

**TESTIMONY OF  
CONNECTICUT HOSPITAL ASSOCIATION  
SUBMITTED TO THE  
INSURANCE AND REAL ESTATE COMMITTEE  
Thursday, February 19, 2004**

**HB 5203, An Act Concerning The Recoding And Denial Of Health Insurance  
Claims And Provider Appeals Of Such Recoding And Denial**

**HB 5208, An Act Allowing Providers To Access The External Appeals Process To  
Appeal Payment Determinations Made By Managed Care Organizations**

The Connecticut Hospital Association (CHA) appreciates the opportunity to submit testimony in support of **HB 5203, An Act Concerning The Recoding And Denial Of Health Insurance Claims And Provider Appeals Of Such Recoding And Denial**, and **HB 5208, An Act Allowing Providers To Access The External Appeals Process To Appeal Payment Determinations Made By Managed Care Organizations**.

HB 5203 and HB 5208 are similar bills that allow providers to appeal certain decisions of managed care companies. HB 5203 allows a provider who is aggrieved by a recoding or denial and who has exhausted any internal mechanisms provided by a managed care organization to appeal the recoding or denial to the Managed Care Ombudsman. HB 5208 amends the existing external appeals process to include determinations where a managed care company recodes claims submitted by providers. These bills are an important extension of the existing external appeals process where providers constantly struggle over admission, services, and other issues with managed care companies and if enacted, will greatly benefit Connecticut's healthcare system.

CHA supports these two bills but respectfully requests that they be amended to ensure that the definition of provider includes hospitals. We request that the bills be amended to provide that any provider, including a hospital, has the right to appeal through the external appeals process the recoding and denial determinations of a managed care company or a utilization review company. In addition, the bill should provide that any such provider, including a hospital, is deemed to be authorized to exercise such right without having to obtain the enrollee's consent or authorization. The bill should be further amended to provide that in any such appeal exercised by a provider, including a hospital, the sole question on appeal shall be whether or not the services were medically necessary. If it is determined on appeal that such services were medically necessary, then the managed care company or utilization review company should be required to reverse its previous determination and pay for such services.

Thank you for your consideration of our position.

JDI:pas