

2024892e2

1 A bill to be entitled
2 An act relating to dental insurance claims; amending
3 s. 627.6131, F.S.; prohibiting a contract between a
4 health insurer and a dentist from containing certain
5 restrictions on payment methods; requiring a health
6 insurer to make certain notifications and obtain a
7 dentist's consent before paying a claim to the dentist
8 through electronic funds transfer; providing that the
9 dentist's consent applies to the dentist's entire
10 practice; requiring the dentist's consent to bear the
11 signature of the dentist; specifying the form of such
12 signature; prohibiting the insurer and dentist from
13 requiring consent on a patient-by-patient basis;
14 specifying the requirements of a certain notification;
15 prohibiting a health insurer from charging a fee to
16 transmit a payment to a dentist through Automated
17 Clearing House (ACH) transfer unless the dentist has
18 consented to such fee; providing applicability;
19 authorizing the Office of Insurance Regulation of the
20 Financial Services Commission to enforce certain
21 provisions; authorizing the commission to adopt rules;
22 prohibiting a health insurer from denying claims for
23 procedures included in a prior authorization;
24 providing exceptions; providing applicability;
25 authorizing the office to enforce certain provisions;
26 authorizing the commission to adopt rules; amending s.
27 636.032, F.S.; prohibiting a contract between a
28 prepaid limited health service organization and a
29 dentist from containing certain restrictions on

2024892e2

30 payment methods; requiring the prepaid limited health
31 service organization to make certain notifications and
32 obtain a dentist's consent before paying a claim to
33 the dentist through electronic funds transfer;
34 providing that a dentist's consent applies to the
35 dentist's entire practice; requiring the dentist's
36 consent to bear the signature of the dentist;
37 specifying the form of such signature; prohibiting the
38 limited health service organization and dentist from
39 requiring consent on a patient-by-patient basis;
40 specifying the requirements of a certain notification;
41 prohibiting a prepaid limited health service
42 organization from charging a fee to transmit a payment
43 to a dentist through ACH transfer unless the dentist
44 has consented to such fee; providing applicability;
45 authorizing the office to enforce certain provisions;
46 authorizing the commission to adopt rules; amending s.
47 636.035, F.S.; prohibiting a prepaid limited health
48 service organization from denying claims for
49 procedures included in a prior authorization;
50 providing exceptions; providing applicability;
51 authorizing the office to enforce certain provisions;
52 authorizing the commission to adopt rules; amending s.
53 641.315, F.S.; prohibiting a contract between a health
54 maintenance organization and a dentist from containing
55 certain restrictions on payment methods; requiring the
56 health maintenance organization to make certain
57 notifications and obtain a dentist's consent before
58 paying a claim to the dentist through electronic funds

2024892e2

59 transfer; providing that the dentist's consent applies
60 to the dentist's entire practice; requiring the
61 dentist's consent to bear the signature of the
62 dentist; specifying the form of such signature;
63 prohibiting the health maintenance organization and
64 dentist from requiring consent on a patient-by-patient
65 basis; specifying the requirements of a certain
66 notification; prohibiting a health maintenance
67 organization from charging a fee to transmit a payment
68 to a dentist through ACH transfer unless the dentist
69 has consented to such fee; providing applicability;
70 authorizing the office to enforce certain provisions;
71 authorizing the commission to adopt rules; prohibiting
72 a health maintenance organization from denying claims
73 for procedures included in a prior authorization;
74 providing exceptions; providing applicability;
75 authorizing the office to enforce certain provisions;
76 authorizing the commission to adopt rules; providing
77 an effective date.

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79 Be It Enacted by the Legislature of the State of Florida:

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81 Section 1. Subsections (20) and (21) are added to section
82 627.6131, Florida Statutes, to read:

83 627.6131 Payment of claims.—

84 (20) (a) A contract between a health insurer and a dentist
85 licensed under chapter 466 for the provision of services to an
86 insured may not specify credit card payment as the only
87 acceptable method for payments from the health insurer to the

2024892e2

88 dentist.

89 (b) When a health insurer employs the method of claims
90 payment to a dentist through electronic funds transfer,
91 including, but not limited to, virtual credit card payment, the
92 health insurer shall notify the dentist as provided in this
93 paragraph and obtain the dentist's consent before employing the
94 electronic funds transfer. The dentist's consent described in
95 this paragraph applies to the dentist's entire practice. For the
96 purpose of this paragraph, the dentist's consent, which may be
97 given through e-mail, must bear the signature of the dentist.
98 Such signature includes an electronic or digital signature if
99 the form of signature is recognized as a valid signature under
100 applicable federal law or state contract law or an act that
101 demonstrates express consent, including, but not limited to,
102 checking a box indicating consent. The insurer or dentist may
103 not require that a dentist's consent as described in this
104 paragraph be made on a patient-by-patient basis. The
105 notification provided by the health insurer to the dentist must
106 include all of the following:

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

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

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

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

2024892e2

117 or renewed on or after January 1, 2025.

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

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

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

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

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

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

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

144 5. The denial of the claim was due to one of the following:
145 a. Another payor is responsible for payment.

2024892e2

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

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

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

154 e. The services were provided during the grace period
155 established under s. 627.608 or applicable federal regulations,
156 and the dental insurer notified the provider that the patient
157 was in the grace period when the provider requested eligibility
158 or enrollment verification from the dental insurer, if such
159 request was made.

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

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

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

166 Section 2. Section 636.032, Florida Statutes, is amended to
167 read:

168 636.032 Acceptable payments.—

169 (1) Each prepaid limited health service organization may
170 accept from government agencies, corporations, groups, or
171 individuals payments covering all or part of the cost of
172 contracts entered into between the prepaid limited health
173 service organization and its subscribers.

174 (2) (a) A contract between a prepaid limited health service

2024892e2

175 organization and a dentist licensed under chapter 466 for the
176 provision of services to a subscriber may not specify credit
177 card payment as the only acceptable method for payments from the
178 prepaid limited health service organization to the dentist.

179 (b) When a prepaid limited health service organization
180 employs the method of claims payment to a dentist through
181 electronic funds transfer, including, but not limited to,
182 virtual credit card payment, the prepaid limited health service
183 organization shall notify the dentist as provided in this
184 paragraph and obtain the dentist's consent before employing the
185 electronic funds transfer. The dentist's consent described in
186 this paragraph applies to the dentist's entire practice. For the
187 purpose of this paragraph, the dentist's consent, which may be
188 given through e-mail, must bear the signature of the dentist.
189 Such signature includes an electronic or digital signature if
190 the form of signature is recognized as a valid signature under
191 applicable federal law or state contract law or an act that
192 demonstrates express consent, including, but not limited to,
193 checking a box indicating consent. The prepaid limited health
194 service organization or dentist may not require that a dentist's
195 consent as described in this paragraph be made on a patient-by-
196 patient basis. The notification provided by the prepaid limited
197 health service organization to the dentist must include all of
198 the following:

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

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

2024892e2

204 payment method.

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

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

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

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

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

217 636.035 Provider arrangements.—

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

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

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

229 3. Subsequent to the issuance of the prior authorization,
230 new procedures are provided to the patient or a change in the
231 condition of the patient occurs such that the prior authorized
232 procedure would no longer be considered medically necessary,

2024892e2

233 based on the prevailing standard of care.

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

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

242 a. Another payor is responsible for payment.

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

245 c. The claim was submitted fraudulently, or the prior
246 authorization was based in whole or material part on erroneous
247 information provided to the prepaid limited health service
248 organization by the dentist, patient, or other person not
249 related to the organization.

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

252 e. The services were provided during the grace period
253 established under s. 627.608 or applicable federal regulations,
254 and the dental insurer notified the provider that the patient
255 was in the grace period when the provider requested eligibility
256 or enrollment verification from the dental insurer, if such
257 request was made.

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

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

2024892e2

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

264 Section 4. Subsections (13) and (14) are added to section
265 641.315, Florida Statutes, to read:

266 641.315 Provider contracts.—

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

273 (b) When a health maintenance organization employs the
274 method of claims payment to a dentist through electronic funds
275 transfer, including, but not limited to, virtual credit card
276 payment, the health maintenance organization shall notify the
277 dentist as provided in this paragraph and obtain the dentist's
278 consent before employing the electronic funds transfer. The
279 dentist's consent described in this paragraph applies to the
280 dentist's entire practice. For the purpose of this paragraph,
281 the dentist's consent, which may be given through e-mail, must
282 bear the signature of the dentist. Such signature includes an
283 electronic or digital signature if the form of signature is
284 recognized as a valid signature under applicable federal law or
285 state contract law or an act that demonstrates express consent,
286 including, but not limited to, checking a box indicating
287 consent. The health maintenance organization or dentist may not
288 require that a dentist's consent as described in this paragraph
289 be made on a patient-by-patient basis. The notification provided
290 by the health maintenance organization to the dentist must

2024892e2

291 include all of the following:

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

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

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

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

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

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

307 (14) (a) A health maintenance organization may not deny any
308 claim subsequently submitted by a dentist licensed under chapter
309 466 for procedures specifically included in a prior
310 authorization unless at least one of the following circumstances
311 applies for each procedure denied:

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

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

318 3. Subsequent to the issuance of the prior authorization,
319 new procedures are provided to the patient or a change in the

2024892e2

320 condition of the patient occurs such that the prior authorized
321 procedure would no longer be considered medically necessary,
322 based on the prevailing standard of care.

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

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

330 a. Another payor is responsible for payment.

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

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

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

340 e. The services were provided during the grace period
341 established under s. 627.608 or applicable federal regulations,
342 and the dental insurer notified the provider that the patient
343 was in the grace period when the provider requested eligibility
344 or enrollment verification from the dental insurer, if such
345 request was made.

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

348 (c) The office has all rights and powers to enforce this

2024892e2

349 subsection as provided by s. 624.307.

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

352 Section 5. This act shall take effect January 1, 2025.