General Assembly

**Raised Bill No. 554**

*February Session, 2006*

LCO No. **2650**

Referred to Committee on

**INSURANCE & REAL ESTATE**

Introduced by:
(INS)

***AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-102d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under sections 38a-102 to 38a-102h, inclusive, a domestic insurer may also: (1) Invest in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates, amounts which do not exceed the lesser of ten per cent of such insurer's assets or fifty per cent of such insurer's surplus as regards policyholders, provided after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries or affiliates shall be excluded, and there shall be included: (A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary or affiliate, including all organizational expenses and contributions to capital and surplus of

such subsidiary or affiliate whether or not represented by the purchase of capital stock or issuance of other securities, and (B) all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital and surplus, of a subsidiary or affiliate subsequent to its acquisition or formation; (2) invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided each such subsidiary or affiliate agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subdivision (1) of this subsection or in sections 38a-102 to 38a-102h, inclusive, applicable to the insurer. For purposes of this subdivision, "the total investment of the insurer" includes: (A) Any direct investment by the insurer in an asset, and (B) the insurer's proportionate share of any investment in an asset by any subsidiary or affiliate of the insurer, which shall be calculated by multiplying the amount of the subsidiary's or affiliate's investment by the percentage of the ownership of such subsidiary or affiliate; and (3) with the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries or affiliates, provided after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) In determining the financial condition of an insurance company, its subsidiaries or affiliates shall be valued in accordance with any applicable valuation method approved by the commissioner and consistent with procedures promulgated by the National Association of Insurance Commissioners.

(c) With respect to the activities conducted by a domestic insurer's subsidiaries or affiliates, the commissioner shall have the power to: (1)

Order said company to curtail the conduct of any activity if he finds, after notice and opportunity to be heard, that such activity is not lawful or is against public policy or that the continuation of such activity is materially adverse to the interests of the insurer's policyholders; and (2) require separate books, accounts and records for such classes of activities of the insurance company subsidiary or affiliate as he shall determine, which books, accounts and records shall be so maintained as to disclose clearly and accurately the nature and details of such activities. The commissioner may determine that an activity is materially adverse to policyholders if he finds that subsidiaries or affiliates are being used to avoid the quantitative limitations directly applicable to insurers under section 38a-102c.

Sec. 2. Subdivision (2) of subsection (a) of section 38a-226c of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of determinations not to certify an admission, service, procedure or extension of stay. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the [medical] healing arts.

Sec. 3. Subsection (d) of section 38a-478n of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's plan is fully insured, self-funded, or otherwise funded. If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

(2) Failure of the managed care organization or health insurer to provide information or notify the plan sponsor in accordance with subdivision (1) of this subsection within said five-business-day period or before the expiration of the thirty-day period for appeals set forth in subdivision (1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service is a covered benefit under the applicable policy or contract, except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract, and (B) entitle the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing a medical necessity

determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

Sec. 4. Subsection (a) of section 38a-478s of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended, shall be construed to apply to the arrangements of managed care organizations offered to individuals covered under self-insured [health plans] employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *October 1, 2006* | 38a-102d |
| Sec. 2 | *October 1, 2006* | 38a-226c(a)(2) |
| Sec. 3 | *from passage* | 38a-478n(d) |
| Sec. 4 | *from passage* | 38a-478s(a) |

***Statement of Purpose:***
To make minor and other revisions to the insurance statutes.

***[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]***

# Senate

General Assembly

**File No. 205**

*February Session, 2006*

Substitute Senate Bill No. 554

*Senate, March 29, 2006*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## *AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.*

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 38a-19 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) Any person or insurer aggrieved by any order or decision of the commissioner made without a hearing may, not later than thirty days after notice of the order to the person or insurer, make written request to the commissioner for a hearing on the order or decision. The commissioner shall hear such party or parties not later than [twenty] thirty days after receipt of such request and shall give not less than ten days' written notice of the time and place of the hearing. Not later than [fifteen] forty-five days after such hearing, the commissioner shall affirm, reverse or modify his previous order or decision, specifying his reasons therefor. Pending such hearing and decision on such hearing the commissioner may suspend or postpone the effective date of his previous order or decision.

Sec. 2. Section 38a-102d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under sections 38a-102 to 38a-102h, inclusive, a domestic insurer may also: (1) Invest in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates, amounts which do not exceed the lesser of ten per cent of such insurer's assets or fifty per cent of such insurer's surplus as regards policyholders, provided after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries or affiliates shall be excluded, and there shall be included: (A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary or affiliate, including all organizational expenses and contributions to capital and surplus of such subsidiary or affiliate whether or not represented by the purchase of capital stock or issuance of other securities, and (B) all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital and surplus, of a subsidiary or affiliate subsequent to its acquisition or formation; (2) invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided each such subsidiary or affiliate agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subdivision (1) of this subsection or in sections 38a-102 to 38a-102h, inclusive, applicable to the insurer. For purposes of this subdivision, "the total investment of the insurer" includes: (A) Any direct investment by the insurer in an asset, and (B) the insurer's proportionate share of any investment in an asset by any subsidiary or affiliate of the insurer, which shall be calculated by

multiplying the amount of the subsidiary's or affiliate's investment by the percentage of the ownership of such subsidiary or affiliate; and (3) with the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries or affiliates, provided after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) In determining the financial condition of an insurance company, its investments in subsidiaries or affiliates shall be valued in accordance with any applicable valuation method approved by the commissioner and consistent with procedures promulgated by the National Association of Insurance Commissioners.

(c) With respect to the activities conducted by a domestic insurer's subsidiaries, the commissioner shall have the power to: (1) Order said company to curtail the conduct of any activity if he finds, after notice and opportunity to be heard, that such activity is not lawful or is against public policy or that the continuation of such activity is materially adverse to the interests of the insurer's policyholders; and (2) require separate books, accounts and records for such classes of activities of the insurance company subsidiary as he shall determine, which books, accounts and records shall be so maintained as to disclose clearly and accurately the nature and details of such activities. The commissioner may determine that an activity is materially adverse to policyholders if he finds that subsidiaries are being used to avoid the quantitative limitations directly applicable to insurers under section 38a-102c.

Sec. 3. Subdivision (2) of subsection (a) of section 38a-226c of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of

determinations not to certify an admission, service, procedure or extension of stay. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the [medical] healing arts.

Sec. 4. Subsection (d) of section 38a-478n of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's plan is fully insured, self-funded, or otherwise funded. If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

(2) Failure of the managed care organization or health insurer to provide information or notify the plan sponsor in accordance with subdivision (1) of this subsection within said five-business-day period or before the expiration of the thirty-day period for appeals set forth in subdivision (1) of subsection (b) of this section, whichever is later as determined by the commissioner, shall (A) create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service is a covered benefit under the applicable policy or contract, except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract, and (B) entitle the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing a medical necessity determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

Sec. 5. Subsection (a) of section 38a-478s of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended, shall be construed to apply to the arrangements of managed care organizations offered to individuals covered under self-insured [health plans] employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *October 1, 2006* | 38a-19(a) |
| Sec. 2 | *October 1, 2006* | 38a-102d |
| Sec. 3 | *October 1, 2006* | 38a-226c(a)(2) |
| Sec. 4 | *from passage* | 38a-478n(d) |
| Sec. 5 | *from passage* | 38a-478s(a) |

***INS*** *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

### *OFA Fiscal Note*

***State Impact:*** None

***Municipal Impact:*** None

### *Explanation*

The bill makes various revisions to the insurance statutes, none of which have a fiscal impact.

### *The Out Years*

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis**
**sSB 554**

***AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.***

**SUMMARY:**

This bill makes a number of substantive and technical revisions to the insurance statutes. It (1) increases the time the insurance commissioner has to hear and decide contested cases related to denied licenses, rates, or forms; (2) allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries; (3) requires self-insured governmental health plans to provide information regarding a plan under which an appeal is made within five business days of receiving a request; and (4) requires a licensed practitioner of the healing arts, instead of the medical arts, to certify a utilization review company's decision following an appeal to not authorize an admission, service, procedure, or extended hospital stay.

EFFECTIVE DATE: October 1, 2006, except for the self-insured governmental health plan provision and a technical change, which are effective upon passage.

**CONTESTED CASE HEARING TIMEFRAMES**

Current law requires the commissioner to (1) hold a hearing within 20 days of receiving a request from a person or insurer aggrieved by an order or decision of hers and (2) render a decision within 15 days of the hearing. The bill increases the timeframes to 30 days in which to hold a hearing and 45 days to issue her decision.

**INVESTMENTS IN AFFILIATES**

By law, and unchanged by the bill, an insurer may invest in one or more of its subsidiaries, subject to certain limitations and

requirements. The bill allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries.

The bill allows an insurer to invest in the common stock, preferred stock, debt obligations, or other securities of one or more of its affiliates in an amount up to the lesser of 10% of the insurer's assets or 50% of its surplus if, after the investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.

Investments in domestic and out-of-state insurance company affiliates are not included in calculating the amount of the investments, but the following items must be:

1. the total amount spent and obligations assumed in the acquisition or formation of an affiliate, including organization expenses and contributions to capital and surplus and

2. all amounts spent in acquiring additional common or preferred stock, debt obligations, and other securities and contributions to the capital and surplus of an affiliate after its acquisition or formation.

Insurers may invest any amount in the common or preferred stock, debt obligations, and other securities of one or more affiliates engaged or exclusively organized to engage in the ownership and management of the insurer's investment, if the affiliate agrees to limit its investments so that they will not cause the insurer's total investments to exceed the investment limitations specified. "Total investment of the insurer" includes (1) any direct investments made by the insurer in assets and (2) the insurer's proportionate share of an investment by an affiliate, which must be calculated by multiplying the amount of the affiliate's investment by the parent insurer's percentage ownership of it.

With the insurance commissioner's approval, an insurer may invest

a greater amount in the common or preferred stock, debt obligations, or other securities of one or more affiliates if, after such investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.

In determining an insurer's financial condition, its investments in affiliates must be valued using a method (1) approved by the commissioner and (2) consistent with procedures established by the National Association of Insurance Commissioners.

## REQUEST FOR INFORMATION FOR APPEAL

By law, and unchanged by the bill, an insurer or managed care organization (MCO) must provide the insurance commissioner, an enrollee, or a provider with certain appeal-related information within five business days of receiving a request. Failure to do so subjects the insurer or MCO to a fine of $100 for each day of violation. The information includes written verification that the plan is fully insured, self-insured, or otherwise funded.

If the plan is fully insured, current law requires the insurer or MCO to also send: (1) written certification to the commissioner or designated review entity that the benefit or service appealed is covered; (2) written certification that the policy or contract is accessible electronically, along with clear and simple instructions on how to access it; or (3) a copy of the entire policy or contract between the enrollee and the MCO. Under the bill, the insurer or MCO must also send this information if the plan is a self-insured governmental health plan, but with respect to forwarding a copy of the contract, an MCO must notify the plan sponsor, who must send or direct the MCO to send the copy. (The bill does not similarly require an insurer to notify the plan sponsor.)

Under the bill, the MCO's failure to notify the plan sponsor within the five-business-day period or before the 30-day appeal period ends, whichever is later as determined by the commissioner, (1) creates a presumption that the benefit or service is a covered benefit for

purposes of accepting the appeal for full review and (2) entitles the commissioner to require the MCO to reimburse the Insurance Department for appeal-related expenses. The presumption established does not create or authorize benefits or services exceeding those in the enrollee's policy or contract. By law, and unchanged by the bill, an insurer's or MCO's failure to provide information within the specified timeframes also creates the presumption and permits the commissioner to require the insurer or MCO to reimburse the department for appeal-related expenses.

## UTILIZATION REVIEW APPEAL DECISION

Current law requires a utilization review company to have a licensed practitioner of the medical arts to certify appeal determinations to not certify an admission, service, procedure, or extended hospital stay. The bill instead requires a licensed practitioner of the healing arts certify the determination. Connecticut statutes define the practice of "healing arts" as the practice of medicine, chiropractic, podiatry, natureopathy, and optometry.

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/16/2006)

General Assembly

[House] **Amendment** [A.]

*February Session, 2006*

LCO No. **3727**

Offered by:
SEN. CRISCO, 17th Dist.
REP. O'CONNOR, 35th Dist.

To: Subst. Senate Bill No. **554** File No. 205 Cal. No. 178

***"AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES."***

In lines 111 and 113, after "organization" insert "or health insurer"

178

SENATE AMENDMENT

Calendar: 178

LCO: 3727

Bill: 554

A

ADOPTED voice ☒ REJECTED voice ☐

ADOPTED roll ☐ REJECTED roll ☐

General Assembly

[SENATE] **Amendment** [B. ]

*February Session, 2006*

LCO No. **4178**

Offered by:
SEN. CRISCO, 17th Dist.
REP. O'CONNOR, 35th Dist.

To: Subst. Senate Bill No. **554** File No. 205 Cal. No. 178

(As Amended by Senate Amendment Schedule "A")

***"AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES."***

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1 In line 139, after "organizations" insert "or health insurers"

178

**SENATE AMENDMENT**

Calendar: 178

LCO: 4178

Bill: 554

B

ADOPTED voice ☒ REJECTED voice ☐

ADOPTED roll ☐ REJECTED roll ☐

General Assembly

[SENATE] **Amendment**

*February Session, 2006*

LCO No. **4133**

*SB00554041335RO*

Offered by:
SEN. FREEDMAN, 26th Dist.

To: Subst. Senate Bill No. **554** File No. 205 Cal. No. 178

***"AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES."***

After the last section, add the following and renumber sections and internal references accordingly:

"Sec. 501. Section 38a-477 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Except where there is an agreement to the contrary between a third-party payer and the health care provider, as defined in section 19a-17b, all health care providers shall submit all third-party claims for payment on the current standard Health Care Financing Administration Fifteen Hundred (HCFA1500) health insurance claim form or its successor, or in the case of a hospital or other health care institution, a Health Care Financing Administration UB-92 health insurance claim form or its successor, or in accordance with other forms which may be prescribed by the Insurance Commissioner.

(b) For any claim submitted to an insurer on the current standard Health Care Financing Administration Fifteen Hundred health

insurance claim form or its successor, if the following information is completed and received by the insurer, the claim may not be deemed to be deficient in the information needed for filing a claim for processing pursuant to subparagraph (B) of subdivision (15) of section 38a-816, as amended.

| Item Number | Item Description |
|---|---|
| 1a | Insured's identification number |
| 2 | Patient's name |
| 3 | Patient's birth date and sex |
| 4 | Insured's name |
| 10a | Patient's condition - employment |
| 10b | Patient's condition - auto accident |
| 10c | Patient's condition - other accident |
| 11 | Insured's policy group number (if provided on identification card) |
| 11d | Is there another health benefit plan? |
| 17a | Identification number of referring physician (if required by insurer) |
| 21 | Diagnosis |
| 24A | Dates of service |
| 24B | Place of service |
| 24D | Procedures, services or supplies |
| 24E | Diagnosis code |
| 24F | Charges |
| [25 | Federal tax identification number] |
| 28 | Total charge |
| 31 | Signature of physician or supplier with date |
| 33 | Physician's, supplier's billing name, address, zip code & telephone number |

(c) For any claim submitted to an insurer on the current standard Health Care Financing Administration UB-92 health insurance claim

form or its successor, if the following information is completed and received by the insurer, the claim may not be deemed to be deficient in the information needed for filing a claim for processing pursuant to subparagraph (B) of subdivision (15) of section 38a-816, as amended.

| | | |
|---|---|---|
| T25 | Item Number | Item Description |
| T26 | 1 | Provider name and address |
| T27 | 5 | Federal tax identification number |
| T28 | 6 | Statement covers period |
| T29 | 12 | Patient name |
| T30 | 14 | Patient's birth date |
| T31 | 15 | Patient's sex |
| T32 | 17 | Admission date |
| T33 | 18 | Admission hour |
| T34 | 19 | Type of admission |
| T35 | 21 | Discharge hour |
| T36 | 42 | Revenue codes |
| T37 | 43 | Revenue description |
| T38 | 44 | HCPCS/CPT4 codes |
| T39 | 45 | Service date |
| T40 | 46 | Service units |
| T41 | 47 | Total charges by revenue code |
| T42 | 50 | Payer identification |
| T43 | 51 | Provider number |
| T44 | 58 | Insured's name |
| T45 | 60 | Patient's identification number |
| T46 | | (policy number and/or |
| T47 | | Social Security number) |
| T48 | 62 | Insurance group number |
| T49 | | (if on identification card) |
| T50 | 67 | Principal diagnosis code |
| T51 | 76 | Admitting diagnosis code |
| T52 | 80 | Principle procedure code and date |

| | | |
|---|---|---|
| T53 | 81 | Other procedures code and date |
| T54 | 82 | Attending physician's identification |
| T55 | | number |

(d) No third party payer shall require a federal tax identification number for a clean claim provided the health care provider, as defined in section 19a-17b, has previously filed a federal tax identification number with such third party payer.

[(d)] (e) The commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section."

**SENATE AMENDMENT**

Calendar: 178

LCO: 4133

Bill: 554

ADOPTED voice ☐ REJECTED voice ☐

ADOPTED roll ☐ REJECTED roll ☐