HOUSE DOCKET, NO. 1686 FILED ON: 1/17/2013

HOUSE . . . . . No. 1034

The Commonwealth of Massachusetts

PRESENTED BY:

Stephen Kulik

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 administering national standards to Medicaid medical necessity reviews.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Stephen Kulik	*1st Franklin*	*1/17/2013*
Denise Andrews	*2nd Franklin*	*1/29/2013*

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HOUSE . . . . . No. 1034

By Mr. Kulik of Worthington, a petition (accompanied by bill, House, No. 1034) of Stephen Kulik and Denise Andrews relative to applying national standards to Medicaid medical necessity reviews. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act relative to administering national standards to Medicaid medical necessity reviews.

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 8 of chapter 118E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting the following new definitions:

"Adverse determination", a determination from a clinical peer reviewer, based upon a review of information provided by a healthcare provider, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

"Clinical peer reviewer", a physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a non-restricted license from the appropriate professional licensing board in the commonwealth, a current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who also actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

SECTION 2. Section 51 of said chapter 118E, as so appearing, is hereby amended by inserting after the first paragraph the following new paragraph

Upon making an adverse determination regarding an admission, procedure or service, the division shall provide a written notification of the adverse determination that shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) discuss the medical assistance recipient's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons based on national evidence based medical standards and criteria that such medical evidence fails to meet a national evidence based medical standard and criteria; (3) specify any alternative treatment option offered by the division, if any; and (4) reference and include applicable clinical practice guidelines and review criteria. The division shall give a provider treating a medical assistance recipient an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer. The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer. If the adverse determination is not reversed by the reconsideration process, the provider may further pursue the division’s appeal process.

SECTION 3: The Office of Medicaid shall promulgate regulations to implement the provisions of this Act no later than 90 days after the effective date of the Act.