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TO: All Licensed Insurers Offering Dental Insurance

RE: Requirements Under the Mississippi Code

Over the last several months, the Department has received a growing number of complaints related to the handling of claims by dental insurers. Assuming that the conduct complained of is true, it is violative of various Mississippi laws related to dental practice and the offering of dental insurance.

As a result, the Department is issuing this Bulletin to remind those offering dental insurance in the State of Mississippi of the various laws in effect relating to dental services.

1) Freedom of Choice of Dental Practitioners. Miss. Code Ann. § 83-51-3(a) provides that, "No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall... Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by such policy or plan, or interfere with such selection, provided the dentist selected is licensed to furnish such dental care services in this state."

Further, Miss. Code Ann. §83-41-209 provides that whenever a policy, plan, or contract provides for reimbursement for any service within the lawful scope of practice of a licensed dentist, the insured or beneficiary is entitled to reimbursement for such services whether they are performed by a licensed physician or a licensed dentist "...notwithstanding any provision to the contrary in any statute or in such policy, plan or contract...."

2) Right to Participate in Network. Miss. Code Ann. §83-51-3(b) provides that no policy or plan may deny any licensed dentist the right to "...participate as a contracting provider for such policy or plan...." This, of course, assumes that the dentist is willing to abide by the terms of the policy or plan.

3) Cannot Require X-rays. Miss. Code Ann. §83-51-3(d) states that no policy or plan can require a dentist to “...make or obtain dental x-rays or any other diagnostic aids...” in the treatment of a patient. It can, however, request copies of existing x-rays.

4) Payment Same for In-Network and Out-of-Network Providers. Miss. Code Ann. §83-51-5 states that, “Payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist...” The plan is not, however, required to pay a non-participating dentist more than the fee charged for the services rendered. For example, if a plan pays a participating dentist \$75 for a cleaning, but the non-participating dentist providing the cleaning only charges \$65 for a cleaning, then the plan only has to pay the non-participating dentist \$65.

Under the same section, the policy or plan must also “...Define and explain the standard upon which the payment of benefits or reimbursement for the cost of the dental care services is based, such as ‘usual and customary,’ ‘reasonable and customary’... or it shall specify in dollars and cents the amount of the payment or reimbursement... to be provided.”

Finally, the policy or plan must, “Disclose, if applicable, that the benefit offered is limited to the least costly treatment.”

5) Prompt Pay Law. Miss. Code Ann. §83-9-5(1)(h) (Supp. 2010) provides that an insurer has 25 days from the receipt of a clean claim filed electronically, and 35 days from the receipt of a clean claim filed on paper, to pay amounts owing to the provider or the insured. “A ‘clean claim’ means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer.”

“If the claim is not denied for **valid and proper reasons** (emphasis added) by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of one and one-half percent (1-½ %) per month accruing from the day after payment was due on the amount of benefits that remain unpaid, until the claim is finally settled or adjudicated.” Annualized, this interest works out to .04931% per day, though other acceptable calculations may be used by the insurer.

Requirements that information be submitted multiple times by a provider or an insured may create a presumption that the submission of same is not for a “valid and proper” reason, but is merely to cause delay in the payment of a claim, in violation of the above statute.

6) Time Limitations on Claim Audits. Miss. Code Ann. §83-41-219 (Supp. 2010) provides that effective July 1, 2010, if an insurer limits the time within which an insured or provider must file a claim, the insurer is limited to the same time period following payment of that claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or for overpayment of a claim. If no time limit for the filing of claims is given, then the insurer has twelve months from the time the claim was paid to do its look-back.

This section does not apply to claims submitted in the context of misrepresentation, omission, concealment or fraud.

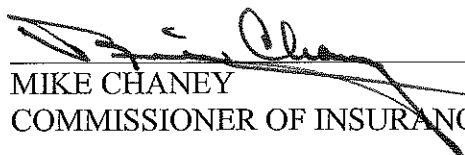
7) Prohibition Against Certain Health Care Entities Establishing Fees for Non-Covered Services. Miss. Code Ann. §83-51-31 (Supp. 2010) states that, “No contract between a health care entity that offers a dental plan or plans and a dentist for the provision of services to subscribers may require that a dentist provide services to his subscribers at a fee set by the health care entity unless the services are covered services under the applicable subscriber agreement. For the purposes of this section, ‘covered services’ means services that are reimbursable under the applicable subscriber agreement, notwithstanding any deductibles, waiting periods or frequency limitations that may apply. For the purposes of this section, ‘dental plan’ means any policy of insurance that is issued by a health care entity that provides for coverage of dental services not in connection with a medical plan.” In other words, when a dentist contracts to provide certain services for a particular fee, only the fees for those contracted services may be set by the health care entity. The dentist is not obliged to accept the entity’s fees for services not covered by the contract, though he may agree to do so.

Similarly, if a dentist enrolls in a particular plan, unless the provider agreement clearly states otherwise, that dentist may not be automatically enrolled in other plans offered by the insurer.

8) Prohibition Against Interfering with Dentist/Patient Relationship. Miss. Code Ann. §83-51-3(c) states that, “No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall...Authorize any person to regulate, interfere or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing or healing dental illness or injury, provided such dentist practices within the scope of his license....”

9) Conflicting Provisions Void. Miss. Code Ann. §83-51-7 states that, “Any provision in a health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this chapter **shall**, to the extent of such conflict, **be void.**” (Emphasis added.)

Failure to comply with the above statutes may result in the imposition of administrative fines, penalties, and/or suspension or revocation of an insurer’s certificate of authority.


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Any questions related to this Bulletin may be directed to Stephanie L. Ganuchau, Special Assistant Attorney General at (601) 359-3577, or by e-mail: Stephanie.ganuchau@mid.state.ms.us