

The Commonwealth of Massachusetts

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In the Year Two Thousand Twelve
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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 the
4 Division to retroactively collect payments already made to a health care provider with respect to
5 a claim by requiring repayment of such payments, reducing other payments currently owed to the
6 provider, withholding or setting off against future payments, or reducing or affecting the future
7 claim payments to the provider in any other manner. The Division shall not impose on any health
8 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 health
10 care provider; and

11 (b) The time which has elapsed since the date of payment of the challenged claim does not
12 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
13 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 already paid
16 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, administrator, or
20 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 imposition of
23 any retroactive denials of previously paid claims. The health care provider shall have 6 months
24 from the date of notification under this paragraph to determine whether the insured has other
25 appropriate insurance, which was in effect on the date of service. Notwithstanding the
26 contractual terms between the Division and provider, the Division shall allow for the submission
27 of a claim that was previously denied by another insurer due to the insured's transfer or
28 termination of coverage.

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

32 4(d) In this section "retroactive denial of a previously paid claim" means any attempt by an
33 insurer to retroactively collect payments already made to a health care provider with respect to a
34 claim by requiring repayment of such payments, reducing other payments currently owed to the

35 provider, withholding or setting off against future payments, or reducing or affecting the future
36 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 paid
38 claim or any part thereof unless:

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

41 (b) The time which has elapsed since the date of payment of the challenged claim does not
42 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
43 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 already paid
46 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 XXI of
50 the Social Security Act;

51 (5) The claim payment is the subject of adjustment with another insurer, administrator, or
52 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 of any
55 retroactive denials of previously paid claims. The health care provider shall have 6 months from
56 the date of notification under this paragraph to determine whether the insured has other
57 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 General
62 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 the health
71 care provider; and

72 (b) The time which has elapsed since the date of payment of the challenged claim does not
73 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
74 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 already paid
77 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 XXI of
81 the Social Security Act;

82 (5) The claim payment is the subject of adjustment with another insurer, administrator, or
83 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 imposition of
86 any retroactive denials of previously paid claims. The health care provider shall have 6 months
87 from the date of notification under this paragraph to determine whether the insured has other
88 appropriate insurance, which was in effect on the date of service. Notwithstanding the
89 contractual terms between the corporation and provider, the corporation shall allow for the
90 submission of a claim that was previously denied by another insurer due to the insured's transfer
91 or termination of coverage.

92 SECTION 4. Section 7 of chapter 176B, as appearing in the 2006 Official Edition of the General
93 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 the health
102 care provider; and

103 (b) The time which has elapsed since the date of payment of the challenged claim does not
104 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
105 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 already paid
108 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 XXI of
112 the Social Security Act;

113 (5) The claim payment is the subject of adjustment with another insurer, administrator, or
114 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 imposition of
117 any retroactive denials of previously paid claims. The health care provider shall have 6 months
118 from the date of notification under this paragraph to determine whether the insured has other
119 appropriate insurance, which was in effect on the date of service. Notwithstanding the
120 contractual terms between the corporation and provider, the corporation shall allow for the
121 submission of a claim that was previously denied by another insurer due to the insured's transfer
122 or termination of coverage.

123 SECTION 5. Section 6 of chapter 176G, as appearing in the 2006 Official Edition of the General
124 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 health
126 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 retroactive
131 denial of a previously paid claim or any part thereof unless:

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

134 (b) The time which has elapsed since the date of payment of the challenged claim does not
135 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
136 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 already paid
139 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 XXI of
143 the Social Security Act;

144 (5) The claim payment is the subject of adjustment with another insurer, administrator, or
145 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 advance
148 of the imposition of any retroactive denials of previously paid claims. The health care provider
149 shall have 6 months from the date of notification under this paragraph to determine whether the
150 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 General
155 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 an
157 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 the
164 health care provider; and

165 (b) The time which has elapsed since the date of payment of the challenged claim does not
166 exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12
167 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 already paid
170 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 XXI of
174 the Social Security Act;

175 (5) The claim payment is the subject of adjustment with another insurer, administrator, or
176 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 imposition
179 of any retroactive denials of previously paid claims. The health care provider shall have 6
180 months from the date of notification under this paragraph to determine whether the insured has
181 other appropriate insurance, which was in effect on the date of service. Notwithstanding the
182 contractual terms between an organization and provider, the organization shall allow for the
183 submission of a claim that was previously denied by another insurer due to the insured's transfer
184 or termination of coverage.

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

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