

HOUSE No. 4315

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, March 22, 2018.

The committee on Financial Services to whom were referred the petition (accompanied by bill, House, No. 2193) of James J. O'Day and others for legislation to limit retroactive denials of health insurance claims for mental health and substance abuse services and the petition (accompanied by bill, House, No. 2974) of James J. O'Day and others for legislation to limit retroactive denials of health insurance claims for behavioral health and substance abuse services, reports recommending that the accompanying bill (House, No. 4315) ought to pass.

For the committee,

AARON MICHLEWITZ.

HOUSE No. 4315

The Commonwealth of Massachusetts

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

An Act to limit retroactive denials of health insurance claims for behavioral health and substance abuse services.

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. Chapter 32A of the General Laws, as appearing in the 20XX Official
2 Edition, is hereby amended by inserting after section 4A the following new section: -

3 Section 4B. (a) The commission or any entity with which the commission contracts to
4 provide or manage health insurance benefits, including mental health services, shall not impose a
5 retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as
6 defined in section 1 of chapter 175, on a provider unless:

7 (i) Less than twelve months have elapsed from the time of submission of the claim
8 by the provider to the commission or other entity responsible for payment;

9 (ii) The commission or other entity has furnished the provider with a written
10 explanation of the reason for the retroactive claim denial, and a description of additional
11 documentation or other corrective actions required for payment of the claim.

12 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
13 permitted after twelve months if:

14 (i) The claim was submitted fraudulently;

15 (ii) The claim payment is subject to adjustment due to expected payment from
16 another payer and not more than 12 months have elapsed since submission of the claim; or

17 (iii) The claims, or services for which the claim has been submitted, is the subject of
18 legal action.

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

21 (v) the health care services identified in the claim were not delivered by the provider.

22 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
23 (b), the commission or other entity shall notify a provider at least 15 days before imposing the
24 retroactive claim denial and the provider shall have twelve months to determine whether the
25 claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms
26 between the provider and insurer, an insurer shall allow for submission of a claim that was
27 previously denied by another insurer due to the insured's transfer or termination of coverage.

28 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
29 substance use disorder program licensed by the department of public health under Chapters 18,
30 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is
31 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
32 consistent with law and who has provided services under an express or implied contract or with

33 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
34 directly or indirectly from the commission or other entity.

35 SECTION 2. Chapter 118E of the General Laws, as so appearing, is amended by
36 inserting after section 38 the following new section: -

37 38A. (a) The division or any entity with which the division contracts to provide or
38 manage health insurance benefits, including mental health services, shall not impose a retroactive
39 claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in
40 section 1 of chapter 175, on a provider unless:

41 (i) Less than twelve months have elapsed from the time of submission of the claim
42 by the provider to the division or other entity responsible for payment;

43 (ii) The division or other entity has furnished the provider with a written explanation
44 of the reason for the retroactive claim denial, and a description of additional documentation or
45 other corrective actions required for payment of the claim.

46 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
47 permitted after twelve months if:

48 (i) The claim was submitted fraudulently;

49 (ii) The claim payment is subject to adjustment due to expected payment from
50 another payer and not more than 12 months have elapsed since submission of the claim;

51 (iii) The claims, or services for which the claim has been submitted, is the subject of
52 legal action;

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

55 (v) the health care services identified in the claim were not delivered by the provider.

56 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
57 (b), the division or other entity shall notify a provider at least 15 days before imposing the
58 retroactive claim denial and the provider shall have twelve months to determine whether the
59 claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms
60 between the provider and insurer, an insurer shall allow for submission of a claim that was
61 previously denied by another insurer due to the insured's transfer or termination of coverage.

62 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
63 substance use disorder program licensed by the department of public health under Chapters 18,
64 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
65 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
66 consistent with law and who has provided services under an express or implied contract or with
67 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
68 directly or indirectly from the division or managed care entity.

69 SECTION 3. Section 1 of Chapter 175 of the General Laws, as so appearing, is amended
70 by inserting before the definition of "Commissioner" the following new definition:

71 "Behavioral Health", mental health and substance use disorder prevention, recovery and
72 treatment services including but not limited to inpatient 24 hour levels of care, 24 hour and non
73 24 hour diversionary levels of care, intermediate levels of care and outpatient services

74 and by inserting after the definition of "Resident" the following new definition:

75 “Retroactive Claim Denial”, an action by a) an insurer, b) an entity with which the
76 insurer subcontracts to manage behavioral health services, c) an entity with which the Group
77 Insurance Commission has entered into an administrative services contract or a contract to
78 manage behavioral health services, or d) the executive office of health and human services acting
79 as the single state agency under section 1902(a)(5) of the Social Security Act authorized to
80 administer programs under title XIX, to deny a previously paid claim for services and to require
81 repayment of the claim, impose a reduction in other payments, or otherwise withhold or affect
82 future payments owed a provider in order to recoup payment for the denied claim.

83 SECTION 4. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby
84 amended by adding the following new subsection at the end thereof: -

85 (a) No insurer shall impose a retroactive claims denial, as defined in section 1 of chapter
86 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

87 (i) Less than twelve months have elapsed from the time of submission of the claim
88 by the provider to the insurer or other entity responsible for payment;

89 (ii) The insurer or other entity has furnished the provider with a written explanation
90 of the reason for the retroactive claim denial, and a description of additional documentation or
91 other corrective actions required for payment of the claim.

92 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
93 permitted after twelve months if:

94 (i) The claim was submitted fraudulently;

95 (ii) The claim payment is subject to adjustment due to expected payment from
96 another payer and not more than 12 months have elapsed since submission of the claim; or

97 (iii) The claims, or services for which the claim has been submitted, is the subject of
98 legal action.

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

101 (v) the health care services identified in the claim were not delivered by the provider.

102 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph

103 (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim

104 denial and the provider shall have twelve months to determine whether the claim is subject to

105 payment by a secondary insurer. Notwithstanding the contractual terms between the provider and

106 insurer, an insurer shall allow for submission of a claim that was previously denied by another

107 insurer due to the insured's transfer or termination of coverage.

108 (d) For the purposes of this subsection, provider shall mean a mental health clinic or

109 substance use disorder program licensed by the department of public health under Chapters 18,

110 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is

111 licensed under Chapter 112 of the General Laws and accredited or certified to provide services

112 consistent with law and who has provided services under an express or implied contract or with

113 the expectation of receiving payment, other than co- payment, deductible or co-insurance,

114 directly or indirectly from an insurer.

115 SECTION 5. Chapter 176A of the General Laws, as so appearing, is amended by

116 inserting after section 8 the following new section:-

117 Section 8A (a) The corporation shall not impose a retroactive claims denial, as defined in
118 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
119 a provider unless:

120 (i) Less than twelve months have elapsed from the time of submission of the claim
121 by the provider to the corporation;

122 (ii) The corporation has furnished the provider with a written explanation of the
123 reason for the retroactive claim denial, and a description of additional documentation or other
124 corrective actions required for payment of the claim.

125 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
126 permitted after twelve months if:

127 (i) The claim was submitted fraudulently;

128 (ii) The claim payment is subject to adjustment due to expected payment from
129 another payer and not more than 12 months have elapsed since submission of the claim; or

130 (iii) The claims, or services for which the claim has been submitted, is the subject of
131 legal action.

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

134 (v) the health care services identified in the claim were not delivered by the provider.

135 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
136 (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim
137 denial and the provider shall have twelve months to determine whether the claim is subject to

138 payment by a secondary payer. Notwithstanding the contractual terms between the provider and
139 secondary payer, the payer shall allow for submission of a claim that was previously denied by
140 the corporation due to the insured's transfer or termination of coverage.

141 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
142 substance use disorder program licensed by the department of public health under Chapters 18,
143 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
144 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
145 consistent with law and who has provided services under an express or implied contract or with
146 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
147 directly or indirectly from an insurer.

148 SECTION 6. Chapter 176B of the General Laws, as so appearing is hereby amended by
149 inserting after section 7C the following new section:-

150 Section 7D (a) The corporation shall not impose a retroactive claims denial, as defined in
151 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
152 a provider unless:

153 (i) Less than twelve months have elapsed from the time of submission of the claim
154 by the provider to the corporation;

155 (ii) The corporation has furnished the provider with a written explanation of the
156 reason for the retroactive claim denial, and a description of additional documentation or other
157 corrective actions required for payment of the claim.

158 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
159 permitted after twelve months if:

160 (i) The claim was submitted fraudulently;

161 (ii) The claim payment is subject to adjustment due to expected payment from
162 another payer and not more than 12 months have elapsed since submission of the claim; or

163 (iii) The claims, or services for which the claim has been submitted, is the subject of
164 legal action.

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

167 (v) the health care services identified in the claim were not delivered by the provider.

168 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
169 (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim
170 denial and the provider shall have twelve months to determine whether the claim is subject to
171 payment by a secondary payer. Notwithstanding the contractual terms between the provider and
172 secondary payer, the payer shall allow for submission of a claim that was previously denied by
173 the corporation due to the insured's transfer or termination of coverage.

174 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
175 substance use disorder program licensed by the department of public health under Chapters 18,
176 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is
177 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
178 consistent with law and who has provided services under an express or implied contract or with

179 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
180 directly or indirectly from an insurer.

181 SECTION 7. Chapter 176G of the General Laws, as so appearing, is hereby amended by
182 inserting after section 6A the following new section:-

183 Section 6B. (a) No insurer shall impose a retroactive claims denial, as defined in section
184 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a
185 provider unless:

186 (i) Less than twelve months have elapsed from the time of submission of the claim
187 by the provider to the insurer or other entity responsible for payment;

188 (ii) The insurer or other entity has furnished the provider with a written explanation
189 of the reason for the retroactive claim denial, and a description of additional documentation or
190 other corrective actions required for payment of the claim.

191 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
192 permitted after twelve months if:

193 (i) The claim was submitted fraudulently;

194 (ii) The claim payment is subject to adjustment due to expected payment from
195 another payer and not more than 12 months have elapsed since submission of the claim; or

196 (iii) The claims, or services for which the claim has been submitted, is the subject of
197 legal action.

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

200 (v) the health care services identified in the claim were not delivered by the provider.

201 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
202 (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim
203 denial and the provider shall have twelve months to determine whether the claim is subject to
204 payment by a secondary insurer. Notwithstanding the contractual terms between the provider and
205 insurer, an insurer shall allow for submission of a claim that was previously denied by another
206 insurer due to the insured's transfer or termination of coverage.

207 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
208 substance use disorder program licensed by the department of public health under Chapters 18,
209 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
210 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
211 consistent with law and who has provided services under an express or implied contract or with
212 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
213 directly or indirectly from an insurer.

214 SECTION 8. The Division of Medical Assistance is hereby authorized and directed to
215 develop an internal process for the reconciliation of claims due to retroactive eligibility changes
216 and/or duplicate enrollments in cases that involve multiple payers for services provided to
217 MassHealth enrollees. This process shall not require provider involvement. The division shall
218 report to the senate and house committees on ways and means on this process no longer than five
219 months after enactment of this legislation.