2018 Regular Session

HOUSE BILL NO. 429

BY REPRESENTATIVE CROMER

INSURANCE/HEALTH: Provides relative to denial of claims for dental services

AN ACT

To amend and reenact R.S. 22:1155, relative to claims for dental services; to provide for prior authorization requests; to provide a time limit for prior authorization approvals; to prohibit a claim denial or recoupment in certain circumstances; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1155 is hereby amended and reenacted to read as follows:

§1155. Denial of claims; appeal; prior authorization

A.(1) 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.

(2)(a) Any ~~such~~ 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.

(b) 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.

(3) 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 speciality designation, license number together with state of issuance, and the direct telephone number of the licensed dentist making the adverse determination.

B.(1) 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.

(2) A dental service contractor shall not deny 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:

(a) 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.

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

(c) 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.

(d) 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.

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

(i) Another payor is responsible for the payment.

(ii) The dentist has already been paid for the procedures identified on the claim.

(iii) 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.

(iv) 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.

(3) 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.

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

(5) The provisions of Subsection A of this Section shall apply to any denial of a claim pursuant to Paragraph (2) of this Subsection for a procedure included in a prior authorization.

C. Any recoupment by a dental service contractor shall be in accordance with R.S. 22:1838. The 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 2. This Act shall become effective on January 1, 2019.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 429 Engrossed 2018 Regular Session Cromer

Abstract: Provides for prior authorizations of claims for dental services.

Present law sets forth the procedures for denial of a claim for dental services and requires 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 is denied based upon lack of medical necessity.

Proposed law retains present law but makes technical changes.

Proposed 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.

Proposed 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.

Proposed 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 on Jan. 1, 2019.

(Amends R.S. 22:1155)

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the original bill:

1. Delineate the circumstances when a claim for a prior authorized procedure may be denied.

2. Clarify that present law applies to any claim denied pursuant to proposed law.

3. Provide for recoupment by a dental service contractor.

4. Add an effective date.

5. Make technical changes.