STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 3023 By: Worthen

COMMITTEE SUBSTITUTE

An Act relating to dental insurance claims; amending 36 O.S. 2021, Section 7301, which relates to dental plans; modifying definition; defining terms; making certain requirements; providing standards for requirements; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 2021, Section 7301, is amended to read as follows:

Section 7301. A. No contract between a dental plan of a health benefit plan and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health benefit plan unless the services are covered services under the applicable subscriber agreement.

B. As used in this section:

1. "Covered services" means services ~~reimbursable~~ reimbursed under the applicable subscriber agreement, subject notwithstanding, or without regard to the contractual limitations on subscriber

benefits as may apply~~, including, for example, deductibles, waiting period or frequency limitations~~;

2. "Dental plan" means and shall include any policy of insurance which is issued by a health benefit plan which provides for coverage of dental services not in connection with a medical plan; and

3. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title or any dental service corporation authorized pursuant to Section 2671 of this title.

C. A health benefit plan or dental plan shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based on lack of medical necessity. Any such denial shall be based upon a determination by a dentist who holds a nonrestricted license in the United States. Any written communication to 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 identifier and license number together with state of issuance, and a contact telephone number of the licensed dentist making the adverse determination. The dentist who reviewed the claim shall only be contacted at the telephone number provided in the written communication about the denial during business hours.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7301.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes;

2. "Dental plan" means and shall include any policy of insurance which is issued by a health benefit plan which provides for coverage of dental services not in connection with a medical plan;

3. "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code;

4. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes or any dental service corporation authorized pursuant to Section 2671 of Title 36 of the Oklahoma Statutes; and

5. "Material change" means a change to the following:

a. a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services,

b. the general practices of the dental plan that affect reimbursements paid to providers, or

c. how a dental plan adjudicates and pays claims for services.

B. An insurer that contracts or renews a contract with a dental provider shall:

1. Make the insurer's current dental plan policies available online; and

2. If requested by a provider, send a copy of the policies to the provider through mail or electronic mail.

C. Dental policies and plans as described in subsection B of this section shall provide the following to providers:

1. A summary of all material changes made to a dental plan since the policies were last updated;

2. The downcoding and bundling policies that the insurer reasonably expects to be applied to the dental provider or provider's services as a matter of policy; and

3. A description of the dental plan's utilization review procedures, including:

a. a procedure for an enrollee of the dental plan to obtain a review of an adverse determination, and

b. a statement of a provider's rights and responsibilities regarding the procedures described in subparagraph a of this paragraph.

D. An insurer may not maintain a dental plan that:

1. Based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental

provider from collecting the fee for actual services performed either from the plan or the patient; or

2. Uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure.

E. An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.

SECTION 3. This act shall become effective November 1, 2022.

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