

The Commonwealth of Massachusetts

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**In the Year Two Thousand Twelve**  
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An Act to limit retroactive denials of health insurance claims.

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

1           SECTION 1. Section 38 of chapter 118E, as appearing in the 2006 Official Edition of the  
2 General Laws, is hereby amended by adding the following two new paragraphs :—

3           In this paragraph, "retroactive denial of a previously paid claim" means any attempt by  
4 the Division to retroactively collect payments already made to a health care provider with respect  
5 to a claim by requiring repayment of such payments, reducing other payments currently owed to  
6 the provider, withholding or setting off against future payments, or reducing or affecting the  
7 future claim payments to the provider in any other manner. The Division shall not impose on any  
8 health care provider any retroactive denial of a previously paid claim or any part thereof unless:

9           (a) The Division has provided the reason for the retroactive denial in writing to the  
10 health care provider; and

11           (b) The time which has elapsed since the date of payment of the challenged claim  
12 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
13 beyond 12 months from the date of payment only for the following reasons:

14           (1) The claim was submitted fraudulently;

15           (2) The claim payment was incorrect because the provider or the insured was  
16 already paid for the health care services identified in the claim;

17           (3) The health care services identified in the claim were not delivered by the  
18 physician/provider;

19           (4) The claim payment is the subject of adjustment with another insurer,  
20 administrator, or payor; or

21 (5) The claim payment is the subject of legal action.

22 The Division shall notify a health care provider at least 15 days in advance of the  
23 imposition of any retroactive denials of previously paid claims. The health care provider shall  
24 have 6 months from the date of notification under this paragraph to determine whether the  
25 insured has other appropriate insurance, which was in effect on the date of service.  
26 Notwithstanding the contractual terms between the Division and provider, the Division shall  
27 allow for the submission of a claim that was previously denied by another insurer due to the  
28 insured's transfer or termination of coverage.

29 SECTION 2. Subsection 4(c) of section 108 of chapter 175, as appearing in the 2006  
30 Official Edition of the General Laws, is hereby amended by adding at the end thereof the  
31 following two new subsections:—

32 4(d) In this section "retroactive denial of a previously paid claim" means any attempt by  
33 an insurer to retroactively collect payments already made to a health care provider with respect  
34 to a claim by requiring repayment of such payments, reducing other payments currently owed to  
35 the provider, withholding or setting off against future payments, or reducing or affecting the  
36 future claim payments to the provider in any other manner.

37 No insurer shall impose on any health care provider any retroactive denial of a previously  
38 paid claim or any part thereof unless:

39 (a) The insurer has provided the reason for the retroactive denial in writing to the  
40 health care provider; and

41 (b) The time which has elapsed since the date of payment of the challenged claim  
42 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
43 beyond 12 months from the date of payment only for the following reasons:

44 (1) The claim was submitted fraudulently;

45 (2) The claim payment was incorrect because the provider or the insured was  
46 already paid for the health care services identified in the claim;

47 (3) The health care services identified in the claim were not delivered by the  
48 physician/provider;

49 (4) The claim payment was for services covered by Title XVIII, Title XIX, or Title  
50 XXI of the Social Security Act;

51 (5) The claim payment is the subject of adjustment with another insurer,  
52 administrator, or payor; or

53 (6) The claim payment is the subject of legal action.

54 An insurer shall notify a health care provider at least 15 days in advance of the imposition  
55 of any retroactive denials of previously paid claims. The health care provider shall have 6  
56 months from the date of notification under this paragraph to determine whether the insured has  
57 other appropriate insurance, which was in effect on the date of service. Notwithstanding the  
58 contractual terms between the insurer and provider, the insurer shall allow for the submission of  
59 a claim that was previously denied by another insurer due to the insured's transfer or termination  
60 of coverage.

61 SECTION 3. Section 8 of chapter 176A, as appearing in the 2006 Official Edition of the  
62 General Laws, is hereby amended by adding at the end thereof the following two new clauses:—

63 (h) In this section "retroactive denial of a previously paid claim" means any attempt by a  
64 corporation to retroactively collect payments already made to a health care provider with respect  
65 to a claim by requiring repayment of such payments, reducing other payments currently owed to  
66 the provider, withholding or setting off against future payments, or reducing or affecting the  
67 future claim payments to the provider in any other manner.

68 The corporation shall not impose on any health care provider any retroactive denial of a  
69 previously paid claim or any part thereof unless:

70 (a) The corporation has provided the reason for the retroactive denial in writing to  
71 the health care provider; and

72 (b) The time which has elapsed since the date of payment of the challenged claim  
73 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
74 beyond 12 months from the date of payment only for the following reasons:

75 (1) The claim was submitted fraudulently;

76 (2) The claim payment was incorrect because the provider or the insured was  
77 already paid for the health care services identified in the claim;

78 (3) The health care services identified in the claim were not delivered by the  
79 physician/provider;

80 (4) The claim payment was for services covered by Title XVIII, Title XIX, or Title  
81 XXI of the Social Security Act;

82 (5) The claim payment is the subject of adjustment with another insurer,  
83 administrator, or payor; or

84 (6) The claim payment is the subject of legal action.

85 A corporation shall notify a health care provider at least 15 days in advance of the  
86 imposition of any retroactive denials of previously paid claims. The health care provider shall

87 have 6 months from the date of notification under this paragraph to determine whether the  
88 insured has other appropriate insurance, which was in effect on the date of service.  
89 Notwithstanding the contractual terms between the corporation and provider, the corporation  
90 shall allow for the submission of a claim that was previously denied by another insurer due to the  
91 insured's transfer or termination of coverage.

92 SECTION 4. Section 7 of chapter 176B, as appearing in the 2006 Official Edition of the  
93 General Laws, is hereby amended by adding at the end thereof the following new paragraph:—

94 In this paragraph "retroactive denial of a previously paid claim" means any attempt by a  
95 corporation to retroactively collect payments already made to a health care provider with respect  
96 to a claim by requiring repayment of such payments, reducing other payments currently owed to  
97 the provider, withholding or setting off against future payments, or reducing or affecting the  
98 future claim payments to the provider in any other manner.

99 The corporation shall not impose on any health care provider any retroactive denial of a  
100 previously paid claim or any part thereof unless:

101 (a) The corporation has provided the reason for the retroactive denial in writing to  
102 the health care provider; and

103 (b) The time which has elapsed since the date of payment of the challenged claim  
104 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
105 beyond 12 months from the date of payment only for the following reasons:

106 (1) The claim was submitted fraudulently;

107 (2) The claim payment was incorrect because the provider or the insured was  
108 already paid for the health care services identified in the claim;

109 (3) The health care services identified in the claim were not delivered by the  
110 physician/provider;

111 (4) The claim payment was for services covered by Title XVIII, Title XIX, or Title  
112 XXI of the Social Security Act;

113 (5) The claim payment is the subject of adjustment with another insurer,  
114 administrator, or payor; or

115 (6) The claim payment is the subject of legal action.

116 A corporation shall notify a health care provider at least 15 days in advance of the  
117 imposition of any retroactive denials of previously paid claims. The health care provider shall  
118 have 6 months from the date of notification under this paragraph to determine whether the  
119 insured has other appropriate insurance, which was in effect on the date of service.

120 Notwithstanding the contractual terms between the corporation and provider, the corporation  
121 shall allow for the submission of a claim that was previously denied by another insurer due to the  
122 insured's transfer or termination of coverage.

123 SECTION 5. Section 6 of chapter 176G, as appearing in the 2006 Official Edition of the  
124 General Laws, is hereby amended by adding at the end thereof the following new paragraph:—

125 “In this paragraph "retroactive denial of a previously paid claim" means any attempt by a  
126 health maintenance organization to retroactively collect payments already made to a health care  
127 provider with respect to a claim by requiring repayment of such payments, reducing other  
128 payments currently owed to the provider, withholding or setting off against future payments, or  
129 reducing or affecting the future claim payments to the provider in any other manner.

130 A health maintenance organization shall not impose on any health care provider any  
131 retroactive denial of a previously paid claim or any part thereof unless:

132 (a) The health maintenance organization has provided the reason for the retroactive  
133 denial in writing to the health care provider; and

134 (b) The time which has elapsed since the date of payment of the challenged claim  
135 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
136 beyond 12 months from the date of payment only for the following reasons:

137 (1) The claim was submitted fraudulently;

138 (2) The claim payment was incorrect because the provider or the insured was  
139 already paid for the health care services identified in the claim;

140 (3) The health care services identified in the claim were not delivered by the  
141 physician/provider;

142 (4) The claim payment was for services covered by Title XVIII, Title XIX, or Title  
143 XXI of the Social Security Act;

144 (5) The claim payment is the subject of adjustment with another insurer,  
145 administrator, or payor; or

146 (6) The claim payment is the subject of legal action.

147 A health maintenance organization shall notify a health care provider at least 15 days in  
148 advance of the imposition of any retroactive denials of previously paid claims. The health care  
149 provider shall have 6 months from the date of notification under this paragraph to determine  
150 whether the insured has other appropriate insurance, which was in effect on the date of service.  
151 Notwithstanding the contractual terms between the health maintenance organization and

152 provider, the health maintenance organization shall allow for the submission of a claim that was  
153 previously denied by another insurer due to the insured's transfer or termination of coverage.”

154 SECTION 6. Section 2 of chapter 176I, as appearing in the 2006 Official Edition of the  
155 General Laws, is hereby amended by adding at the end thereof the following new paragraph:—

156 “In this paragraph "retroactive denial of a previously paid claim" means any attempt by  
157 an organization to retroactively collect payments already made to a health care provider with  
158 respect to a claim by requiring repayment of such payments, reducing other payments currently  
159 owed to the provider, withholding or setting off against future payments, or reducing or affecting  
160 the future claim payments to the provider in any other manner.

161 An organization shall not impose on any health care provider any retroactive denial of a  
162 previously paid claim or any part thereof unless:

163 (a) The organization has provided the reason for the retroactive denial in writing to  
164 the health care provider; and

165 (b) The time which has elapsed since the date of payment of the challenged claim  
166 does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted  
167 beyond 12 months from the date of payment only for the following reasons:

168 (1) The claim was submitted fraudulently;

169 (2) The claim payment was incorrect because the provider or the insured was  
170 already paid for the health care services identified in the claim;

171 (3) The health care services identified in the claim were not delivered by the  
172 physician/provider;

173 (4) The claim payment was for services covered by Title XVIII, Title XIX, or Title  
174 XXI of the Social Security Act;

175 (5) The claim payment is the subject of adjustment with another insurer,  
176 administrator, or payor; or

177 (6) The claim payment is the subject of legal action.

178 An organization shall notify a health care provider at least 15 days in advance of the  
179 imposition of any retroactive denials of previously paid claims. The health care provider shall  
180 have 6 months from the date of notification under this paragraph to determine whether the  
181 insured has other appropriate insurance, which was in effect on the date of service.  
182 Notwithstanding the contractual terms between an organization and provider, the organization  
183 shall allow for the submission of a claim that was previously denied by another insurer due to the  
184 insured's transfer or termination of coverage.

185 SECTION 7. Chapter 176O as appearing in the 2008 Official Edition is hereby amended  
186 by adding at the end thereof the following new section:

187 Section 22. All carriers providing medical care coverage to eligible individuals shall, in  
188 its payment to physicians, recognize the use of modifiers to billing codes employed by the  
189 carriers. Modifiers that indicate that a procedure or service is distinct or separate from other  
190 services performed on the same day, including services provided in a separate session or  
191 encounter; a different procedure or surgery; a different site, or a separate lesion, or separate  
192 injury or site of injury shall be reimbursed in a manner consistent with that of programs  
193 providing health coverage under Title XVIII of the Social Security Act. Modifiers that identify a  
194 significant, separate evaluation and management service by the same physician on the same day  
195 of another, non-comprehensive, billed service or procedure shall be recognized by the carriers  
196 and be compensated in a manner consistent with that of programs providing health coverage  
197 under Title XVIII of the Social Security Act. In implementation of the provisions of this  
198 paragraph, carriers shall use the Medicare Correct Coding Initiative standards for modifiers 25  
199 and 59.”