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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/13/2024	.	
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The Appropriations Committee on Agriculture, Environment, and General Government (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete lines 70 - 341

and insert:

(b) When a health insurer employs the method of claims payment to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payment, the health insurer shall notify the dentist as provided in this paragraph and obtain the dentist’s consent in writing before employing the electronic funds transfer. The dentist’s written

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consent described in this paragraph applies to the dentist's entire practice. The insurer or dentist may not require that a dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health insurer to the dentist must include all of the following:

1. The fees, if any, associated with the electronic funds transfer.

2. The available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

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

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

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

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior

authorization, are reached subsequent to issuance of the prior authorization.

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

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

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

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

a. Another payor is responsible for payment.

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

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

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this

subsection or that purports to waive any requirements of this subsection is null and void.

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

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

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

627.6474 Provider contracts.—

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Section 3. Section 636.032, Florida Statutes, is amended to read:

636.032 Acceptable payments.—

(1) Each prepaid limited health service organization may accept from government agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health

service organization and its subscribers.

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber may not specify credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) When a prepaid limited health service organization employs the method of claims payment to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payment, the prepaid limited health service organization shall notify the dentist as provided in this paragraph and obtain the dentist's consent in writing before employing the electronic funds transfer. The dentist's written consent described in this paragraph applies to the dentist's entire practice. The prepaid limited health service organization or dentist may not require that the dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the prepaid limited health service organization to the dentist must include all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the prepaid limited health service organization, with clear instructions to the dentist on how to select an alternative payment method.

(c) A prepaid limited health service organization that pays a claim to a dentist through Automatic Clearing House transfer may not charge a fee solely to transmit the payment to the

dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

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

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

Section 4. Subsection (13) of section 636.035, Florida Statutes, is amended, and subsection (15) is added to that section, to read:

636.035 Provider arrangements.—

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

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

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

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

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

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

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

a. Another payor is responsible for payment.

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

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous

information provided to the prepaid limited health service organization by the dentist, patient, or other person not related to the organization.

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the prepaid limited health service organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or that purports to waive any requirements of this subsection is null and void.

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

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

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

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement

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is available under the subscriber's contract, notwithstanding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) When a health maintenance organization employs the method of claims payment to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payment, the health maintenance organization shall notify the dentist as provided in this paragraph and obtain the dentist's consent in writing before employing the electronic funds transfer. The dentist's written consent described in this paragraph applies to the dentist's entire practice. The health maintenance organization or dentist may not require a dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health maintenance organization to the dentist must include all of the following:

1. The fees, if any, that are associated with the electronic funds transfer.

2. The available methods of payment of claims by the health maintenance organization, with clear instructions to the dentist

on how to select an alternative payment method.

(c) A health maintenance organization that pays a claim to a dentist through Automated Clearing House transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.

(d) This subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

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

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

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

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

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

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

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

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

a. Another payor is responsible for payment.

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

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

d. The person receiving the procedure was not eligible to receive the procedure on the date of service and the health maintenance organization did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

(b) The subsection may not be waived, voided, or nullified by contract, and any contractual clause in conflict with this subsection or which purports to waive any requirements of this subsection is null and void.

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

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

Section 6. This act shall take effect December 1, 2024.

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301
302 ========== T I T L E A M E N D M E N T ==========
303 And the title is amended as follows:
304 Delete lines 6 - 47
305 and insert:
306 insurer to make certain notifications and obtain a
307 dentist’s consent before paying a claim to the dentist
308 through electronic funds transfer; providing that the
309 dentist’s consent applies to the dentist’s entire
310 practice; prohibiting the insurer and dentist from
311 requiring consent on a patient-by-patient basis;
312 specifying the requirements of a certain notification;
313 prohibiting a health insurer from charging a fee to
314 transmit a payment to a dentist through Automated
315 Clearing House (ACH) transfer unless the dentist has
316 consented to such fee; providing construction;
317 authorizing the Office of Insurance Regulation of the
318 Financial Services Commission to enforce certain
319 provisions; authorizing the commission to adopt rules;
320 prohibiting a health insurer from denying claims for
321 procedures included in a prior authorization;
322 providing exceptions; providing construction;
323 authorizing the office to enforce certain provisions;
324 authorizing the commission to adopt rules; amending s.
325 627.6474, F.S.; revising the definition of the term
326 “covered services”; amending s. 636.032, F.S.;
327 prohibiting a contract between a prepaid limited
328 health service organization and a dentist from
329 containing certain restrictions on payment methods;

requiring the prepaid limited health service organization to make certain notifications and obtain a dentist's consent before paying a claim to the dentist through electronic funds transfer; providing that the dentist's consent applies to the dentist's entire practice; prohibiting the limited health service organization and dentist from requiring consent on a patient-by-patient basis; specifying the requirements of a certain notification; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; revising the definition of the term "covered services"; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 641.315, F.S.; revising the definition of the term "covered services"; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring the health maintenance organization to make certain notifications and obtain a dentist's consent before paying a claim to the dentist through


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electronic funds transfer; providing that the dentist’s consent applies to the dentist’s entire practice; prohibiting the health maintenance organization and dentist from requiring consent on a patient-by-patient basis; specifying the requirements of a certain notification; prohibiting a health maintenance