

**SENATE . . . . . No. 588**

---

**The Commonwealth of Massachusetts**

**In the Year Two Thousand Nine**

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

6 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health  
7 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter  
8 176A; a nonprofit medical service corporation organized under chapter 176B; a health  
9 maintenance organization organized under chapter 176G; and an organization entering into a  
10 preferred provider arrangement under chapter 176I, but not including an employer purchasing  
11 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or  
12 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not  
13 include any entity to the extent it offers a policy, certificate or contract that provides coverage  
14 solely for dental care services or visions care services.”;

15 and, the insertion of the following paragraph:

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

28 SECTION 3.Said Chapter 176 O is further amended by the deletion in the first section of  
29 the following definition:

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

32 And, the insertion of the following definition:

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

36 SECTION 4. Said Chapter 176 O is further amended by the deletion in Section 1 of the  
37 following definition:

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

43 And, the insertion of the following definition:

44 "Grievance", any oral or written complaint submitted to the carrier or the Division of  
45 Medical Assistance or its successor entity under M. G. L. Chapter 118 E which has been initiated  
46 by an insured or a recipient of public assistance, or on behalf of an insured or recipient of public  
47 assistance with the consent of the insured or the recipient, concerning any aspect or action of the  
48 carrier or the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118  
49 E relative to the insured or the recipient, including, but not limited to, review of adverse  
50 determinations regarding scope of coverage, denial of services, quality of care and administrative  
51 operations, in accordance with the requirements of this chapter.

52 SECTION 5. Said Chapter 176 O is further amended by the deletion in Section 1 of the  
53 following definition:

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

57 And, the insertion of the following definition:

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

62 SECTION 6. Said Chapter 176 O is further amended by the deletion in Section 1 of the  
63 following definition:

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

68 And, the insertion of the following definition:

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

74 SECTION 7. Said Chapter 176 O is further amended by the deletion in Section 2 of lines  
75 1 through 3 and the insertion in their place of the following:

76 Section 2. (a) There is hereby established within the division a bureau of managed care.  
77 Said bureau shall by regulation establish minimum standards for the accreditation of carriers,

78 other than the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118  
79 E, in the following areas:

80 SECTION 8. Said Chapter 176 O is further amended by the deletion in Section 8 of lines  
81 1 through 8 and the insertion in their place of the following:

82 Section 8. A carrier, other than the Division of Medical Assistance or its successor entity  
83 under M. G. L. Chapter 118 E, neglecting to make and file its annual statement or the materials  
84 required by the commissioner to be filed with the division under this chapter or under chapter  
85 176G in the form and within the time required thereby shall be fined \$5,000 for each day during  
86 which such neglect continues after being notified by said commissioner of such neglect, and,  
87 after notice and a hearing by the commissioner to that effect, its authority to do new business  
88 shall cease while such neglect continues

89 SECTION 9. M.G.L. Chapter 118 E Section 38 as appearing in the 2004 Official Edition  
90 is hereby amended by insertion at the end thereof of the following new paragraphs:

91 “Within 45 days after the receipt by the Division of completed forms for reimbursement  
92 to a physician who participates in a medical service program established pursuant to this chapter,  
93 or within 15 days if such claim is received electronically, the Division shall (i) make payments  
94 for such services provided by the physician that are services covered under such medical  
95 assistance program and for which claim is made, or (ii) notify the physician in writing or by  
96 electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any  
97 and all reasons for non-payment, or (iii) notify the physician in writing or by electronic means,  
98 within 15 days for written claim forms or 48 hours for electronic claims, of all additional  
99 information or documentation that is necessary to establish such physician’s entitlement to such

100 reimbursement. If the Division fails to comply with the provisions of this paragraph for any such  
101 completed claim, the Division shall pay, in addition to any reimbursement for health care  
102 services provided to which the physician is entitled, interest on any unpaid amount of such  
103 benefits, which shall accrue beginning 45 days after the Division's receipt of request for  
104 reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per  
105 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest  
106 payments shall not apply to a claim that the Division is investigating because of suspected  
107 fraud.”

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

116         “The Division shall, in its payment to physicians, recognize the use of modifiers to billing  
117 codes employed by the Division. Modifiers that indicate that a procedure or service is distinct or  
118 separate from other services performed on the same day, including services provided in a  
119 separate session or encounter; a different procedure or surgery; a different site, or a separate  
120 lesion, or separate injury or site of injury shall be reimbursed in a manner consistent with that of  
121 programs providing health coverage under Title XVIII of the Social Security Act. Modifiers that  
122 identify a significant, separate evaluation and management service by the same physician on the

123 same day of another, non-comprehensive, billed service or procedure shall be recognized by the  
124 Division and be compensated in a manner consistent with that of programs providing health  
125 coverage under Title XVIII of the Social Security Act. In implementation of the provisions of  
126 this paragraph, the Division shall use the Medicare Correct Coding Initiative standards for  
127 modifiers 25 and 59.”

128           The Division shall institute no policy or practice of recoupment, reduction, review or  
129 retroactive denial of payments to any physician or physicians for services provided one year or  
130 more prior to the date of the Division’s initiating said policy or practice. Physicians must be  
131 given written notice by the Division specifying any and all policy changes which may result in  
132 recoupments, reductions or reviews of payments for physician services at least 90 days prior to  
133 the implementation of such recoupments, reductions or reviews.