

**HOUSE . . . . . No. 294**

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The Commonwealth of Massachusetts

PRESENTED BY:

*Peter J. Koutoujian*

*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 passage of the accompanying:

An Act to provide prompt, fair and equitable settlement of claims for health care services.

PETITION OF:

NAME:

*Peter J. Koutoujian*

DISTRICT/ADDRESS:

*10th Middlesex*

**HOUSE . . . . . No. 294**

By Mr. Koutoujian of Waltham, a petition (accompanied by bill, House, No. 294) of Peter J. Koutoujian for legislation to provide prompt fair and equitable settlement of claims for health care services. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE  
□ SENATE  
□ , NO. 458 OF 2009-2010.]

**The Commonwealth of Massachusetts**

An Act to provide prompt, fair and equitable settlement of claims for health care 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: Section 24B of chapter 175 of the General Laws, as appearing in the 2008  
2 Official Edition, is hereby amended by inserting after the first paragraph the following  
3 paragraphs:

4 A health care insurer, including any self-insured sickness, health, or welfare plan, under  
5 this section shall be required to pay for health care services ordered by the treating health care  
6 provider if (1) the services are a covered benefit under the insured’s health benefit plan; and (2)  
7 the services follow the insurer's medically necessity policies or guidelines. A claim for treatment  
8 for medically necessary services may not be denied if the treating health care provider follows  
9 the health care insurer’s approved method for securing authorization procedures and receives  
10 authorization for a covered service for the policy holder or subscriber, unless the provider  
11 submitted information to the insurer with the willful intention to misinform the insurer.

12 An insurer shall not deny payment for a claim for medically necessary covered services  
13 on the basis of an administrative or technical defect in the claim except in the case where the  
14 insurer has a reasonable basis, supported by specific information available for review, that the  
15 claim for health care services rendered was submitted fraudulently. An insurer shall have no  
16 more than twelve months after the original payment was received by the provider to recoup a full  
17 or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect  
18 a recoupment of a full or partial payment. However, an insurer shall not recoup payments more

19 than ninety days after the original payment was received by a provider for services provided to a  
20 policy holder or subscriber that the insurer deems ineligible for coverage because the  
21 policyholder or subscriber was retroactively terminated or retroactively disenrolled for services,  
22 provided that the provider can document that it received verification of an individual's eligibility  
23 status using the insurer's approved method for verifying eligibility at the time service was  
24 provided. Claims may also not be recouped for utilization review purposes if the services were  
25 already deemed medically necessary or the manner in which the services were accessed or  
26 provided were previously approved by the insurer or its contractor.

27 An insurer which seeks to make an adjustment pursuant to this section shall provide the  
28 health care provider with written notice that explains in detail the reasons for the recoupment,  
29 identifies each previously paid claim for which a recoupment is sought, and provides the health  
30 care provider with thirty days to challenge the request for recoupment. Such written notice shall  
31 be made to the provider not less than thirty days prior to the seeking of a recoupment or the  
32 making of an adjustment.

33 If a claim is denied because the provider, due to an unintentional act of error or omission,  
34 obtained no authorizations or only a partial authorization, the provider may appeal the denial and  
35 the Insurer must conduct and complete within thirty days of the provider's submitted appeal a  
36 retrospective review of the medical necessity of the service. If the insurer determines that the  
37 service is medically necessary, the Insurer must reverse the denial and pay the claim. If the  
38 insurer determines that the service is not medically necessary, the insurer shall provide the  
39 provider with specific written clinical justification for the determination and a process for  
40 appealing the determination.

41 SECTION 2: The Commissioner of Insurance shall promulgate regulations to enforce the  
42 provisions this Act no later than 90 days after the effective date of the Act. Such regulations  
43 shall be effective for all contracts between health care insurers, so-called, and providers of health  
44 care services, so-called, which are entered into, renewed, or amended on or after the regulations  
45 effective date.