HOUSE DOCKET, NO. 2480 FILED ON: 1/15/2015

HOUSE . . . . No. 925

The Commonwealth of Massachusetts

PRESENTED BY:

James J. O'Day

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 limit retroactive denials of health insurance claims for mental health and substance abuse services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
James J. O'Day	*14th Worcester*
Angelo J. Puppolo, Jr.	*12th Hampden*
Jonathan Hecht	*29th Middlesex*
Louis L. Kafka	*8th Norfolk*
Denise Provost	*27th Middlesex*
David Paul Linsky	*5th Middlesex*
Carmine L. Gentile	*13th Middlesex*
John V. Fernandes	*10th Worcester*
Edward F. Coppinger	*10th Suffolk*
Elizabeth A. Malia	*11th Suffolk*
Denise C. Garlick	*13th Norfolk*
John W. Scibak	*2nd Hampshire*
Brian A. Joyce	*Norfolk, Bristol and Plymouth*
Marjorie C. Decker	*25th Middlesex*
Peter V. Kocot	*1st Hampshire*
Barbara L'Italien	*Second Essex and Middlesex*
Thomas A. Golden, Jr.	*16th Middlesex*

Jennifer L. Flanagan	*Worcester and Middlesex*
Walter F. Timilty	*7th Norfolk*
Sean Garballey	*23rd Middlesex*
Antonio F. D. Cabral	*13th Bristol*

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HOUSE . . . . No. 925

By Mr. O'Day of West Boylston, a petition (accompanied by bill, House, No. 925) of James J. O'Day and others for legislation to limit retroactive denials of health insurance claims for mental health and substance abuse services. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act to limit retroactive denials of health insurance claims for mental 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, on a provider unless:

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

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

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

13 (i) The claim was submitted fraudulently;

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

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

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

24 (d) For the purposes of this subsection, provider shall mean a behavioral, substance use
25 disorder, or mental health professional who is licensed under Chapter 112 of the General Laws
26 and accredited or certified to provide services consistent with law and who has provided services
27 under an express or implied contract or with the expectation of receiving payment, other than co-
28 payment, deductible or co-insurance, directly or indirectly from the commission or other entity.

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

31 38A. (a) The divison or any entity with which the division contracts to provide or manage
32 health insurance benefits, including mental health services, shall not impose a retroactive claims
33 denial, as defined in section 1 of chapter 175, on a provider unless:

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

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

39 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
40 permitted after six months if:

41 (i) The claim was submitted fraudulently;

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

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

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

52 (d) For the purposes of this subsection, provider shall mean a behavioral, substance use
53 disorder, or mental health professional who is licensed under Chapter 112 of the General Laws
54 and accredited or certified to provide services consistent with law and who has provided services
55 under an express or implied contract or with the expectation of receiving payment, other than co-
56 payment, deductible or co-insurance, directly or indirectly from the division or managed care
57 entity.

58 SECTION 3. Section 1 of Chapter 175 of the General Laws, as so appearing, is amended
59 by inserting after the definition of "Resident" the following new definition:

60 "Retroactive Claim Denial", an action by a) an insurer, b) an entity with which the
61 insurer subcontracts to manage behavioral health services, c) an entity with which the Group
62 Insurance Commission has entered into an administrative services contract or a contract to
63 manage behavioral health services, or d) the executive office of health and human services acting
64 as the singe state agency under section 1902(a)(5) of the Social Security Act authorized to
65 administer programs under title XIX, to deny a previously paid claim for services and to require
66 repayment of the claim, impose a reduction in other payments , or otherwise withhold or affect
67 future payments owed a provider in order to recoup payment for the denied claim.

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

70 14 (a) No insurer shall impose a retroactive claims denial, as defined in section 1 of
71 chapter 175, on a provider unless:

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

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

77 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
78 permitted after six months if:

79 (i) The claim was submitted fraudulently;

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

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

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

90 (d) For the purposes of this subsection, provider shall mean a behavioral, substance use
91 disorder, or mental health professional who is licensed under Chapter 112 of the General Laws
92 and accredited or certified to provide services consistent with law and who has provided services
93 under an express or implied contract or with the expectation of receiving payment, other than co-
94 payment, deductible or co-insurance, directly or indirectly from an insurer.

95 SECTION 5. Chapter 176A of the General Laws, as so appearing, is amended by
96 inserting after section 8 the following new section:-

97 Section 8A a) The corporation shall not impose a retroactive claims denial, as defined in
98 section 1 of chapter 175, on a provider unless:

99 (i) Less than six months have elapsed from the time of submission of the claim by
100 the provider to the corporation;

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

104 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
105 permitted after six months if:

106 (i) The claim was submitted fraudulently;

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

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

111 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
112 (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim
113 denial and the provider shall have six months to determine whether the claim is subject to
114 payment by a secondary payer. Notwithstanding the contractual terms between the provider and

115 secondary payer, the payer shall allow for submission of a claim that was previously denied by
116 the corporation due to the insured's transfer or termination of coverage.

117 (d) For the purposes of this subsection, provider shall mean a behavioral, substance use
118 disorder, or mental health professional who is licensed under Chapter 112 of the General Laws
119 and accredited or certified to provide services consistent with law and who has provided services
120 under an express or implied contract or with the expectation of receiving payment, other than co-
121 payment, deductible or co-insurance, directly or indirectly from an insurer.

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

124 Section 7D a) The corporation shall not impose a retroactive claims denial, as defined in
125 section 1 of chapter 175, on a provider unless:

126 (i) Less than six months have elapsed from the time of submission of the claim by
127 the provider to the corporation;

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

131 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
132 permitted after six months if:

133 (i) The claim was submitted fraudulently;

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

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

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

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

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

151 Section 6B. (a) No insurer shall impose a retroactive claims denial, as defined in section
152 1 of chapter 175, on a provider unless:

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

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

158 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
159 permitted after six 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 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
166 (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim
167 denial and the provider shall have six months to determine whether the claim is subject to
168 payment by a secondary insurer. Notwithstanding the contractual terms between the provider and
169 insurer, an insurer shall allow for submission of a claim that was previously denied by another
170 insurer due to the insured's transfer or termination of coverage.

171 (d) For the purposes of this subsection, provider shall mean a behavioral, substance use
172 disorder, or mental health professional who is licensed under Chapter 112 of the General Laws
173 and accredited or certified to provide services consistent with law and who has provided services
174 under an express or implied contract or with the expectation of receiving payment, other than co-
175 payment, deductible or co-insurance, directly or indirectly from an insurer.

176 SECTION 8. The Division of Medical Assistance is hereby authorized and directed to
177 develop a process for the reconciliation of claims in cases that involve multiple payers for
178 services provided to MassHealth enrollees, with the goal of reducing or eliminating the burden
179 on the provider to seek payment from the appropriate payer. The division shall report to the
180 senate and house committees on ways and means on this process by December 31, 2015.