

Chapter 7.00: Practices by Insurers

Section

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7.01: Scope and Authority

452 CMR 7.00 is promulgated pursuant to MGL c. 152, § 5 for the purpose of carrying out applicable provisions of MGL c. 23E and MGL c. 152, as most recently amended by St. 1991, c. 398.

7.02: Definitions

Request for Reimbursement, as used in MGL c. 152, § 13 and 452 CMR 7.00, shall mean a request for payment of health services provided pursuant to MGL c. 152, § 13 that:

(a) is submitted on a standard form prescribed by the Department based on the most recent Universal Billing (UB) form and Health Care Financing Administration (HCFA) 1500 billing form pursuant to 452 CMR 6.05;

(b) is signed by the provider, as defined in 452 CMR 6.02, performing such service (or by that provider's authorized representative or signature stamp), accompanied by a detailed description of the service rendered, the name and licensure number of the provider performing such service, as required by MGL c. 152, § 13; where the request for reimbursement is for hospital outpatient services, including but not limited to, restorative services, the signature, name, and licensure number of the practitioner, as defined in 452 CMR 6.02, actually performing the service shall be placed on the detailed description accompanying the request, and

(c) contains, at a minimum, the following:

1. employee name,
2. date of injury,
3. date(s) of service,
4. itemized services rendered,

5. where applicable, International Classification of Diseases-9 (ICD-9 **or subsequent**) code(s), diagnosis code(s), Current Procedural Terminology (CPT) code(s), administrative and all other procedure code(s) promulgated by the Rate Setting Commission,

6. in the case of restorative and chiropractic services, the applicable Current Procedural Terminology (CPT) code(s) for utilization descriptive purposes; and applicable charges for each service.

Standard Workers' Compensation Premium , as used in MGL c. 152, § 65 and 452 CMR 7.00, shall mean the direct written premium equal to the product of payroll by class code and the currently applicable manual rates multiplied by any applicable experience modification factor.

7.03: Collection Of Trust Fund Assessments

Insurers shall remit to the department an amount equal to that established under MGL c. 152, § 65(5) in proportion to the direct written premium received. No such assessment remitted to the department shall be reimbursed until a request for reimbursement is filed with the department and approved by the department.

7.04: Questionable Claims Handling Techniques/Patterns Of Unreasonably Controverting Claims

(1) Pursuant to MGL c. 23E, § 3(b)(8), **except in the case of open cases active in the Division of Dispute Resolution**, the Department's Division of Administration shall receive for investigation, on a form prescribed by the Department, written allegations of questionable claims handling techniques or patterns of unreasonably controvert claims by insurers, group self-insurers, self-insurers, third party administrators, employers, or other entities, including agents and brokers, handling workers' compensation claims.

(2) The Division of Administration shall conduct an investigation, and shall provide the party against whom the allegation is made an opportunity to respond in writing to the written allegations within 30 days. The findings of said investigation shall be reported to the Commissioner of Insurance, to the party making the allegation, and to the respondent party, except that when a written allegation involves a self-insured employer, a Department-certified vocational rehabilitation provider, or a Department-approved utilization review agent, the findings shall be forwarded to the ~~Commissioner~~ **Director** of the Department **or his designee** rather than to the Commissioner of Insurance.

(3) Questionable claims handling techniques or patterns of unreasonably controvert claims shall include, but not be limited to, techniques or patterns of practice which involve the following:

(a) misrepresenting pertinent facts or policy provisions relating to coverage, entitlement to benefits under MGL c. 152, or any other material facts or provisions pursuant to MGL c. 152, or for any other purpose;

(b) failing to adopt and utilize reasonable standards for the handling of claims consistent with the provisions of MGL c. 152, § 7;

(c) failing to effectuate prompt, fair, and equitable adjustments of claims in which liability, causal relationship, and/or extent of disability have become reasonably clear;

(d) failing to make payment or to provide the written reason(s) for not doing so to a provider, as defined in 452 CMR 6.02, who has submitted a request for reimbursement for payment in accordance with the provisions of MGL c. 152, §§ 13 and 30 and regulations promulgated thereunder within 45 days of receipt of the request for reimbursement;

(e) prosecuting complaints or defending against claims without reasonable grounds, including, but not limited to, engaging in practices found violative of MGL c. 152, § 14;

(f) delaying or prolonging the processing or payment of requests for reimbursement, including, but not limited to, engaging in repetitive, unnecessary, or otherwise unreasonable requests for the submission of reimbursement or medical information;

(g) making payment to providers at rates below those prescribed by the Massachusetts Rate Setting Commission, unless said rates have been negotiated pursuant to MGL c. 152, § 13;

(h) failing to undertake utilization review pursuant to 452 CMR 6.00 *et seq.*, including, but not limited to, failing to:

1. become a Department-approved utilization review agent or, alternatively, contract with a Department-approved utilization review agent;

2. maintain and utilize adequate standards and procedures to monitor and coordinate utilization review practices; or

3. comply with the reporting requirements of 452 CMR 6.05(2);

(i) failing to conform with the time frames and notice requirements set forth in MGL c. 152 and regulations promulgated thereunder;

(j) misrepresenting facts or law to an experienced modified insured concerning settlement of a claim in order to obtain the insured's written consent, or otherwise failing to obtain such consent when so required by MGL c. 152;

(k) failing to submit a revised statistical unit report to the appropriate rating bureau within 60 days of a finding of non-compensability, a recovery of previously paid workers' compensation benefits from a third party, or reimbursements from the Workers' Compensation Trust Fund for payments made pursuant to MGL c. 152, § 65(2).

(l) failing to pay, in a timely manner, referral fees due under the provisions of MGL c. 152, § 10(5).

(4) The submission of evidence of any questionable claims handling techniques or patterns of unreasonably controvert claims, including but not limited to, the techniques or patterns of practice set out in 452 CMR 7.04(3), may be sufficient to support a finding by the Division of Administration that an insurer, group self-insurer, third party administrator, or agent or broker has, or is, engaging in questionable claims handling techniques or patterns of unreasonably controvert claims. The Division of Administration shall refer its findings to the Commissioner of Insurance to undertake such enforcement, license revocation, and/or other actions as may be applicable by law.

(5) The submission of evidence of any questionable claims handling techniques or patterns of unreasonably controvert claims, including but not limited to, the techniques or patterns of practice set out in 452 CMR 7.04(3), may be sufficient to support a finding by the Division of Administration that a self-insurer, vocational rehabilitation provider, or utilization review agent has, or is, engaging in questionable claims handling techniques or patterns of unreasonably controvert claims. The Division of Administration shall refer its findings to the ~~Commissioner~~ Director of the Department to undertake such enforcement, fine, license revocation, and/or other actions as may be applicable by law.