

# SENATE NO. 694

## **AN ACT** TO EXTEND PATIENT PROTECTIONS TO RECIPIENTS OF MASSHEALTH

*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. M.G.L. CHAPTER 176O as Appearing in the 2004 Official Edition is hereby  
2 amended by the deletion of the title and insertion of the following new title. HEALTH  
3 INSURANCE AND DIVISION OF MEDICAL ASSISTANCE CONSUMER PROTECTIONS.

4 Section 2.

5 Said Chapter 176 O Section 1, as amended by Chapter 162 of the Acts of 2005, is further amended  
6 by the deletion of the following paragraph:

7 ““Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance under  
8 chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit  
9 medical service corporation organized under chapter 176B; a health maintenance organization  
10 organized under chapter 176G; and an organization entering into a preferred provider arrangement  
11 under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its

12 employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

13 Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy,  
14 certificate or contract that provides coverage solely for dental care services or visions care  
15 services.”;

16 and, the insertion of the following paragraph:

17 "Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under  
18 chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit  
19 medical service corporation organized under chapter 176B; a health maintenance organization  
20 organized under chapter 176G, the Primary Care Clinician Program or any entity providing  
21 managed care services under contract to the Division, or any similar managed care arrangement of  
22 the Division of Medical Assistance or its successor providing medical care coverage to eligible  
23 individuals under M. G. L. Chapter 118 E; and an organization entering into a preferred provider  
24 arrangement under chapter 176I, but not including an employer purchasing coverage or acting on  
25 behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of  
26 the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it  
27 offers a policy, certificate or contract that provides coverage solely for dental care services or  
28 visions care services.”

29 Section 3.

30 Said Chapter 176 O is further amended by the deletion in the first section of the following  
31 definition:

32 "Covered benefits" or "benefits", health care services to which an insured is entitled under the  
33 terms of the health benefit plan.”

34 And, the insertion of the following definition:

35 "Covered benefits" or "benefits", health care services to which an insured or a recipient of services  
36 under the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118 E is  
37 entitled under the terms of a health benefit plan or program.

38 Section 4.

39 Said Chapter 176 O is further amended by the deletion in Section 1 of the following definition:

40 "Grievance", any oral or written complaint submitted to the carrier which has been initiated by an  
41 insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action  
42 of the carrier relative to the insured, including, but not limited to, review of adverse determinations  
43 regarding scope of coverage, denial of services, quality of care and administrative operations, in  
44 accordance with the requirements of this chapter.

45 And, the insertion of the following definition:

46 "Grievance", any oral or written complaint submitted to the carrier or the Division of Medical  
47 Assistance or its successor entity under M. G. L. Chapter 118 E which has been initiated by an  
48 insured or a recipient of public assistance, or on behalf of an insured or recipient of public  
49 assistance with the consent of the insured or the recipient, concerning any aspect or action of the  
50 carrier or the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118 E  
51 relative to the insured or the recipient, including, but not limited to, review of adverse

52 determinations regarding scope of coverage, denial of services, quality of care and administrative  
53 operations, in accordance with the requirements of this chapter.

54 Section 5.

55 Said Chapter 176 O is further amended by the deletion in Section 1 of the following definition:

56 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by  
57 a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care  
58 services.

59 And, the insertion of the following definition:

60

61 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a  
62 carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;  
63 or a managed care arrangement of the Division of Medical Assistance or its successor entity under  
64 M. G. L. Chapter 118 E.

65 Section 6.

66 Said Chapter 176 O is further amended by the deletion in Section 1 of the following definition:

67 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier,  
68 including an individual whose eligibility as an insured of a carrier is in dispute or under review, or  
69 any other individual whose care may be subject to review by a utilization review program or entity  
70 as described under other provisions of this chapter.

71 And, the insertion of the following definition:

72 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier,  
73 including an assistance recipient of the Division of Medical Assistance, and including an individual  
74 whose eligibility as an insured of a carrier is in dispute or under review, or any other individual  
75 whose care may be subject to review by a utilization review program or entity as described under  
76 other provisions of this chapter.

77 Section 7.

78 Said Chapter 176 O is further amended by the deletion in Section 2 of lines 1 through 3 and the  
79 insertion in their place of the following:

80 Section 2. (a) There is hereby established within the division a bureau of managed care. Said bureau  
81 shall by regulation establish minimum standards for the accreditation of carriers, other than the  
82 Division of Medical Assistance or its successor entity under M. G. L. Chapter 118 E, in the  
83 following areas:

84 Section 8.

85 Said Chapter 176 O is further amended by the deletion in Section 8 of lines 1 through 8 and the  
86 insertion in their place of the following:

87 Section 8. A carrier, other than the Division of Medical Assistance or its successor entity under M.  
88 G. L. Chapter 118 E, neglecting to make and file its annual statement or the materials required by  
89 the commissioner to be filed with the division under this chapter or under chapter 176G in the form  
90 and within the time required thereby shall be fined \$5,000 for each day during which such neglect

91 continues after being notified by said commissioner of such neglect, and, after notice and a hearing  
92 by the commissioner to that effect, its authority to do new business shall cease while such neglect  
93 continues

94 Section 9.

95 M.G.L. Chapter 118 E Section 38 as appearing in the 2004 Official Edition is hereby amended by  
96 insertion at the end thereof of the following new paragraphs:

97 “Within 45 days after the receipt by the Division of completed forms for reimbursement to a  
98 physician who participates in a medical service program established pursuant to this chapter, or  
99 within 15 days if such claim is received electronically, the Division shall (i) make payments for  
100 such services provided by the physician that are services covered under such medical assistance  
101 program and for which claim is made, or (ii) notify the physician in writing or by electronic means,  
102 within 15 days for written claim forms or 48 hours for electronic claims, of any and all reasons for  
103 non-payment, or (iii) notify the physician in writing or by electronic means, within 15 days for  
104 written claim forms or 48 hours for electronic claims, of all additional information or  
105 documentation that is necessary to establish such physician’s entitlement to such reimbursement. If  
106 the Division fails to comply with the provisions of this paragraph for any such completed claim, the  
107 Division shall pay, in addition to any reimbursement for health care services provided to which the  
108 physician is entitled, interest on any unpaid amount of such benefits, which shall accrue beginning  
109 45 days after the Division's receipt of request for reimbursement, or 15 days after the receipt of an  
110 electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The  
111 provisions of this paragraph relating to interest payments shall not apply to a claim that the Division  
112 is investigating because of suspected fraud.”

113 “The division shall provide written guidelines to providers of medical services that participate in a  
114 medical assistance program established pursuant to this chapter setting forth a statement of its  
115 policies and procedures that is complete, detailed and specific with regard to what such providers  
116 must include in claims for reimbursement in order to qualify as a completed claim for  
117 reimbursement payment for which any such provider is entitled. Such guidelines shall identify all of  
118 the data and documentation that is to accompany each claim for reimbursement and shall identify  
119 all utilization review and other screening policies and procedures employed by the division in  
120 reviewing such claims submitted by a provider of medical services.

121 “The Division shall, in its payment to physicians, recognize the use of modifiers to billing codes  
122 employed by the Division. Modifiers that indicate that a procedure or service is distinct or separate  
123 from other services performed on the same day, including services provided in a separate session or  
124 encounter; a different procedure or surgery; a different site, or a separate lesion, or separate injury  
125 or site of injury shall be reimbursed in a manner consistent with that of programs providing health  
126 coverage under Title XVIII of the Social Security Act. Modifiers that identify a significant, separate  
127 evaluation and management service by the same physician on the same day of another, non-  
128 comprehensive, billed service or procedure shall be recognized by the Division and be compensated  
129 in a manner consistent with that of programs providing health coverage under Title XVIII of the  
130 Social Security Act. In implementation of the provisions of this paragraph, the Division shall use  
131 the Medicare Correct Coding Initiative standards for modifiers 25 and 59.”

132 The Division shall institute no policy or practice of recoupment, reduction, review or retroactive  
133 denial of payments to any physician or physicians for services provided one year or more prior to  
134 the date of the Division’s initiating said policy or practice. Physicians must be given written notice  
135 by the Division specifying any and all policy changes which may result in recoupments, reductions

136 or reviews of payments for physician services at least 90 days prior to the implementation of such  
137 recoupments, reductions or reviews.