Prepared by the Legislative Council staff for
Representative Keiser
February 16, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1154

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact chapter 26.1-36.9 and sections 26.1-47-02.2 and 26.1-47-02.3 of the North Dakota Century Code, relating to prior authorization of dental services, dental networks, and payment of dental claims.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

26.1-36.9-01. Definitions.

As used in this chapter:

1. "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a dental insurer.

2. "Dental insurer" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide dental benefits.

3. "Dental provider" means a licensed provider of dental services in this state.

4. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.

5. "Prior authorization" means confirmation by the covered individual's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for coverage under the covered individual's dental benefit plan as defined by the covered individual's dental benefit plan.

26.1-36.9-02. Dental benefit plans - Prior authorization.

A dental benefit plan may not deny a claim subsequently submitted by a dental provider 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 the prior authorization, are reached due to utilization after issuance of the prior authorization.

2. The documentation for the claim provided by the dental provider submitting the claim clearly fails to support the claim as originally authorized.

3. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs

such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. If, after 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 used.

5. The denial of the payment was due to one of the following:

   a. Another payor is responsible for payment.

   b. The dental provider already has been paid for the procedures identified on the claim.

   c. The claim was submitted fraudulently.

   d. The individual receiving the procedure was not eligible to receive the procedure on the date of service.

SECTION 2. Section 26.1-47-02.2 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.2. Dental networks.

1. As used in this section:

   a. "Affiliate" means a person that directly or indirectly through one or more intermediaries controls, or is under the control of, or is under common control with, the person specified.

   b. "Contracting entity" means a person that enters a direct contract with a dental provider for the delivery of dental services.

   c. "Network" means a group of preferred dental providers providing services under a network plan.

   d. "Network plan" means a dental benefit plan that requires a covered individual to use, or creates incentives, including financial incentives, for a covered individual to use a dental provider managed by, owned by, under contract with, or employed by the dental insurer.

   e. "Third party" means an entity that is not a party to a contracting entity's dental provider network.

2. A contracting entity may grant a third party access to a dental provider network contract, or a provider's dental services or contractual discounts provided pursuant to a dental provider network contract, if all of the following are met:

   a. The contract specifically states the contracting entity may enter an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

b. If the contracting entity is a dental insurer, the dental provider may opt out of the third-party access at the time the dental provider network contract was entered or renewed.

c. The contracting entity identifies, in writing or electronic form to the dental provider, all third parties in existence as of the date the contract is entered or renewed.

d. The contracting entity notifies dental network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect.

e. The contracting entity makes available a copy of the dental provider network contract relied on in the adjudication of a claim to a participating dental provider within thirty days of a request from the dental provider.

3. A dental provider's refusal to agree in writing to the third-party access to the dental provider network does not permit the contracting entity to end the contractual relationship with the dental provider.

4. The provisions of this section do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity.

SECTION 3. Section 26.1-47-02.3 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.3. Postpayment of dental claims - Payment recovery limitations.

1. As used in this section, "dental care provider" means a licensed provider of dental care services in this state.

2. Other than recovery for duplicate payments, a dental insurer, if engaging in overpayment recovery efforts, shall provide written notice to the dental care provider which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

3. A dental insurer shall provide a dental care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dental care provider to follow to challenge an overpayment recovery.

4. A dental insurer may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:

   a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

   b. Required by, or initiated at the request of, a self-insured plan; or

   c. Required by a state or federal government plan."

Renumber accordingly