



General Assembly

Amendment

February Session, 2010

LCO No. 4803

SB0039304803SD0

Offered by:

SEN. CRISCO, 17th Dist.

REP. FONTANA, 87th Dist.

To: Subst. Senate Bill No. 393

File No. 207

Cal. No. 143

"AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER CONTRACTS."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Subparagraph (B) of subdivision (15) of section 38a-816
4 of the general statutes is repealed and the following is substituted in
5 lieu thereof (*Effective January 1, 2011*):

6 (B) Each insurer [,] or other entity responsible for providing
7 payment to a health care provider pursuant to an insurance policy
8 subject to this section, shall pay claims not later than: [forty-five]

9 (i) For claims filed in paper format, sixty days after receipt by the
10 insurer of the claimant's proof of loss form or the health care provider's
11 request for payment filed in accordance with the insurer's practices or
12 procedures, except that when there is a deficiency in the information
13 needed for processing a claim, as determined in accordance with

14 section 38a-477, the insurer shall [(i)] (I) send written notice to the
15 claimant or health care provider, as the case may be, of all alleged
16 deficiencies in information needed for processing a claim not later than
17 thirty days after the insurer receives a claim for payment or
18 reimbursement under the contract, and [(ii)] (II) pay claims for
19 payment or reimbursement under the contract not later than thirty
20 days after the insurer receives the information requested; and

21 (ii) For claims filed in electronic format, twenty days after receipt by
22 the insurer of the claimant's proof of loss form or the health care
23 provider's request for payment filed in accordance with the insurer's
24 practices or procedures, except that when there is a deficiency in the
25 information needed for processing a claim, as determined in
26 accordance with section 38a-477, the insurer shall (I) notify the
27 claimant or health care provider, as the case may be, of all alleged
28 deficiencies in information needed for processing a claim not later than
29 ten days after the insurer receives a claim for payment or
30 reimbursement under the contract, and (II) pay claims for payment or
31 reimbursement under the contract not later than ten days after the
32 insurer receives the information requested.

33 Sec. 2. Section 38a-479b of the 2010 supplement to the general
34 statutes is repealed and the following is substituted in lieu thereof
35 (*Effective January 1, 2011*):

36 (a) No contracting health organization shall make material changes
37 to a provider's fee schedule except as follows:

38 (1) At one time annually, provided providers are given at least
39 ninety days' advance notice by mail, electronic mail or facsimile by
40 such organization of any such changes. Upon receipt of such notice, a
41 provider may terminate the participating provider contract with at
42 least sixty days' advance written notice to the contracting health
43 organization;

44 (2) At any time for the following, provided providers are given at
45 least thirty days' advance notice by mail, electronic mail or facsimile by

46 such organization of any such changes:

47 (A) To comply with requirements of federal or state law, regulation
48 or policy. If such federal or state law, regulation or policy takes effect
49 in less than thirty days, the organization shall give providers as much
50 notice as possible;

51 (B) To comply with changes to the medical data code sets set forth
52 in 45 CFR 162.1002, as amended from time to time;

53 (C) To comply with changes to national best practice protocols made
54 by the National Quality Forum or other national accrediting or
55 standard-setting organization based on peer-reviewed medical
56 literature generally recognized by the relevant medical community or
57 the results of clinical trials generally recognized and accepted by the
58 relevant medical community;

59 (D) To be consistent with changes made in Medicare pertaining to
60 billing or medical management practices, provided any such changes
61 are applied to relevant participating provider contracts where such
62 changes pertain to the same specialty or payment methodology;

63 (E) If a drug, treatment, procedure or device is identified as no
64 longer safe and effective by the federal Food and Drug Administration
65 or by peer-reviewed medical literature generally recognized by the
66 relevant medical community;

67 (F) To address payment or reimbursement for a new drug,
68 treatment, procedure or device that becomes available and is
69 determined to be safe and effective by the federal Food and Drug
70 Administration or by peer-reviewed medical literature generally
71 recognized by the relevant medical community; or

72 (G) As mutually agreed to by the contracting health organization
73 and the provider. If the contracting health organization and the
74 provider do not mutually agree, the provider's current fee schedule
75 shall remain in force until the annual change permitted pursuant to

76 subdivision (1) of this subsection.

77 (b) Notwithstanding subsection (a) of this section, a contracting
78 health organization may introduce a new insurance product to a
79 provider at any time, provided such provider is given at least sixty
80 days' advance notice by mail, electronic mail or facsimile by such
81 organization if the introduction of such insurance product will make
82 material changes to the provider's administrative requirements under
83 the participating provider contract or to the provider's fee schedule.
84 The provider may decline to participate in such new product by
85 providing notice to the contracting health organization as set forth in
86 the advance notice, which shall include a period of not less than thirty
87 days for a provider to decline, or in accordance with the time frames
88 under the applicable terms of such provider's participating provider
89 contract.

90 [(b)] (c) (1) No contracting health organization shall cancel, deny or
91 demand the return of full or partial payment for an authorized covered
92 service due to administrative or eligibility error, more than eighteen
93 months after the date of the receipt of a clean claim, except if:

94 (A) Such organization has a documented basis to believe that such
95 claim was submitted fraudulently by such provider;

96 (B) The provider did not bill appropriately for such claim based on
97 the documentation or evidence of what medical service was actually
98 provided;

99 (C) Such organization has paid the provider for such claim more
100 than once;

101 (D) Such organization paid a claim that should have been or was
102 paid by a federal or state program; or

103 (E) The provider received payment for such claim from a different
104 insurer, payor or administrator through coordination of benefits or
105 subrogation, or due to coverage under an automobile insurance or

106 workers' compensation policy. Such provider shall have one year after
107 the date of the cancellation, denial or return of full or partial payment
108 to resubmit an adjusted secondary payor claim with such organization
109 on a secondary payor basis, regardless of such organization's timely
110 filing requirements.

111 (2) (A) Such organization shall give at least thirty days' advance
112 notice to a provider by mail, electronic mail or facsimile of the
113 organization's cancellation, denial or demand for the return of full or
114 partial payment pursuant to subdivision (1) of this subsection.

115 (B) If such organization demands the return of full or partial
116 payment from a provider, the notice required under subparagraph (A)
117 of this subdivision shall disclose to the provider (i) the amount that is
118 demanded to be returned, (ii) the claim that is the subject of such
119 demand, and (iii) the basis on which such return is being demanded.

120 (C) Not later than thirty days after the receipt of the notice required
121 under subparagraph (A) of this subdivision, a provider may appeal
122 such cancellation, denial or demand in accordance with the procedures
123 provided by such organization. Any demand for the return of full or
124 partial payment shall be stayed during the pendency of such appeal.

125 (D) If there is no appeal or an appeal is denied, such provider may
126 resubmit an adjusted claim, if applicable, to such organization, not
127 later than thirty days after the receipt of the notice required under
128 subparagraph (A) of this subdivision or the denial of the appeal,
129 whichever is applicable, except that if a return of payment was
130 demanded pursuant to subparagraph (C) of subdivision (1) of this
131 subsection, such claim shall not be resubmitted.

132 (E) A provider shall have one year after the date of the written
133 notice set forth in subparagraph (A) of this subdivision to identify any
134 other appropriate insurance coverage applicable on the date of service
135 and to file a claim with such insurer, health care center or other issuing
136 entity, regardless of such insurer's, health care center's or other issuing
137 entity's timely filing requirements.

138 Sec. 3. (NEW) (*Effective January 1, 2011*) Each insurer, health care
139 center, managed care organization or other entity that delivers, issues
140 for delivery, renews, amends or continues an individual or group
141 health insurance policy or medical benefits plan, and each preferred
142 provider network, as defined in section 38a-479aa of the general
143 statutes, that contracts with a health care provider, as defined in
144 section 38a-478 of the general statutes, for the purposes of providing
145 covered health care services to its enrollees, shall maintain a network
146 of such providers that is consistent with the National Committee for
147 Quality Assurance's network adequacy requirements or URAC's
148 provider network access and availability standards.

149 Sec. 4. (NEW) (*Effective January 1, 2011*) (a) No contract between an
150 insurer, health care center, fraternal benefit society, hospital service
151 corporation, medical service corporation or other entity delivering,
152 issuing for delivery, renewing, amending or continuing in this state an
153 individual or group policy or plan providing coverage of dental
154 services and a dentist licensed pursuant to chapter 379 of the general
155 statutes, shall contain any provision that requires such dentist to
156 accept an amount set by such insurer, health care center, fraternal
157 benefit society, hospital service corporation, medical service
158 corporation or other entity as reimbursement for dental services
159 provided to an enrollee unless such services are covered services
160 under the enrollee's policy or plan. As used in this section, "covered
161 services" means services that are reimbursable under an enrollee's
162 policy or plan, regardless of any applicable contractual limitations on
163 such enrollee's benefits, including, but not limited to, coinsurance,
164 copayments, deductibles, waiting periods, annual or lifetime
165 maximums or limitations on frequency of visits.

166 (b) This section shall not apply to a self-insured plan that covers
167 dental services.

168 (c) This section shall not be construed to prohibit a dentist from
169 voluntarily agreeing to provide dental services that are not covered
170 services under the enrollee's policy or plan at an amount set by the

- 171 insurer, health care center, fraternal benefit society, hospital service
172 corporation, medical service corporation or other entity."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2011</i>	38a-816(15)(B)
Sec. 2	<i>January 1, 2011</i>	38a-479b
Sec. 3	<i>January 1, 2011</i>	New section
Sec. 4	<i>January 1, 2011</i>	New section