SENATE DOCKET, NO. 2267 FILED ON: 1/20/2023

SENATE . . . . . No. 663

The Commonwealth of Massachusetts

PRESENTED BY:

John F. Keenan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to prevent inappropriate denials by insurers for medically necessary services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
John F. Keenan	*Norfolk and Plymouth*	
Lindsay N. Sabadosa	*1st Hampshire*	*2/9/2023*

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SENATE . . . . . No. 663

By Mr. Keenan, a petition (accompanied by bill, Senate, No. 663) of John F. Keenan and Lindsay N. Sabadosa for legislation to prevent inappropriate denials by insurers for medically necessary services. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act to prevent inappropriate denials by insurers for medically necessary services.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 24B of chapter 175 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the first paragraph the following four paragraphs:

A carrier, as defined in section 1 of chapter 176O, shall be required to pay for health care services ordered by the treating health care provider if (i) the services are a covered benefit under the insured's health benefit plan and (ii) the services follow the carrier's clinical review criteria; provided further, a claim for treatment of medically necessary services may not be denied if the treating health care provider follows the carrier's approved method for securing authorization for a covered service for the insured at the time the service were provided.

A carrier shall not deny payment for a claim for medically necessary covered services on the basis of an administrative or technical defect in the claim, except in the case where the carrier has a reasonable basis supported by specific information available for review that the claim was

submitted fraudulently. A carrier shall have no more than twelve months after the original payment was received by the provider to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a full or partial payment; provided however, a carrier shall not recoup payments more than ninety days after the original payment was received by a provider for services provided to an insured that the carrier deems ineligible for coverage because the insured was retroactively terminated or retroactively disenrolled for services; provided further, that the provider can document that it received verification of an insured's eligibility status using the carrier's approved method for verifying eligibility at the time service was provided. Claims may also not be recouped for utilization review purposes if the services were already deemed medically necessary or the manner in which the services were accessed or provided were previously approved by the carrier or its contractor.

A carrier that seeks to make an adjustment pursuant to this section shall provide the health care provider with written notice that explains in detail the reasons for the recoupment, identifies each previously paid claim for which a recoupment is sought and provides the health care provider with thirty days to challenge the request for recoupment. Such written notice shall be made to the health provider not less than thirty days prior to the seeking of a recoupment or the making of an adjustment.

If a claim is denied because the provider, due to an unintentional act of error or omission, obtained no authorizations or only a partial authorization, the provider may appeal the denial and the carrier must conduct and complete within thirty days of the provider's submitted appeal a retrospective review of the medical necessity of the service. If the carrier determines that the service is medically necessary, the carrier must reverse the denial and pay the claim. If the carrier determines that the service does not meet its clinical review criteria, the carrier shall provide the

provider with specific written clinical justification for the determination and a process for appealing the determination.

SECTION 2. The commissioner of insurance shall promulgate regulations to enforce the provisions of this act no later than 90 days after the effective date, which shall be effective for provider contracts that are entered into, renewed or amended on or after the effective date of said regulations.