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## **OLR Bill Analysis**

### **sHB 5377**

#### ***AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS AND SITE OF SERVICE BILLING REQUIREMENTS.***

#### **SUMMARY**

This bill makes various changes to laws regarding claim payments and appeals between contracting health organizations (managed care organizations and preferred provider networks) and health care providers (for example, physicians).

The bill also establishes billing requirements for hospital-based facilities that are located off-site from a hospital campus, primarily requiring them to submit their national provider identifier and federal tax identification number when they submit claims for reimbursement or payment, regardless of whether the claim is filed or submitted by or through a separate facility or hospital. It also authorizes the insurance commissioner to adopt implementing regulations.

Regarding provider claim payment and appeals, the bill:

1. reduces, from 18 months to 15 months, the time period after receiving a clean (complete and error-free) claim during which a contracting health organization may generally cancel, deny, or demand full or partial return of payment from a health care provider due to an administrative or eligibility error;
2. allows organizations to use a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications to give providers the 30-day minimum advance notice of a payment cancellation, denial, or demand, notice required by law;

3. specifies that if the above notice is sent (a) by mail, it must be sent by certified mail, return receipt requested, or (b) by email, it must be sent to an email address the provider designates; and
4. requires the organization to notify the provider of its appeal determination within 12 business days after receiving the provider's appeal, otherwise the appeal must be construed in the provider's favor.

EFFECTIVE DATE: January 1, 2027, except the provision on site-of-service billing requirements is effective October 1, 2026

### **CLAIM PAYMENT CANCELLATION, DENIAL, OR RETURN**

#### ***Time Limit***

Current law generally 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 receiving the claim. The bill reduces this to 15 months after receiving the clean claim.

Under existing law, unchanged by the bill, the time limit does not apply if the:

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

#### ***Advance Notice***

Under existing law, an organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return

demand by mail, email, or fax. The bill specifies that if the notice is sent by mail, it must be sent by certified mail, return receipt requested; and if it is sent by email, it must be sent to the provider's designated email. The bill also gives organizations the option of providing this notice through a secure electronic provider portal or electronic clearinghouse used for claims or remittance communications.

### ***Appeal***

By law, a provider may appeal, in accordance with the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. Current law does not specify a mode for the appeal process. The bill explicitly requires organizations to have an electronic appeal process available to providers but allows them to have additional means to appeal available.

Further, the bill requires the organization to notify the provider of the appeal determination within 12 days after receiving the appeal. Under the bill, if the organization fails to do so, then the appeal must be construed in the provider's favor.

Existing law, unchanged by the bill, requires a payment return demand to be stayed (postponed) during the appeal.

### **SITE OF SERVICE BILLING REQUIREMENTS**

The bill establishes site of service billing requirements for hospital-based facilities that are located off-site from a hospital campus.

### ***Definitions***

Under the bill, a "hospital-based facility" is one that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided.

A "campus" is (1) the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, or (2) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus.

A “national provider identifier” is a standard, unique health identifier for each health care provider issued by the Centers for Medicare and Medicaid Services’ National Plan and Provider Enumeration System.

***Claim Submission and Reimbursement***

Starting January 1, 2027, the bill specifically does the following:

1. requires off-site hospital-based facilities to include the facility’s national provider identifier and federal tax identification number (see below) with each claim it submits for reimbursement or payment for health care services provided at the facility;
2. specifies that unless the provider submits the claim as described above, a health carrier must not be required to reimburse or pay the provider at an off-site hospital-based facility in Connecticut; and
3. prohibits any off-site hospital-based facility, or its designee, from holding the covered person under the claim liable for payment due to its failure to submit the claim to the health carrier in accordance with the bill.

***National Provider Identifier and Federal Tax Identification Number***

Under the bill, the national provider identifier and federal tax ID number a facility provides must be separate from the identifier or ID number issued to the hospital campus. They must also be included on any claim for reimbursement or payment for health care services provided at the facility, regardless of whether the claim or reimbursement is filed or submitted by or through a separate facility or hospital.

**BACKGROUND**

***Related Bill***

SB 341, favorably reported by the Insurance and Real Estate Committee, has similar provisions on (1) provider payment, cancellation, denial, and return and (2) the appeal determination notice.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 0 (03/12/2026)