



Senate

General Assembly

File No. 176

January Session, 2009

Substitute Senate Bill No. 47

Senate, March 25, 2009

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS.

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

1 Section 1. (NEW) (*Effective October 1, 2009*) (a) As used in this
2 section:

3 (1) "Contracting health organization" means a managed care
4 organization, as defined in section 38a-478 of the general statutes, or a
5 preferred provider network, as defined in section 38a-479aa of the
6 general statutes.

7 (2) "Provider" means a physician, surgeon, chiropractor, podiatrist,
8 optometrist or nurse practitioner.

9 (b) A contracting health organization shall include with each
10 contract offered by such organization to a provider for services to be
11 rendered to residents of this state: (1) Access to the contracting health
12 organization's current procedural terminology codes and Healthcare
13 Common Procedure Coding System fee schedules applicable to such

14 provider's specialty; (2) the name and contact information of the
 15 medical director responsible for internal appeals and a description of
 16 the procedures used to provide a response to provider inquiries; and
 17 (3) access to the contracting health organization's policies and
 18 guidelines that directly or indirectly impact patients' rights or
 19 providers' payments, duties, requirements or appeals.

20 (c) No contracting health organization shall:

21 (1) Make unilateral changes to the provisions of (A) such contract,
 22 (B) its medical payment policy, including, but not limited to, methods
 23 of payment, or (C) its administrative policy, that directly or indirectly
 24 impact patients' rights or providers' payments, duties, requirements or
 25 appeals, more than once a year, and such changes shall be made
 26 simultaneously; or

27 (2) Cancel, deny or demand the return of full or partial payment for
 28 a service authorized due to administrative or eligibility error, more
 29 than one year from the date of the filing of a clean claim. If a claim is
 30 returned by such organization to a provider due to the identification of
 31 a different payor as the appropriate source of provider payment, such
 32 provider may submit such returned claim to such identified payor up
 33 to one year after such claim is returned.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2009	New section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

This bill alters contact standards between health care providers and contracting health organizations and does not result in a fiscal impact.

The Out Years

None

OLR Bill Analysis**sSB 47*****AN ACT CONCERNING HEALTH CARE PROVIDER CONTRACTS.*****SUMMARY:**

This bill requires each contracting health organization (i.e., a managed care organization or preferred provider network) to include with each contract it offers a specified provider:

1. access to the organization's current procedural terminology (CPT) codes and Healthcare Common Procedure Coding System fee schedules that apply to the provider's specialty (see COMMENT);
2. the name of, and contact information for, the medical director responsible for internal appeals;
3. a description of the procedures used to respond to a provider's inquiries; and
4. access to the organization's policies and guidelines that directly or indirectly impact patients' rights or providers' payments, duties, requirements, or appeals.

It defines "provider" as a physician, surgeon, chiropractor, podiatrist, nurse practitioner, and optometrist. However, nurse practitioners are licensed as and called advanced practice registered nurses (APRNs) in Connecticut. The bill does not define Healthcare Common Procedure Coding fee schedule.

The bill prohibits an organization from making, more than once a year, unilateral changes that directly or indirectly affect patients' rights or providers' payments, duties, requirements, or appeals, in a (1) provider contract; (2) medical payment policy, including payment

method; or (3) administrative policy. It requires the organization to make any such changes simultaneously.

The bill prohibits an organization, more than one year after receiving a “clean claim,” from canceling, denying, or demanding a refund of payment for an authorized service paid in error because of an administrative or eligibility mistake. (The law considers a claim “clean” if it is submitted with all information required by law (CGS § 38a-477)). (It is unclear if this prohibition applies to all claims subject to the prompt payment law (see BACKGROUND) or only those a physician, surgeon, chiropractor, podiatrist, APRN, or optometrist files.)

If an organization returns a claim to a provider because it determined a different payor is the appropriate one to pay the claim, the bill allows the provider up to one year from when the claim is returned to file it with the correct payor. (Contracts between an organization and a provider usually include the amount of time a provider has to file a claim with a payor after rendering services to a patient. The bill, therefore, may impact such a contractual provision.)

EFFECTIVE DATE: October 1, 2009

BACKGROUND

Related Laws

Access to CPT Codes (CGS § 38a-479). The law requires each contracting health organization to have a process in place through which a contracted physician, physician group, or physician organization may confidentially view what the organization pays for the (1) 50 CPT codes the physician or group most commonly performs and (2) CPT codes the physician or group bills, or intends to bill, as long as they are within the physician’s specialty or subspecialty. The law applies with respect to a physician, physician group, or physician organization whose services the organization reimburses on a fee-for-service basis per CPT code. For this law, “physician” includes a physician, surgeon, chiropractor, podiatrist, psychologist, and

optometrist.

By law, the organization must present the fee information digitally or electronically. The law makes the fee information proprietary and confidential. It permits the organization to impose penalties, including termination from its provider network, for unauthorized disclosure.

Prompt Claim Payment (CGS § 38a-816(15)). By law, an insurer or other entity must pay a clean claim within 45 days of receiving it if. If a claim contains a deficiency, the entity must send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies within 30 days of receiving the claim. The entity must process the claim within 30 days of receiving the corrected claim. The entity must add 15% interest if payment is late.

In this case, the law defines “health care provider” as a physician, surgeon, chiropractor, naturopath, podiatrist, athletic trainer, physical therapist, occupational therapist, alcohol and drug counselor, radiologist, midwife, nurse, nurse's aide, dentist, dental hygienist, optometrist, optician, respiratory care practitioner, perfusionist, pharmacist, psychologist, marital and family therapist, clinical social worker, professional counselor, massage therapist, dietician-nutritionist, acupuncturist, emergency medical service technician (EMT), and licensed health care institution. Licensed health care institution includes a hospital; residential care home; health care facility for the handicapped; nursing home; rest home; home health care agency; homemaker-home health aide agency; mental health facility; substance abuse treatment facility; student infirmary; an EMT organization; a facility providing services for the prevention, diagnosis, and treatment of human health conditions; and a Medicaid-certified residential facility for the mentally retarded.

COMMENT

Potential Conflict with Existing Law

It is unclear how this bill, with respect to CPT codes, differs from existing law that requires organizations to give certain providers

access to CPT codes, except the bill appears to include APRNs and exclude psychologists.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 6 (03/10/2009)