

By: Representative Steverson

To: Insurance

HOUSE BILL NO. 752  
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 83-51-1, MISSISSIPPI CODE OF 1972, TO  
2 DEFINE CERTAIN TERMS AS USED IN THE DENTAL CARE BENEFITS LAW; TO  
3 CREATE A NEW SECTION TO REQUIRE DENTAL SERVICE CONTRACTORS TO  
4 ESTABLISH APPEAL PROCEDURES FOR CLAIM DENIALS BASED UPON LACK OF  
5 MEDICAL NECESSITY; TO PROHIBIT CLAIM DENIALS FOR PROCEDURES  
6 SPECIFICALLY INCLUDED IN A PRIOR AUTHORIZATION UNLESS CERTAIN  
7 CIRCUMSTANCES APPLY; TO PROVIDE A TIME LIMIT FOR PRIOR  
8 AUTHORIZATION APPROVALS; TO PROHIBIT THE RECOUPMENT OF A CLAIM IN  
9 CERTAIN CIRCUMSTANCES; AND FOR RELATED PURPOSES.

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

11 **SECTION 1.** Section 83-51-1, Mississippi Code of 1972, is  
12 amended as follows:

13 83-51-1. As used in this chapter, the following words have  
14 the meanings ascribed herein unless the context clearly requires  
15 otherwise:

16 (a) "Health insurance policy" means any individual,  
17 group, blanket or franchise insurance policy, insurance agreement  
18 or group hospital service contract which provides benefits for  
19 dental care expenses incurred as a result of an accident or  
20 sickness \* \* \*.



21 (b) "Employee benefit plan" means any plan, fund or  
22 program heretofore or hereafter established or maintained by an  
23 employer or by an employee organization, or by both, to the extent  
24 that such plan, fund or program was established or is maintained  
25 for the purpose of providing for its participants or their  
26 beneficiaries, through the purchase of insurance or otherwise,  
27 dental care benefits in the event of accident or sickness \* \* \*.

28 (c) "Dental care services" means those general and  
29 usual services furnished to any person for the purpose of  
30 preventing, alleviating, curing or healing human dental illness or  
31 injury as defined in Sections 73-9-1 through 73-9-65, Mississippi  
32 Code of 1972.

33 (d) "Dentist" means any person who furnishes dental  
34 care services and who is licensed as a dentist by the State of  
35 Mississippi.

36 (e) "Dental service contractor" means any person who  
37 accepts a prepayment from or for the benefit of any other person  
38 or group of persons as consideration for providing to such person  
39 or group of persons the opportunity to receive dental services at  
40 such times in the future as such services may be appropriate or  
41 required, but shall not be construed to include a dentist or  
42 professional dental corporation that accepts prepayment on a  
43 fee-for-service basis for providing specific dental services to  
44 individual patients for whom such services have been prediagnosed.  
45 Nothing in this paragraph (e) shall apply to a funded or



46 self-funded trust qualified with the United States Department of  
47 Labor in accordance with Public Law 93-406, or the Division of  
48 Medicaid or any contractor of the division when providing services  
49 to eligible Medicaid beneficiaries.

50 (f) "Participant" means a dentist who has contracted  
51 with a dental service contractor to accept from and to look solely  
52 to such contractor for payment for any health care services  
53 rendered to a subscriber, subject to any co-payment obligations  
54 included in the contract of the subscriber with the dental service  
55 contractor.

56 (g) "Person" means an individual, insurer, association,  
57 organization, partnership, business, trust, except Employee  
58 Retirement Income Security Act (E.R.I.S.A.) trusts qualified with  
59 the United States Department of Labor under Public Law 93-406,  
60 corporation, or other legal entity.

61 (h) "Subscriber" means any person by or for whom a  
62 dental service contractor is paid a periodic premium as prepayment  
63 for dental services to be rendered to him by a participant.

64 (i) "Commissioner" means the Commissioner of Insurance  
65 of the State of Mississippi.

66 **SECTION 2.** (1) (a) A dental service contractor or a  
67 contract of dental insurance shall establish and maintain appeal  
68 procedures for any claim by a dentist or a subscriber that is  
69 denied based upon lack of medical necessity.



70 (b) Any denial shall be based upon a determination by a  
71 dentist who holds a nonrestricted license issued in the United  
72 States in the same or an appropriate specialty that typically  
73 manages the dental condition, procedure, or treatment under  
74 review.

75 (c) Subsequent to an initial denial, the licensed  
76 dentist making the adverse determination shall not be an employee  
77 of the dental service contractor or dental insurer.

78 (d) Any written communication to an insured or a  
79 dentist that includes or pertains to a denial of benefits for all  
80 or part of a claim on the basis of a lack of medical necessity  
81 shall include the name, applicable specialty designation, license  
82 number together with state of issuance, and the email address of  
83 the licensed dentist making the adverse determination.

84 (2) (a) For the purposes of this subsection, a "prior  
85 authorization" shall mean any predetermination, prior  
86 authorization or similar authorization that is verifiable, whether  
87 through issuance of letter, facsimile, e-mail or similar means,  
88 indicating that a specific procedure is, or multiple procedures  
89 are, covered under the patient's plan and reimbursable at a  
90 specific amount, subject to applicable coinsurance and  
91 deductibles, and issued in response to a request submitted by a  
92 dentist using a prescribed format.

93 (b) A dental service contractor shall not deny any  
94 claim subsequently submitted for procedures specifically included



95 in a prior authorization unless at least one (1) of the following  
96 circumstances applies for each procedure denied:

97 (i) Benefit limitations such as annual maximums  
98 and frequency limitations not applicable at the time of prior  
99 authorization are reached due to utilization subsequent to  
100 issuance of the prior authorization;

101 (ii) The documentation for the claim provided by  
102 the person submitting the claim clearly fails to support the claim  
103 as originally authorized;

104 (iii) If, subsequent to the issuance of the prior  
105 authorization, new procedures are provided to the patient or a  
106 change in the patient's condition occurs such that the prior  
107 authorized procedure would no longer be considered medically  
108 necessary, based on the prevailing standard of care;

109 (iv) If, subsequent to the issuance of the prior  
110 authorization, new procedures are provided to the patient or a  
111 change in the patient's condition occurs such that the prior  
112 authorized procedure would at that time require disapproval  
113 pursuant to the terms and conditions for coverage under the  
114 patient's plan in effect at the time the prior authorization was  
115 issued; or

116 (v) The dental service contractor's denial is  
117 because of one (1) of the following:

118 1. Another payor is responsible for the  
119 payment;



120                   2. The dentist has already been paid for the  
121 procedures identified on the claim;

122                   3. The claim was submitted fraudulently or  
123 the prior authorization was based in whole or material part on  
124 erroneous information provided to the dental service contractor by  
125 the dentist, patient, or other person not related to the carrier;  
126 or

127                   4. The person receiving the procedure was not  
128 eligible to receive the procedure on the date of service and the  
129 dental service contractor did not know, and with the exercise of  
130 reasonable care could not have known, of the person's eligibility  
131 status.

132                   (c) A dental service contractor shall not require any  
133 information be submitted for a prior authorization request that  
134 would not be required for submission of a claim.

135                   (d) A dental service contractor shall issue a prior  
136 authorization within thirty (30) days of the date a request is  
137 submitted by a dentist.

138                   (e) The provisions of subsection (1) of this section  
139 shall apply to any denial of a claim pursuant to paragraph (b) of  
140 this subsection for a procedure included in a prior authorization.

141                   (3) A contractor shall not recoup a claim solely due to a  
142 patient's loss of coverage or ineligibility if, at the time of  
143 treatment, the contractor erroneously confirms coverage and  
144 eligibility, but had sufficient information available to it



145 indicating that the patient was no longer covered or was  
146 ineligible for coverage.

147           **SECTION 3.** This act shall take effect and be in force from  
148 and after July 1, 2019.

