

HOUSE No.

The Commonwealth of Massachusetts

PRESENTED BY:

Vincent A. Pedone

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 bill:

An Act to extend patient protections to recipients of MassHealth .

PETITION OF:

NAME:

Vincent A. Pedone

DISTRICT/ADDRESS:

15th Worcester

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 1159 OF 2007-2008.]

The Commonwealth of Massachusetts

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In the Year Two Thousand and 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 hereby amended by
2 the deletion of the title and insertion of the following new title. HEALTH INSURANCE AND DIVISION OF
3 MEDICAL ASSISTANCE CONSUMER PROTECTIONS.

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

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

13 and, the insertion of the following paragraph:

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

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

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

28 And, the insertion of the following definition:

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

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

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

38 And, the insertion of the following definition:

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

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

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

50 And, the insertion of the following definition:

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

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

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

60 And, the insertion of the following definition:

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

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

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

70 Section 8.

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

73 **SECTION 8.** A carrier, other than the Division of Medical Assistance or its successor entity under M. G.
74 L. Chapter 118 E, neglecting to make and file its annual statement or the materials required by the commissioner to
75 be filed with the division under this chapter or under [chapter 176G](#) in the form and within the time required thereby
76 shall be fined \$5,000 for each day during which such neglect continues after being notified by said commissioner of
77 such neglect, and, after notice and a hearing by the commissioner to that effect, its authority to do new business shall
78 cease while such neglect continues

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

81 "Within 45 days after the receipt by the Division of completed forms for reimbursement to a physician
82 who participates in a medical service program established pursuant to this chapter, or within 15 days if such claim
83 is received electronically, the Division shall (i) make payments for such services provided by the physician that are
84 services covered under such medical assistance program and for which claim is made, or (ii) notify the physician in
85 writing or by electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any and
86 all reasons for non-payment, or (iii) notify the physician in writing or by electronic means, within 15 days for
87 written claim forms or 48 hours for electronic claims, of all additional information or documentation that is
88 necessary to establish such physician's entitlement to such reimbursement. If the Division fails to comply with the
89 provisions of this paragraph for any such completed claim, the Division shall pay, in addition to any reimbursement
90 for health care services provided to which the physician is entitled, interest on any unpaid amount of such
91 benefits, which shall accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days
92 after the receipt of an electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year.
93 The provisions of this paragraph relating to interest payments shall not apply to a claim that the Division is
94 investigating because of suspected fraud."

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

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

112 The Division shall institute no policy or practice of recoupment, reduction, review or retroactive denial of
113 payments to any physician or physicians for services provided one year or more prior to the date of the Division’s
114 initiating said policy or practice. Physicians must be given written notice by the Division specifying any and all
115 policy changes which may result in recoupments, reductions or reviews of payments for physician services at least
116 90 days prior to the implementation of such recoupments, reductions or reviews.