

Public Act 09-204 broadens the type of fee information a contracting health organization must give to health care providers with whom they contract. It also requires the organization to give providers Internet, electronic, or digital access to policies and procedures regarding:

- payments to providers;
- providers' duties and requirements under the participating provider contract;
- inquiries and appeals from providers;
- contact information;
- a description of the rights of a provider, enrollee and enrollee's dependents with respect to an appeal; and
- the Health Care Procedure Coding System (HCPCS) codes applicable to or requested by such provider for other services for which the provider actually bills or intends to bill, provided such codes are within the provider's specialty or subspecialty.

In addition, the bill prohibits contracting health organizations from making material changes to a provider's fee schedule except as specified below:

- once a year if it gives providers at least 90 days' advance notice by mail, electronic mail, or fax of the changes; and
- at any time if it gives providers at least 30 days' advance notice by mail, electronic mail, or fax of any changes that are based on certain circumstances the bill specifies, such as (a) to comply with changes to national best practice protocols made by the National Quality Forum or other national accrediting or standard-setting organization, or (b) to be consistent with changes made in Medicare pertaining to billing or medical management practices.

The bill also prohibits a contracting health organization from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than 18 months after the date of the receipt of a clean claim, unless:

- the organization has a documented basis to believe that the claim was fraudulently submitted by such provider;
- the provider did not bill appropriately for the claim based on the documentation or evidence of what medical service was actually provided;
- the organization already paid the provider for the claim;
- the organization paid a claim that should have been or was paid by a federal or state program; or
- the provider received payment from a different insurer, payer, or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy.

Lastly, the bill gives a provider that receives a payment from another source one year after the date of the cancellation, denial, or return of full or partial payment to resubmit an adjusted secondary payer claim with the organization on a secondary payer basis, regardless of the organization's timely filing requirements. (Public Act 09-204 OLR Analysis).

This bill is considered a huge victory for medicine and will hopefully have a significant impact on physician/MCO contracting.