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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/AD/2R	.	
02/28/2024 04:27 PM	.	
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Senator Harrell moved the following:

Senate Amendment (with title amendment)

Delete lines 121 - 403

and insert:

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

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

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

(21)(a) A health insurer may not deny any claim

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subsequently submitted by a dentist licensed under chapter 466 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

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

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

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

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change 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.

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

a. Another payor is responsible for payment.

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

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

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

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

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

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

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

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

636.032 Acceptable payments.—

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

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

(b) When a prepaid limited health service organization employs the method of claims payment to a dentist through

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electronic funds transfer, including, but not limited to, virtual credit card payment, the prepaid limited health service organization shall notify the dentist as provided in this paragraph and obtain the dentist's consent in writing before employing the electronic funds transfer. The dentist's written consent described in this paragraph applies to the dentist's entire practice. For purposes of this paragraph, the dentist's written consent, which may be given through e-mail, must bear the signature of the dentist. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not limited to, checking a box indicating consent. The prepaid limited health service organization or dentist may not require that the dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the prepaid limited health service organization to the dentist must include all of the following:

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

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

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

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

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or renewed on or after January 1, 2025.

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

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

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

636.035 Provider arrangements.—

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

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

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

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

4. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change 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

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plan in effect at the time the prior authorization was issued.

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

a. Another payor is responsible for payment.

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

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

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

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

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

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

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

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

641.315 Provider contracts.—

(13)(a) A contract between a health maintenance

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organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) When a health maintenance organization employs the method of claims payment to a dentist through electronic funds transfer, including, but not limited to, virtual credit card payment, the health maintenance organization shall notify the dentist as provided in this paragraph and obtain the dentist's consent in writing before employing the electronic funds transfer. The dentist's written consent described in this paragraph applies to the dentist's entire practice. For purposes of this paragraph, the dentist's written consent, which may be given through e-mail, must bear the signature of the dentist. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not limited to, checking a box indicating consent. The health maintenance organization or dentist may not require a dentist's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health maintenance organization to the dentist must include all of the following:

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

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

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

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

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

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

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

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

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

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

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

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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.

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

a. Another payor is responsible for payment.

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

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

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

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

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

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

And the title is amended as follows:

Delete lines 18 - 79

and insert:

consented to such fee; providing applicability;

authorizing the Office of Insurance Regulation of the

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Financial Services Commission to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health insurer from denying claims for procedures included in a prior authorization; providing exceptions; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain notifications and obtain a dentist's consent before paying a claim to the dentist through electronic funds transfer; providing that a dentist's consent applies to the dentist's entire practice; requiring the dentist's consent to bear the signature of the dentist; specifying the form of such signature; prohibiting the limited health service organization and dentist from requiring consent on a patient-by-patient basis; specifying the requirements of a certain notification; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; prohibiting a prepaid limited health service organization from denying claims for

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procedures included in a prior authorization; providing exceptions; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 641.315, F.S.; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring the health maintenance organization to make certain notifications and obtain a dentist’s consent before paying a claim to the dentist through electronic funds transfer; providing that the dentist’s consent applies to the dentist’s entire practice; requiring the dentist’s consent to bear the signature of the dentist; specifying the form of such signature; prohibiting the health maintenance organization and dentist from requiring consent on a patient-by-patient basis; specifying the requirements of a certain notification; prohibiting a health maintenance organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health maintenance organization from denying claims for procedures included in a prior authorization; providing exceptions; providing applicability; authorizing the