



642356

LEGISLATIVE ACTION

| Senate     | . | House |
|------------|---|-------|
| Comm: RCS  | . |       |
| 02/08/2024 | . |       |
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|            | . |       |

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The Committee on Banking and Insurance (Harrell) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 90 - 307  
and insert:  
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



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11 subsection as provided by s. 624.307.

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

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

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

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

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

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

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

37 a. Another payor is responsible for payment.

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



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

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

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

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

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

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

58           627.6474 Provider contracts.—

59           (2) A contract between a health insurer and a dentist  
60 licensed under chapter 466 for the provision of services to an  
61 insured may not contain a provision that requires the dentist to  
62 provide services to the insured under such contract at a fee set  
63 by the health insurer unless such services are covered services  
64 under the applicable contract. As used in this subsection, the  
65 term "covered services" means dental care services for which a  
66 reimbursement is available under the insured's contract,  
67 ~~notwithstanding or for which a reimbursement would be available~~  
68 ~~but for~~ the application of contractual limitations such as



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69 deductibles, coinsurance, waiting periods, annual or lifetime  
70 maximums, frequency limitations, alternative benefit payments,  
71 or any other limitation.

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

74 636.032 Acceptable payments.—

75 (1) Each prepaid limited health service organization may  
76 accept from government agencies, corporations, groups, or  
77 individuals payments covering all or part of the cost of  
78 contracts entered into between the prepaid limited health  
79 service organization and its subscribers.

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

85 (b) At least 10 days before a limited health service  
86 organization pays a claim to a dentist through electronic funds  
87 transfer, including, but not limited to, virtual credit card  
88 payments, the prepaid limited health service organization shall  
89 notify the dentist in writing of all of the following:

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

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

96 (c) A prepaid limited health service organization that pays  
97 a claim to a dentist through Automatic Clearing House (ACH)



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98 transfer may not charge a fee solely to transmit the payment to  
99 the dentist unless the dentist has consented to the fee.

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

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

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

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

111 636.035 Provider arrangements.—

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



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127 limitation.

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

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

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

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

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

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

152 a. Another payor is responsible for payment.

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

155 c. The claim was submitted fraudulently, or the prior



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156 authorization was based in whole or material part on erroneous  
157 information provided to the prepaid limited health service  
158 organization by the dentist, patient, or other person not  
159 related to the organization.

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

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

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

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

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

176 641.315 Provider contracts.—

177 (11) A contract between a health maintenance organization  
178 and a dentist licensed under chapter 466 for the provision of  
179 services to a subscriber of the health maintenance organization  
180 may not contain a provision that requires the dentist to provide  
181 services to the subscriber of the health maintenance  
182 organization at a fee set by the health maintenance organization  
183 unless such services are covered services under the applicable  
184 contract. As used in this subsection, the term "covered



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185 services" means dental care services for which a reimbursement  
186 is available under the subscriber's contract, notwithstanding ~~or~~  
187 ~~for which a reimbursement would be available but for the~~  
188 application of contractual limitations such as deductibles,  
189 coinsurance, waiting periods, annual or lifetime maximums,  
190 frequency limitations, alternative benefit payments, or any  
191 other limitation.

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

198 (b) At least 10 days before a health maintenance  
199 organization pays a claim to a dentist through electronic funds  
200 transfer, including, but not limited to, virtual credit card  
201 payments, the health maintenance organization shall notify the  
202 dentist in writing of all of the following:

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

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

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

212  
213 ===== T I T L E A M E N D M E N T =====





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214 And the title is amended as follows:  
215       Delete lines 11 - 58  
216 and insert:  
217       providing construction; authorizing the Office of  
218       Insurance Regulation of the Financial Services  
219       Commission to enforce certain provisions; authorizing  
220       the commission to adopt rules; prohibiting a health  
221       insurer from denying claims for procedures included in  
222       a prior authorization; providing exceptions; providing  
223       construction; authorizing the office to enforce  
224       certain provisions; authorizing the commission to  
225       adopt rules; amending s. 627.6474, F.S.; revising the  
226       definition of the term "covered services"; amending s.  
227       636.032, F.S.; prohibiting a contract between a  
228       prepaid limited health service organization and a  
229       dentist from containing certain restrictions on  
230       payment methods; requiring the prepaid limited health  
231       service organization to make certain notifications  
232       before paying a claim to a dentist through electronic  
233       funds transfer; prohibiting a prepaid limited health  
234       service organization from charging a fee to transmit a  
235       payment to a dentist through ACH transfer unless the  
236       dentist has consented to such fee; providing  
237       construction; authorizing the office to enforce  
238       certain provisions; authorizing the commission to  
239       adopt rules; amending s. 636.035, F.S.; revising the  
240       definition of the term "covered services"; prohibiting  
241       a prepaid limited health service organization from  
242       denying claims for procedures included in a prior



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243 authorization; providing exceptions; providing  
244 construction; authorizing the office to enforce  
245 certain provisions; authorizing the commission to  
246 adopt rules; amending s. 641.315, F.S.; revising the  
247 definition of the term "covered service"; prohibiting  
248 a contract between a health maintenance organization  
249 and a dentist from containing certain restrictions on  
250 payment methods; requiring the health maintenance  
251 organization to make certain notifications before  
252 paying a claim to a dentist through electronic funds  
253 transfer; prohibiting a health maintenance  
254 organization from charging a fee to transmit a payment  
255 to a dentist through ACH transfer unless the dentist  
256 has consented to such fee; providing construction;