

HOUSE No. 4257

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

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.”