MISSISSIPPI LEGISLATURE REGULAR SESSION 2019

By: Representative Steverson

To: Insurance

HOUSE BILL NO. 752
(As Sent to Governor)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) If, 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 no longer be considered medically necessary, based on the prevailing standard of care;

(iv) If, 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 require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued; or

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

1. Another payor is responsible for the payment;

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

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

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

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

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

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

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

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

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