RÉSUMÉ DIGEST

ACT 208 (HB 429) **2018 Regular Session** **Cromer**

Prior law set forth the procedures for denial of a claim for dental services and required a dental service contractor or a contract of dental insurance to establish and maintain appeal procedures for any claim by a dentist or a subscriber that was denied based upon lack of medical necessity.

New law makes technical changes.

New law prohibits a dental service contractor from denying any claim subsequently submitted 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 prior authorization are reached due to utilization subsequent to issuance of the prior authorization.

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

(3) 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.

(4) 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.

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

(a) Another payor is responsible for the payment.

(b) The dentist has already been paid for the procedures identified on 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 dental service contractor by the dentist, patient, or other person not related to the carrier.

(d) 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.

New law prohibits a dental service contractor from requiring any information be submitted for a prior authorization request that would not be required for submission of a claim and requires the dental service contractor to issue a prior authorization within 30 days of the date a request is submitted by a dentist.

New law prohibits a dental service contractor from denying or recouping 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.

Effective January 1, 2019.

(Amends R.S. 22:1155)