1 Representative Black offered the following:

2

3 **Amendment**

4 Remove lines 89-291 and insert:

5 (b) When a health insurer employs the method of claims
6 payment to a dentist through electronic funds transfer,
7 including, but not limited to, virtual credit card payment, the
8 health insurer shall notify the dentist as provided in this
9 paragraph and obtain the dentist's consent before employing the
10 electronic funds transfer. The dentist's consent described in
11 this paragraph applies to the dentist's entire practice. For the
12 purpose of this paragraph, the dentist's consent, which may be
13 given through e-mail, must bear the signature of the dentist.

14 Such signature includes an electronic or digital signature if
15 the form of signature is recognized as a valid signature under
16 applicable federal law or state contract law or an act that
17 demonstrates express consent, including, but not limited to,
18 checking a box indicating consent. The insurer or dentist may
19 not require that a dentist's consent as described in this
20 paragraph be made on a patient-by-patient basis. The
21 notification provided by the health insurer to the dentist must
22 include all of the following:
23 1. The fees, if any, associated with the electronic funds
24 transfer.
25 2. The available methods of payment of claims by the
26 health insurer, with clear instructions to the dentist on how to
27 select an alternative payment method.
28 (c) A health insurer that pays a claim to a dentist
29 through Automated Clearing House transfer may not charge a fee
30 solely to transmit the payment to the dentist unless the dentist
31 has consented to the fee.
32 (d) This subsection applies to contracts delivered,
33 issued, or renewed on or after January 1, 2025.
34 (e) The office has all rights and powers to enforce this
35 subsection as provided by s. 624.307.
36 (f) The commission may adopt rules to implement this
37 subsection.

38 (21)(a) A health insurer may not deny any claim
39 subsequently submitted by a dentist licensed under chapter 466
40 for procedures specifically included in a prior authorization
41 unless at least one of the following circumstances applies for
42 each procedure denied:
43 1. Benefit limitations, such as annual maximums and
44 frequency limitations not applicable at the time of the prior
45 authorization, are reached subsequent to issuance of the prior
46 authorization.
47 2. The documentation provided by the person submitting the
48 claim fails to support the claim as originally authorized.
49 3. Subsequent to the issuance of the prior authorization,
50 new procedures are provided to the patient or a change in the
51 condition of the patient occurs such that the prior authorized
52 procedure would no longer be considered medically necessary,
53 based on the prevailing standard of care.
54 4. Subsequent to the issuance of the prior authorization,
55 new procedures are provided to the patient or a change in the
56 patient's condition occurs such that the prior authorized
57 procedure would at that time have required disapproval pursuant
58 to the terms and conditions for coverage under the patient's
59 plan in effect at the time the prior authorization was issued.
60 5. The denial of the claim was due to one of the
61 following:
62 a. Another payor is responsible for payment.

63 b. The dentist has already been paid for the procedures
64 identified in the claim.
65 c. The claim was submitted fraudulently, or the prior
66 authorization was based in whole or material part on erroneous
67 information provided to the health insurer by the dentist,
68 patient, or other person not related to the insurer.
69 d. The person receiving the procedure was not eligible to
70 receive the procedure on the date of service.
71 e. The services were provided during the grace period
72 established under s. 627.608 or applicable federal regulations,
73 and the dental insurer notified the provider that the patient
74 was in the grace period when the provider requested eligibility
75 or enrollment verification from the dental insurer, if such
76 request was made.
77 (b) This subsection applies to all contracts delivered,
78 issued, or renewed on or after January 1, 2025.
79 (c) The office has all rights and powers to enforce this
80 subsection as provided by s. 624.307.
81 (d) The commission may adopt rules to implement this
82 subsection.
83 Section 2. Section 636.032, Florida Statutes, is amended
84 to read:
85 636.032 Acceptable payments.—
86 (1) Each prepaid limited health service organization may
87 accept from government agencies, corporations, groups, or

88 individuals payments covering all or part of the cost of
89 contracts entered into between the prepaid limited health
90 service organization and its subscribers.
91 (2)(a) A contract between a prepaid limited health service
92 organization and a dentist licensed under chapter 466 for the
93 provision of services to a subscriber may not specify credit
94 card payment as the only acceptable method for payments from the
95 prepaid limited health service organization to the dentist.
96 (b) When a prepaid limited health service organization
97 employs the method of claims payment to a dentist through
98 electronic funds transfer, including, but not limited to,
99 virtual credit card payment, the prepaid limited health service
100 organization shall notify the dentist as provided in this
101 paragraph and obtain the dentist's consent before employing the
102 electronic funds transfer. The dentist's consent described in
103 this paragraph applies to the dentist's entire practice. For the
104 purpose of this paragraph, the dentist's consent, which may be
105 given through e-mail, must bear the signature of the dentist.
106 Such signature includes an electronic or digital signature if
107 the form of signature is recognized as a valid signature under
108 applicable federal law or state contract law or an act that
109 demonstrates express consent, including, but not limited to,
110 checking a box indicating consent. The prepaid limited health
111 service organization or dentist may not require that a dentist's
112 consent as described in this paragraph be made on a patient-by-

113 patient basis. The notification provided by the prepaid limited
114 health service organization to the dentist must include all of
115 the following:
116 1. The fees, if any, that are associated with the
117 electronic funds transfer.
118 2. The available methods of payment of claims by the
119 prepaid limited health service organization, with clear
120 instructions to the dentist on how to select an alternative
121 payment method.
122 (c) A prepaid limited health service organization that
123 pays a claim to a dentist through Automatic Clearing House
124 transfer may not charge a fee solely to transmit the payment to
125 the dentist unless the dentist has consented to the fee.
126 (d) This subsection applies to contracts delivered,
127 issued, or renewed on or after January 1, 2025.
128 (e) The office has all rights and powers to enforce this
129 subsection as provided by s. 624.307.
130 (f) The commission may adopt rules to implement this
131 subsection.
132 Section 3. Subsection (15) is added to section 636.035,
133 Florida Statutes, to read:
134 636.035 Provider arrangements.—
135 (15)(a) A prepaid limited health service organization may
136 not deny any claim subsequently submitted by a dentist licensed
137 under chapter 466 for procedures specifically included in a

138 prior authorization unless at least one of the following
139 circumstances applies for each procedure denied:
140 1. Benefit limitations, such as annual maximums and
141 frequency limitations not applicable at the time of the prior
142 authorization, are reached subsequent to issuance of the prior
143 authorization.
144 2. The documentation provided by the person submitting the
145 claim fails to support the claim as originally authorized.
146 3. Subsequent to the issuance of the prior authorization,
147 new procedures are provided to the patient or a change in the
148 condition of the patient occurs such that the prior authorized
149 procedure would no longer be considered medically necessary,
150 based on the prevailing standard of care.
151 4. Subsequent to the issuance of the prior authorization,
152 new procedures are provided to the patient or a change in the
153 patient's condition occurs such that the prior authorized
154 procedure would at that time have required disapproval pursuant
155 to the terms and conditions for coverage under the patient's
156 plan in effect at the time the prior authorization was issued.
157 5. The denial of the dental service claim was due to one
158 of the following:
159 a. Another payor is responsible for payment.
160 b. The dentist has already been paid for the procedures
161 identified in the claim.

162 c. The claim was submitted fraudulently, or the prior
163 authorization was based in whole or material part on erroneous
164 information provided to the prepaid limited health service
165 organization by the dentist, patient, or other person not
166 related to the organization.
167 d. The person receiving the procedure was not eligible to
168 receive the procedure on the date of service.
169 e. The services were provided during the grace period
170 established under s. 627.608 or applicable federal regulations,
171 and the dental insurer notified the provider that the patient
172 was in the grace period when the provider requested eligibility
173 or enrollment verification from the dental insurer, if such
174 request was made.
175 (b) This subsection applies to all contracts delivered,
176 issued, or renewed on or after January 1, 2025.
177 (c) The office has all rights and powers to enforce this
178 subsection as provided by s. 624.307.
179 (d) The commission may adopt rules to implement this
180 subsection.
181 Section 4. Subsections (13) and (14) are added to section
182 641.315, Florida Statutes, to read:
183 641.315 Provider contracts.—
184 (13)(a) A contract between a health maintenance
185 organization and a dentist licensed under chapter 466 for the
186 provision of services to a subscriber of the health maintenance

187 organization may not specify credit card payment as the only
188 acceptable method for payments from the health maintenance
189 organization to the dentist.
190 (b) When a health maintenance organization employs the
191 method of claims payment to a dentist through electronic funds
192 transfer, including, but not limited to, virtual credit card
193 payment, the health maintenance organization shall notify the
194 dentist as provided in this paragraph and obtain the dentist's
195 consent before employing the electronic funds transfer. The
196 dentist's consent described in this paragraph applies to the
197 dentist's entire practice. For the purpose of this paragraph,
198 the dentist's consent, which may be given through e-mail, must
199 bear the signature of the dentist. Such signature includes an
200 electronic or digital signature if the form of signature is
201 recognized as a valid signature under applicable federal law or
202 state contract law or an act that demonstrates express consent,
203 including, but not limited to, checking a box indicating
204 consent. The health maintenance organization or dentist may not
205 require that a dentist's consent as described in this paragraph
206 be made on a patient-by-patient basis. The notification provided
207 by the health maintenance organization to the dentist must
208 include all of the following: