Session of 2025

HOUSE BILL No. 2247

By Committee on Health and Human Services

Requested by Representative Reavis on behalf of the Kansas Dental Association

2-4

AN ACT concerning insurance; relating to contracts between an insurer and a dental healthcare provider; requiring reviews, audits or investigations be completed within six months; prohibiting denial for claims submitted by dentists for procedures included in a prior authorization; amending K.S.A. 40-2,185 and repealing the existing section.

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

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

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

(1) Fraudulently submitted claims;

(2) claims that the healthcare provider knew, or should have known, to be a pattern of inappropriate billing according to the standards of the respective dental or medical specialty;

(3) claims that are related to the coordination of benefits; or

(4) claims that are subjected to any federal law or regulation that permits claims review beyond the specified period in subsection (a).

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

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

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

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

(B) an insurer that writes health insurance policies;

(C) a preferred provider organization or health maintenance

organization; or

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

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

(1) Benefit limitations, including annual maximums and frequency limitations, that were not applicable at the time of the prior authorization are reached due to utilization subsequent to the 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) new procedures are provided to the patient subsequent to the issuance of the prior authorization or the patient's condition changes such that the prior authorized procedure would no longer be considered medically necessary based on the prevailing standard of care; or

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

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

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

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

(2) include a provision that both:

(A) Allows the insurer to disallow a service, resulting in denial of payment to the dentist for a service that ordinarily would have been covered; and

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

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

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

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

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