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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



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

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

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

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

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

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

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

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

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



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

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

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

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

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

56 a. Another payor is responsible for payment.

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

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

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

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



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

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

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

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

77 627.6474 Provider contracts.—

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

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

93 636.032 Acceptable payments.—

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



98 service organization and its subscribers.

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

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

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

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

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



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127 dentist unless the dentist has consented to the fee.

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

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

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

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

139 636.035 Provider arrangements.—

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



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

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

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

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

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

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

180 a. Another payor is responsible for payment.

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

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



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

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

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

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

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

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

204 641.315 Provider contracts.—

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



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

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

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

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

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



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243 on how to select an alternative payment method.

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

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

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

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

256 (14) (a) A health maintenance organization may not deny any
257 claim subsequently submitted by a dentist licensed under chapter
258 466 for procedures specifically included in a prior
259 authorization unless at least one of the following circumstances
260 applies for each procedure denied:

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

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

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



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

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

279 a. Another payor is responsible for payment.

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

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

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

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

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

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

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



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===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 6 - 47

and insert:

insurer 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 insurer and dentist from
requiring consent on a patient-by-patient basis;
specifying the requirements of a certain notification;
prohibiting a health insurer from charging a fee to
transmit a payment to a dentist through Automated
Clearing House (ACH) transfer unless the dentist has
consented to such fee; providing construction;
authorizing the Office of Insurance Regulation of the
Financial Services Commission to enforce certain
provisions; authorizing the commission to adopt rules;
prohibiting a health insurer 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.
627.6474, F.S.; revising the definition of the term
"covered services"; amending s. 636.032, F.S.;

prohibiting a contract between a prepaid limited
health service organization and a dentist from
containing certain restrictions on payment methods;



330 requiring the prepaid limited health service
331 organization to make certain notifications and obtain
332 a dentist's consent before paying a claim to the
333 dentist through electronic funds transfer; providing
334 that the dentist's consent applies to the dentist's
335 entire practice; prohibiting the limited health
336 service organization and dentist from requiring
337 consent on a patient-by-patient basis; specifying the
338 requirements of a certain notification; prohibiting a
339 prepaid limited health service organization from
340 charging a fee to transmit a payment to a dentist
341 through ACH transfer unless the dentist has consented
342 to such fee; providing construction; authorizing the
343 office to enforce certain provisions; authorizing the
344 commission to adopt rules; amending s. 636.035, F.S.;
345 revising the definition of the term "covered
346 services"; prohibiting a prepaid limited health
347 service organization from denying claims for
348 procedures included in a prior authorization;
349 providing exceptions; providing construction;
350 authorizing the office to enforce certain provisions;
351 authorizing the commission to adopt rules; amending s.
352 641.315, F.S.; revising the definition of the term
353 "covered services"; prohibiting a contract between a
354 health maintenance organization and a dentist from
355 containing certain restrictions on payment methods;
356 requiring the health maintenance organization to make
357 certain notifications and obtain a dentist's consent
358 before paying a claim to the dentist through



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359 electronic funds transfer; providing that the
360 dentist's consent applies to the dentist's entire
361 practice; prohibiting the health maintenance
362 organization and dentist from requiring consent on a
363 patient-by-patient basis; specifying the requirements
364 of a certain notification; prohibiting a health
365 maintenance