



General Assembly

February Session, 2004

**Raised Bill No. 5203**

LCO No. 1130

\*01130\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

**AN ACT CONCERNING THE RECODING AND DENIAL OF HEALTH INSURANCE CLAIMS AND PROVIDER APPEALS OF SUCH RECODING AND DENIAL.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective January 1, 2005*) (a) As used in this  
2 section: (1) "Managed care organization" means a managed care  
3 organization, as defined in section 38a-478 of the general statutes, as  
4 amended, (2) "provider" means a provider, as defined in section 38a-  
5 478 of the general statutes, as amended, (3) "enrollee" means an  
6 enrollee, as defined in section 38a-478 of the general statutes, as  
7 amended, (4) "ombudsman" means the Managed Care Ombudsman,  
8 (5) "recode" or "recoding" means the changing, by a managed care  
9 organization on a claim submitted by a provider, of a code or group of  
10 codes for health care services for the purpose of reimbursing the  
11 provider at a lower rate. "Recode" or "recoding" includes, but is not  
12 limited to, the reduction of an evaluation or management service level,  
13 the combining of codes for two or more separate and distinct services  
14 or procedures performed on a single patient during a single office visit,  
15 the change of a code to a different classification code, or the bundling  
16 of physician services codes in any manner that conflicts with the

17 American Medical Association's Current Procedural Terminology  
18 coding policy or instructions, and (6) "denial" means any claim denied  
19 by a managed care organization.

20 (b) On and after January 1, 2005, any provider who is aggrieved by a  
21 recoding or denial and who has exhausted any internal mechanisms  
22 provided by a managed care organization to appeal such recoding or  
23 denial may appeal the recoding or denial to the Managed Care  
24 Ombudsman in accordance with this section.

25 (c) (1) To appeal a recoding or denial, a provider shall, within thirty  
26 days from receiving a final written determination from the managed  
27 care organization, file a written request for appeal with the  
28 ombudsman. The appeal shall be made on such form as the  
29 ombudsman prescribes and shall include the filing fee set forth in  
30 subdivision (2) of this subsection and a general release executed by the  
31 enrollee for all medical records pertinent to the appeal.

32 (2) The filing fee shall be twenty-five dollars and shall be deposited  
33 in the Insurance Fund established in section 38a-52a of the general  
34 statutes.

35 (3) Upon receipt of the appeal together with the executed release  
36 and fee the ombudsman shall assign the appeal for review to an entity  
37 engaged by the ombudsman pursuant to subsection (d) of this section.

38 (4) Upon receipt of the request for appeal from the ombudsman, the  
39 entity conducting the appeal shall conduct a preliminary review of the  
40 appeal and accept the appeal if such entity determines: (A) The  
41 provider has or had a contract or other arrangement with the managed  
42 care organization; (B) the benefit or service that is the subject of the  
43 appeal reasonably appears to be a covered service, benefit or service  
44 under the agreement provided by contract to the enrollee; (C) the  
45 provider has exhausted any internal appeal mechanisms offered to the  
46 provider by the managed care organization; and (D) the provider has  
47 submitted all information required to make a preliminary

48 determination including the appeal form, a copy of the final  
49 determination and a fully-executed release to obtain any necessary  
50 medical records from the managed care organization, enrollee and any  
51 other relevant provider.

52 (5) Upon completion of the preliminary review, the entity  
53 conducting the review shall immediately notify the provider in writing  
54 as to whether the appeal has been accepted for full review and, if not  
55 so accepted, the reasons therefor.

56 (6) If accepted for full review, the entity shall conduct such review  
57 in accordance with the regulations which the Managed Care  
58 Ombudsman shall adopt, after consultation with the Commissioner of  
59 Public Health, in accordance with chapter 54 of the general statutes.

60 (d) To provide for such review the Managed Care Ombudsman,  
61 after consultation with the Commissioner of Public Health, shall  
62 engage impartial health entities to provide medical review under the  
63 provisions of this section. Such review entities shall be known as an  
64 external board of review and shall be composed of representatives  
65 from (1) medical peer review organizations, (2) independent utilization  
66 review companies, provided any such company is not related to or  
67 associated with any managed care organization, and (3) at least three  
68 and no more than six physicians approved by the ombudsman.

69 (e) The ombudsman shall accept the decision of the external board  
70 of review and shall notify the managed care organization or its agent  
71 and the provider of the decision. If the external board of review finds  
72 that the claim should not have been recoded or denied, the managed  
73 care organization shall pay the provider the amount of the claim plus  
74 interest at the rate of fifteen per cent per annum except that no interest  
75 shall be due if the board finds that the recoding or denial resulted from  
76 the provider's failure to submit necessary claim information. If the  
77 external board of review finds that the recoding or denial was justified,  
78 the ombudsman shall notify the parties in writing. The decision of the  
79 ombudsman shall be binding and final.

80 (f) Nothing in this section shall be construed to alter the  
81 requirements of subdivision (15) of section 38a-816 of the general  
82 statutes, as amended.

This act shall take effect as follows:	
Section 1	January 1, 2005

**Statement of Purpose:**

To allow health care providers to appeal denials and recoding determinations made by managed care organizations.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*