Committee on Banking and Insurance

CS/CS/CS/SB 892 — Dental Insurance Claims

by Fiscal Policy Committee; Appropriations Committee on Agriculture, Environment, and General Government; Banking and Insurance Committee; and Senator Harrell

The bill revises provisions within the Florida Insurance Code relating to covered dental services, contractual agreements, and dental claims payments by a health insurer, prepaid limited health service organization (PLHSO), or a health maintenance organization (HMO). The Office of Insurance Regulation is responsible for regulating these entities. The bill:

- Prohibits a contract between a dentist and the health insurer, HMO, or PLHSO from limiting the method of claim payments for dental services to credit card payments only;
- Requires the health insurer, PLHSO, or HMO to notify the dentist of any fees associated with an electronic funds transfer (EFT) and alternative payment methods before the insurer, HMO or PLHSO pays a dentist via EFT;
- Requires the health insurer, PLHSO, or HMO to obtain the dentist's consent via an email bearing the signature of the dentist or checking a box indicating consent prior to employing the claim payment through EFT;
- Prohibits the health insurer, HMO or PLHSO that pays a claim to a dentist through an automatic clearing house (ACH) from charging a fee solely to transmit the payment unless the dentist has consented to the fee;
- Prohibits the health insurer, HMO, or PLHSO from denying the payment of a claim if the procedure was previously authorized by an insurer, HMO, or PLHSO prior to the dentist rendering the service except under the following circumstances:
  - Benefit limitations were reached subsequent to the issuance of the prior authorization.
  - Inadequate documentation was submitted by the dentist to support the originally authorized procedures and claim.
  - Subsequent to the issuance of the prior authorization, new procedures are provided to the insured or the insured's condition changes, resulting in the prior authorized procedure not being medically necessary.
  - Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or the insured's condition changes in the patient's condition occurs such that the prior authorized procedure would at that time have required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued.
  - The claim was denied because:
    - Another payor is responsible for payment.
    - The dentist has already been paid.
    - The claim was submitted fraudulently or the prior authorization was based on erroneous information submitted to the insurer, HMO, or PLHSO.
    - The person receiving the procedure was not eligible to receive the procedure on the date of service.
    - The services were provided during the grace period established under s. 627.608, F.S., or applicable federal regulations, and the dental insurer, HMO, or PLHSO notified the provider that the patient was in a grace period when the provider

requested eligibility or enrollment verification from the dental insurer, HMO, or PLHSO, if such request was made.

The provisions of the bill apply to all policies and contracts issued or renewed on or after January 1, 2025. The Office of Insurance Regulation has all rights and powers to enforce the provisions of the bill pursuant to s. 624.307, F.S.

If approved by the Governor, or allowed to become law without the Governor's signature, these provisions take effect January 1, 2025.
Vote: Senate 40-0; House 113-0