General Assembly

Amendment

January Session, 2019

LCO No. **10504**

HB06088105O4HDO

Offered by:
REP. SCANLON, 98th Dist.

To: Subst. House Bill No. **6088** File No. 280 Cal. No. 186

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

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

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 Section 38a-479 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

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

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

(2) "Provider" means a physician, surgeon, chiropractor, podiatrist, psychologist, optometrist, dentist, naturopath or advanced practice registered nurse licensed in this state or a group or organization of such individuals, who has entered into or renews a participating

provider contract with a contracting health organization to render services to such organization's enrollees and enrollees' dependents.

(b) Each contracting health organization shall establish and implement a procedure to provide to each provider:

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

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

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

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

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

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

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

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

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

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

(C) 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;

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

(E) If a drug, treatment, procedure or device is identified as no

longer safe and effective by the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community;

(F) 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 the federal Food and Drug Administration or by peer-reviewed medical literature generally recognized by the relevant medical community; or

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

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

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

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

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

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

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

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

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

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

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

(D) If there is no appeal or an appeal is denied, such provider may

resubmit an adjusted claim, if applicable, to such organization, not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision or the denial of the appeal, whichever is applicable, except that if a return of payment was demanded pursuant to subparagraph (C) of subdivision (1) of this subsection, such claim shall not be resubmitted.

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

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

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

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

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

(C) Certify to the contracting health organization that the provider **[**, dentist**]** or hospital has not contracted with any other contracting

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

(2) Prohibits or limits the provider **[**, dentist**]** or hospital from contracting with any other contracting health organization to provide services or procedures at a payment or reimbursement rate lower than the rates contracted for with the contracting health organization; or

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

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

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

Sec. 3. Section 38a-472c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) For any policy delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for inpatient or outpatient dental services only, the person who issues the policy shall provide the insured or a licensed dentist acting on behalf of the insured, upon request, an estimate of reimbursement under the policy

with respect to specific dental procedure codes ordered or recommended for the insured by a licensed dentist, except that the actual reimbursement may be adjusted based on factors such as the insured's eligibility, plan design, utilization of benefits and the actual claim submitted.

(b) No person that issues a policy described in subsection (a) of this section that uses a provider network for such policy shall materially adjust the fee schedule for in-network providers more than once annually.

(c) Each person that makes a material adjustment described in subsection (b) of this section shall issue a notice to each in-network provider at least ninety days before the effective date of such adjustment. Each such notice shall be sent by mail, electronic mail or facsimile, and disclose:

(1) The percentage effect that such adjustment will have on such provider's fees; or

(2) A measure, other than the measure described in subdivision (1) of this subsection, that will enable such provider to understand how such adjustment will affect such provider's fees for the twenty covered procedures that such provider most frequently performed, and for which such provider sought reimbursement, during the twelve months immediately preceding the date of such notice."

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
Sec. 3	*January 1, 2020*	38a-472c