

HOUSE BILL No. 2556

By Committee on Health and Human Services

Requested by Representative Reavis on behalf of the Kansas Dental Association

1-27

1 AN ACT concerning insurance; relating to contracts between an insurer
2 and a dental healthcare provider; prohibiting certain terms in a contract
3 between a health insurer and a dentist; requiring that reviews, audits or
4 investigations of healthcare providers concerning healthcare provider
5 claims be completed within six months; providing certain exceptions
6 thereto; amending K.S.A. 40-2,185 and repealing the existing section.

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8 *Be it enacted by the Legislature of the State of Kansas:*

9 New Section 1. (a) Except as otherwise provided, any review, audit or
10 investigation by a nonprofit dental service corporation concerning
11 healthcare provider claims that result in the recoupment or setoff of funds
12 previously paid to the healthcare provider shall be completed not more
13 than six months after the completed claims were initially paid.

14 (b) This section shall not restrict any review, audit or investigation
15 concerning the following:

- 16 (1) Fraudulently submitted claims;
17 (2) claims that the healthcare provider knew, or should have known,
18 to be a pattern of inappropriate billing according to the standards of the
19 respective dental or medical specialty;
20 (3) claims that are related to the coordination of benefits; or
21 (4) claims that are subject to any federal law or regulation that
22 permits claims review beyond the specified period in subsection (a).

23 New Sec. 2. (a) As used in this section:

24 (1) "Prior authorization" means any written communication by a
25 dental benefit plan or utilization review entity indicating that a specific
26 procedure is covered under the patient's dental plan and is reimbursable at
27 a specific amount, subject to the applicable coinsurance and deductibles,
28 and is issued in response to a request submitted by a dentist using a format
29 prescribed by the health insurer.

30 (2) "Utilization review entity" means an individual or entity that
31 performs prior authorization for:

32 (A) An employer with employees in Kansas who are covered under a
33 health benefit plan or health insurance policy;

34 (B) an insurer that writes health insurance policies;

35 (C) a preferred provider organization or health maintenance

1 organization; or

2 (D) any other individual or entity that provides, offers to provide or
3 administers hospital, outpatient, medical, prescription drug or other health
4 benefits to a person treated by a healthcare professional in Kansas under a
5 policy, plan or contract.

6 (b) A dental benefit plan or utilization review entity shall not deny a
7 claim submitted by a dentist for a procedure specifically included in a
8 prior authorization, unless for each procedure denied:

9 (1) Benefit limitations, including annual maximums and frequency
10 limitations, that were not applicable at the time of the prior authorization
11 have been reached due to utilization subsequent to the issuance of the prior
12 authorization;

13 (2) the documentation for the claim provided by the person
14 submitting the claim clearly fails to support the claim as originally
15 authorized;

16 (3) new procedures are provided to the patient subsequent to the
17 issuance of the prior authorization or the patient's condition changes such
18 that the prior authorized procedure would no longer be considered
19 medically necessary based on the prevailing standard of care; or

20 (4) new procedures are provided to the patient subsequent to the
21 issuance of the prior authorization or the patient's condition changes such
22 that the prior authorized procedure would presently require disapproval.

23 Sec. 3. K.S.A. 40-2,185 is hereby amended to read as follows: 40-
24 2,185. (a) No contract ~~issued or renewed after July 1, 2010~~, between a
25 health insurer and a dentist who is a participating provider with respect to
26 such health insurer's health benefit plan shall contain ~~any~~ a provision
27 ~~which~~ *that* requires the dentist ~~who provides to provide~~ any service to an
28 insured under such health benefit plan at a fee set or prescribed by the
29 health insurer unless such service is a covered service.

30 (b) *A contract between an insurer and a dentist shall not:*

31 (1) *Limit the fee that the dentist may charge for a service that is not a*
32 *covered service; or*

33 (2) *include a provision that both:*

34 (A) *Allows the insurer to disallow a service that results in the denial*
35 *of payment to the dentist for a service that ordinarily would have been*
36 *covered; and*

37 (B) *prohibits the dentist from billing for and collecting the amount*
38 *owed from the patient for such service if there is a dental necessity for*
39 *such service.*

40 (c) *As used in this section, "dental necessity" means whether a*
41 *prudent dentist, acting in accordance with generally accepted practices of*
42 *the professional dental community and within the American dental*
43 *association's parameters of care for dentistry and the quality assurance*

1 *criteria of the American academy of pediatric dentistry, as applicable,*
2 *would provide the service or product to a patient to diagnose, prevent or*
3 *treat orofacial pain, infection, disease, dysfunction or disfiguration.*

4 Sec. 4. K.S.A. 40-2,185 is hereby repealed.

5 Sec. 5. This act shall take effect and be in force from and after its
6 publication in the statute book.