HOUSE DOCKET, NO. 1057 FILED ON: 1/18/2017

HOUSE . . . . . No. 563

The Commonwealth of Massachusetts

PRESENTED BY:

David M. Nangle

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 to prevent inappropriate denials for medically necessary services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
David M. Nangle	*17th Middlesex*	*1/18/2017*
Rady Mom	*18th Middlesex*	

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HOUSE . . . . . No. 563

By Mr. Nangle of Lowell, a petition (accompanied by bill, House, No. 563) of David M. Nangle and Rady Mom relative to insurance coverage for medically necessary services. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *919* OF 2015-2016.]

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act to prevent inappropriate denials for medically necessary 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. Section 24B of chapter 175 of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after the first paragraph the following paragraphs:

A carrier , as defined in section 1 of chapter 176O, shall be required to pay for health care services ordered by the treating health care provider if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services follow the carrier's clinical review criteria. Provided however, a claim for treatment of medically necessary services may not be denied if the treating health care provider follows the carrier's approved method for securing authorization for a covered service for the insured at the time the service was provided. A carrier shall have no more than twelve months after the original payment was received by the provider

to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a full or partial payment. However, a carrier shall not recoup payments more than ninety days after the original payment was received by a provider for services provided to an insured that the carrier deems ineligible for coverage because the insured was retroactively terminated or retroactively disenrolled for services, provided that the provider can document that it received verification of an insured's eligibility status using the carrier's approved method for verifying eligibility at the time service was provided. Claims may also not be recouped for utilization review purposes if the services were already deemed medically necessary or the manner in which the services were accessed or provided were previously approved by the carrier or its contractor. A carrier which seeks to make an adjustment pursuant to this section shall provide the health care provider with written notice that explains in detail the reasons for the recoupment, identifies each previously paid claim for which a recoupment is sought, and provides the health care provider with thirty days to challenge the request for recoupment. Such written notice shall be made to the health provider not less than thirty days prior to the seeking of a recoupment or the making of an adjustment.