Committee Substitute for Committee Substitute for Committee Substitute for Senate Bill No. 1508 and Committee Substitute for Senate Bill Nos. 706 and 2234

An act relating to managed care organizations; amending s. 641.315, F.S.; deleting provisions relating to provider billings; revising provisions relating to provider contracts; requiring a health maintenance organization to make certain disclosures to a provider; providing procedures for requesting and granting authorization for utilization of services; creating s. 641.3154, F.S.; providing that a health maintenance organization is liable for payment for services rendered to subscribers; prohibiting a provider from billing a subscriber under specified circumstances; requiring a health maintenance organization and the Department of Insurance to report violations to the Department of Health or the Agency for Health Care Administration; amending s. 641.3155, F.S.; defining the term "clean claim"; specifying the basis for determining when a claim is to be considered clean or not clean; requiring the Department of Insurance to adopt rules to establish a claim form; providing requirements; authorizing the Department of Insurance to adopt rules for coding standards; providing requirements for paying clean claims; providing requirements for denying or contesting a portion of a claim; providing for interest accrual and payment of interest; providing an uncontestable obligation to pay a claim; requiring a health maintenance organization to make a claim for overpayment; prohibiting an organization from reducing payment for other services; providing exceptions; requiring a provider to pay a claim for overpayment within a specified time; providing a procedure and timeframes for a provider to notify a health maintenance organization that it is denying or contesting a claim for overpayment; specifying when a provider payment of a claim for overpayment is to be considered made; providing for assessment of simple interest against overdue payment of a claim; specifying when interest on overdue payments of claims for overpayment begins to accrue; specifying a timeframe for a provider to deny or contest a claim for overpayment; providing an uncontestable obligation to pay a claim; specifying when a provider claim that is electronically transmitted or mailed is considered received; specifying when a health maintenance organization claim for overpayment is considered received; mandating acknowledgment of receipts for electronically submitted provider claims; prescribing a timeframe for a health maintenance organization to retroactively deny a claim for services provided to an ineligible subscriber; creating s. 641.3156, F.S.; providing for treatment authorization and payment of claims by a health maintenance organization; clarifying that treatment authorization and payment of a claim for emergency services is subject to specified provisions of law; amending s. 641.3903, F.S.; providing that downcoding with intent to deny reimbursement by a health maintenance organization is an unfair method of competition and an unfair or deceptive act or practice; amending s.

641.3909, F.S.; authorizing the Department of Insurance to issue a cease and desist order for a violation of s. 641.3155, F.S., relating to payment of claims; amending s. 641.495, F.S.; revising provisions relating to treatment-authorization capabilities; requiring agreement to pending authorizations and tracking numbers as a precondition to such an authorization; creating s. 408.7057, F.S.; providing for the establishment of a statewide claim-dispute-resolution program for providers and managed care organizations; providing rulemaking authority to the Agency for Health Care Administration; amending s. 395.1065, F.S., relating to criminal and administrative penalties for health care providers; authorizing administrative sanctions against a hospital's license for improper subscriber billing and violations of requirements relating to claims payment; amending s. 631.818, F.S., relating to the health maintenance organization consumer assistance plan; conforming provisions to changes made by the act; amending s. 817.234, F.S.; providing that certain actions by a provider are punishable under s. 641.52, F.S., in addition to any other provision of law; amending s. 817.50, F.S., relating to fraud against hospitals; expanding applicability to health care providers; amending s. 641.31, F.S., relating to health maintenance contracts; conforming a cross-reference to changes made by the act; providing applicability; providing an appropriation; providing an effective date.

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

Section 1. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.—

~~(1) Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.~~

~~(2) No subscriber of an HMO shall be liable to any provider of health care services for any services covered by the HMO.~~

~~(3) No provider of services or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.~~

(1)~~(4)~~ Each ~~Every~~ contract between a health maintenance organization ~~an HMO~~ and a provider of health care services must ~~shall~~ be in writing and must ~~shall~~ contain a provision that the subscriber is ~~shall~~ not ~~be~~ liable to the provider for any services for which the health maintenance organization is liable as specified in s. 641.3154 ~~covered by the subscriber's contract with the HMO~~.

~~(5) The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.~~

(2)~~(6)~~(a) For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:

1. The contracts must require ~~provide that~~ the provider to give ~~shall provide~~ 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason; and

2. The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is ~~shall~~ not ~~be~~ a valid reason for avoiding the 60-day advance notice of cancellation.

(b) ~~For~~ All provider contracts ~~executed after October 1, 1996, and within 180 days after October 1, 1996, for contracts in existence as of October 1, 1996, the contracts~~ must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(3)~~(7)~~ Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.

(4) Whenever a contract exists between a health maintenance organization and a provider, the health maintenance organization shall disclose to the provider:

(a) The mailing address or electronic address where claims should be sent for processing;

(b) The telephone number that a provider may call to have questions and concerns regarding claims addressed; and

(c) The address of any separate claims-processing centers for specific types of services.

A health maintenance organization shall provide to its contracted providers no less than 30 calendar days' prior written notice of any changes in the information required in this subsection.

(5)~~(8)~~ A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider

deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(6)~~(9)~~ A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(7)~~(10)~~ A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required in this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466.

(8) The health maintenance organization must establish written procedures for a contract provider to request and the health maintenance organization to grant authorization for utilization of health care services. The health maintenance organization must give written notice to the contract provider prior to any change in these procedures.

Section 2. Section 641.3154, Florida Statutes, is created to read:

641.3154 Organization liability; provider billing prohibited.—

(1) If a health maintenance organization is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.

(2) For purposes of this section, a health maintenance organization is liable for services rendered to an eligible subscriber by a provider if the provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

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

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, 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 organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute-resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; or

(c) The department or agency 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 pursuant to s. 408.7056.

(5) An organization and the department shall 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 shall take such action as authorized by law.

Section 3. Section 641.3155, Florida Statutes, is amended to read:

641.3155 ~~Provider contracts;~~ Payment of claims.—

(1)(a) As used in this section, the term "clean claim" for a noninstitutional provider means a claim submitted on a HCFA 1500 form which has no defect or impropriety, including lack of required substantiating documentation for noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because a health maintenance organization refers the claim to a medical specialist within the health maintenance organization for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from a source outside the health maintenance organization, the claim is considered not clean. This definition of "clean claim" is repealed on the effective date of rules adopted by the department which define the term "clean claim."

(b) Absent a written definition that is agreed upon through contract, 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.

(c) The department shall adopt rules to establish claim forms consistent with federal claim-filing standards for health maintenance organizations

required by the federal Health Care Financing Administration. The department may adopt rules relating to coding standards consistent with Medicare coding standards adopted by the federal Health Care Financing Administration.

(2)~~(1)~~(a) A health maintenance organization shall pay any clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with the health maintenance organization or a clean claim made by a noncontract provider 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 or any portion of a claim shall notify the ~~contract~~ provider, in writing, within 35 days after ~~receipt of the claim by~~ the health maintenance organization receives the claim 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, if contested, must ~~may~~ include a request for additional information. If the provider submits ~~health maintenance organization requests~~ additional information, the provider must ~~shall~~, within 35 days after receipt of the ~~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.

(3)~~(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. 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. The interest is payable with the payment of the claim.

(4)~~(3)~~ A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the health maintenance organization to pay the claim to the provider.

(5)(a) If, as a result of retroactive review of coverage decisions or payment levels, a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the organization must make a claim for such overpayment. The organization may not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to the organization's claim as required in this subsection.

(b) A provider shall pay a claim for an overpayment made by a health maintenance organization which the provider does not contest or deny within 35 days after receipt of the claim that is mailed or electronically transferred to the provider.

(c) A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information.

(d) Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of 10 percent a year. 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 has been received.

(e) A provider shall pay or deny any claim for overpayment no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the provider to pay the claim to the organization.

(6)~~(4)~~ Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

(7)(a) A provider claim for payment shall be considered received by the health maintenance organization, if the claim has been electronically transmitted to the health maintenance organization, when 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. A provider must wait 45 days following receipt of a claim before submitting a duplicate claim.

(b) A health maintenance organization claim for overpayment shall be considered received by a provider, if the claim has been electronically transmitted to the provider, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the provider, on the date indicated on the return receipt. An organization must wait 45 days following the provider's receipt of a claim for overpayment before submitting a duplicate claim.

(c) This section does not preclude the health maintenance organization and provider from agreeing to other methods of transmission and receipt of claims.

(8) A provider, or the provider's designee, who bills electronically is entitled to electronic acknowledgement of the receipt of a claim within 72 hours.

(9) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the clean claim.

Section 4. Section 641.3156, Florida Statutes, is created to read:

641.3156 Treatment authorization; payment of claims.—

(1) A health maintenance organization must pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a provider empowered by contract with the health maintenance organization to authorize or direct the patient's utilization of health care services and which was also authorized in accordance with the health maintenance organization's current and communicated procedures, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

(2) A claim for treatment may not be denied if a provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.

(3) Emergency services are subject to the provisions of s. 641.513 and are not subject to the provisions of this section.

Section 5. Subsection (5) of section 641.3903, Florida Statutes, is amended to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(5) UNFAIR CLAIM SETTLEMENT PRACTICES.—

(a) Attempting to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, the subscriber or group of subscribers to a health maintenance organization;

(b) Making a material misrepresentation to the subscriber for the purpose and with the intent of effecting settlement of claims, loss, or damage under a health maintenance contract on less favorable terms than those provided in, and contemplated by, the contract; or

(c) Committing or performing with such frequency as to indicate a general business practice any of the following:

1. Failing to adopt and implement standards for the proper investigation of claims;

2. Misrepresenting pertinent facts or contract provisions relating to coverage at issue;

3. Failing to acknowledge and act promptly upon communications with respect to claims;

4. Denying of claims without conducting reasonable investigations based upon available information;

5. Failing to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the health maintenance organization;

6. Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

7. Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies, provided that the organization may receive from the subscriber a reasonable administrative charge for the cost of preparing such statement; ~~or~~

8. Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the health maintenance organization results in the inability of the facilities, personnel, or financial resources of the health maintenance organization to provide or arrange for provision of a health service in accordance with requirements of this part, the health maintenance organization is required only to make a good faith effort to provide or arrange for provision of the service, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of the health maintenance organization if the health maintenance organization cannot exercise influence or dominion over its occurrence; or~~.~~

9. Systematic downcoding with the intent to deny reimbursement otherwise due.

Section 6. Section 641.3909, Florida Statutes, is amended to read:

641.3909 Cease and desist and penalty orders.—After the hearing provided in s. 641.3907, the department shall enter a final order in accordance with s. 120.569. If it is determined that the person, entity, or health maintenance organization charged has engaged in an unfair or deceptive act or practice or the unlawful operation of a health maintenance organization without a subsisting certificate of authority, the department shall also issue

an order requiring the violator to cease and desist from engaging in such method of competition, act, or practice or unlawful operation of a health maintenance organization. Further, if the act or practice constitutes a violation of s. 641.3155, s. 641.3901, or s. 641.3903, the department may, at its discretion, order any one or more of the following:

(1) Suspension or revocation of the health maintenance organization's certificate of authority if it knew, or reasonably should have known, it was in violation of this part.

(2) If it is determined that the person or entity charged has engaged in the business of operating a health maintenance organization without a certificate of authority, an administrative penalty not to exceed $1,000 for each health maintenance contract offered or effectuated.

Section 7. Subsection (4) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(4) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(13)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs. The health maintenance organization must provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.

Section 8. Section 408.7057, Florida Statutes, is created to read:

408.7057 Statewide provider and managed care organization claim dispute resolution program.—

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

(a) "Managed care organization" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(b) "Resolution organization" means a qualified independent third-party claim-dispute-resolution entity selected by and contracted with the Agency for Health Care Administration.

(2)(a) The Agency for Health Care Administration shall establish a program by January 1, 2001, to provide assistance to contracted and noncontracted providers and managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. The agency shall contract with a resolution organization to timely review and consider claim disputes submitted by providers and managed

care organizations and recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes that may be considered by the resolution organization.

(b) The resolution organization shall review claim disputes filed by contracted and noncontracted providers and managed care organizations unless the disputed claim:

1. Is related to interest payment;

2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided in paragraph (a);

3. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;

4. Is related to a health plan that is not regulated by the state;

5. Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

6. Is the basis for an action pending in state or federal court; or

7. 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.

(c) Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or health maintenance organization to the resolution organization when the dispute-resolution program becomes effective.

(d) 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 has been made on a claim by a health maintenance organization.

(3) The agency shall adopt rules to establish a process to be used by the resolution organization in considering claim disputes submitted by 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 receipt of the claim dispute submission.

(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order.

(5) 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. Such rule must provide for an apportionment of the review fee in any case in which both parties prevail in part. If the nonprevailing party fails to pay the ordered review cost within 35 days after the agency's order, the nonpaying

party is subject to a penalty of not more than $500 per day until the penalty is paid.

(6) The Agency for Health Care Administration may adopt rules to administer this section.

Section 9. Paragraph (a) of subsection (2) of section 395.1065, Florida Statutes, is amended, and paragraph (d) is added to that subsection, to read:

395.1065 Criminal and administrative penalties; injunctions; emergency orders; moratorium.—

(2)(a) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $1,000 per violation, per day, for the violation of any provision of this part or rules adopted under this part ~~promulgated hereunder~~. Each day of violation constitutes a separate violation and is subject to a separate fine.

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

Section 10. Paragraph (c) of subsection (1) of section 631.818, Florida Statutes, is amended to read:

631.818 Powers and duties of the plan.—

(1) In the event that an HMO is insolvent, the plan shall:

(c) Defend any claim filed contrary to the provisions of s. 641.315 or s. 641.3154 against a subscriber of an insolvent HMO asserted by a health care provider for services covered by the HMO contract. In the event that a provider obtains a judgment despite the provisions of s. 641.315 or s. 641.3154, the plan shall pay the judgment. If a provider fails to obtain a judgment as to such claim, the plan shall be entitled to recover its reasonable costs and attorney's fees incurred in defending the claim.

Section 11. Subsection (2) of section 817.234, Florida Statutes, is amended, and subsection (11) of that section is reenacted, to read:

817.234 False and fraudulent insurance claims.—

(2)(a) Any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, or other practitioner licensed under the laws of this state who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractic physician, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud, punishable as provided in subsection

(11). In the event that a physician, osteopathic physician, chiropractic physician, or practitioner is adjudicated guilty of a violation of this section, the Board of Medicine as set forth in chapter 458, the Board of Osteopathic Medicine as set forth in chapter 459, the Board of Chiropractic Medicine as set forth in chapter 460, or other appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopathic physician, chiropractic physician, or practitioner.

(b) In addition to any other provision of law, systematic upcoding by a provider, as defined in s. 641.19(15), with the intent to obtain reimbursement otherwise not due from an insurer is punishable as provided in s. 641.52(5).

(11) If the value of any property involved in a violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 12. Section 817.50, Florida Statutes, is amended to read:

817.50 Fraudulently obtaining goods, services, etc., from a health care provider ~~hospital~~.—

(1) Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise, or services from any health care provider ~~hospital~~ in this state, as defined in s. 641.19(15), commits ~~shall be guilty of~~ a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) If any person gives to any health care provider ~~hospital~~ in this state a false or fictitious name or a false or fictitious address or assigns to any health care provider ~~hospital~~ the proceeds of any health maintenance contract or insurance contract, then knowing that such contract is no longer in force, is invalid, or is void for any reason, such action shall be prima facie evidence of the intent of such person to defraud the health care provider ~~such hospital~~.

Section 13. Paragraph (d) of subsection (38) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(38)

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay

a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.3154 ~~641.315(2) and (3)~~ does not apply to a point-of-service rider authorized under this subsection.

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

Section 15. This act shall take effect October 1, 2000, and shall apply to claims for services rendered after such 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.

Approved by the Governor June 8, 2000.

Filed in Office Secretary of State June 8, 2000.