547364

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/25/2024	.	
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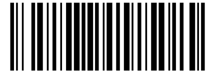
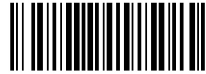
The Committee on Fiscal Policy (Harrell) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete lines 95 - 383
4 and insert:
5 entire practice. For purposes of this paragraph, the dentist's
6 written consent, which may be given through e-mail, must bear
7 the signature of the dentist. Such signature includes an
8 electronic or digital signature if the form of signature is
9 recognized as a valid signature under applicable federal law or
10 state contract law or an act that demonstrates express consent,

 547364

11 including, but not limited to, checking a box indicating
12 consent. The insurer or dentist may not require that a dentist's
13 consent as described in this paragraph be made on a patient-by-
14 patient basis. The notification provided by the health insurer
15 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

 547364

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

547364

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

547364

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. For purposes of this paragraph, the dentist's
113 written consent, which may be given through e-mail, must bear
114 the signature of the dentist. Such signature includes an
115 electronic or digital signature if the form of signature is
116 recognized as a valid signature under applicable federal law or
117 state contract law or an act that demonstrates express consent,
118 including, but not limited to, checking a box indicating
119 consent. The prepaid limited health service organization or
120 dentist may not require that the dentist's consent as described
121 in this paragraph be made on a patient-by-patient basis. The
122 notification provided by the prepaid limited health service
123 organization to the dentist must include all of the following:
124 1. The fees, if any, that are associated with the
125 electronic funds transfer.
126 2. The available methods of payment of claims by the

547364

127 prepaid limited health service organization, with clear
128 instructions to the dentist on how to select an alternative
129 payment method.
130 (c) A prepaid limited health service organization that pays
131 a claim to a dentist through Automatic Clearing House transfer
132 may not charge a fee solely to transmit the payment to the
133 dentist unless the dentist has consented to the fee.
134 (d) This subsection may not be waived, voided, or nullified
135 by contract, and any contractual clause in conflict with this
136 subsection or that purports to waive any requirements of this
137 subsection is null and void.
138 (e) The office has all rights and powers to enforce this
139 subsection as provided by s. 624.307.
140 (f) The commission may adopt rules to implement this
141 subsection.
142 Section 4. Subsection (13) of section 636.035, Florida
143 Statutes, is amended, and subsection (15) is added to that
144 section, to read:
145 636.035 Provider arrangements.—
146 (13) A contract between a prepaid limited health service
147 organization and a dentist licensed under chapter 466 for the
148 provision of services to a subscriber of the prepaid limited
149 health service organization may not contain a provision that
150 requires the dentist to provide services to the subscriber of
151 the prepaid limited health service organization at a fee set by
152 the prepaid limited health service organization unless such
153 services are covered services under the applicable contract. As
154 used in this subsection, the term "covered services" means
155 dental care services for which a reimbursement is available

547364

156 under the subscriber's contract, notwithstanding ~~or for which a~~
157 ~~reimbursement would be available but for~~ the application of
158 contractual limitations such as deductibles, coinsurance,
159 waiting periods, annual or lifetime maximums, frequency
160 limitations, alternative benefit payments, or any other
161 limitation.
162 (15)(a) A prepaid limited health service organization may
163 not deny any claim subsequently submitted by a dentist licensed
164 under chapter 466 for procedures specifically included in a
165 prior authorization unless at least one of the following
166 circumstances applies for each procedure denied:
167 1. Benefit limitations, such as annual maximums and
168 frequency limitations not applicable at the time of the prior
169 authorization, are reached subsequent to issuance of the prior
170 authorization.
171 2. The documentation provided by the person submitting the
172 claim fails to support the claim as originally authorized.
173 3. Subsequent to the issuance of the prior authorization,
174 new procedures are provided to the patient or a change in the
175 condition of the patient occurs such that the prior authorized
176 procedure would no longer be considered medically necessary,
177 based on the prevailing standard of care.
178 4. Subsequent to the issuance of the prior authorization,
179 new procedures are provided to the patient or a change in the
180 patient's condition occurs such that the prior authorized
181 procedure would at that time have required disapproval pursuant
182 to the terms and conditions for coverage under the patient's
183 plan in effect at the time the prior authorization was issued.
184 5. The denial of the dental service claim was due to one of

547364

185 the following:
186 a. Another payor is responsible for payment.
187 b. The dentist has already been paid for the procedures
188 identified in the claim.
189 c. The claim was submitted fraudulently, or the prior
190 authorization was based in whole or material part on erroneous
191 information provided to the prepaid limited health service
192 organization by the dentist, patient, or other person not
193 related to the organization.
194 d. The person receiving the procedure was not eligible to
195 receive the procedure on the date of service and the prepaid
196 limited health service organization did not know, and with the
197 exercise of reasonable care could not have known, of his or her
198 ineligibility.
199 (b) This subsection may not be waived, voided, or nullified
200 by contract, and any contractual clause in conflict with this
201 subsection or that purports to waive any requirements of this
202 subsection is null and void.
203 (c) The office has all rights and powers to enforce this
204 subsection as provided by s. 624.307.
205 (d) The commission may adopt rules to implement this
206 subsection.
207 Section 5. Subsection (11) of section 641.315, Florida
208 Statutes, is amended, and subsections (13) and (14) are added to
209 that section, to read:
210 641.315 Provider contracts.—
211 (11) A contract between a health maintenance organization
212 and a dentist licensed under chapter 466 for the provision of
213 services to a subscriber of the health maintenance organization

547364

214 may not contain a provision that requires the dentist to provide
215 services to the subscriber of the health maintenance
216 organization at a fee set by the health maintenance organization
217 unless such services are covered services under the applicable
218 contract. As used in this subsection, the term “covered
219 services” means dental care services for which a reimbursement
220 is available under the subscriber’s contract, notwithstanding ~~or~~
221 ~~for which a reimbursement would be available but for~~ the
222 application of contractual limitations such as deductibles,
223 coinsurance, waiting periods, annual or lifetime maximums,
224 frequency limitations, alternative benefit payments, or any
225 other limitation.
226 (13)(a) A contract between a health maintenance
227 organization and a dentist licensed under chapter 466 for the
228 provision of services to a subscriber of the health maintenance
229 organization may not specify credit card payment as the only
230 acceptable method for payments from the health maintenance
231 organization to the dentist.
232 (b) When a health maintenance organization employs the
233 method of claims payment to a dentist through electronic funds
234 transfer, including, but not limited to, virtual credit card
235 payment, the health maintenance organization shall notify the
236 dentist as provided in this paragraph and obtain the dentist’s
237 consent in writing before employing the electronic funds
238 transfer. The dentist’s written consent described in this
239 paragraph applies to the dentist’s entire practice. For purposes
240 of this paragraph, the dentist’s written consent, which may be
241 given through e-mail, must bear the signature of the dentist.
242 Such signature includes an electronic or digital signature if

547364

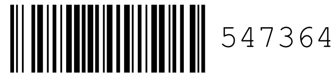
243 the form of signature is recognized as a valid signature under
244 applicable federal law or state contract law or an act that
245 demonstrates express consent, including, but not limited to,
246 checking a box indicating consent. The health maintenance
247 organization or dentist may not require a dentist’s consent as
248 described in this paragraph be made on a patient-by-patient
249 basis. The notification provided by the health maintenance
250 organization to the dentist must include all of the following:
251 1. The fees, if any, that are associated with the
252 electronic funds transfer.
253 2. The available methods of payment of claims by the health
254 maintenance organization, with clear instructions to the dentist
255 on how to select an alternative payment method.
256 (c) A health maintenance organization that pays a claim to
257 a dentist through Automated Clearing House transfer may not
258 charge a fee solely to transmit the payment to the dentist
259 unless the dentist has consented to the fee.
260 (d) This subsection may not be waived, voided, or nullified
261 by contract, and any contractual clause in conflict with this
262 subsection or which purports to waive any requirements of this
263 subsection is null and void.
264 (e) The office has all rights and powers to enforce this
265 subsection as provided by s. 624.307.
266 (f) The commission may adopt rules to implement this
267 subsection.
268 (14)(a) A health maintenance organization may not deny any
269 claim subsequently submitted by a dentist licensed under chapter
270 466 for procedures specifically included in a prior
271 authorization unless at least one of the following circumstances

547364

272 applies for each procedure denied:
273 1. Benefit limitations, such as annual maximums and
274 frequency limitations not applicable at the time of the prior
275 authorization, are reached subsequent to issuance of the prior
276 authorization.
277 2. The documentation provided by the person submitting the
278 claim fails to support the claim as originally authorized.
279 3. Subsequent to the issuance of the prior authorization,
280 new procedures are provided to the patient or a change in the
281 condition of the patient occurs such that the prior authorized
282 procedure would no longer be considered medically necessary,
283 based on the prevailing standard of care.
284 4. Subsequent to the issuance of the prior authorization,
285 new procedures are provided to the patient or a change in the
286 patient’s condition occurs such that the prior authorized
287 procedure would at that time have required disapproval pursuant
288 to the terms and conditions for coverage under the patient’s
289 plan in effect at the time the prior authorization was issued.
290 5. The denial of the claim was due to one of the following:
291 a. Another payor is responsible for payment.
292 b. The dentist has already been paid for the procedures
293 identified in the claim.
294 c. The claim was submitted fraudulently, or the prior
295 authorization was based in whole or material part on erroneous
296 information provided to the health maintenance organization by
297 the dentist, patient, or other person not related to the
298 organization.
299 d. The person receiving the procedure was not eligible to
300 receive the procedure on the date of service and the health

547364

301 maintenance organization did not know, and with the exercise of
302 reasonable care could not have known, of his or her
303 ineligibility.
304 (b) The subsection may not be waived, voided, or nullified
305 by contract, and any contractual clause in conflict with this
306 subsection or which purports to waive any requirements of this
307 subsection is null and void.
308 (c) The office has all rights and powers to enforce this
309 subsection as provided by s. 624.307.
310 (d) The commission may adopt rules to implement this
311 subsection.
312 Section 6. This act shall take effect January 1, 2025.
313
314 ================ T I T L E A M E N D M E N T ================
315 And the title is amended as follows:
316 Delete lines 10 - 61
317 and insert:
318 practice; requiring the dentist’s consent to bear the
319 signature of the dentist; specifying the form of such
320 signature; prohibiting the insurer and dentist from
321 requiring consent on a patient-by-patient basis;
322 specifying the requirements of a certain notification;
323 prohibiting a health insurer from charging a fee to
324 transmit a payment to a dentist through Automated
325 Clearing House (ACH) transfer unless the dentist has
326 consented to such fee; providing construction;
327 authorizing the Office of Insurance Regulation of the
328 Financial Services Commission to enforce certain
329 provisions; authorizing the commission to adopt rules;


547364

330 prohibiting a health insurer from denying claims for
331 procedures included in a prior authorization;
332 providing exceptions; providing construction;
333 authorizing the office to enforce certain provisions;
334 authorizing the commission to adopt rules; amending s.
335 627.6474, F.S.; revising the definition of the term
336 “covered services”; amending s. 636.032, F.S.;
337 prohibiting a contract between a prepaid limited
338 health service organization and a dentist from
339 containing certain restrictions on payment methods;
340 requiring the prepaid limited health service
341 organization to make certain notifications and obtain
342 a dentist’s consent before paying a claim to the
343 dentist through electronic funds transfer; providing
344 that a dentist’s consent applies to the dentist’s
345 entire practice; requiring the dentist’s consent to
346 bear the signature of the dentist; specifying the form
347 of such signature; prohibiting the limited health
348 service organization and dentist from requiring
349 consent on a patient-by-patient basis; specifying the
350 requirements of a certain notification; prohibiting a
351 prepaid limited health service organization from
352 charging a fee to transmit a payment to a dentist
353 through ACH transfer unless the dentist has consented
354 to such fee; providing construction; authorizing the
355 office to enforce certain provisions; authorizing the
356 commission to adopt rules; amending s. 636.035, F.S.;
357 revising the definition of the term “covered
358 services”; prohibiting a prepaid limited health

547364

359 service organization from denying claims for
360 procedures included in a prior authorization;
361 providing exceptions; providing construction;
362 authorizing the office to enforce certain provisions;
363 authorizing the commission to adopt rules; amending s.
364 641.315, F.S.; revising the definition of the term
365 “covered services”; prohibiting a contract between a
366 health maintenance organization and a dentist from
367 containing certain restrictions on payment methods;
368 requiring the health maintenance organization to make
369 certain notifications and obtain a dentist’s consent
370 before paying a claim to the dentist through
371 electronic funds transfer; providing that the
372 dentist’s consent applies to the dentist’s entire
373 practice; requiring the dentist’s consent to bear the
374 signature of the dentist; specifying the form of such
375 signature; prohibiting the health maintenance