



328282

LEGISLATIVE ACTION

Senate

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House

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Floor: 1/AD/2R

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02/28/2024 04:27 PM

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Senator Harrell moved the following:

Senate Amendment (with title amendment)

Delete lines 121 - 403

and insert:

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

(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



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12 subsequently submitted by a dentist licensed under chapter 466
13 for procedures specifically included in a prior authorization
14 unless at least one of the following circumstances applies for
15 each procedure denied:

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

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

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

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

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

34 a. Another payor is responsible for payment.

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

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



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

43 e. The services were provided during the grace period
44 established under s. 627.608 or applicable federal regulations,
45 and the dental insurer notified the provider that the patient
46 was in the grace period when the provider requested eligibility
47 or enrollment verification from the dental insurer, if such
48 request was made.

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

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

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

55 Section 2. Section 636.032, Florida Statutes, is amended to
56 read:

57 636.032 Acceptable payments.—

58 (1) Each prepaid limited health service organization may
59 accept from government agencies, corporations, groups, or
60 individuals payments covering all or part of the cost of
61 contracts entered into between the prepaid limited health
62 service organization and its subscribers.

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

68 (b) When a prepaid limited health service organization
69 employs the method of claims payment to a dentist through



70 electronic funds transfer, including, but not limited to,
71 virtual credit card payment, the prepaid limited health service
72 organization shall notify the dentist as provided in this
73 paragraph and obtain the dentist's consent in writing before
74 employing the electronic funds transfer. The dentist's written
75 consent described in this paragraph applies to the dentist's
76 entire practice. For purposes of this paragraph, the dentist's
77 written consent, which may be given through e-mail, must bear
78 the signature of the dentist. Such signature includes an
79 electronic or digital signature if the form of signature is
80 recognized as a valid signature under applicable federal law or
81 state contract law or an act that demonstrates express consent,
82 including, but not limited to, checking a box indicating
83 consent. The prepaid limited health service organization or
84 dentist may not require that the dentist's consent as described
85 in this paragraph be made on a patient-by-patient basis. The
86 notification provided by the prepaid limited health service
87 organization to the dentist must include all of the following:

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

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

94 (c) A prepaid limited health service organization that pays
95 a claim to a dentist through Automatic Clearing House transfer
96 may not charge a fee solely to transmit the payment to the
97 dentist unless the dentist has consented to the fee.

98 (d) This subsection applies to contracts delivered, issued,



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99 or renewed on or after January 1, 2025.

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

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

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

106 636.035 Provider arrangements.—

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

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

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

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

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



128 plan in effect at the time the prior authorization was issued.

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

131 a. Another payor is responsible for payment.

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

134 c. The claim was submitted fraudulently, or the prior
135 authorization was based in whole or material part on erroneous
136 information provided to the prepaid limited health service
137 organization by the dentist, patient, or other person not
138 related to the organization.

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

141 e. The services were provided during the grace period
142 established under s. 627.608 or applicable federal regulations,
143 and the dental insurer notified the provider that the patient
144 was in the grace period when the provider requested eligibility
145 or enrollment verification from the dental insurer, if such
146 request was made.

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

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

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

153 Section 4. Subsections (13) and (14) are added to section
154 641.315, Florida Statutes, to read:

155 641.315 Provider contracts.—

156 (13) (a) A contract between a health maintenance



157 organization and a dentist licensed under chapter 466 for the
158 provision of services to a subscriber of the health maintenance
159 organization may not specify credit card payment as the only
160 acceptable method for payments from the health maintenance
161 organization to the dentist.

162 (b) When a health maintenance organization employs the
163 method of claims payment to a dentist through electronic funds
164 transfer, including, but not limited to, virtual credit card
165 payment, the health maintenance organization shall notify the
166 dentist as provided in this paragraph and obtain the dentist's
167 consent in writing before employing the electronic funds
168 transfer. The dentist's written consent described in this
169 paragraph applies to the dentist's entire practice. For purposes
170 of this paragraph, the dentist's written consent, which may be
171 given through e-mail, must bear the signature of the dentist.
172 Such signature includes an electronic or digital signature if
173 the form of signature is recognized as a valid signature under
174 applicable federal law or state contract law or an act that
175 demonstrates express consent, including, but not limited to,
176 checking a box indicating consent. The health maintenance
177 organization or dentist may not require a dentist's consent as
178 described in this paragraph be made on a patient-by-patient
179 basis. The notification provided by the health maintenance
180 organization to the dentist must include all of the following:

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

183 2. The available methods of payment of claims by the health
184 maintenance organization, with clear instructions to the dentist
185 on how to select an alternative payment method.



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

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

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

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

196 (14) (a) A health maintenance organization may not deny any
197 claim subsequently submitted by a dentist licensed under chapter
198 466 for procedures specifically included in a prior
199 authorization unless at least one of the following circumstances
200 applies for each procedure denied:

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

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

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

212 4. Subsequent to the issuance of the prior authorization,
213 new procedures are provided to the patient or a change in the
214 patient's condition occurs such that the prior authorized



215 procedure would at that time have required disapproval pursuant
216 to the terms and conditions for coverage under the patient's
217 plan in effect at the time the prior authorization was issued.

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

219 a. Another payor is responsible for payment.

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

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

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

229 e. The services were provided during the grace period
230 established under s. 627.608 or applicable federal regulations,
231 and the dental insurer notified the provider that the patient
232 was in the grace period when the provider requested eligibility
233 or enrollment verification from the dental insurer, if such
234 request was made.

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

237
238 ===== T I T L E A M E N D M E N T =====

239 And the title is amended as follows:

240 Delete lines 18 - 79

241 and insert:

242 consented to such fee; providing applicability;

243 authorizing the Office of Insurance Regulation of the



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244 Financial Services Commission to enforce certain
245 provisions; authorizing the commission to adopt rules;
246 prohibiting a health insurer from denying claims for
247 procedures included in a prior authorization;
248 providing exceptions; providing applicability;
249 authorizing the office to enforce certain provisions;
250 authorizing the commission to adopt rules; amending s.
251 636.032, F.S.; prohibiting a contract between a
252 prepaid limited health service organization and a
253 dentist from containing certain restrictions on
254 payment methods; requiring the prepaid limited health
255 service organization to make certain notifications and
256 obtain a dentist's consent before paying a claim to
257 the dentist through electronic funds transfer;
258 providing that a dentist's consent applies to the
259 dentist's entire practice; requiring the dentist's
260 consent to bear the signature of the dentist;
261 specifying the form of such signature; prohibiting the
262 limited health service organization and dentist from
263 requiring consent on a patient-by-patient basis;
264 specifying the requirements of a certain notification;
265 prohibiting a prepaid limited health service
266 organization from charging a fee to transmit a payment
267 to a dentist through ACH transfer unless the dentist
268 has consented to such fee; providing applicability;
269 authorizing the office to enforce certain provisions;
270 authorizing the commission to adopt rules; amending s.
271 636.035, F.S.; prohibiting a prepaid limited health
272 service organization from denying claims for



273 procedures included in a prior authorization;
274 providing exceptions; providing applicability;
275 authorizing the office to enforce certain provisions;
276 authorizing the commission to adopt rules; amending s.
277 641.315, F.S.; prohibiting a contract between a health
278 maintenance organization and a dentist from containing
279 certain restrictions on payment methods; requiring the
280 health maintenance organization to make certain
281 notifications and obtain a dentist's consent before
282 paying a claim to the dentist through electronic funds
283 transfer; providing that the dentist's consent applies
284 to the dentist's entire practice; requiring the
285 dentist's consent to bear the signature of the
286 dentist; specifying the form of such signature;
287 prohibiting the health maintenance organization and
288 dentist from requiring consent on a patient-by-patient
289 basis; specifying the requirements of a certain
290 notification; prohibiting a health maintenance
291 organization from charging a fee to transmit a payment
292 to a dentist through ACH transfer unless the dentist
293 has consented to such fee; providing applicability;
294 authorizing the office to enforce certain provisions;
295 authorizing the commission to adopt rules; prohibiting
296 a health maintenance organization from denying claims
297 for procedures included in a prior authorization;
298 providing exceptions; providing applicability;
299 authorizing the