

Amendment No.1

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WITHDRAWN	_____	(Y/N)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: Health & Human Services  
 2 Committee

3 Representative Black offered the following:

4  
 5 **Amendment (with title amendment)**

6 Remove lines 62-339 and insert:

7 Section 1. Subsections (20) and (21) are added to section  
 8 627.6131, Florida Statutes, to read:

9 627.6131 Payment of claims.—

10 (20) (a) A contract between a health insurer and a dentist  
 11 licensed under chapter 466 for the provision of services to an  
 12 insured may not require credit card payment as the only  
 13 acceptable method for payments from the health insurer to the  
 14 dentist.

15 (b) If initiating or changing payments to a dentist using  
 16 electronic funds transfer payments, including but not limited

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17 to, virtual credit card payments, a health insurer shall:

18 1. Notify the dentist in writing of the fees, if any,  
19 associated with the electronic funds transfer.

20 2. Notify the dentist in writing of the available methods  
21 of payment of claims by the health insurer, with clear  
22 instructions to the dentist on how to select an alternative  
23 payment method, if any.

24 (c) A health insurer that pays a claim to a dentist  
25 through Automated Clearing House (ACH) transfer may not charge a  
26 fee solely to transmit the payment to the dentist unless the  
27 dentist has consented to the fee. A health insurer may charge  
28 reasonable fees for value-added services related to the ACH  
29 transfer, including but not limited to, transaction management,  
30 data management, and portal services.

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

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

35 (f) The commission may adopt rules to implement this  
36 subsection.

37 (21) (a) A health insurer may not deny any claim  
38 subsequently submitted by a dentist licensed under chapter 466  
39 for procedures specifically included in a prior authorization  
40 unless at least one of the following circumstances applies for  
41 each procedure denied:

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42 1. Benefit limitations, such as annual maximums and  
43 frequency limitations not applicable at the time of the prior  
44 authorization, are reached subsequent to issuance of the prior  
45 authorization.

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

48 3. Subsequent to the issuance of the prior authorization,  
49 new procedures are provided to the patient or a change in the  
50 condition of the patient occurs such that the prior authorized  
51 procedure would no longer be considered medically necessary,  
52 based on the prevailing standard of care.

53 4. Subsequent to the issuance of the prior authorization,  
54 new procedures are provided to the patient or a change in the  
55 patient's condition occurs such that the prior authorized  
56 procedure would at that time have required disapproval pursuant  
57 to the terms and conditions for coverage under the patient's  
58 plan in effect at the time the prior authorization was issued.

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

61 a. Another payor is responsible for payment.

62 b. The dentist has already been paid for the procedures  
63 identified in the claim.

64 c. The claim was submitted fraudulently, or the prior  
65 authorization was based in whole or material part on erroneous  
66 information provided to the health insurer by the dentist,

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67 patient, or other person not related to the insurer.

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

70 e. The services were provided during the grace period  
71 established under s. 627.608 or applicable federal regulations,  
72 and the dental insurer notified the provider that the patient  
73 was in the grace period when the provider requested eligibility  
74 or enrollment verification from the dental insurer, if such  
75 request was made.

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

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

80 (d) The commission may adopt rules to implement this  
81 subsection

82 Section 2. Section 636.032, Florida Statutes, is amended  
83 to read:

84 636.032 Acceptable payments.—

85 (1) Each prepaid limited health service organization may  
86 accept from government agencies, corporations, groups, or  
87 individuals payments covering all or part of the cost of  
88 contracts entered into between the prepaid limited health  
89 service organization and its subscribers.

90 (2)(a) A contract between a prepaid limited health service  
91 organization and a dentist licensed under chapter 466 for the

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92 provision of services to a subscriber may not require credit  
93 card payment as the only acceptable method for payments from the  
94 prepaid limited health service organization to the dentist.

95 (b) If initiating or changing payments to a dentist using  
96 electronic funds transfer payments, including but not limited  
97 to, virtual credit card payments, a health insurer shall:

98 1. Notify the dentist in writing of the fees, if any,  
99 associated with the electronic funds transfer.

100 2. Notify the dentist in writing of the available methods  
101 of payment of claims by the health insurer, with clear  
102 instructions to the dentist on how to select an alternative  
103 payment method, if any.

104 (c) A health insurer that pays a claim to a dentist  
105 through Automated Clearing House (ACH) transfer may not charge a  
106 fee solely to transmit the payment to the dentist unless the  
107 dentist has consented to the fee. A health insurer may charge  
108 reasonable fees for value-added services related to the ACH  
109 transfer, including but not limited to, transaction management,  
110 data management, and portal services.

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

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

115 (f) The commission may adopt rules to implement this  
116 subsection.

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117 Section 3. Subsection (15) is added to section 636.035,  
118 Florida Statutes, to read:

119 (15) (a) A prepaid limited health service organization may  
120 not deny any claim subsequently submitted by a dentist licensed  
121 under chapter 466 for procedures specifically included in a  
122 prior authorization unless at least one of the following  
123 circumstances applies for each procedure denied:

124 1. Benefit limitations, such as annual maximums and  
125 frequency limitations not applicable at the time of the prior  
126 authorization, are reached subsequent to issuance of the prior  
127 authorization.

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

130 3. Subsequent to the issuance of the prior authorization,  
131 new procedures are provided to the patient or a change in the  
132 condition of the patient occurs such that the prior authorized  
133 procedure would no longer be considered medically necessary,  
134 based on the prevailing standard of care.

135 4. Subsequent to the issuance of the prior authorization,  
136 new procedures are provided to the patient or a change in the  
137 patient's condition occurs such that the prior authorized  
138 procedure would at that time have required disapproval pursuant  
139 to the terms and conditions for coverage under the patient's  
140 plan in effect at the time the prior authorization was issued.

141 5. The denial of the dental service claim was due to one

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142 of the following:

143 a. Another payor is responsible for payment.

144 b. The dentist has already been paid for the procedures  
145 identified in the claim.

146 c. The claim was submitted fraudulently, or the prior  
147 authorization was based in whole or material part on erroneous  
148 information provided to the prepaid limited health service  
149 organization by the dentist, patient, or other person not  
150 related to the organization.

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

153 e. The services were provided during the grace period  
154 established under s. 636.016 or applicable federal regulations,  
155 and the dental insurer notified the provider that the patient  
156 was in the grace period when the provider requested eligibility  
157 or enrollment verification from the dental insurer, if such  
158 request was made.

159 (d) This paragraph applies to contracts delivered, issued,  
160 or renewed on or after January 1, 2025

161 Section 4. Subsections (13) and (14) of section 641.315,  
162 Florida Statutes, are added to read:

163 641.315 Provider contracts.—

164 (13) (a) A contract between a health maintenance  
165 organization and a dentist licensed under chapter 466 for the  
166 provision of services to a subscriber of the health maintenance

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167 organization may not require credit card payment as the only  
168 acceptable method for payments from the health maintenance  
169 organization to the dentist.

170 (b) If initiating or changing payments to a dentist using  
171 electronic funds transfer payments, including but not limited  
172 to, virtual credit card payments, a health insurer shall:

173 1. Notify the dentist in writing of the fees, if any,  
174 associated with the electronic funds transfer.

175 2. Notify the dentist in writing of the available methods  
176 of payment of claims by the health insurer, with clear  
177 instructions to the dentist on how to select an alternative  
178 payment method, if any.

179 (c) A health insurer that pays a claim to a dentist  
180 through Automated Clearing House (ACH) transfer may not charge a  
181 fee solely to transmit the payment to the dentist unless the  
182 dentist has consented to the fee. A health insurer may charge  
183 reasonable fees for value-added services related to the ACH  
184 transfer, including but not limited to, transaction management,  
185 data management, and portal services.

186 (d) This subsection applies to all contracts delivered,  
187 issued, or renewed on or after January 1, 2025.

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

190 (f) The commission may adopt rules to implement this  
191 subsection.



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192 (14) (a) A health maintenance organization may not deny any  
193 claim subsequently submitted by a dentist licensed under chapter  
194 466 for procedures specifically included in a prior  
195 authorization unless at least one of the following circumstances  
196 applies for each procedure denied:

197 1. Benefit limitations, such as annual maximums and  
198 frequency limitations not applicable at the time of the prior  
199 authorization, are reached subsequent to issuance of the prior  
200 authorization.

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

203 3. Subsequent to the issuance of the prior authorization,  
204 new procedures are provided to the patient or a change in the  
205 condition of the patient occurs such that the prior authorized  
206 procedure would no longer be considered medically necessary,  
207 based on the prevailing standard of care.

208 4. Subsequent to the issuance of the prior authorization,  
209 new procedures are provided to the patient or a change in the  
210 patient's condition occurs such that the prior authorized  
211 procedure would at that time have required disapproval pursuant  
212 to the terms and conditions for coverage under the patient's  
213 plan in effect at the time the prior authorization was issued.

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

216 a. Another payor is responsible for payment.

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217 b. The dentist has already been paid for the procedures  
218 identified in the claim.

219 c. The claim was submitted fraudulently, or the prior  
220 authorization was based in whole or material part on erroneous  
221 information provided to the health maintenance organization by  
222 the dentist, patient, or other person not related to the  
223 organization.

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

226 e. The services were provided during the grace period  
227 established under s. 641.31 or applicable federal regulations,  
228 and the dental insurer notified the provider that the patient  
229 was in the grace period when the provider requested eligibility  
230 or enrollment verification from the dental insurer, if such  
231 request was made.

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

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236 **T I T L E A M E N D M E N T**

237 Remove lines 19-41 and insert:  
238 amending s. 636.032, F.S.; prohibiting a contract between a  
239 prepaid limited health service organization and a dentist from  
240 containing certain restrictions on payment methods; requiring  
241 the prepaid limited health service organization to make certain

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242 notifications before paying a claim to a dentist through  
243 electronic funds transfer; prohibiting a prepaid limited health  
244 service organization from charging a fee to transmit a payment  
245 to a dentist through ACH transfer unless the dentist has  
246 consented to such fee; providing construction; providing an  
247 effective date for contractual changes; authorizing the office  
248 to enforce certain provisions; authorizing the commission to  
249 adopt rules; amending s. 636.035, F.S.; prohibiting a prepaid  
250 limited health service organization from denying claims for  
251 procedures included in a prior authorization; providing  
252 exceptions; providing construction; authorizing the office to  
253 enforce certain provisions; providing an effective date for  
254 contractual changes; authorizing the commission to adopt rules;  
255 amending s. 641.315, F.S.; prohibiting