
OLR Bill Analysis

sHB 6088

AN ACT CONCERNING CONTRACTING HEALTH ORGANIZATIONS AND DENTISTS, DENTAL PLANS AND PROCEDURES.

SUMMARY

This bill extends to dentists the same provider contract requirements and transparency provisions that are already applicable to other health care providers.

In doing so, it requires a managed care organization or preferred provider network (i.e., contracting health organization) to give dentists with whom it contracts certain fee information. It prohibits a contracting health organization from making material changes to a dentist's fee schedule except when and as specified in the bill.

The bill also requires a contracting health organization to give each contracted dentist Internet, electronic, or digital access to policies and procedures regarding a dentist's (1) payments; (2) contractual duties and requirements; and (3) inquiries and appeals, including contact information for the office responsible for responding to them and a description of appeal rights applicable to dentists, enrollees, and enrollees' dependents.

The bill prohibits a contracting health organization, more than 18 months after receiving a dentist's clean (i.e., complete) claim, from canceling, denying, or demanding the return of full or partial payment it made in error for an authorized covered service except under specified circumstances and subject to certain procedures.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: January 1, 2020

ACCESS TO FEE INFORMATION

The bill requires a contracting health organization to establish and implement a procedure to provide each contracted dentist Internet, electronic, or digital access to the organization's fees for the current procedural terminology (CPT), current dental terminology (CDT), and Health Care Procedure Coding System codes (1) applicable to the dentist's specialty and (2) that the dentist requests for other services for which he or she actually bills or intends to bill the organization, provided the codes are within the dentist's specialty or subspecialty.

The right to access fees applies only to a dentist whose services are reimbursed using CPT or CDT codes, and fee information is proprietary and confidential. The organization may penalize the unauthorized distribution of the information, including terminating a dentist's contract.

CHANGES TO FEE SCHEDULES

The bill prohibits a contracting health organization from making material changes to a dentist's fee schedule except as specified. An organization may make changes to a fee schedule once a year if it gives dentists at least 90 days' advance notice by mail, e-mail, or fax. The notice must include the maximum allowable charge for each dental procedure code. Upon receipt of the notice, a dentist may terminate its contract by giving the organization at least 60 days' advance written notice.

The bill also allows an organization to make changes to a dentist's fee schedule at any time if it gives dentists at least 30 days' advance notice by mail, e-mail, or fax when the changes are:

1. to comply with a federal or state requirement, but if the requirement takes effect in fewer than 30 days, the organization must give dentists as much notice as possible;
2. to comply with changes to the medical data code sets in federal regulations (45 CFR 162.1002);
3. to comply with changes to national best practice protocols made by the National Quality Forum or other national accrediting or

standard-setting organization based on peer-reviewed medical literature generally recognized by the relevant medical community or the results of clinical trials generally recognized and accepted by the relevant medical community;

4. consistent with changes in Medicare billing or medical management practices, as long as the changes are made to relevant dentist contracts and relate to the same specialty or payment methodology;
5. because the federal Food and Drug Administration (FDA) or peer-reviewed medical literature generally recognized by the relevant medical community identifies a drug, treatment, procedure, or device as no longer safe and effective;
6. to address payment or reimbursement for a new drug, treatment, procedure, or device that becomes available and is determined to be safe and effective by FDA or peer-reviewed medical literature generally recognized by the relevant medical community; or
7. mutually agreed to by the organization and the dentist.

NEW INSURANCE PRODUCTS

The bill permits a contracting health organization to introduce a new insurance product to a dentist at any time as long as it gives the dentist at least 60 days' advance notice by mail, e-mail, or fax if the new product makes material changes to the administrative or fee schedule portions of the dentist's contract. The notice must allow the dentist at least 30 days to decide whether to participate in the new product. The dentist may decline participation.

PAYMENT CANCELLATION, DENIAL, OR RETURN

The bill prohibits a contracting health organization, more than 18 months after receiving a dentist's clean (i.e., complete) claim, from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, unless the:

1. organization (a) has a documented basis to believe that the dentist fraudulently submitted the claim, (b) already paid the dentist for the claim, or (c) paid a claim that should have been or was paid by a federal or state program or
2. dentist (a) did not bill the claim appropriately based on documentation or evidence of what service was actually provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits, subrogation, or coverage under an auto insurance or workers' compensation policy.

The bill gives a dentist that receives a payment from another source one year after the date of the payment cancellation, denial, or return to resubmit an adjusted claim with the organization on a secondary payor basis, regardless of the organization's timely filing requirements.

Advanced Notice Required

The bill requires an organization to give a dentist at least 30 days' advance notice of a payment cancellation, denial, or return demand by mail, e-mail, or fax. The organization must include in a notice demanding a return of payment the (1) amount it wants returned, (2) claim to which it relates, and (3) basis for it.

Appeal

The bill allows a dentist to appeal, in accordance with the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. It requires a payment return demand to be stayed (i.e., postponed) during the appeal.

Adjusted Claim

If there is no appeal or an appeal is denied, the bill allows a dentist to resubmit an adjusted claim, if applicable, to the organization within 30 days after receiving notice of (1) a payment cancellation or denial or (2) an appeal denial. A claim may not be resubmitted if the organization demanded a return of payment.

Other Appropriate Insurance Coverage

The bill gives a dentist one year after the date of the written notice of a payment cancellation, denial, or return demand to (1) identify any other appropriate insurance coverage applicable on the date of service and (2) file a claim with the insurer, HMO, or other issuing entity, regardless of its timely filing requirements.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 19 Nay 0 (03/14/2019)