



**PA 19-155**—sHB 6088

*Insurance and Real Estate Committee*

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

**SUMMARY:** This act extends to dentists the same provider contract requirements and transparency provisions that already apply to other health care providers (e.g., physicians). 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 as specified in the act.

The act 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. This includes contact information for the office responsible for responding to inquiries and appeals and a description of appeal rights applicable to dentists, enrollees, and enrollees' dependents.

The act 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.

Additionally, the act (1) prohibits a person who issues a policy covering only dental services from materially changing the fee schedule for in-network providers more than once annually and (2) requires at least 90 days' notice of such a change.

The act also makes technical and conforming changes.

EFFECTIVE DATE: January 1, 2020

**§ 1 — ACCESS TO FEE INFORMATION**

The act 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) (upon request), 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 whose fee information is proprietary

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and confidential. The organization may penalize the unauthorized distribution of the information, including terminating a dentist's contract.

### § 2 — CHANGES TO FEE SCHEDULES

The act prohibits a contracting health organization from making material changes to a dentist's fee schedule except as specified in the act. An organization may make changes to a fee schedule once a year if it gives the dentist at least 90 days' advance notice by mail, e-mail, or fax. Upon receiving the notice, the dentist may terminate the contract by giving the organization at least 60 days' advance written notice.

The act also allows an organization to make changes to a dentist's fee schedule at any time to address the following, as long as it provides at least 30 days' advance notice by mail, e-mail, or fax:

1. a federal or state requirement (if the requirement takes effect in fewer than 30 days, the organization must give dentists as much notice as possible);
2. changes to the medical data code sets in federal regulations (45 CFR 162.1002);
3. changes to national best practice protocols made by the National Quality Forum or other national accrediting or standard-setting organization based on (a) peer-reviewed medical literature generally recognized by the relevant medical community or (b) the results of clinical trials generally recognized and accepted by the relevant medical community;
4. 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. the federal Food and Drug Administration (FDA), or peer-reviewed medical literature generally recognized by the relevant medical community, identifying a drug, treatment, procedure, or device as no longer safe and effective; or
6. 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.

The act also allows changes at any time, subject to the above 30-day notice requirement, that are mutually agreed to by the organization and the dentist.

### § 2 — NEW INSURANCE PRODUCTS

The act permits a contracting health organization to introduce a new insurance product to a dentist at any time. The organization must give 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.

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### § 2 — PAYMENT CANCELLATION, DENIAL, OR RETURN

The act prohibits a contracting health organization, more than 18 months after receiving a dentist's clean 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) paid the dentist more than once for the claim, or (c) paid a claim that was or should have been 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 act gives a dentist that received 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.

#### *Notice and Appeal*

The act 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. The act 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 that a payment return demand be stayed (i.e., postponed) during the appeal.

#### *Adjusted Claim*

If there is no appeal or an appeal is denied, the act 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 because it paid the claim more than once.

#### *Other Appropriate Insurance Coverage*

The act 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 their timely filing requirements.

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### § 3 — FEE SCHEDULE CHANGES FOR DENTAL-ONLY POLICIES

The act prohibits a person who issues a policy covering only inpatient or outpatient dental services from materially changing an in-network provider's fee schedule more than once annually. Any person making a material change to a fee schedule must give each in-network provider at least 90 days' advance notice by mail, e-mail, or fax. The notice must disclose the following information:

1. the percentage effect that the change will have on the provider's fees or
2. another measure that will let the provider understand how the change will affect his or her fees for the 20 covered procedures the provider performs most frequently, and for which the provider sought reimbursement, during the most recent 12 months.