

26 before paying a claim to a dentist through electronic
27 funds transfer; prohibiting a prepaid limited health
28 service organization from charging a fee to transmit a
29 payment to a dentist through ACH transfer unless the
30 dentist has consented to such fee; providing
31 construction; authorizing the office to enforce
32 certain provisions; authorizing the commission to
33 adopt rules; amending s. 636.035, F.S.; revising the
34 definition of the term "covered services"; prohibiting
35 a prepaid limited health service organization from
36 denying claims for procedures included in a prior
37 authorization; providing exceptions; providing
38 construction; authorizing the office to enforce
39 certain provisions; authorizing the commission to
40 adopt rules; amending s. 641.315, F.S.; revising the
41 definition of the term "covered service"; prohibiting
42 a contract between a health maintenance organization
43 and a dentist from containing certain restrictions on
44 payment methods; requiring the health maintenance
45 organization to make certain notifications before
46 paying a claim to a dentist through electronic funds
47 transfer; prohibiting a health maintenance
48 organization from charging a fee to transmit a payment
49 to a dentist through ACH transfer unless the dentist
50 has consented to such fee; providing construction;

51 | authorizing the office to enforce certain provisions;
 52 | authorizing the commission to adopt rules; prohibiting
 53 | a health maintenance organization from denying claims
 54 | for procedures included in a prior authorization;
 55 | providing exceptions; providing construction;
 56 | authorizing the office to enforce certain provisions;
 57 | authorizing the commission to adopt rules; providing
 58 | an effective date.

59 |
 60 | Be It Enacted by the Legislature of the State of Florida:
 61 |

62 | Section 1. Subsections (20) and (21) are added to section
 63 | 627.6131, Florida Statutes, to read:

64 | 627.6131 Payment of claims.—

65 | (20) (a) A contract between a health insurer and a dentist
 66 | licensed under chapter 466 for the provision of services to an
 67 | insured may not specify credit card payment as the only
 68 | acceptable method for payments from the health insurer to the
 69 | dentist.

70 | (b) At least 10 days before a health insurer pays a claim
 71 | to a dentist through electronic funds transfer, including, but
 72 | not limited to, virtual credit card payments, the health insurer
 73 | shall notify the dentist in writing of all of the following:

74 | 1. The fees, if any, associated with the electronic funds
 75 | transfer.

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

79 (c) A health insurer that pays a claim to a dentist
 80 through Automated Clearing House (ACH) transfer may not charge a
 81 fee solely to transmit the payment to the dentist unless the
 82 dentist has consented to the fee.

83 (d) This subsection may not be waived, voided, or
 84 nullified by contract, and any contractual clause in conflict
 85 with this subsection or which purports to waive any requirements
 86 of this subsection is null and void.

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

89 (f) The commission may adopt rules to implement this
 90 subsection.

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

96 1. Benefit limitations, such as annual maximums and
 97 frequency limitations not applicable at the time of the prior
 98 authorization, are reached subsequent to issuance of the prior
 99 authorization.

100 2. The documentation provided by the person submitting the

101 claim fails to support the claim as originally authorized.

102 3. Subsequent to the issuance of the prior authorization,
103 new procedures are provided to the patient or a change in the
104 condition of the patient occurs such that the prior authorized
105 procedure would no longer be considered medically necessary,
106 based on the prevailing standard of care.

107 4. Subsequent to the issuance of the prior authorization,
108 new procedures are provided to the patient or a change in the
109 patient's condition occurs such that the prior authorized
110 procedure would at that time have required disapproval pursuant
111 to the terms and conditions for coverage under the patient's
112 plan in effect at the time the prior authorization was issued.

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

115 a. Another payor is responsible for payment.

116 b. The dentist has already been paid for the procedures
117 identified in the claim.

118 c. The claim was submitted fraudulently, or the prior
119 authorization was based in whole or material part on erroneous
120 information provided to the health insurer by the dentist,
121 patient, or other person not related to the insurer.

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

126 (b) This subsection may not be waived, voided, or
 127 nullified by contract, and any contractual clause in conflict
 128 with this subsection or which purports to waive any requirements
 129 of this subsection is null and void.

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

132 (d) The commission may adopt rules to implement this
 133 subsection.

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

136 627.6474 Provider contracts.—

137 (2) A contract between a health insurer and a dentist
 138 licensed under chapter 466 for the provision of services to an
 139 insured may not contain a provision that requires the dentist to
 140 provide services to the insured under such contract at a fee set
 141 by the health insurer unless such services are covered services
 142 under the applicable contract. As used in this subsection, the
 143 term "covered services" means dental care services for which a
 144 reimbursement is available under the insured's contract,
 145 notwithstanding ~~or for which a reimbursement would be available~~
 146 ~~but for~~ the application of contractual limitations, such as
 147 deductibles, coinsurance, waiting periods, annual or lifetime
 148 maximums, frequency limitations, alternative benefit payments,
 149 or any other limitation.

150 Section 3. Section 636.032, Florida Statutes, is amended

151 to read:

152 636.032 Acceptable payments.—

153 (1) Each prepaid limited health service organization may
 154 accept from government agencies, corporations, groups, or
 155 individuals payments covering all or part of the cost of
 156 contracts entered into between the prepaid limited health
 157 service organization and its subscribers.

158 (2)(a) A contract between a prepaid limited health service
 159 organization and a dentist licensed under chapter 466 for the
 160 provision of services to a subscriber may not specify credit
 161 card payment as the only acceptable method for payments from the
 162 prepaid limited health service organization to the dentist.

163 (b) At least 10 days before a prepaid limited health
 164 service organization pays a claim to a dentist through
 165 electronic funds transfer, including, but not limited to,
 166 virtual credit card payments, the prepaid limited health service
 167 organization shall notify the dentist in writing of all of the
 168 following:

169 1. The fees, if any, associated with the electronic funds
 170 transfer.

171 2. The available methods of payment of claims by the
 172 prepaid limited health service organization, with clear
 173 instructions to the dentist on how to select an alternative
 174 payment method.

175 (c) A prepaid limited health service organization that

176 pays a claim to a dentist through Automatic Clearing House (ACH)
 177 transfer may not charge a fee solely to transmit the payment to
 178 the dentist unless the dentist has consented to the fee.

179 (d) This subsection may not be waived, voided, or
 180 nullified by contract, and any contractual clause in conflict
 181 with this subsection or which purports to waive any requirements
 182 of this subsection is null and void.

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

185 (f) The commission may adopt rules to implement this
 186 subsection.

187 Section 4. Subsection (13) of section 636.035, Florida
 188 Statutes, is amended, and subsection (15) is added to that
 189 section, to read:

190 636.035 Provider arrangements.—

191 (13) A contract between a prepaid limited health service
 192 organization and a dentist licensed under chapter 466 for the
 193 provision of services to a subscriber of the prepaid limited
 194 health service organization may not contain a provision that
 195 requires the dentist to provide services to the subscriber of
 196 the prepaid limited health service organization at a fee set by
 197 the prepaid limited health service organization unless such
 198 services are covered services under the applicable contract. As
 199 used in this subsection, the term "covered services" means
 200 dental care services for which a reimbursement is available

201 under the subscriber's contract, ~~notwithstanding or for which a~~
202 ~~reimbursement would be available but for~~ the application of
203 contractual limitations such as deductibles, coinsurance,
204 waiting periods, annual or lifetime maximums, frequency
205 limitations, alternative benefit payments, or any other
206 limitation.

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

212 1. Benefit limitations, such as annual maximums and
213 frequency limitations not applicable at the time of the prior
214 authorization, are reached subsequent to issuance of the prior
215 authorization.

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

218 3. Subsequent to the issuance of the prior authorization,
219 new procedures are provided to the patient or a change in the
220 condition of the patient occurs such that the prior authorized
221 procedure would no longer be considered medically necessary,
222 based on the prevailing standard of care.

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

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

229 5. The denial of the dental service claim was due to one
230 of the following:

231 a. Another payor is responsible for payment.

232 b. The dentist has already been paid for the procedures
233 identified in the claim.

234 c. The claim was submitted fraudulently, or the prior
235 authorization was based in whole or material part on erroneous
236 information provided to the prepaid limited health service
237 organization by the dentist, patient, or other person not
238 related to the organization.

239 d. The person receiving the procedure was not eligible to
240 receive the procedure on the date of service, and the prepaid
241 limited health service organization did not know, and with the
242 exercise of reasonable care could not have known, of his or her
243 ineligibility.

244 (b) This subsection may not be waived, voided, or
245 nullified by contract, and any contractual clause in conflict
246 with this subsection or which purports to waive any requirements
247 of this subsection is null and void.

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

250 (d) The commission may adopt rules to implement this

251 subsection.

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

255 641.315 Provider contracts.—

256 (11) A contract between a health maintenance organization
 257 and a dentist licensed under chapter 466 for the provision of
 258 services to a subscriber of the health maintenance organization
 259 may not contain a provision that requires the dentist to provide
 260 services to the subscriber of the health maintenance
 261 organization at a fee set by the health maintenance organization
 262 unless such services are covered services under the applicable
 263 contract. As used in this subsection, the term "covered
 264 services" means dental care services for which a reimbursement
 265 is available under the subscriber's contract, notwithstanding ~~or~~
 266 ~~for which a reimbursement would be available but for the~~
 267 application of contractual limitations such as deductibles,
 268 coinsurance, waiting periods, annual or lifetime maximums,
 269 frequency limitations, alternative benefit payments, or any
 270 other limitation.

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

276 organization to the dentist.

277 (b) At least 10 days before a health maintenance
278 organization pays a claim to a dentist through electronic funds
279 transfer, including, but not limited to, virtual credit card
280 payments, the health maintenance organization shall notify the
281 dentist in writing of all of the following:

282 1. The fees, if any, associated with the electronic funds
283 transfer.

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

287 (c) A health maintenance organization that pays a claim to
288 a dentist through Automated Clearing House (ACH) transfer may
289 not charge a fee solely to transmit the payment to the dentist
290 unless the dentist has consented to the fee.

291 (d) This subsection may not be waived, voided, or
292 nullified by contract, and any contractual clause in conflict
293 with this subsection or which purports to waive any requirements
294 of this subsection is null and void.

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

297 (f) The commission may adopt rules to implement this
298 subsection.

299 (14) (a) A health maintenance organization may not deny any
300 claim subsequently submitted by a dentist licensed under chapter

301 466 for procedures specifically included in a prior
302 authorization unless at least one of the following circumstances
303 applies for each procedure denied:

304 1. Benefit limitations, such as annual maximums and
305 frequency limitations not applicable at the time of the prior
306 authorization, are reached subsequent to issuance of the prior
307 authorization.

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

310 3. Subsequent to the issuance of the prior authorization,
311 new procedures are provided to the patient or a change in the
312 condition of the patient occurs such that the prior authorized
313 procedure would no longer be considered medically necessary,
314 based on the prevailing standard of care.

315 4. Subsequent to the issuance of the prior authorization,
316 new procedures are provided to the patient or a change in the
317 patient's condition occurs such that the prior authorized
318 procedure would at that time have required disapproval pursuant
319 to the terms and conditions for coverage under the patient's
320 plan in effect at the time the prior authorization was issued.

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

323 a. Another payor is responsible for payment.

324 b. The dentist has already been paid for the procedures
325 identified in the claim.

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326 c. The claim was submitted fraudulently, or the prior
327 authorization was based in whole or material part on erroneous
328 information provided to the health maintenance organization by
329 the dentist, patient, or other person not related to the
330 organization.

331 d. The person receiving the procedure was not eligible to
332 receive the procedure on the date of service, and the health
333 maintenance organization did not know, and with the exercise of
334 reasonable care could not have known, of his or her
335 ineligibility.

336 (b) The subsection may not be waived, voided, or nullified
337 by contract, and any contractual clause in conflict with this
338 subsection or which purports to waive any requirements of this
339 subsection is null and void.

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

342 (d) The commission may adopt rules to implement this
343 subsection.

344 Section 6. This act shall take effect July 1, 2024.