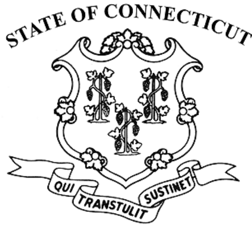

House of Representatives

General Assembly **File No. 280**

January Session, 2019 Substitute House Bill No. 6088

House of Representatives, April 2, 2019

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

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

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

1 Section 1. Section 38a-479 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2020*):

3 (a) As used in this section and section 38a-479b, as amended by this
4 act:

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

8 (2) "Provider" means a physician, surgeon, chiropractor, podiatrist,
9 psychologist, optometrist, dentist, naturopath or advanced practice
10 registered nurse licensed in this state or a group or organization of
11 such individuals, who has entered into or renews a participating
12 provider contract with a contracting health organization to render
13 services to such organization's enrollees and enrollees' dependents.

14 (b) Each contracting health organization shall establish and

15 implement a procedure to provide to each provider:

16 (1) Access via the Internet or other electronic or digital format to the
17 contracting health organization's fees for (A) the current procedural
18 terminology (CPT) codes or current dental terminology (CDT) codes
19 applicable to such provider's specialty, (B) the Health Care Procedure
20 Coding System (HCPCS) codes applicable to such provider, and (C)
21 such CPT codes, CDT codes and HCPCS codes as may be requested by
22 such provider for other services such provider actually bills or intends
23 to bill the contracting health organization, provided such codes are
24 within the provider's specialty or subspecialty; and

25 (2) Access via the Internet or other electronic or digital format to the
26 contracting health organization's policies and procedures regarding
27 (A) payments to providers, (B) providers' duties and requirements
28 under the participating provider contract, (C) inquiries and appeals
29 from providers, including contact information for the office or offices
30 responsible for responding to such inquiries or appeals and a
31 description of the rights of a provider, enrollee and enrollee's
32 dependents with respect to an appeal.

33 (c) The provisions of subdivision (1) of subsection (b) of this section
34 shall not apply to any provider whose services are reimbursed in a
35 manner that does not utilize current procedural terminology (CPT) or
36 current dental terminology (CDT) codes.

37 (d) The fee information received by a provider pursuant to
38 subdivision (1) of subsection (b) of this section is proprietary and shall
39 be confidential, and the procedure adopted pursuant to this section
40 may contain penalties for the unauthorized distribution of fee
41 information, which may include termination of the participating
42 provider contract.

43 Sec. 2. Section 38a-479b of the general statutes is repealed and the
44 following is substituted in lieu thereof (*Effective January 1, 2020*):

45 (a) No contracting health organization shall make material changes

46 to a provider's fee schedule except as follows:

47 (1) At one time annually, provided providers are given at least
48 ninety days' advance notice by mail, electronic mail or facsimile by
49 such organization of any such changes. With respect to a dental plan,
50 such notice shall include the maximum allowable charge for each
51 dental procedure code. Upon receipt of such notice, a provider may
52 terminate the participating provider contract with at least sixty days'
53 advance written notice to the contracting health organization;

54 (2) At any time for the following, provided providers are given at
55 least thirty days' advance notice by mail, electronic mail or facsimile by
56 such organization of any such changes:

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

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

63 (C) To comply with changes to national best practice protocols made
64 by the National Quality Forum or other national accrediting or
65 standard-setting organization based on peer-reviewed medical
66 literature generally recognized by the relevant medical community or
67 the results of clinical trials generally recognized and accepted by the
68 relevant medical community;

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

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

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

82 (G) As mutually agreed to by the contracting health organization
83 and the provider. If the contracting health organization and the
84 provider do not mutually agree, the provider's current fee schedule
85 shall remain in force until the annual change permitted pursuant to
86 subdivision (1) of this subsection.

87 (b) Notwithstanding subsection (a) of this section, a contracting
88 health organization may introduce a new insurance product to a
89 provider at any time, provided such provider is given at least sixty
90 days' advance notice by mail, electronic mail or facsimile by such
91 organization if the introduction of such insurance product will make
92 material changes to the provider's administrative requirements under
93 the participating provider contract or to the provider's fee schedule.
94 The provider may decline to participate in such new product by
95 providing notice to the contracting health organization as set forth in
96 the advance notice, which shall include a period of not less than thirty
97 days for a provider to decline, or in accordance with the time frames
98 under the applicable terms of such provider's participating provider
99 contract.

100 (c) (1) No contracting health organization shall cancel, deny or
101 demand the return of full or partial payment for an authorized covered
102 service due to administrative or eligibility error, more than eighteen
103 months after the date of the receipt of a clean claim, except if:

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

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

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

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

113 (E) The provider received payment for such claim from a different
114 insurer, payor or administrator through coordination of benefits or
115 subrogation, or due to coverage under an automobile insurance or
116 workers' compensation policy. Such provider shall have one year after
117 the date of the cancellation, denial or return of full or partial payment
118 to resubmit an adjusted secondary payor claim with such organization
119 on a secondary payor basis, regardless of such organization's timely
120 filing requirements.

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

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

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

135 (D) If there is no appeal or an appeal is denied, such provider may
136 resubmit an adjusted claim, if applicable, to such organization, not
137 later than thirty days after the receipt of the notice required under
138 subparagraph (A) of this subdivision or the denial of the appeal,
139 whichever is applicable, except that if a return of payment was

140 demanded pursuant to subparagraph (C) of subdivision (1) of this
141 subsection, such claim shall not be resubmitted.

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

148 (d) Except as provided in subsection (e) of this section, no
149 contracting health organization shall include in any participating
150 provider contract **[**, contract with a dentist**]** or contract with a hospital
151 licensed under chapter 368v, that is entered into, renewed or amended
152 on or after October 1, 2011, or contract offered to a provider **[**, dentist**]**
153 or hospital on or after October 1, 2011, any clause, covenant or
154 agreement that:

155 (1) Requires the provider **[**, dentist**]** or hospital to:

156 (A) Disclose to the contracting health organization the provider's **[**,
157 dentist's**]** or hospital's payment or reimbursement rates from any other
158 contracting health organization the provider **[**, dentist**]** or hospital has
159 contracted, or may contract, with;

160 (B) Provide services or procedures to the contracting health
161 organization at a payment or reimbursement rate equal to or lower
162 than the lowest of such rates the provider **[**, dentist**]** or hospital has
163 contracted, or may contract, with any other contracting health
164 organization;

165 (C) Certify to the contracting health organization that the provider **[**,
166 dentist**]** or hospital has not contracted with any other contracting
167 health organization to provide services or procedures at a payment or
168 reimbursement rate lower than the rates contracted for with the
169 contracting health organization;

170 (2) Prohibits or limits the provider **[**, dentist**]** or hospital from

171 contracting with any other contracting health organization to provide
172 services or procedures at a payment or reimbursement rate lower than
173 the rates contracted for with the contracting health organization; or

174 (3) Allows the contracting health organization to terminate or
175 renegotiate a contract with the provider **[**, dentist**]** or hospital prior to
176 renewal if the provider **[**, dentist**]** or hospital contracts with any other
177 contracting health organization to provide services or procedures at a
178 lower payment or reimbursement rate than the rates contracted for
179 with the contracting health organization.

180 (e) (1) If a contract described in subsection (d) of this section is in
181 effect prior to October 1, 2011, and includes a clause, covenant or
182 agreement set forth under subdivisions (1) to (3), inclusive, of said
183 subsection (d), such clause, covenant or agreement shall be void and
184 unenforceable on the date such contract is next renewed or on January
185 1, 2014, whichever is earlier. Such invalidity shall not affect other
186 provisions of such contract.

187 (2) Nothing in subdivision (1) of this subsection shall be construed
188 to affect the rights of a contracting health organization to enforce such
189 clause, covenant or agreement prior to the invalidation of such clause,
190 covenant or agreement.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	38a-479
Sec. 2	*January 1, 2020*	38a-479b

Statement of Legislative Commissioners:
In Section 2(d), ", contract with a dentist", ", dentist" and ", dentist's" were bracketed to conform with the changes being made in Section 1(a)(2).

INS *Joint Favorable Subst. -LCO*

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

The bill does not result in a fiscal impact to the state or municipalities as it pertains to certain disclosure and contract requirements between managed care organization or preferred provider network and dental providers.

The Out Years

State Impact: None

Municipal Impact: None

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)