



Oral and maxillofacial surgeons:  
The experts in face, mouth and  
jaw surgery®

**ADA** American  
Dental  
Association®

**VIA EMAIL: AKENNEDY@NCOIL.ORG**

September 4, 2025

The Honorable Michael Sarge Pollock  
Chair  
Health Insurance & Long-Term Care Issues  
National Council of Insurance Legislators  
616 5th Avenue, Suite 106  
Belmar, NJ 07719

The Honorable Justin Boyd  
Vice Chair  
Health Insurance & Long-Term Care Issues  
National Council of Insurance Legislators  
616 5th Avenue, Suite 106  
Belmar, NJ 07719

Dear Representative Pollock and Senator Boyd:

On behalf of the 9,000 fellows and members of the American Association of Oral and Maxillofacial Surgeons (AAOMS) and the 159,000 members of the American Dental Association (ADA), we commend the National Council of Insurance Legislators' (NCOIL) Health Insurance & Long Term Care Issues Committee for its efforts to develop model legislation addressing prior authorization reform. We respectfully request several minor amendments to the draft *Prior Authorization Reform Model Act* to ensure inclusiveness of dental specialties and practice models.

In particular, oral and maxillofacial surgeons (OMSs) are surgically and medically trained doctors of dental medicine (DMD) or dental surgery (DDS) who diagnose and treat a wide range of complex conditions. These include facial trauma, temporomandibular joint (TMJ) disorders, third molar and other dental extractions, and reconstructive surgical procedures. In addition, OMSs frequently serve on trauma call in community hospitals, providing care for facial fractures involving the lower and upper jaws, palate, cheekbones, and eye sockets.

OMSs regularly accept both medical and dental insurance benefits due to the unique nature of their training and the scope of their practice. This dual role across dental and medical domains gives OMSs a distinctive perspective on prior authorization challenges that span both systems, making their inclusion in related policy reform essential.

To this end, the attached proposed amendments are designed to ensure the model act's applicability to these practitioners, who frequently encounter burdensome prior authorization requirements. While we recognize the model act was not originally intended to include exempted benefits – such as dental insurance – we suggest including a drafting note within the definitions section to clarify that states may choose to apply the act to those benefits. Additionally, we recommend expanding the definition of eligible providers to explicitly include dental providers, who hold DDS or DMD degrees, are licensed under state dental boards, and often fall outside the model act's current definition of "physician."

Thank you again for your leadership on this important issue. Should you have any questions or require further information, please contact Sandy Guenther, AAOMS Director of State Government Affairs, at

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800-822-6637, ext. 4388, or [sguenther@aaoms.org](mailto:sguenther@aaoms.org), or Chad Olson, ADA Sr. Director of State Government Affairs, at 630-408-6558 or [olsonc@ada.org](mailto:olsonc@ada.org).

Sincerely,



J. David Morrison, DMD  
President  
American Association of Oral and Maxillofacial  
Surgeons



Brett Kessler, DDS  
President  
American Dental Association

Attachments

## Suggested edits to be inclusive of OMS practice

*Draft as of March 26, 2025*

### Section 4. Definitions

[...]

(F) "Emergency ~~medical~~ condition" means a ~~medical~~ condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(G) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency ~~medical~~ condition.

[...]

(K) "Health care service" means any services or level of services included in the furnishing to an individual of ~~medical~~ care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health and pharmaceutical services and products.

(L) "Health insurance issuer" has the meaning given to that term in [applicable state insurance statute]. Any provision of this act that applies to a "health insurance issuer" also applies to any person or entity covered under the scope of this act. [\[DRAFTING NOTE: States need to specifically cite and include dental insurance provisions for this to apply to dental treatment.\]](#)

[...]

(M) "Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms and that are:

(i) In accordance with generally accepted standards of ~~medical~~ [health care](#) practice; and

- (ii) Clinically appropriate in terms of type, frequency, extent, site and duration and are considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member or other interested party, but focused on what is best for the patient's health outcome.

[...]

(P) "Urgent health care service" means a health care service with respect to which the application of the time periods 180 for making a non-expedited prior authorization that in the opinion of a treating health care professional or health care provider with knowledge of the enrollee's ~~medical~~ condition:

- (i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function;
- (ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; or
- (iii) Could lead to likely onset of an emergency 190 medical condition if the service is not rendered during the time period to render a prior authorization determination for an urgent medical service.

[...]

#### **Section 5. Disclosure and review of prior authorization requirements.**

[...]

- (C) The clinical review criteria must:
- (1) Be based on nationally recognized, generally accepted standards except where state law provides its own standard;
  - (2) Be developed in accordance with the current standards of a national ~~medical~~ accreditation entity;
  - (3) Ensure quality of care and access to needed health care services;
  - (4) Be evidence-based;
  - (5) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and
  - (6) Be evaluated and updated, if necessary, at least annually.

[...]

#### **Section 8. Prior authorizations in urgent circumstances.**

[...]

- (B) To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to ~~physicians~~ appropriately credentialed health care providers for the condition being treated for consultation.

#### **Section 10. Personnel qualified to review appeals.**

[...]

[*New section (B)*]

- (B) A health insurance insurer must ensure that all appeals are reviewed by dentist when the request is by a dentist or a representative of a dentist. The dentist must:
- (1) Possess a current and valid nonrestricted license to practice dentistry in any United States jurisdiction;
  - (2) Be certified by a board recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards within the relevant specialty of the dentist who typically manages the condition or disease;
  - (3) Be knowledgeable of, and have experience providing, the health care services under appeal;
  - (4) Not have been directly involved in making the adverse determination; and
  - (5) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent records provided to the health insurance issuer by the enrollee's health care professional or health care provider and any medical or dental literature provided to the health insurance issuer by the health care professional or health care provider.
- (~~B~~C) Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements in this section may review appeal requests submitted by a health care professional licensed and board certified in the same profession.

#### **Section 17. Enforcement and administration.**

[...]

- (B) Any person or his or her treating ~~physician~~ health care provider who has evidence that his or her health insurance issuer or health benefit plan is in violation of the provisions of this act may file a complaint with the department. The department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The department shall fairly, efficiently and timely review and investigate complaints. Health insurance issuers, health benefit plans and private review agents found to be in violation of this act shall be penalized in accordance with this section.

[...]