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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:

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

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

4(d) In this section "retroactive denial of a previously paid claim" means any attempt by an insurer to retroactively collect payments already made to a health care provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to

the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner.

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

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

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

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

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

In this paragraph "retroactive denial of a previously paid claim" means any attempt by a corporation to retroactively collect payments already made to a health care provider with respect

to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner.

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

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

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

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

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

“In this paragraph "retroactive denial of a previously paid claim" means any attempt by an organization to retroactively collect payments already made to a health care provider with

respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner.

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

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

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

(1) The claim was submitted fraudulently;

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

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

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

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

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

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

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

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