO issues. Medicare regulations concerning prompt payment by Medicare + Choice Organizations (previously known as Medicare HMOs) clearly have some potential for application in state regulation of commercial insurers.

The efforts of the Workgroup for Electronic Data Interchange (WEDI) to establish standards for electronic billing and payment for commercial insurers and their providers offer a possible mechanism to make billing and payment faster and less problematic. The Emergency Medical Treatment and Labor Act (EMTALA) imposes standards upon hospitals and physicians for the treatment of emergency conditions. Finally, the federal false claims act and its enforcement is one of the leading means available to control systematic over-billing and other types of billing fraud.

Medicare + Choice

Medicare + Choice Organizations are frequently required to make payments to unaffiliated providers. In this circumstance, these insurers are required to pay 95% of clean claims in full within 30 days or else compute and add interest payments. Clean claims are defined as claims with no defect, impropriety or circumstances that require special treatment in the claims handling process. While a wide variety of minor errors or omissions may qualify a claim as an unclean claim, there are still requirements that apply to the processing of unclean claims. Ninety five percent of these must be paid or denied within 60 days of receipt.

Additionally, under Medicare law, claim denials may be appealed. Although the enrollee nominally files the appeal, frequently the provider files the appeal with the agreement of the enrollee or their family. Providers can pursue their appeal through as many as 5 levels. The 1st level of appeal is made to the plan itself. If the plan upholds its initial decision to deny coverage, this decision is automatically forwarded to the Center for Health Dispute Resolution (CHDR). Beyond that, it is possible for either party to successively appeal to an Administrative Law Judge, the Departmental Appeals Council and, in certain cases, to Federal District Court.

Electronic Billing and Payment

The effort to promote electronic billing and payment of health insurance claims has a long history. As early as 1980, major insurers formed the National Electronic Insurance Corp. (NEIC) to serve as a central electronic claims processor. Although NEIC never evolved as planned, efforts to standardize and automate claims processing have been continuous. The Health Care Financing Administration (HCFA) developed the standard Medicare billing form, the UB-82, since revised into the UB-92. The American National Standards Institute (ANSI), working with WEDI, promulgated the first of its standardized health insurance transaction formats in 1991.

The drive to implement electronic billing entered a new era in 1996 when the Health Insurance Portability and Accountability Act (HIPAA, previously known as Kennedy-Kassebaum) was passed. Among other provisions, HIPAA charges HCFA with identifying and implementing standard electronic formats for health insurance transactions, including claims, eligibility and payment. Estimates of savings from the universal adoption of electronic data interchange (EDI) have run as high as over $100 billion annually.

Unfortunately, there have been a number of problems and delays with the implementation of HIPAA. Although potential long term cost savings may be enormous, initial implementation costs, which are expected to run into billions of dollars nationwide, constitute an economic and political stumbling block for implementation. Under HIPAA, every one of millions of providers must be assigned a unique identification code, the National Provider Identifier (NPI). Enumerating, assigning codes to and registering these providers will constitute a serious expense in itself.

It may be possible for Florida providers, insurers and state government to agree to implement EDI standards ahead of the national process. Any such accelerated program in our state would need to take consideration of the special needs of small and rural providers Additionally, it would be desirable for any program implemented by the State of Florida to be as compatible as possible with any eventual national standardization.

EMTALA

In the 1980s there was considerable concern across the country about hospitals dumping emergency patients who did not have adequate insurance coverage to reimburse for all the medical treatments they might need. As a result, the Federal EMTALA act was passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. EMTALA specifies that hospitals with emergency departments (EDs) must screen all patients for the presence of emergency medical conditions; it also specifies that physicians are responsible for following its requirements

The act provides for fines against hospitals and physicians who violate its provisions. It also provides for exclusion from the Medicare and Medicaid programs for serious violations. In recent years enforcement of EMTALA has been increased, but no comprehensive statistics are available concerning enforcement. However, emergency physicians and hospitals report that they are required to give emergency patients appropriate and uniform assessment and treatments which may be extensive because of EMTALA, and they contend that MCOs should be required to reimburse for assessment and treatments provided in accordance with this act.

The MCOs state that a recent case in United States District Court "Gardner v. Elmore Community Hospital" disputes the providers' position.

Federal False Claims Act

Under federal law, submitting false claims to the federal government (or to joint federal-state programs such as Medicaid) can generate both civil liability and criminal culpability. Whistle-blowers who file suit in federal court can collect up to 25% of federal funds recovered from fraudulent contractors. These federal provisions affect issues of claims and payment because precautions against fraudulent or illegally exaggerated bills may delay or reduce payments to many providers and because parties who defraud federal programs often defraud private insurers as well.

In 1992, the U.S. General Accounting Office reported to Congress that losses from health care fraud amounted to as much as 10% of the nation's total annual health care expenditures, an estimated $84 billion for that year.

In August of 1999, a physician business management firm agreed to pay $15 million to federal and state governments to settle charges of false claims over a period of several years. The firm submitted bills for thousands of physicians, primarily emergency physicians, across the country. The case arose from a whistle-blower lawsuit filed by a former employee of the firm. No physicians were charged and the company did not admit to any wrongdoing.

Extensive HCFA clarification of billing requirements have been implemented on a national level. These requirements have been enhanced by the passage of HIPAA. Accordingly, providers and third party billing companies have implemented compliance programs and implemented procedures to provide clarity in this area.

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Chapter 4 – Issues and Recommendations: Non-Emergent Treatments

The Advisory Group considered a very broad array of issues. This was the first time in the state's history that all the major aspects of health care reimbursement and claims and payment were considered and evaluated by a state government body. Issues and recommendations are divided between two chapters. This chapter deals with non-emergent medical treatments of all types. The following chapter deals with emergency medical treatments.

Claims and payment issues for non-emergent treatments are divided into seven categories:

A. Authorization to Treat

B. Electronic Billing and Clean Claims

C. Late Payments

D. Claims Review

E. Balance and Duplicate Billing

F. Non-Participating Providers

G. Fraud and Abuse

For each of these categories, a few introductory paragraphs summarize the nature of the issues and the perspectives of providers and insurers. These are followed by the recommendations of the Advisory Group. Unless otherwise noted, the recommendations are made with the consent of all of the group members.

A) Authorization To Treat

In non-emergency situations, most MCOs require that providers secure authorization before performing certain medical services, usually including hospitalization and other high intensity services; this is sometimes referred to as pre-authorization. Pre-authorization is usually provided through the assignment of an authorization number or code to a specific authorized service for a specific patient.

Providers report that occasionally they find it difficult to contact MCOs to request pre-authorizations. In some cases, MCOs decline to either authorize or deny a request for pre-authorization, but "pend" the request, providing a pending number or a tracking number which does not provide a meaningful response to the provider. Additionally, in a small number of cases, providers report that MCOs authorize a treatment prior to performance but

then deny reimbursement for the treatment. MCO representatives agree that it is in an MCO's best interest to be responsive to providers who request pre-authorization in accordance with the MCO's requirements. They claim that denial of pre-authorized treatments is rare and limited primarily to denials caused by lack of member eligibility. MCO representatives believe that denial of a pre-authorized treatment can be justified in some circumstances.

The Advisory Group recommends that when a provider obtains pre-authorization for services from an MCO, in compliance with an MCO's procedures, such pre-authorization is binding provided that the patient is a current member of the MCO and the service provided is a covered service.

Recommendations

24-Hour Service

Agreement that MCOs should have capability to provide authorizations 24 hours a day, 7 days a week for all services for which pre-authorization is required.

Binding Authorization of Services

IF:

1. a provider follows authorization procedure and applicable laws, and
2. receives authorization
3. for a covered service
4. for an eligible employee, THEN
5. the plan is bound by its authorization to pay and the service is deemed medically necessary.

Pend Numbers

It is inappropriate for MCOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number.

B) Electronic Billing and Clean Claims

MCOs and other insurers sometimes find it is difficult to process and pay a claim because the provider did not fill out or submit the claim form correctly. However, there has been no universally accepted claim form for health insurance, and there has been no universally accepted definition of a "clean claim", a claim that is formatted and completed in accordance with the processing needs of the insurer.

HIPAA includes extensive requirements for automated claims processing and administrative simplification. Although the implementation of these provisions has fallen behind schedule, industry and government experts believe that implementation will take place within the next 3 years.

Administrative simplification is intended to improve the efficiency and reliability of health insurance in the U.S. An industry group working on the implementation of HIPAA, the National Uniform Billing Committee (NUBC) recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC) is expected to agree to an equivalent definition of a practitioner clean claim. The NUBC/NUCC recommendations, and other administrative simplification recommendations, will be submitted to the Federal Secretary of Health and Human Services for action.

Recommendations

Definition of Clean Claim

The Advisory Group voted 6-1 to recommend adoption of the recently adopted NUBC definition of institutional Clean Claim. (Please see Appendix B for the text of this definition.) However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them.

HIPAA Standards

Recommendation that the State of Florida adopt the expected Federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be applied to all MCOs and providers. It was agreed that the State should consider implementing more severe penalties for non-compliance than currently provided for under Federal law and code for all participants. Extended deadlines or special assistance for rural or small providers may also merit consideration.

Cost of Automation

AHCA staff estimate the costs of HIPAA implementation in the State of Florida to average between $24,000 and $30,000 per office practice.

C) Late Payments

Providers report that they experience unreasonable delays in the payment of numerous claims, including some routine claims. MCO representatives believe that some providers have exaggerated the extent of the problem.

In 1998 the Florida legislature mandated that MCOs process provider claims within 35 days of receipt. Naturally, MCOs retain the right to deny incorrect claims and to contest others by requesting additional information or documentation. However, clean claims must be paid or denied within 35 days, and all claims must be processed and resolved by the MCO, in some

cases with the cooperation of the provider, within 120 days. The 1998 law specifies that interest at a rate of 10% must be paid on late payments. However, it does not currently specify when interest begins to accrue or how the interest is to be paid. MCOs contend current software will not allow for interest calculations to be included in the original payment.

Automation and other changes may reduce the incidence of late payment and other disputes between providers and insurers. However, given the volume of medical claims and the complexity of financial issues for some of them, it is likely that some claims-related disputes will continue to arise. Providers believe that the status quo does not give them sufficient venue for complaints or for dispute resolution. Some MCO representatives recognize the difficulties providers face, but are concerned that 3rd Party intervention in disputes could be bureaucratic and arbitrary.

Recommendations

Interest Payments

Section 641.3155 should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, i.e. 35 days after the receipt of a clean claim. For other valid claims the uncontested portion is also overdue after 35 days. The contested portion of a contested claim becomes overdue after no more than 120 days, providing that the provider has met their statutory obligation to submit additional information within 35 days of a germane request from the insurer Statute should also clarify that accrued interest must automatically be included with any late payment of a claim, i.e. insurers may not require providers to submit separate claims for interest payments This revised statute should apply equally to payments to contracted and non-contracted providers.

Venue for Complaints and Dispute Resolution

The Advisory Group agrees that the State of Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. It agrees that, if created by legislation, the scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmerited appeals. The mechanism should not pre-empt aggrieved parties from filing suit in civil court for breach of contract or diminish the rights of non-contracted providers.

AHCA and the Department of Insurance (DOI), in consultation with members of the Advisory Group or their designated representatives, will study possible mechanisms for resolution of claims disputes. AHCA and DOI will assess feasibility, procedures for submitting complaints and filing appeals, procedures for resolving appeals, the experience of other states and the Federal government, and budget and funding issues.

Sub-Contractor Processing and Payment of Claims

In instances where an MCO delegates authority for issuing authorizations or processing or paying claims to a Third Party Sub-Contractor, the current policy of the Department of Insurance is to hold the licensed MCO financially and legally responsible for all actions or failures to act of the Third Party Sub-Contractor. The Advisory Group and the Agency supports this policy.

D) Claims Review

Insurers perform a variety of functions and actions in their review and processing of claims Claims are sometimes denied because the patient was not an eligible member of the MCO insurance plan at the time of treatment. Sometimes, the amount paid is lower than the amount claimed for any number of reasons. Sometimes MCOs erroneously pay a claim or pay more than is warranted; in such cases, MCOs then "claim" the overpayment back from the provider. As with late payments, there is a widely held belief, especially among providers, that the status quo does not provide sufficient mechanisms for the voicing of complaints and the resolution of disputes.

Recommendations

Eligibility Determination

Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days.

Receipts

Providers who submit claims electronically should be entitled to electronic acknowledgement of receipts of claims, although not necessarily a separate document for each claim. Providers who receive acknowledgement of receipts of claims should be prohibited from sending a duplicate bill for 45 days.

Take Backs

Take Backs should be treated as Claims made by an MCO to a Provider. Insurers should notify providers of all over-payments with written notice, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments.

Venue for Complaints and Dispute Resolution

See recommendations listed in (C) Late Payments under the same heading.

E) Balance and Duplicate Billing

Florida statute prohibits balance billing by providers for MCO covered services. If a provider is paid and accepts payment by an MCO for a medical service, that provider is not permitted to bill the patient for additional payments except for co-payments as designated by the MCO insurance policy.

Insurers have reported that many providers continue to balance bill patients in violation of state law. In some cases, providers maintain that statute is ambiguous and that they are entitled to bill the patient. Ambiguities have been perceived concerning treatments which are not covered or for which pre-authorization is denied and concerning treatments by non-contracted providers

Recommendations

Enforcement of Balance Billing Prohibition

The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. AHCA, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards or their appropriate subgroups. Balance billing by facilities shall be referred to AHCA in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered services. It was agreed providers may not balance bill patients while billing disputes are going through any future State of Florida supervised dispute resolution process.

Medical Necessity

The majority of the Advisory Group agreed that, except in emergency situations, if an MCO denies authorization for a service on the grounds that it is not medically necessary, and neither the provider nor the patient overturns the denial on appeal,[2] then the treatment is not covered by the MCO. In such cases, the provider is entitled to bill the patient for the service. It is important to educate the subscriber that he or she will be responsible for payment of services sought under these conditions

Non-covered Services

The majority of the Advisory Group agreed that, providers have a right to bill patients for non-covered services.

Non-Participating Providers

The majority of the Advisory Group agreed that, current Florida statute (641.315) is ambiguous because the heading refers to provider contracts, but the language says no provider

[2] If the denial is decisively overturned through any appeal process at all, be it the MCO's internal appeals process, a state supervised appeals process or civil litigation, then the service is covered, and the provider is not permitted to balance bill

is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing or eliminating the heading to this statute. Non-participating providers should not bill patients (beyond MCO designated co-payments) if they are billing the MCO, going through a dispute resolution process to secure payment from an MCO or have accepted MCO payment for the specific service.

Restriction on Referral to Credit Agencies

The majority of the panel determined that it is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations.

Duplicate Billing

See Recommendation concerning Receipts, under (D) Claims Review.

F) Non-Participating Providers

A non-participating provider does not have a contract with a particular MCO. In many cases non-participating providers treat MCO enrollees and MCOs reimburse these providers. However, in the absence of a contract or a pre-authorization, an MCO is not obliged to reimburse a health care provider except for emergency treatment or other circumstances provided in law (please see the following chapter for discussion and recommendations concerning emergency treatment).

In some cases, non-participating providers have accepted referrals from MCO designated primary care physicians (PCPs) or other participating providers. Non-contracted providers may have been under the impression that MCOs are obliged to reimburse them for such services. If the MCO has authorized care, directly or through a PCP, then they have a duty to pay. However, MCOs point out that they have no obligation to reimburse non-participating providers unless they have pre-authorized the specific treatment with an authorization number or code.

Recommendations

The majority of the Advisory Group recommends that when a physician empowered by an MCO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the MCO is obligated to reimburse that other provider for the authorized services.

G) Fraud and Abuse

With the large amounts of money being expended in the delivery of and reimbursement for health care, it is no surprise that a few unscrupulous individuals attempt to extract or withhold

monies that they are not legally or ethically entitled to. Fraud and abuse has resulted in the pilfering of billions of dollars from legitimate and honest companies, charitable organizations and individuals involved in health care. Fortunately, the vast majority of providers and insurers maintain high ethical standards and do not knowingly abuse our complex health finance system.

As data and claims processing continues to advance and automate, difficult ethical issues have arisen and will continue to arise. In the area of automated processing of claims, there have been charges of abusive practices against both providers and insurers. Automated upcoding or downcoding of claims is an area of particular concern.

Recommendations

Automated Recoding of Claims

Systematic downcoding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The Department of Insurance has already issued a Statement to that effect.

Incentives for Billing Agent to Submit Fraudulent Claims

The State of Florida should follow the same policies as Medicare. Under current Medicare regulations (42 CFR 424 73), billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised or enforced more stringently by the Health Care Financing Administration (HCFA) in the near future. Similarly, if Medicare implements a policy against percentage incentives for MCO audit or credit collection firms, the Advisory Group recommends that the State of Florida do likewise.

Reporting Liability of Additional Payors

The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial MCOs.

Auditing of Claims

The Advisory Group agreed that providers should not charge MCOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the MCO, but still should not add an extra charge for MCO staff reviewing provider records.

Civil Liability for Whistleblowers

The Advisory Group requested the Department of Insurance to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud.

Chapter 5 – Issues and Recommendations: Emergency Treatments

Emergency treatments are logically different from other types of medical treatment because patients have little choice of provider in an emergency. The patient must be sent to an appropriate facility, usually a hospital emergency department (ED), within hours (sometimes minutes) in order to avoid serious damage to the patient's health. Because emergencies are different in nature, the statutory definitions of emergency are critical to the evaluation of payment for emergency treatment.

There are at least two sets of distinctions differentiating the various statutory definitions of emergency treatment. Florida statutory definitions are distinct from Federal Medicare definitions, and both "emergency medical condition" and "emergency medical services" must be defined in order to evaluate the applicability of regulations. All four definitions are included here:

Florida Statutory Definition (Chapter 641.19)

"Emergency medical condition" means:

A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

Federal Medicare Code (CFR Title 42, Part 422)

"Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part."

Florida Statutory Definition (Chapter 641.19)

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

Federal Medicare Code (CFR Title 42, Part 422)

"Emergency services means covered inpatient and outpatient services that are –

1. Furnished by a provider qualified to furnish emergency services; and
2. Needed to evaluate or stabilize an emergency medical condition."

Florida statutory definitions apply to commercial MCOs that are subject to state regulation. State authority to regulate employer self-insured plans that are administered by MCOs is ambiguous, and the U.S. Congress is considering legislation to impose additional regulations on those plans. However, whether the Florida definition or the prudent layperson standard is applied, the reality is that large numbers of patients feel that they have emergency conditions and require some degree of screening, evaluation or treatment.

The proper coding of the hospital component of ED visits is a controversial issue. In 1999, Florida Medical Quality Assurance Inc. (FMQAI) submitted a report to AHCA recommending that Medicaid institute new criteria for hospital coding of ED visits. Although the data and recommendations of this report only applied to Medicaid patients, some MCOs and other interested parties believe that similar criteria would be appropriate for commercially insured patients as well. In brief, FMQAI recommended that as many as 77% of ED visits could be coded as non-emergent and could be reimbursed at a lower rate by Medicaid.

Emergency providers have a number of criticisms and objections to the recommendations of the FMQAI report. Many conditions, especially for infants and children, require medical attention during off hours, and, for many patients, there is no alternative to presenting at the ED. It was pointed out that there are basically 5 codes for different levels of care by Emergency Physicians, and that 2 codes, as recommended by the FMQAI study, might not be enough for hospital claims. Hospitals, under either code, are allowed to line item bill for all tests, supplies, etc. in addition to charging the visit code. Finally, hospital representatives pointed out that the physician determines the diagnosis of emergency, and if the physician codes the visit as such, the hospital must do the same.

As of January 2000, AHCA Medicaid staff, in consultation with the Florida Hospital Association (FHA), is trying to develop a system for hospital coding of emergency visits that will be fair, clear and efficient The result of their efforts may influence practices of commercial insurers and hospital ED coding for commercially insured patients. Some MCOs have requested that they be allowed to participate in this process, since they are also a payor.

In some cases of emergency treatment, the patient's MCO has a contract with all the providers of emergency care, including hospitals, emergency physician groups, medical residency programs, pharmacies and others. Typically in these cases, emergency care can be delivered

and reimbursed without raising a host of financial and legal issues. However, in many emergency cases the patient's MCO does not have a contract with one or more of the providers.

Hospitals and MCOs decide to contract or not to contract based on a large number of issues. No systematic estimates of the extent of contracting between emergency physician groups and MCOs are available, but both communities acknowledge that frequently they do not contract. Contracts are not signed and implemented because one or both of the potentially contracting parties see more disadvantage than advantage in signing a specific contract. Many of the usual incentives for physicians or physician groups to sign MCO contracts do not apply to emergency physicians.[3]

Current Florida law requires commercial MCOs to contract with hospitals with adequate emergency treatment capacity for their enrollee population. Emergency physicians maintain that MCOs are also responsible for physician coverage for emergency services and care and for after hours care under Florida statute.

In the last few years, there have been reports that some specialized physicians (not emergency physicians) have refused to treat emergency patients because of concerns over reimbursement. This is a serious problem in other states, and it may be a serious problem in Florida for small and medium sized community hospitals that do not have extensive residency programs. Under Florida statute (458.3295), last amended 1997, a physician "may not instigate or engage in a concerted effort to refuse or get physicians to refuse to render services to a patient or patients in a hospital emergency room ..." This statute is administered by the Florida Board of Medicine.

Florida statute provides a mechanism for determining reimbursement of non-contracted emergency providers, both hospitals and physicians, by MCOs. The statute concerning requirements for emergency services and care reads:

Florida Statute (641.513, in part)

"Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:

A. The provider's charges;

B. The usual and customary provider charges for similar services in the community where the services were provided; or

C. The charges mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."

[3] Specifically, MCOs often offer physicians a large volume of patients in return for the physicians accepting a discounted reimbursement rate However, MCOs also try to substantially reduce ED usage, so that dynamic usually does not apply to emergency physicians. Further, MCOs believe ER providers have no incentive to contract with them because the providers have a near "monopolist" situation and feel they can demand anything they desire for their services. Emergency physicians maintain that MCOs often offer rates of reimbursement or contractual terms unacceptable to them.

Providers and insurers have disagreed concerning the meaning of this statute. Providers claim that many MCOs arbitrarily determine the levels of the "usual and customary provider charges" that they reimburse. Insurers claim that many providers bill excessive and unreasonable charges for emergency services and that providers' market power makes it difficult to fairly assess "usual and customary provider charges."

There was extensive discussion of the usual and customary charges phrase currently in Florida statute. At least one MCO advocated the development of a UC&R for reimbursing services delivered to commercial members by non-participating providers, but the majority of the Advisory Group chose to take no action.

Recommendations

Hospital Code System

The Advisory Group acknowledges AHCA's review of Medicaid standards concerning the coding of hospital ED treatments. The group recommends that AHCA look into redoing the FMQAI study of hospital emergency room coding in light of the objections to that study that have been presented to the group.

Availability of Specialized Physicians for Emergency Treatment

In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific MCO, the hospital (or other provider experiencing difficulty) should notify the MCO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the AHCA Bureau of Managed Care, which assesses MCO network adequacy.

Access to emergency care and follow-up care in general are addressed in Section 395.1041. This law gives the Agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need. Willful schemes by physicians to refuse to render emergency services are addressed in Section 458 3295 last amended in 1997. This statute enjoins physicians from instigating or engaging in a concerted effort to refuse to render services to hospital emergency patients. The Board of Medicine administers this legislation. It is the intent of the Agency and the Board of Medicine to strictly enforce the aforementioned statutes.

Chapter 6 – Conclusions

Managed care organizations (MCOs) are essential to the functioning of our health care sector. Their goal is to provide quality health care at a reasonable price. They insure a large fraction of Florida's population and support institutional and medical innovations that are often widely adopted. However, it is essential for MCOs to maintain positive, equitable and innovative relations with the physicians, hospitals and other providers on the "front lines" of Florida health care. In far too many cases, relations between providers and MCOs in the last few years have been poor and deteriorating. Many issues have contributed to this tension, but allegations of late payments and other claims disputes, including allegations of overzealous billing by providers have been a significant factor in the estrangement of these two essential parts of the health care system.

The Advisory Group, consisting of representatives of providers, MCOs and Florida state government, has sought to address divisive health claims issues. Practices and policies that fairly and efficiently address the leading causes of provider frustration and financial uncertainty are in the best interests of MCOs. This is so because most MCOs seek very broad provider networks to attract enrollees, because lengthy disputes, formal appeals and civil litigation reduce functionality, and because provider disapproval has negatively affected the public image of MCOs.

At the same time, MCO representatives raised legitimate issues about the practices of some providers. These include questionable balance billing practices and the use of billing agents with incentive arrangements. The Advisory Group has provided a forum for the public discussion of these issues and has developed recommendations to improve claims submission practices of providers.

The Advisory Group and its sub-groups heard extensive public testimony and weighed the relative merits and importance of dozens of issues, allegations and proposals. The group members discussed, debated, compromised, contemplated and occasionally agonized in the process of fulfilling their legislative charge. In the end, the group achieved substantial consensus on which issues were within its purview, which of these were resolvable by the group and which proposals had the greatest merit

All the specific recommendations of the Advisory Group are listed in Chapters 4 and 5, and each of these recommendations is significant to at least some of the stakeholders in the Florida health economy. Some of the highlights of the recommendations are:

- The recommendation to clarify statute on the inclusion of interest with late payments helps eliminate a major obstacle to the implementation and effectiveness of this law.
- The recommendation to develop a state-supervised mediation mechanism for both providers and MCOs for hearing and resolving claims disputes promises to help resolve serious disputes, including disputes over reimbursement for emergency care, without the parties resorting to civil litigation or the termination of their contracts and service relationships.

- The proposed clarification of the balance billing prohibition can make it easier to enforce this consumer protection statute.
- The adoption of the NUBC definition of institutional clean claim and the endorsement of the HIPAA Administrative Simplification process expedites the standardization of claims forms and the automated processing of claims. The group recommended to providers and insurers that they adopt electronic claims processing as soon as possible.
- The recommendation that MCOs should pay for pre-authorized services except under very limited circumstances can reduce the volume of claims disputes and encourage both providers and insurers to address claims issues before they create financial problems.
- The recommended requirement of a receipt for claims submitted electronically can also reduce the number of disputes, encourage the use of electronic billing and reduce duplicate billing.

The Advisory Group hopes its recommendations influence the submission and payment of claims through several mechanisms. Some of the most significant group recommendations can only take effect through changes in Florida Statutes or through new policies of the Governor, the Insurance Commissioner, the Executive Director of AHCA and their respective staffs. In some cases, recommended changes can be implemented through industry agreements or contracts between insurers and providers. In other cases, recommendations may influence the behavior of health care insurers and providers simply by being publicized and discussed without formal implementation mechanisms.

Hopefully, one of the major long-term benefits from implementing the program endorsed by the advisory group would be reduced administrative costs. An additional benefit may be that fraudulent claims and health care costs could be reduced. Another major benefit would be that many providers, including emergency providers, will be able to concentrate more on delivering care and less on submitting claims and pursuing reimbursement. A fourth major benefit would be reduced balance billing and reduced involvement of patients in billing disputes.

The Advisory Group is honored to have been given this opportunity to address some very difficult issues on behalf of the State of Florida. Group members hope their deliberations, findings and recommendations will be useful to the Legislature. This effort is intended to improve working relationships between providers, MCOs and state regulators for the benefit of all Floridians.

Appendix A: Florida Statutes

A1. Language from Statute Authorizing Advisory Group

HB 1927, 1999 (with abbreviations)

Section 6. The Director of AHCA shall establish an advisory group composed of 8 members, with 3 members from HMOs licensed in Florida, 1 from a non-profit hospital, 1 from a for-profit hospital, 1 licensed physician, 1 from DOI and 1 from AHCA. The advisory group shall study and make recommendations concerning:

1. Trends and issues relating to legislative, regulatory, or private sector solutions for timely and accurate submission and payment of health claims.
2. Development of electronic billing and claims processing for providers and health care facilities that provide for electronic processing of eligibility requests; benefit verification; authorizations; pre-certifications; business expensing of assets, including software, used for electronic billing and claims processing; and claims status, including use of models such as those compatible with federal billing systems.
3. The form and content of claims.
4. Measures to reduce Fraud and Abuse relating to the submission and payment of claims.

The advisory group shall be appointed and convened by July 1, 1999, and shall meet in Tallahassee. Members of the advisory group shall not receive per diem or travel reimbursement. The advisory group shall submit its recommendations in a report, by January 1, 2000, to the President of the Senate and the Speaker of the House of Representatives.

A2. Language from Statute Concerning Late Payment of Claims

641.3155 Provider contracts; payment of claims

(1)(a) A health maintenance organization shall pay any claim or any portion of a claim made by a contract provider for services or goods provided under a contract provider for services or goods provided under a contract with the health maintenance organization which the organization does not contest or deny within 35 days after receipt of the claim by the health maintenance organization which is mailed or electronically transferred by the provider.

(b) A health maintenance organization that denies or contests a provider's claim shall notify the contract provider, in writing, within 35 days after receipt of the claim by the health maintenance organization that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for

contesting or denying the claim, and may include a request for additional information. If the health maintenance organization requests additional information, the provider shall, within 35 days after receipt of such request, mail or electronically transfer the information to the health maintenance organization. The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(2) Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

(3) A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim.

A3. Language from Statute Concerning Required Emergency Care

641.513 Requirements for providing emergency services and care

(1) In providing for emergency services and care as a covered service, a health maintenance organization may not:

(a) Require prior authorization for the receipt of prehospital transport or treatment or for emergency services and care.

(b) Indicate that emergencies are covered only if care is secured within a certain period of time.

(c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.

(d) Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given.

(2) Prehospital and hospital-based trauma services and emergency services and care must be provided to a subscriber of a health maintenance organization as required under ss. 395.1041, 395.4045, and 401.45.

(3)(a) When a subscriber is present at a hospital seeking emergency services and care, the determination as to whether an emergency medical condition, as defined in s. 641.47 exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The physician or the appropriate personnel shall indicate in the patient's chart the results of the screening, examination, and evaluation. The evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The health maintenance organization shall compensate the provider for

emergency services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered.

(b) If a determination has been made that an emergency medical condition exists and the subscriber has notified the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a subscriber of the health maintenance organization, the hospital must make a reasonable attempt to notify the subscriber's primary care physician, if known, or the health maintenance organization, if the health maintenance organization had previously requested in writing that the notification be made directly to the health maintenance organization, of the existence of the emergency medical condition. If the primary care physician is not known, or has not been contacted, the hospital must:

1. Notify the health maintenance organization as soon as possible prior to discharge of the subscriber from the emergency care area; or

2. Notify the health maintenance organization within 24 hours or on the next business day after admission of the subscriber as an inpatient to the hospital.

If notification required by this paragraph is not accomplished, the hospital must document its attempts to notify the health maintenance organization of the circumstances that precluded attempts to notify the health maintenance organization. A health maintenance organization may not deny payment or emergency services and care based on a hospital's failure to comply with the notification requirements of this paragraph. Nothing in this paragraph shall alter any contractual responsibility of a subscriber to make contact with the health maintenance organization, subsequent to receiving treatment for the emergency medical condition.

(c) If the subscriber's primary care physician responds to the notification, the hospital physician and the primary care physician may discuss the appropriate care and treatment of the subscriber. The health maintenance organization may have a member of the hospital staff with whom it has a contract participate in the treatment of the subscriber within the scope of the physician's hospital staff privileges. The subscriber may be transferred, in accordance with state and federal law, to a hospital that has a contract with the health maintenance organization and has the service capability to treat the subscriber's emergency medical condition. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient is a subscriber of a health maintenance organization, if emergency services and care are not delayed.

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(12), for the use of an emergency room.

(5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:

(a) The provider's chargers;

(b) The usual and customary provider charges for similar services in the community where the services were provided; or

(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

(6) Reimbursement for services under this section provided to subscribers who are Medicaid recipients by a provider for whom no contract exists between the provider and the health maintenance organization shall be the lesser of :

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided;

(c) The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

(d) The Medicaid rate.

Appendix B – Official Documents

The Recently Adopted NUBC Definition of Clean Claim

"Absent a written definition that is agreed upon through contract, participation agreement, law or regulation, the NUBC recommends that a clean institutional claim is a properly completed billing instrument (paper and electronic) that consists of the UB-92 data set, or its successor, submitted on the designated paper or electronic formats as adopted by the UNBC with entries stated as mandatory by the NUBC, along with any state designated data requirements determined and approved by the state uniform billing committee and included in the UB-92 manual effective at the time of service. It does not involve coordination of benefits (COB) for third-party liability or subrogation as evidenced by the information provided on the claim related to COB."

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Appendix C – Advisory Group Minutes

(June 29, 1999 — No minutes were taken for this first meeting, which was primarily organizational in purpose.)

Advisory Group on the Submission and Payment of Health Claims, Minutes for August 3, 1999

The Advisory Group meeting was held on August 3, 1999 at the Agency for Health Care Administration in the Executive Director's Third Floor Conference Room.

Members Attending: Ruben J. King-Shaw, Jr., Chairman, John Benz, Joe Berding, Bruce Carpenter, Fred Dunlap, Susanne Murphy, and Kathryn Torres.

Member Absent: Dr. Spurgeon McWilliams.

Chairman King-Shaw welcomed the Advisory members and guests. He explained that the guest were there as observers and would not be participating in the Advisory Group discussion at this time. He indicated that the panel would establish the format for public participation at a later time. The time frame for the completion of the report is January 1, 2000.

The list of 15 topics outlined at the last meeting was reviewed/revised. Number seven was expanded to "clarify emergency room law and determination of clean claims." Number nine was clarified as "Define protocols and process for determining medical necessity and decision making." The topic number two, "Categorizing. Later denied" was removed from the list. "Timely and accurate verification of benefits" was added as number 16.

The Panel was divided into four Workgroups to work on the specific topics:

Workgroup I - The Blue Team - John Benz/Leader, Fred Dunlap, Susanne Murphy, Spurgeo McWilliams

Topics:

- Uniform Information Submission - What should be included in a Claim?
- Standard data elements
- Identify processes causing stress
- Identify best practices
- Define protocols and process for determining medical necessity and decision making
- Retroactive decision making on eligibility and reimbursement

- Access and accuracy of billing and procedures
- Timely and accurate verification of benefits

Workgroup II - The Red Team - Bruce Carpenter/leader, Kathryn Torres

Topic:

- Clarify emergency room law and determination of clean claims

Workgroup III - The Green Team - Kathy Torres/leader, Joe Berding

Topics:

- Identify best practices
- Connectivity and common interface engines
- Define protocols and process for determining medical necessity and decision making
- Accountability measures

Workgroup IV - The Yellow Team - Joe Berding/leader, Bruce Carpenter, Susanne Murphy, Spurgeon McWilliams, Ruben King-Shaw, Jr.

Topics:

- Balance billing
- Access and accuracy of billing and procedures

The Advisory Group discussed ways to include others not officially on the panel - by public hearings or holding meetings around the state or accepting written input. It was decided that the four workgroups would meet in different places around the state and written input will be accepted by the workgroups The meeting times and places will be published in the Florida Administrative Weekly.

The workgroups will work on a draft report to bring back to the full Advisory Group for the next meeting.

The Advisory Group established the following schedule for future meetings:

September 2, 1999, 8:30 a m. - 4:30 p.m.

Advisory Group

AHCA Executive Conference Room

October 1, 1999, 8:30 a.m. - 4:30 p.m.

Public Testimony and Advisory Group Meeting

(Orlando Airport Hyatt) - Staff Recommendation

November 4, 1999, 8:30 a.m. - 4:30 p.m.

Advisory Group Meeting

AHCA Executive Conference Room

December 1, 1999, 8:30 a.m. - 4:30 p.m.

Public Testimony and Advisory Group Meeting

(Miami-Dade International Airport Hilton) - Staff

Recommendation

John Benz gave a presentation using claims data and "Best Practices" from the Memorial Health Care System. He distributed copies of a Managed Care Denial Report for Fiscal Year 5/98-4/99 and a draft report of Managed Care Best Practices.

Next Meeting Assignments

- Kathryn Torres will report on facilities at the next meeting.
- Joe Berding will report Data on Emergency Room Denials.
- Pete Buigas was asked to share criteria and procedures for managed care audits.
- Dr. Shea will see about putting together information on how doctors are audited.

Advisory Group on the Submission and Payment of Health Claims, Minutes for September 2, 1999

The Advisory Group meeting was held on September 2, 1999 at the Agency for Health Care Administration in the First Floor Conference Room - A.

Members Attending: Ruben J. King-Shaw, Jr., Chairman, John Benz, Joe Berding, Bruce Carpenter, Fred Dunlap, Susanne Murphy, and Kathryn Torres.

Member Absent: Dr. Spurgeon McWilliams.

Dr. Glenn Bryan sat on Panel in Dr. McWilliams' absence.

Chairman King-Shaw welcomed the Advisory members and guests and acknowledged the presence of Senator Brown-Waite.

The minutes of the last meeting were approved with two changes: (1) Subgroup one, Blue Team, will present on Trends, Issues and Clean Claims and (2) Joe Berdings' presentation will be a report on denied claims.

The Agenda for this meeting was approved.

Detail Presentations were made by the following Subgroups reporting the results of their meetings with interested parties attending:

Subgroup 1 - Blue - John Benz, Chair, reported that the group met on August 25, 1999. Members of the group attending the meeting were John Benz, Fred Dunlap, and Susanne Murphy. Dr. McWilliams participated by conference call. Sandy Berger attended as the AHCA representative. Approximately 30 interested parties also attended the meeting.

The purpose of the meeting was to develop goals relating to trends and issues relating to the timely, accurate submission and payment of health claims. The subjects on the agenda included uniform information submission, definition/clarification of a clean claim, best practices of managed organizations and providers, medical necessity, access and accuracy of billing and verification of membership benefits.

A new issue/Topic was discussed - The responsibility of the employer/member's behavior.

A list of 16 recommendations was presented to the full Advisory Panel.

Subgroup II - Red - Bruce Carpenter, Chair, reported that the group met on August 26, 1999 in Winter Park, FL. Members of the group attending the meeting were Bruce carpenter and Kathryn Torres. Barbara Foley attended as the AHCA representative. Approximately 12 interested parties also attended the meeting.

The purpose of the meeting was to develop goals relating to the clarification of emergency room law and a forum to obtain as much information as possible from the participants regarding their concerns and issues with the current method of delivery and payment of emergency care in Florida

Public comments were heard from interested parties present. The most common complaint voiced was that a good number of people who come to the ER do not need to be there. The committee requested that a copy of the previous AHCA Task Force report of ER issues and other analysis be sent to Bruce Carpenter by September 10, 1999.

Another meeting of the group will be scheduled in a few days.

Subgroup III - Green - Kathryn Torres, Chair, reported that the group met on August 25, 1999 in Winter Park, FL. Members attending were Kathryn Torres and Joe Berding. Barbara Foley attended as the AHCA representative. 9 interested parties also attended the meeting.

The purpose of the meeting was a public forum for community participants to discuss issues and problems they foresaw with a potential requirement that providers would have to bill electronically. Most of the comments and discussion geared to the Health Insurance Portability and Accountability Act of 1996 (HIPA). The Committee will accept comments regarding any issues relating to this topic until September 30, 1999.

Subgroup IV - Yellow - Joe Berding, Chair, reported that the group met on August 27, 1999 in Miramar, FL. Members of the group attending the meeting were Joe Berding, Ruben King-Shaw, Jr., Susanne Murphy, and Bruce Carpenter. Pete Buigas attended as the AHCA representative. Approximately 26 interested parties also attended the meeting.

The purpose of the meeting was to discuss four issues relating to fraud and abuse - violations, balance billing, authorization/pre-certification and medical necessity. The sub-committee decided that medical necessity would not be addressed.

Meeting participants were given two weeks to provide additional information to the committee on topics related to Fraud and Abuse.

The Panel decided that Medical necessity should be a topic for the entire panel and would be removed from the work-group list. There question of whom makes the authorization and to what extent can the provider rely on it and what is the recourse still needs to be clarified?

Assign Subgroup V - Orange - The panel decided to go with the 4 subgroups already established and the result of the 4 should improve provider relations. Therefore Subgroup V would not be necessary.

Assignment Presentations

Kathryn Torres presented a summary by facility, payer and reason code pointing out the need for tracking hospital claims.

Joe Berding presented data on denials

Kate Morgan presented a report on the Criteria and Procedures for Managed Care Audits and reviewed the statute).

Assignments for next meeting:

Develop standards for determining network adequacy. (Kate Morgan at AHCA will provide information on this.)

The Panel decided to establish a Clean Claims Work Group - each panel member was asked to appoint two people who are experienced in the issues of authorization work force and reporting. Names are to be submitted to Ruben King-Shaw and he will appoint a chair.

Policy on Automatic down coding - Get information from HMO and the Doctors experiences and (Kate Morgan and Dr. Bryan)

Clarify the law on Balance Billing (Susanne Murphy and Pamela Thomas)

The next meeting of the Panel will be a public hearing and will be held on October 1, 1999 in Orlando. Topics for Public testimony should be e-mailed to Ruben King-Shaw so they can be included in the public notice. The meeting place will be finalized next week and will be published in the Administrative Weekly. Public testimony cards will be provided to those individuals requesting to speak at the hearing.

Advisory Group on the Submission and Payment of Health Claims, Minutes for October 1, 1999

The Advisory Group meeting was held on October 1, 1999 at the Hyatt Regency Orlando International Airport in the Mirabel Conference Room.

Members Attending: Ruben J. King-Shaw, Jr., Chairman, John Benz, Joe Berding, Bruce Carpenter, Fred Dunlap, Susanne Murphy, and Kathryn Torres.

Dr. Arthur Diskin attended as the FMA Representative on the Panel. The Chair asked that the FMA decide who will be the permanent member of the Panel, pointing out that a different representative has attended each meeting.

This meeting was a public forum and was also attended by 35 plus interested representatives from the health care industry.

Chairman King-Shaw greeted and welcomed the Advisory Panel and called the meeting to order.

The minutes of the September 2, 1999, meeting were approved as written.

Subgroup Updates

John Benz, Chair of Work Group I, reported that they continue to work with the recommendations that came out of their August 25, 1999, meeting and were presented at the last Panel meeting. The list may be slightly revised.

Bruce Carpenter, Chair of Work Group II, reported that he had put together an interim report consisting of a collection of letters from Emergency Room doctors, articles regarding fines against HMOs, FMQA Emergency Room Study and information from FAMCO regarding the Emergency Room Law. His work group is scheduled to meet again on October 20, 1999.

Dr. Arthur Diskin, FMA Panel representative, will be added to Work Group II.

Kathryn Torres, Chair of Work Group III, reported that the committee has received a sample of the survey for physicians from One Source PHO. The results of the survey will measure cost burden on physicians and are expected by October 6, 1999. The Work Group meeting will be scheduled and noticed next week.

Joe Berding, Chair of Work Group IV, reported that the committee is scheduled to meet again on October 27, 1999, in Tallahassee to complete recommendations.

Presentation

A detailed presentation was given by George Arges on the Health Insurance Portability and Accountability Act of 1996.

Public Testimony

Public testimony was heard from the following individuals:

Carol Plato Nicosia - Martin Memorial Health Systems

Subject: Managed Care Problems - Recognized the fact that the problems are being addressed but feels we are getting there too slow.

Gary Clarke - Florida Association of Managed Care, Inc.

Subject: Emergency Care Requirements - Recommends that AHCA in coordination with HMO's and emergency physicians review the current billing practices of hospital emergency rooms to identify potentially cost-increasing and abusive practices.

Nancy Gareau - Well Care Health and Staywell Health Plans

Subject Balance Billing and Medical Records Access

Have problems with non-par hospitals and hospital-based providers contracting with her plan. Problems with recipient being sent to collection agencies. Need definition for usual and customary charges. Problems with medical records not being provided to HMO. Need clarity of current ER Law.

David Weisman - Cigna Health Care of Florida, Inc.

Subject: Emergency Room Physicians and Balance Billing

Need clarity of current ER Law.

Sharon Jacobs - Florida Association of Health Maintenance Organizations, Inc.

Submitted a list of recommendations for Emergency Room Changes.

Linna Van Nette - United Healthcare

Expressed the need for an improved privacy law and the need to clarify what is required electronically to be compliant as it relates to privacy.

Dr. Dennis Mihale - Physicians Health Plan

Subject: ER Claims Payment

Reported that he had been asked by Physicians Health Plans to review ER claims submitted to Physicians Health Plan for payment and specifically review the coding of ER Claims. His review showed in more than 1/3 of the claims, the level of coding was higher than what was

supported by the documentation. His conclusion is that this is a system problem for the providers.

Michael Johnson - Blue Cross/Blue Shield

Terry Meek - Florida College of Emergency Physician

Subject: Emergency Services Law

Dr. Robert Ailes - PHP Medical Director

Subject: Emergency Room issues and the Law

Need clarification of the Laws and the concept that Emergency Room Physicians can charge whatever they want for anything they do in the ER.

Dr. Herbert F. Rest - Internist

Emergency Room Issues

Reviewing ER Claims for issues of Triage

Roland Fusten - Memorial Health Care Systems

Subject: ER Claims Issue

Ann Marie Brattain, AHCA, presented a draft report done by the Bureau of Managed Health Care on the use of automated down-coding or correct coding systems. Twenty-six responses out of 34 requests were received. Fifteen HMOs use automated software that may reduce or deny payment. Eleven HMOs do not use automated software to reduce or deny payment.

As requested at the September meeting, the Chairman appointed two clean claims sub-committees from the list of nominees received from the Panel.

Kara Atchison (Claims & Authorization)
Roland Funsten (Claims & Authorization)
Orrie Mullen (Claims)
Cindy Carlton (Claims)
Cathy King (Authorization)
Dr. Robert Ailes (Authorization)
Maureen Parker (Authorization)
Maureen Lach (Claims)
Debbie Tersigni (Claims)
Allan Miller, (Claims & Authorization)
Jan Bowman, (Claims and Authorization)
Jim Bracher, DOI (Claims)
Janie Patterson (Claims)
Kimberly Tucker (Claims)
Shawn Trotter (Authorization)
Cathy Cohan (Authorization)

Jim Bracher of the Department of Insurance will be asked to be the leader on the subject of claims and Pete Buigas of the Agency for Health Care Administration was asked to be the leader on the subject of authorization.

Assignments

Pete Buigas was asked to review the articles on HMO fines and Settlements referred to by Bruce Carpenter in his report.

AHCA to look at the Medicaid Study Review on Emergency Room Admissions and determine if there is a need to perform another audit. (Pete Buigas)

Joe Berding and/or Kathryn Torres will have someone come and make a presentation to the full board on recommendations as to how to deal with clarification of balance billing.

Draft a proposal on the standardization of the appeals and resolution process. (Pete Buigas).

AHCA do a profile of ER Patients.

Advisory Group on the Submission and Payment of Health Claims, Minutes for November 15, 1999

The Advisory Group meeting was held on November 15, 1999, at the Agency for Health Care Administration in the First Floor Conference Room - A.

Members Attending Ruben J. King-Shaw, Jr., Chairman, Joe Berding, Bruce Carpenter, Fred Dunlap, Susanne Murphy and Kathryn Torres

Member absent: John Benz

Chairman King-Shaw welcomed the Advisory Panel members and guest.

The minutes of the last meeting were approved. The Agenda for this meeting was approved and changed to have the presentation made before the Subgroup updates.

Presentation

William Bell, Senior Vice President and General Counsel for Florida Hospital Association, Inc., made a presentation to the Panel on the Emergency Treatment and Active Labor Act (EMTALA) and the Consolidated Omnibus Budget Reconciliation Act-1985 (COBRA). Copies of the presentation were given to each Panel member.

Subgroup Updates

Joe Berding, Chair of **Subgroup IV - Yellow**, reported that the group met on October 27, 1999, in Tallahassee. Members of the group attending the meeting were Joe

Berding, Susanne Murphy and Bruce Carpenter The Chairman presented eight issues and recommendations that had been discussed at the subgroup meeting in October. After receiving comments from interested parties, the issues and recommendations were revised and reduced five recommendations to the Panel. (Report and recommendations distributed to each panel member).

Kathryn Torres, Chair of **Subgroup III - Green**, distributed the report of October 28, 1999 meeting of the Business Expense of Electronic Billing, Processing, Status Reporting and Profiling group. The report included the results of the

Survey on physician electronic billing indicating that the majority of the physicians surveyed are in favor of electronic billing.

Bruce Carpenter, Chair of **Subgroup II - Red**, reported that the Sub-committee on Assessing Emergency Room Issues met on October 20, 1999 in Winter Park, FL. The committee submitted two sets of recommendations and received public comments.

The committee recommendations are:

- Both payers and providers have an obligation to educate members as to the proper use of the emergency rooms.
- The present ER claims forms should be assessed by the special claims sub-committee for efficacy in allowing proper recording/billing of ER Claims.
- Clear payment abuses, such as automatic down coding of all claims, requesting medical records on all claims as a guise for slow payment, payment of a screening fee only or all claims should not be allowed.

Assignments

AHCA Staff to provide HCFA Language on contingency fee reimbursement for third party collections.

AHCA Staff to provide HCFA Language defining a "covered benefit."

AHCA Staff to determine whether this is HCFA language defining "coordinated screening."

AHCA Staff to provide Florida statutory language (Section 483.331 Florida Statutes) regarding rounds for disciplinary action as it relates to balance billing.

Kathryn Torres will check with other hospital representatives to see if they think there should be a change in state law as it relates to balance billing.

Next Meeting

The next meeting is a public hearing and is scheduled on December 3, 1999 in Miami. There was some discussion as to whether to change the date because Hanukkah begins at sundown

on that date. The Chair asked staff to check to see if an alternate date and place could be arranged. Staff will check and let the Panel know the results.

Advisory Group on the Submission and Payment of Health Claims, Minutes for December 3, 1999

The Advisory Group meeting was held on December 3, 1999 at the Miami International Airport Hotel, Executive Conference Center.

Members Present: Ruben J. King-Shaw, Jr., Chairman, John Benz, Joe Berding, Bruce Carpenter, Dr. Arthur Diskin, Susanne Murphy, and Kathryn Torres.

Chairman King-Shaw welcomed the Advisory Panel members and guest. The Agenda for the day was revised to start the meeting with the public testimony.

The minutes of the last meeting were approved with the correction showing that Dr. Diskin did attend the November 15, 1999 meeting.

Public Testimony

David Hammer - System Director of Patient Financial Services - Intracoastal Health System - Has concerns that the collection period is to lengthy, cash payments artificially limited, no definition of clean claims, poor customer service, authorization not equal to approval and interest not automatically paid. Recommends HMOs license renewals be dependent on paying 95% of all claims with 35 days of receipt, add auditors to investigate providers' concerns, define clean claim in law or regulation and require HMOs to accept the definition, mandate acceptable standards for telephone and mail response times and make HMOs license renewals dependent on meeting standards, "define authorization equals approval" in law or regulation and require HMOs to accept the definition, and mandate that HMOs must automatically pay interest on delinquent payments.

Kim Streit - Florida Hospital Association Concern that Florida hospitals continue to experience delays in payment and denials.

Diane Kazmierski - Bay Care Health - Thinks that the primary care physician or specialist should function as an agent or representative of the HMO and assure payment for services rendered to the member, Authorization should be a guarantee of payment and authorizations be available on 24 hour, 7 day a week basis with a maximum response time of 15 minutes.

Carol Nicosia - Martin Memorial Health System - Recommends non-participating providers should be allowed to bill the patient for the portion of the bill not covered by the HMO for services that are covered whether they are medially necessary or authorized.

Paul Marineau - Tenet Health System - Feels the current interest penalty should be enforced and clarified to state that interest accrues from the date of initial billing on claims that are not paid, denied or contested after the 35 day prompt pay standard.

Chris Rohe - Orlando Regional Healthcare System - Feels that HMOs should not be allowed to reduce or take back payments for payments due or unrelated claims.

Kathy Reep - Florida Hospital Association, Vice President Financial Services - Recommends the adoption of a standard clean claims definition and strengthening the penalties for failure to comply with the standards of the Health Insurance Portability and Accountability Act.

Gregory Boyer - CEO Wellington Regional Medical Center - Representing the South Florida Hospital and Healthcare Association - Presented the results of a survey done by SFHHA on selected HMO Payments and recommended that the Panel develop uniform contract definitions, clean claim definition, begin electronic billing, require status reports on claims submitted and propose payment on disputed claims and reconcile on an audit basis.

Dr. Jeff Bettinger - Florida College of Emergency Physicians. Has concerns about emergency care and determination of an emergency medical condition. ER medical conditions should be made by the ER doctor.

Roland Funsten - Memorial Healthcare System - Recommends that the Panel develop a joint mission and vision statement for DOI, AHCA, providers and plans, create an ongoing task force to facilitate uniform standards of operations, strengthen the penalties or sanctions for those plans and providers who are not operating within the current and new guidelines and provide a clear opportunity for recourse for plans and providers that will keep from clogging the court systems.

Dr. Kemp Crockett - Miami Children's Hospital - Expressed concerns about the use of the FMQAI Study of Screening Criteria for hospital ER coding.

Elaine Benjamin - Sheridan HealthCorp, Inc. - Has concerns with downcoding of Emergency Room Claims. Recommended that the Panel ensure that the provider comply with legislation on downcoding

Art Weinblatt - Columbia/HCA Healthcare - Feels that there should not be an instance where neither health plan nor patient are responsible for paying for hospital services provided that were ordered by an attending physician, health plans should acknowledge that physician orders control and support the services rendered and supplies used in a healthcare setting, non -covered services should include those denied by a health plan through decertification or determinations of medical necessity, and DOI interpretation of statute 641.315 does not make sense.

Dr. Timothy Bullard - Medical Director Orlando Regional Healthcare System - Representing Florida College of Emergency Physicians. Has concerns about the impact of EMTALA and managed care on emergency services.

Dr. Rodney Kang - Florida College of Emergency Physicians - Has concerns about the balance billing issues and contracting issues for consulting.

Mark Owen - Has concerns regarding usual and customary charges. Feels a reasonable process needs to be put in place to determine usual and customary charges fairly using independent survey data.

Linda Quick - President, South Florida Hospital and Health Care Association - Urged the Panel to take into consideration the non-hospital members when considering solutions to late payment issues. Feels that there is a need for payers to better educate the consumers about their plans.

Presentation

Pamela Anne Thomas, Acting Chief, Bureau of Managed Health Care, gave a brief presentation on independent vendors which publish usual and customary rates of reimbursement, by specialty, for specific geographic areas.

Pete Buigas, Deputy Director Manage Care and Health Quality, presented the grievance and appeals process utilized by the Health Care Finance Administration (HCFA) for the Medicare product. The objective of the presentation was to highlight the formal process and strict turnaround times used by HCFA whenever a Medicare subscriber is denied services or payment.

The Chairman will ask for an extension of the due date for turning in the Panel's report to the legislature. The Panel will meet again the first week in January.

The meeting adjourned.

Advisory Group on the Submission and Payment of Health Claims, Minutes for January 21, 2000

The Advisory Group meeting was held on January 21, 2000, at the Embassy Suites Hotel in Tampa.

Members Attending: Ruben J. King-Shaw, Jr., Chairman, John Benz, Joe Berding, Bruce Carpenter, Dr. Arthur Diskin, Fred Dunlap, Susanne Murphy, and Kathryn Torres

The meeting was also attended by forty plus interested parties and Agency staff.

Chairman King-Shaw welcomed the Advisory Panel members and guest. The minutes of the last meeting were approved. The Agenda and the handouts for the day's discussion were reviewed. The handouts included a preliminary draft table of substantive issues for the Advisory Group review, a Preliminary Outline for the final report and a report from a staff level meeting. Chairman King-Shaw pointed out that the staff level meeting report was being

submitted to the Panel for their review and consideration, as suggestions would not be binding for the report.

The Panel spent the day working through the Preliminary Draft Table of Substantive Issues for Advisory Group Review item by item as listed in the table making changes as they went along.

The Agency staff was asked to rework the draft of Substantive Issues for the Advisory Group's review. The second draft will be sent back to the members via e-mail and Federal Express at least by Thursday, January 27, 2000. The Panel should send their comments, corrections, etc. back to the Agency by Monday, January 31, 2000.

The final report is expected to be complete and ready for submission by January 31, 2000.

The meeting adjourned.