

26 prohibiting fees for payment transmittals; providing
 27 exceptions; prohibiting waivers; requiring
 28 enforcement; prohibiting denials of certain claims
 29 under specified circumstances; providing exceptions;
 30 amending s. 641.315, F.S.; prohibiting certain
 31 restrictions on payment methods by health maintenance
 32 organizations to dentists; providing requirements if
 33 certain payment methods are initiated or changed;
 34 prohibiting fees for payment transmittals; providing
 35 exceptions; prohibiting waivers; requiring
 36 enforcement; prohibiting denials of certain claims
 37 under specified circumstances; providing exceptions;
 38 providing an effective date.

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

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 42 Section 1. Subsections (20) and (21) are added to section
 43 627.6131, Florida Statutes, to read:

44 627.6131 Payment of claims.—

45 (20) (a) A contract between a health insurer and a dentist
 46 licensed under chapter 466 for the provision of dental services
 47 to an insured may not contain restrictions by the health insurer
 48 or its contracted vendor on methods of payment by the health
 49 insurer or its contracted vendor to the dentist in which the
 50 only acceptable payment method is by credit card.

51 (b)1. If initiating or changing payment methods to a
52 dentist to payments by electronic funds transfers, including
53 virtual credit card payments, a health insurer under its dental
54 benefit plan or a health insurer's contracted vendor must:

55 a. Notify the dentist if any fees are associated with a
56 particular payment method.

57 b. Advise the dentist of the available payment methods and
58 provide clear instructions to the dentist as to how to select an
59 alternative payment method.

60 2. If initiating or changing payments to a dentist to
61 payments through the Automated Clearing House network, as
62 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health
63 insurer under its dental benefit plan or a health insurer's
64 contracted vendor may not charge a fee solely to transmit the
65 payment to the dentist, unless the dentist has consented to the
66 fee. However, a dentist's agent may charge the dentist
67 reasonable fees when transmitting an Automated Clearing House
68 network payment related to transaction management, data
69 management, portal services, and other value-added services in
70 addition to the bank transmittal.

71 (c) The provisions of this subsection may not be waived by
72 contract. A contractual clause that is in conflict with this
73 subsection or that purports to waive any requirement of this
74 subsection is void.

75 (d) The commission shall enforce this subsection.

76 (21) (a) A health insurer providing coverage for dental
77 services may not deny a claim submitted by a dentist licensed
78 under chapter 466 for a procedure specifically included in a
79 prior authorization unless at least one of the following
80 circumstances applies:

81 1. Benefit limitations such as annual maximums and
82 frequency limitations not applicable at the time of the prior
83 authorization are reached due to use after issuance of the prior
84 authorization.

85 2. If, after issuance of the prior authorization, a new
86 procedure is provided to the patient or a change in the
87 condition of the patient occurs such that the prior authorized
88 procedure would:

89 a. No longer be considered medically necessary, based on
90 the prevailing standard of care; or

91 b. At the time of the use of the procedure, require denial
92 of authorization under the terms and conditions for coverage
93 under the patient's plan in effect at the time the prior
94 authorization was used.

95 3. The patient receiving the procedure was not eligible to
96 receive the procedure on the date of service, and the dentist
97 did not know, and with the exercise of reasonable care could not
98 have known, of the patient's eligibility status.

99 4. Another payer is responsible for the payment.

100 5. The dentist has already been paid for the procedure

101 identified on the claim.

102 6. The documentation for the claim provided by the person
 103 submitting the claim clearly fails to support the claim as
 104 originally authorized.

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

109 (b) The provisions of this subsection may not be waived by
 110 contract. A contractual clause that is in conflict with this
 111 subsection or that purports to waive any requirement of this
 112 subsection is void.

113 Section 2. Subsection (2) of section 627.6474, Florida
 114 Statutes, is amended to read:

115 627.6474 Provider contracts.—

116 (2) A contract between a health insurer and a dentist
 117 licensed under chapter 466 for the provision of services to an
 118 insured may not contain a provision that requires the dentist to
 119 provide services to the insured under such contract at a fee set
 120 by the health insurer unless such services are covered services
 121 under the applicable contract. As used in this subsection, the
 122 term "covered services" means dental care services for which a
 123 reimbursement is available under the insured's contract,
 124 excluding ~~or for which a reimbursement would be available but~~
 125 ~~for~~ the application of contractual limitations such as

126 deductibles, coinsurance, waiting periods, annual or lifetime
127 maximums, frequency limitations, alternative benefit payments,
128 or any other limitation.

129 Section 3. Section 627.65772, Florida Statutes, is created
130 to read:

131 627.65772 Payment methods for dental services; claim
132 payment denials.-

133 (1) (a) A contract between a health insurer and a dentist
134 licensed under chapter 466 for the provision of dental services
135 to an insured may not contain restrictions by the health insurer
136 or its contracted vendor on methods of payment by the health
137 insurer or its contracted vendor to the dentist in which the
138 only acceptable payment method is by credit card.

139 (b)1. If initiating or changing payment methods to a
140 dentist to payments by electronic funds transfers, including
141 virtual credit card payments, a health insurer under its dental
142 benefit plan or a health insurer's contracted vendor must:

143 a. Notify the dentist if any fees are associated with a
144 particular payment method.

145 b. Advise the dentist of the available payment methods and
146 provide clear instructions to the dentist as to how to select an
147 alternative payment method.

148 2. If initiating or changing payments to a dentist to
149 payments through the Automated Clearing House network, as
150 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health

151 insurer under its dental benefit plan or a health insurer's
152 contracted vendor may not charge a fee solely to transmit the
153 payment to the dentist, unless the dentist has consented to the
154 fee. However, a dentist's agent may charge the dentist
155 reasonable fees when transmitting an Automated Clearing House
156 network payment related to transaction management, data
157 management, portal services, and other value-added services in
158 addition to the bank transmittal.

159 (c) The commission shall enforce this subsection.

160 (2) A health insurer providing coverage for dental
161 services may not deny a claim submitted by a dentist licensed
162 under chapter 466 for a procedure specifically included in a
163 prior authorization unless at least one of the following
164 circumstances applies:

165 (a) Benefit limitations such as annual maximums and
166 frequency limitations not applicable at the time of the prior
167 authorization are reached due to use after issuance of the prior
168 authorization.

169 (b) If, after issuance of the prior authorization, a new
170 procedure is provided to the patient or a change in the
171 condition of the patient occurs such that the prior authorized
172 procedure would:

173 1. No longer be considered medically necessary, based on
174 the prevailing standard of care; or

175 2. At the time of the use of the procedure, require denial

176 of authorization pursuant to the terms and conditions for
177 coverage under the patient's plan in effect at the time the
178 prior authorization was used.

179 (c) The patient receiving the procedure was not eligible
180 to receive the procedure on the date of service, and the dentist
181 did not know, and with the exercise of reasonable care could not
182 have known, of the patient's eligibility status.

183 (d) Another payer is responsible for the payment.

184 (e) The dentist has already been paid for the procedure
185 identified on the claim.

186 (f) The documentation for the claim provided by the person
187 submitting the claim clearly fails to support the claim as
188 originally authorized.

189 (g) The claim was submitted fraudulently, or the prior
190 authorization was based in whole or material part on erroneous
191 information provided by the dentist, the patient, or any other
192 person not related to the health insurer.

193 (3) The provisions of this section may not be waived by
194 contract. A contractual clause that is in conflict with this
195 section or that purports to waive any requirement of this
196 section is void.

197 Section 4. Subsection (13) of section 636.035, Florida
198 Statutes, is amended, and subsections (15) and (16) are added to
199 that section, to read:

200 636.035 Provider arrangements.—

201 (13) A contract between a prepaid limited health service
 202 organization and a dentist licensed under chapter 466 for the
 203 provision of services to a subscriber of the prepaid limited
 204 health service organization may not contain a provision that
 205 requires the dentist to provide services to the subscriber of
 206 the prepaid limited health service organization at a fee set by
 207 the prepaid limited health service organization unless such
 208 services are covered services under the applicable contract. As
 209 used in this subsection, the term "covered services" means
 210 dental care services for which a reimbursement is available
 211 under the subscriber's contract, excluding ~~or for which a~~
 212 ~~reimbursement would be available but for~~ the application of
 213 contractual limitations such as deductibles, coinsurance,
 214 waiting periods, annual or lifetime maximums, frequency
 215 limitations, alternative benefit payments, or any other
 216 limitation.

217 (15) (a) A contract between a prepaid limited health
 218 service organization and a dentist licensed under chapter 466
 219 for the provision of dental services to a subscriber may not
 220 contain restrictions by the prepaid limited health service
 221 organization or its contracted vendor on methods of payment by
 222 the prepaid limited health service organization or its
 223 contracted vendor to the dentist in which the only acceptable
 224 payment method is by credit card.

225 (b)1. If initiating or changing payments to a dentist to

226 payments by electronic funds transfers, including virtual credit
227 card payments, a prepaid limited health service organization
228 under its dental benefit plan or a prepaid limited health
229 service organization's contracted vendor must:

230 a. Notify the dentist if any fees are associated with a
231 particular payment method.

232 b. Advise the dentist of the available payment methods and
233 provide clear instructions to the dentist as to how to select an
234 alternative payment method.

235 2. If initiating or changing payments to a dentist to
236 payments through the Automated Clearing House network, as
237 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a prepaid
238 limited health service organization under its dental benefit
239 plan or a prepaid limited health service organization's
240 contracted vendor may not charge a fee solely to transmit the
241 payment to the dentist, unless the dentist has consented to the
242 fee. However, a dentist's agent may charge the dentist
243 reasonable fees when transmitting an Automated Clearing House
244 network payment related to transaction management, data
245 management, portal services, and other value-added services in
246 addition to the bank transmittal.

247 (c) The provisions of this subsection may not be waived by
248 contract. A contractual clause that is in conflict with this
249 subsection or that purports to waive any requirement of this
250 subsection is void.

- 251 (d) The commission shall enforce this subsection.
- 252 (16) (a) A prepaid limited health service organization
253 providing coverage for dental services may not deny a claim
254 submitted by a dentist licensed under chapter 466 for a
255 procedure specifically included in a prior authorization unless
256 at least one of the following circumstances applies:
- 257 1. Benefit limitations such as annual maximums and
258 frequency limitations not applicable at the time of the prior
259 authorization are reached due to use after issuance of the prior
260 authorization.
- 261 2. If, after issuance of the prior authorization, a new
262 procedure is provided to the patient or a change in the
263 condition of the patient occurs such that the prior authorized
264 procedure would:
- 265 a. No longer be considered medically necessary, based on
266 the prevailing standard of care; or
- 267 b. At the time of the use of the procedure, require denial
268 of authorization pursuant to the terms and conditions for
269 coverage under the patient's plan in effect at the time the
270 prior authorization was used.
- 271 3. The patient receiving the procedure was not eligible to
272 receive the procedure on the date of service, and the dentist
273 did not know, and with the exercise of reasonable care could not
274 have known, of the patient's eligibility status.
- 275 4. Another payer is responsible for the payment.

276 5. The dentist has already been paid for the procedure
277 identified on the claim.

278 6. The documentation for the claim provided by the person
279 submitting the claim clearly fails to support the claim as
280 originally authorized.

281 7. The claim was submitted fraudulently, or the prior
282 authorization was based in whole or material part on erroneous
283 information provided by the dentist, the patient, or any other
284 person not related to the prepaid limited health service
285 organization.

286 (b) The provisions of this subsection may not be waived by
287 contract. A contractual clause that is in conflict with this
288 subsection or that purports to waive any requirement of this
289 subsection is void.

290 Section 5. Subsection (11) of section 641.315, Florida
291 Statutes, is amended, and subsections (13) and (14) are added to
292 that section, to read:

293 641.315 Provider contracts.—

294 (11) A contract between a health maintenance organization
295 and a dentist licensed under chapter 466 for the provision of
296 services to a subscriber of the health maintenance organization
297 may not contain a provision that requires the dentist to provide
298 services to the subscriber of the health maintenance
299 organization at a fee set by the health maintenance organization
300 unless such services are covered services under the applicable

301 contract. As used in this subsection, the term "covered
302 services" means dental care services for which a reimbursement
303 is available under the subscriber's contract, excluding ~~or for~~
304 ~~which a reimbursement would be available but for~~ the application
305 of contractual limitations such as deductibles, coinsurance,
306 waiting periods, annual or lifetime maximums, frequency
307 limitations, alternative benefit payments, or any other
308 limitation.

309 (13) (a) A contract between a health maintenance
310 organization and a dentist licensed under chapter 466 for the
311 provision of dental services to a subscriber of the health
312 maintenance organization may not contain restrictions by the
313 health maintenance organization or its contracted vendor on
314 methods of payment by the health maintenance organization or its
315 contracted vendor to the dentist in which the only acceptable
316 payment method is by credit card.

317 1. If initiating or changing payments to a dentist to
318 payments by electronic funds transfers, including virtual credit
319 card payments, a health maintenance organization under its
320 dental benefit plan or a health maintenance organization's
321 contracted vendor must:

322 a. Notify the dentist if any fees are associated with a
323 particular payment method.

324 b. Advise the dentist of the available payment methods and
325 provide clear instructions to the dentist as to how to select an

326 alternative payment method.

327 2. If initiating or changing payments to a dentist to
328 payments through the Automated Clearing House network, as
329 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health
330 maintenance organization under its dental benefit plan or
331 through a contracted vendor may not charge a fee solely to
332 transmit the payment to the dentist, unless the dentist has
333 consented to the fee. However, a dentist's agent may charge the
334 dentist reasonable fees when transmitting an Automated Clearing
335 House network payment related to transaction management, data
336 management, portal services, and other value-added services in
337 addition to the bank transmittal.

338 (b) The provisions of this subsection may not be waived by
339 contract. A contractual clause that is in conflict with this
340 subsection or that purports to waive any requirement of this
341 subsection is void.

342 (c) The commission shall enforce this subsection.

343 (14) (a) A health maintenance organization providing
344 coverage for dental services may not deny a claim submitted by a
345 dentist licensed under chapter 466 for a procedure specifically
346 included in a prior authorization unless at least one of the
347 following circumstances applies:

348 1. Benefit limitations such as annual maximums and
349 frequency limitations not applicable at the time of the prior
350 authorization are reached due to use after issuance of the prior

351 authorization.

352 2. If, after issuance of the prior authorization, a new
353 procedure is provided to the patient or a change in the
354 condition of the patient occurs such that the prior authorized
355 procedure would:

356 a. No longer be considered medically necessary, based on
357 the prevailing standard of care; or

358 b. At the time of the use of the procedure, require denial
359 of authorization pursuant to the terms and conditions for
360 coverage under the patient's plan in effect at the time the
361 prior authorization was used.

362 3. The patient receiving the procedure was not eligible to
363 receive the procedure on the date of service, and the dentist
364 did not know, and with the exercise of reasonable care could not
365 have known, of the patient's eligibility status.

366 4. Another payer is responsible for the payment.

367 5. The dentist has already been paid for the procedure
368 identified on the claim.

369 6. The documentation for the claim provided by the person
370 submitting the claim clearly fails to support the claim as
371 originally authorized.

372 7. The claim was submitted fraudulently, or the prior
373 authorization was based in whole or material part on erroneous
374 information provided by the dentist, the patient, or any other
375 person not related to the health maintenance organization.

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376 (b) The provisions of this subsection may not be waived by
377 contract. A contractual clause that is in conflict with this
378 subsection or that purports to waive any requirement of this
379 subsection is void.

380 Section 6. This act shall take effect July 1, 2023.