CHAPTER 26.1-36.9
DENTAL BENEFIT PLANS

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.