COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Black offered the following:
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5 **Amendment (with title amendment)**
6 Remove lines 90-308 and insert:
7 dentist has consented to the fee.
8 (d) This subsection may not be waived, voided, or
9 nullified by contract, and any contractual clause in conflict
10 with this subsection or which purports to waive any requirements
11 of this subsection is null and void.
12 (e) The office has all rights and powers to enforce this
13 subsection as provided by s. 624.307.
14 (f) The commission may adopt rules to implement this
15 subsection.

16 (21)(a) A health insurer may not deny any claim
17 subsequently submitted by a dentist licensed under chapter 466
18 for procedures specifically included in a prior authorization
19 unless at least one of the following circumstances applies for
20 each procedure denied:
21 1. Benefit limitations, such as annual maximums and
22 frequency limitations not applicable at the time of the prior
23 authorization, are reached subsequent to issuance of the prior
24 authorization.
25 2. The documentation provided by the person submitting the
26 claim fails to support the claim as originally authorized.
27 3. Subsequent to the issuance of the prior authorization,
28 new procedures are provided to the patient or a change in the
29 condition of the patient occurs such that the prior authorized
30 procedure would no longer be considered medically necessary,
31 based on the prevailing standard of care.
32 4. Subsequent to the issuance of the prior authorization,
33 new procedures are provided to the patient or a change in the
34 patient's condition occurs such that the prior authorized
35 procedure would at that time have required disapproval pursuant
36 to the terms and conditions for coverage under the patient's
37 plan in effect at the time the prior authorization was issued.
38 5. The denial of the claim was due to one of the
39 following:
40 a. Another payor is responsible for payment.

41 b. The dentist has already been paid for the procedures
42 identified in the claim.
43 c. The claim was submitted fraudulently, or the prior
44 authorization was based in whole or material part on erroneous
45 information provided to the health insurer by the dentist,
46 patient, or other person not related to the insurer.
47 d. The person receiving the procedure was not eligible to
48 receive the procedure on the date of service and the health
49 insurer did not know, and with the exercise of reasonable care
50 could not have known, of his or her ineligibility.
51 (b) This subsection may not be waived, voided, or
52 nullified by contract, and any contractual clause in conflict
53 with this subsection or which purports to waive any requirements
54 of this subsection is null and void.
55 (c) The office has all rights and powers to enforce this
56 subsection as provided by s. 624.307.
57 (d) The commission may adopt rules to implement this
58 subsection.
59 Section 2. Subsection (2) of section 627.6474, Florida
60 Statutes, is amended to read:
61 627.6474 Provider contracts.—
62 (2) A contract between a health insurer and a dentist
63 licensed under chapter 466 for the provision of services to an
64 insured may not contain a provision that requires the dentist to
65 provide services to the insured under such contract at a fee set

66 by the health insurer unless such services are covered services
67 under the applicable contract. As used in this subsection, the
68 term "covered services" means dental care services for which a
69 reimbursement is available under the insured's contract,
70 notwithstanding ~~or for which a reimbursement would be available~~
71 ~~but for~~ the application of contractual limitations, such as
72 deductibles, coinsurance, waiting periods, annual or lifetime
73 maximums, frequency limitations, alternative benefit payments,
74 or any other limitation.
75 Section 3. Section 636.032, Florida Statutes, is amended
76 to read:
77 636.032 Acceptable payments.—
78 (1) Each prepaid limited health service organization may
79 accept from government agencies, corporations, groups, or
80 individuals payments covering all or part of the cost of
81 contracts entered into between the prepaid limited health
82 service organization and its subscribers.
83 (2)(a) A contract between a prepaid limited health service
84 organization and a dentist licensed under chapter 466 for the
85 provision of services to a subscriber may not specify credit
86 card payment as the only acceptable method for payments from the
87 prepaid limited health service organization to the dentist.
88 (b) At least 10 days before a limited health service
89 organization pays a claim to a dentist through electronic funds
90 transfer, including, but not limited to, virtual credit card

91 payments, the prepaid limited health service organization shall
92 notify the dentist in writing of all of the following:
93 1. The fees, if any, that are associated with the
94 electronic funds transfer.
95 2. The available methods of payment of claims by the
96 prepaid limited health service organization, with clear
97 instructions to the dentist on how to select an alternative
98 payment method.
99 (c) A prepaid limited health service organization that
100 pays a claim to a dentist through Automatic Clearing House (ACH)
101 transfer may not charge a fee solely to transmit the payment to
102 the dentist unless the dentist has consented to the fee.
103 (d) This subsection may not be waived, voided, or
104 nullified by contract, and any contractual clause in conflict
105 with this subsection or which purports to waive any requirements
106 of this subsection is null and void.
107 (e) The office has all rights and powers to enforce this
108 subsection as provided by s. 624.307.
109 (f) The commission may adopt rules to implement this
110 subsection.
111 Section 4. Subsection (13) of section 636.035, Florida
112 Statutes, is amended, and subsection (15) is added to that
113 section, to read:
114 636.035 Provider arrangements.—

115 (13) A contract between a prepaid limited health service
116 organization and a dentist licensed under chapter 466 for the
117 provision of services to a subscriber of the prepaid limited
118 health service organization may not contain a provision that
119 requires the dentist to provide services to the subscriber of
120 the prepaid limited health service organization at a fee set by
121 the prepaid limited health service organization unless such
122 services are covered services under the applicable contract. As
123 used in this subsection, the term "covered services" means
124 dental care services for which a reimbursement is available
125 under the subscriber's contract, notwithstanding ~~or for which a~~
126 ~~reimbursement would be available but for~~ the application of
127 contractual limitations such as deductibles, coinsurance,
128 waiting periods, annual or lifetime maximums, frequency
129 limitations, alternative benefit payments, or any other
130 limitation.
131 (15)(a) A prepaid limited health service organization may
132 not deny any claim subsequently submitted by a dentist licensed
133 under chapter 466 for procedures specifically included in a
134 prior authorization unless at least one of the following
135 circumstances applies for each procedure denied:
136 1. Benefit limitations, such as annual maximums and
137 frequency limitations not applicable at the time of the prior
138 authorization, are reached subsequent to issuance of the prior
139 authorization.

140 2. The documentation provided by the person submitting the
141 claim fails to support the claim as originally authorized.
142 3. Subsequent to the issuance of the prior authorization,
143 new procedures are provided to the patient or a change in the
144 condition of the patient occurs such that the prior authorized
145 procedure would no longer be considered medically necessary,
146 based on the prevailing standard of care.
147 4. Subsequent to the issuance of the prior authorization,
148 new procedures are provided to the patient or a change in the
149 patient's condition occurs such that the prior authorized
150 procedure would at that time have required disapproval pursuant
151 to the terms and conditions for coverage under the patient's
152 plan in effect at the time the prior authorization was issued.
153 5. The denial of the dental service claim was due to one
154 of the following:
155 a. Another payor is responsible for payment.
156 b. The dentist has already been paid for the procedures
157 identified in the claim.
158 c. The claim was submitted fraudulently, or the prior
159 authorization was based in whole or material part on erroneous
160 information provided to the prepaid limited health service
161 organization by the dentist, patient, or other person not
162 related to the organization.
163 d. The person receiving the procedure was not eligible to
164 receive the procedure on the date of service and the prepaid

165 limited health service organization did not know, and with the
166 exercise of reasonable care could not have known, of his or her
167 ineligibility.
168 (b) This subsection may not be waived, voided, or
169 nullified by contract, and any contractual clause in conflict
170 with this subsection or which purports to waive any requirements
171 of this subsection is null and void.
172 (c) The office has all rights and powers to enforce this
173 subsection as provided by s. 624.307.
174 (d) The commission may adopt rules to implement this
175 subsection.
176 Section 5. Subsection (11) of section 641.315, Florida
177 Statutes, is amended, and subsections (13) and (14) are added to
178 that section, to read:
179 641.315 Provider contracts.—
180 (11) A contract between a health maintenance organization
181 and a dentist licensed under chapter 466 for the provision of
182 services to a subscriber of the health maintenance organization
183 may not contain a provision that requires the dentist to provide
184 services to the subscriber of the health maintenance
185 organization at a fee set by the health maintenance organization
186 unless such services are covered services under the applicable
187 contract. As used in this subsection, the term "covered
188 services" means dental care services for which a reimbursement
189 is available under the subscriber's contract, notwithstanding ~~or~~

190 ~~for which a reimbursement would be available but for~~ the
191 application of contractual limitations such as deductibles,
192 coinsurance, waiting periods, annual or lifetime maximums,
193 frequency limitations, alternative benefit payments, or any
194 other limitation.
195 (13)(a) A contract between a health maintenance
196 organization and a dentist licensed under chapter 466 for the
197 provision of services to a subscriber of the health maintenance
198 organization may not specify credit card payment as the only
199 acceptable method for payments from the health maintenance
200 organization to the dentist.
201 (b) At least 10 days before a health maintenance
202 organization pays a claim to a dentist through electronic funds
203 transfer, including, but not limited to, virtual credit card
204 payments, the health maintenance organization shall notify the
205 dentist in writing of all of the following:
206 1. The fees, if any, that are associated with the
207 electronic funds transfer.
208 2. The available methods of payment of claims by the
209 health maintenance organization, with clear instructions to the
210 dentist on how to select an alternative payment method.
211 (c) A health maintenance organization that pays a claim to
212 a dentist through Automated Clearing House (ACH) transfer may
213 not charge a fee solely to transmit the payment to the dentist
214 unless the dentist has consented to the fee.

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217 **T I T L E A M E N D M E N T**
218 Remove lines 11-58 and insert:
219 providing construction; authorizing the Office of Insurance
220 Regulation of the Financial Services Commission to enforce
221 certain provisions; authorizing the commission to adopt rules;
222 prohibiting a health insurer from denying claims for procedures
223 included in a prior authorization; providing exceptions;
224 providing construction; authorizing the office to enforce
225 certain provisions; authorizing the commission to adopt rules;
226 amending s. 627.6474, F.S.; revising the definition of the term
227 "covered services"; amending s. 636.032, F.S.; prohibiting a
228 contract between a prepaid limited health service organization
229 and a dentist from containing certain restrictions on payment
230 methods; requiring the prepaid limited health service
231 organization to make certain notifications before paying a claim
232 to a dentist through electronic funds transfer; prohibiting a
233 prepaid limited health service organization from charging a fee
234 to transmit a payment to a dentist through ACH transfer unless
235 the dentist has consented to such fee; providing construction;
236 authorizing the office to enforce certain provisions;
237 authorizing the commission to adopt rules; amending s. 636.035,
238 F.S.; revising the definition of the term "covered services";
239 prohibiting a prepaid limited health service organization from

240 denying claims for procedures included in a prior authorization;
241 providing exceptions; providing construction; authorizing the
242 office to enforce certain provisions; authorizing the commission
243 to adopt rules; amending s. 641.315, F.S.; revising the
244 definition of the term "covered service"; prohibiting a contract
245 between a health maintenance organization and a dentist from
246 containing certain restrictions on payment methods; requiring
247 the health maintenance organization to make certain
248 notifications before paying a claim to a dentist through
249 electronic funds transfer; prohibiting a health maintenance
250 organization from charging a fee to transmit a payment to a
251 dentist through ACH transfer unless the dentist has consented to
252 such fee; providing construction;