HOUSE DOCKET, NO. 176 FILED ON: 1/11/2011

HOUSE . . . . . No. 322

The Commonwealth of Massachusetts

PRESENTED BY:

John W. Scibak

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 relative to pre-authorization of medical and health care services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
John W. Scibak	*2nd Hampshire*	*10/4/2012*
James B. Eldridge		*2/2/2011*
David B. Sullivan	*6th Bristol*	*2/4/2011*

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HOUSE . . . . . No. 322

By Mr. Scibak of South Hadley, a petition (accompanied by bill, House, No. 322) of John W. Scibak, James B. Eldridge and David B. Sullivan for legislation to further regulate the payments by health care carries. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1035* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to pre-authorization of medical and health care 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. Chapter 176O is hereby amended by adding the following section:-

Section 18.

(a) As used in this section, the following words shall, except as otherwise provided, have the following meanings:-

"Pre-authorization", the prospective approval obtained from an insurance carrier prior to the provision of medical care or health care services which have been determined by the insurance carrier to be medically necessary and appropriate.

(b) A carrier shall pay claims for any and all medical care or health care services for which a pre-authorization was required by, and received from, the carrier prior to the rendering of such service, unless:

(1) the insured was not a covered person at the time the medical care or health care services were rendered. Notwithstanding the provisions of this paragraph, a carrier shall not deny a claim on this basis if the insured's, coverage was retroactively terminated more than one hundred twenty days after the date of the medical care or health care services, provided that the claim is submitted within ninety days after the date of the medical care or health care services. If the claim is submitted more than ninety days after the date of the medical care or health care services, the health plan shall have thirty days after the claim is received to deny the claim on the basis that the insured was not a covered person on the date of the medical care or health care services;

(2) the submission of the claim with respect to an insured was not timely under the terms of the applicable provider contract, if the claim is submitted by a provider, or the policy or contract, if the claim is submitted by the insured;

(3) at the time the pre-authorization was issued, the insured had not exhausted contract or policy benefit limitations based on information available to the health plan at such time, but subsequently exhausted contract or policy benefit limitations after authorization was issued and prior to the provision of the medical care or health services for which authorization was received; provided, however, that the carrier shall notify the provider in advance that the visits authorized might exceed the limits of the contract or policy and accordingly would not be covered under the contract or policy;

(4) the pre-authorization was based on materially inaccurate or incomplete information provided by the insured, the designee of the insured, or the health care provider such that if the correct or complete information had been provided, such pre-authorization would not have been granted;

(5) the physician or provider has substantially failed to perform the proposed medical care or health care services; or

(6) the pre-authorized service was related to a pre-existing condition that was excluded from coverage.

(c) Nothing in this section shall be construed to prohibit a health plan from denying continued or extended coverage as part of a concurrent review of a health care service.