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IS 2/29/08

§§1-7, 17, 20, 21
C.17B:30-48
to
17B:30-57
§§22
Note to §§1-21

P.L. 2005, CHAPTER 352, *approved January 12, 2006*
Senate, No. 2824 (*First Reprint*)

1 **AN ACT** concerning health claims and amending and supplementing
2 various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. (New section) This act shall be known and may be cited as the
8 "Health Claims Authorization, Processing and Payment Act."

9

10 2. (New section) The Legislature finds and declares that:

11 a. Health care services available under health benefits plans must
12 be promptly provided to covered persons under all circumstances,
13 along with timely reimbursement to hospital and physicians for their
14 services rendered;

15 b. However, confusion still exists among consumers, hospitals,
16 physicians and carriers with respect to time frames for communication
17 of determinations by carriers to deny, reduce or terminate benefits
18 under the provisions of a health benefits plan based upon utilization
19 management decisions;

20 c. Since it is the declared public policy of the State that hospital
21 and related health care services be of the highest quality and
22 demonstrated need and be efficiently provided and properly utilized at
23 a reasonable cost, the hospital care and related health care services
24 must be appropriate to the condition of the patient and payment must
25 be for services that were rendered to the patient;

26 d. Because it is fair and reasonable for hospitals and physicians to
27 receive reimbursement for health care services delivered to covered
28 persons under their health benefits plans and inefficiencies in any area
29 of the health care delivery system reflect poorly on all aspects of the
30 health care delivery system, and because those inefficiencies can harm
31 the consumers of health care, it is appropriate for the Legislature now
32 to establish uniform procedures and guidelines for hospitals, physicians
33 and health insurance carriers to follow in communicating and following
34 utilization management decisions and determinations on behalf of
35 consumers.

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SCM committee amendments adopted December 5, 2005.

1 3. (New section) As used in sections 3 through ¹[9] ⁷ of ¹[this
2 act] P.L. , c. (C.) (pending before the Legislature as this bill)¹:

3 "Authorization" means a determination required under a health
4 benefits plan, that based on the information provided, satisfies the
5 requirements under the member's health benefits plan for medical
6 necessity.

7 "Carrier" means an insurance company, health service corporation,
8 hospital service corporation, medical service corporation or health
9 maintenance organization authorized to issue health benefits plans in
10 this State.

11 "Commissioner" means the Commissioner of Banking and
12 Insurance.

13 "Covered person" means a person on whose behalf a carrier offering
14 the plan is obligated to pay benefits or provide services pursuant to the
15 health benefits plan.

16 "Covered service" means a health care service provided to a
17 covered person under a health benefits plan for which the carrier is
18 obligated to pay benefits or provide services.

19 ¹"Generally accepted standards of medical practice" means
20 standards that are based on: credible scientific evidence published in
21 peer-reviewed medical literature generally recognized by the relevant
22 medical community; physician and health care provider specialty
23 society recommendations; the views of physicians and health care
24 providers practicing in relevant clinical areas; and any other relevant
25 factor as determined by the commissioner by regulation.¹

26 "Health benefits plan" means a benefits plan which pays or provides
27 hospital and medical expense benefits for covered services, and is
28 delivered or issued for delivery in this State by or through a carrier.
29 Health benefits plan includes, but is not limited to, Medicare
30 supplement coverage and Medicare+Choice contracts to the extent not
31 otherwise prohibited by federal law. For the purposes of sections 3
32 through ¹[9] ⁷ of ¹[this act] P.L. , c. (C.) (pending before the
33 Legislature as this bill)¹, health benefits plan shall not include the
34 following plans, policies or contracts: accident only, credit, disability,
35 long-term care, Civilian Health and Medical Program for the
36 Uniformed Services, CHAMPUS supplement coverage, coverage
37 arising out of a workers' compensation or similar law, automobile
38 medical payment insurance, personal injury protection insurance issued
39 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital
40 confinement indemnity coverage.

41 "Hospital" means a general acute care facility licensed by the
42 Commissioner of Health and Senior Services pursuant to P.L.1971,
43 c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and
44 long-term acute facilities.

45 ¹"Medical necessity" or "medically necessary" means or describes
46 a health care service that a health care provider, exercising his prudent

1 clinical judgement, would provide to a covered person for the purpose
2 of evaluating, diagnosing or treating an illness, injury, disease or its
3 symptoms and that is: in accordance with the generally accepted
4 standards of medical practice; clinically appropriate, in terms of type,
5 frequency, extent site and duration, and considered effective for the
6 covered person's illness, injury or disease; not primarily for the
7 convenience of the covered person or the health care provider; and not
8 more costly than an alternative service or sequence of services at least
9 as likely to produce equivalent therapeutic or diagnostic results as to
10 the diagnosis or treatment of that covered person's illness, injury or
11 disease.¹

12 "Network provider" means a participating hospital or physician
13 under contract or other agreement with a carrier to furnish health care
14 services to covered persons.

15 "Payer" means a carrier which requires that utilization management
16 be performed to authorize the approval of a health care service and
17 includes an organized delivery system that is certified by the
18 Commissioner of Health and Senior Services or licensed by the
19 commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

20 "Payer's agent" or "agent" means an intermediary contracted or
21 affiliated with the payer to provide authorization for service or
22 perform administrative functions including, but not limited to, the
23 payment of claims or the receipt, processing or transfer of claims or
24 claim information.

25 "Physician" means a physician licensed pursuant to Title 45 of the
26 Revised Statutes.

27 "Utilization management" means a system for reviewing the
28 appropriate and efficient allocation of health care services under a
29 health benefits plan according to specified guidelines, in order to
30 recommend or determine whether, or to what extent, a health care
31 service given or proposed to be given to a covered person should or
32 will be reimbursed, covered, paid for, or otherwise provided under the
33 health benefits plan. The system may include, but shall not be limited
34 to: preadmission certification, the application of practice guidelines,
35 continued stay review, discharge planning, preauthorization of
36 ambulatory care procedures and retrospective review.

37
38 ¹4. (New section) a. A payer shall provide the following
39 information concerning utilization management and the processing and
40 payment of claims in a clear and conspicuous manner through an
41 Internet website no later than 30 calendar days before the information
42 or policies or any changes in the information or policies take effect:
43 (1) a description of the source of all commercially produced clinical
44 criteria guidelines and a copy of all internally produced clinical criteria
45 guidelines used by the payer or its agent to determine the medical

1 necessity of health care services;

2 (2) a list of the material, documents or other information required
3 to be submitted to the payer with a claim for payment for health care
4 services;

5 (3) a description of claims for which the submission of additional
6 documentation or information is required for the adjudication of a
7 claim fitting that description;

8 (4) the payer's policy or procedure for reducing the payment for a
9 duplicate or subsequent service provided by a health care provider on
10 the same date of service; and

11 (5) any other information the commissioner deems necessary.

12 b. Any changes in the information or policies required to be
13 provided pursuant to subsection a. of this section shall be clearly noted
14 on the Internet website.¹

15

16 ¹[4.] 5.¹ (New section) a. A payer shall respond to a hospital or
17 physician request for authorization of health care services by either
18 approving or denying the request based on the covered person's health
19 benefits plan. Any denial of a request for authorization or limitation
20 imposed by a payer on a requested service shall be made by a physician
21 under the clinical direction of the medical director who shall be
22 licensed in this State and communicated to the hospital or physician by
23 facsimile, E-mail or any other means of written communication agreed
24 to by the payer and hospital or physician, as follows:

25 (1) in the case of a request for prior authorization for a covered
26 person who will be receiving inpatient hospital services, the payer shall
27 communicate the denial of the request or the limitation imposed on the
28 requested service to the hospital or physician within a time frame
29 appropriate to the medical exigencies of the case but no later than 15
30 days following the time the request was made;

31 (2) in the case of a request for authorization for a covered person
32 who is currently receiving inpatient hospital services or care rendered
33 in the emergency department of a hospital, the payer shall
34 communicate the denial of the request or the limitation imposed on the
35 requested service to the hospital or physician within a time frame
36 appropriate to the medical exigencies of the case but no later than 24
37 hours following the time the request was made;

38 (3) in the case of a request for prior authorization for a covered
39 person who will be receiving health care services in an outpatient or
40 other setting, including, but not limited to, a clinic, rehabilitation
41 facility or nursing home, the payer shall communicate the denial of the
42 request or the limitation imposed on the requested service to the
43 hospital or physician within a time frame appropriate to the medical
44 exigencies of the case but no later than 15 days following the time the
45 request was made; and

46 (4) if the payer requires additional information to approve or deny

1 a request for authorization, the payer shall so notify the hospital or
2 physician by facsimile, E-mail or any other means of written
3 communication agreed to by the payer and hospital or physician within
4 the applicable time frame set forth in paragraphs (1), (2) or (3) of this
5 subsection and shall identify the specific information needed to
6 approve or deny the request for authorization.

7 If the payer is unable to approve or deny a request for authorization
8 within the applicable time frame set forth in paragraphs (1), (2) or (3)
9 of this subsection because of the need for this additional information,
10 the payer shall have an additional period within which to approve or
11 deny the request, as follows:

12 (a) in the case of a request for prior authorization for a covered
13 person who will be receiving inpatient hospital services, within a time
14 frame appropriate to the medical exigencies of the case but no later
15 than 15 days beyond the time of receipt by the payer from the hospital
16 or physician of the additional information that the payer has identified
17 as needed to approve or deny the request for authorization;

18 (b) in the case of a request for authorization for a covered person
19 who is currently receiving inpatient hospital services or care rendered
20 in the emergency department of a hospital, no more than 24 hours
21 beyond the time of receipt by the payer from the hospital or physician
22 of the additional information that the payer has identified as needed to
23 approve or deny the request for authorization; and

24 (c) in the case of a request for authorization for a covered person
25 who will be receiving health care services in another setting, within a
26 time frame appropriate to the medical exigencies of the case but no
27 more than 15 days beyond the time of receipt by the payer from the
28 hospital or physician of the additional information that the payer has
29 identified as needed to approve or deny the request for authorization.

30 b. Payers and hospitals shall have appropriate staff available
31 between the hours of 9 a.m. and 5 p.m., seven days a week, to respond
32 to authorization requests within the time frames established pursuant
33 to subsection a. of this section.

34 c. If a payer fails to respond to an authorization request within the
35 time frames established pursuant to subsection a. of this section, the
36 hospital or physician's request shall be deemed approved and the payer
37 shall be responsible to the hospital or physician for the payment of the
38 covered services delivered pursuant to the hospital or physician's
39 contract with the payer.

40 d. If a hospital or physician fails to respond to a payer's request for
41 additional information necessary to render an authorization decision
42 within 72 hours, the hospital or physician's request for authorization
43 shall be deemed withdrawn.

44

45 ¹[5.] 6.¹ (New section) a. When a hospital ¹or physician¹
46 complies with the provisions set forth in section ¹[4] 5¹ of ¹[this act]
47 P.L. , c. (C.) (pending before the Legislature as this bill)¹, no

1 payer, or payer's agent, shall deny reimbursement to a hospital ¹or
2 physician¹ for covered services rendered to a covered person on
3 grounds of medical necessity in the absence of fraud or
4 misrepresentation if ¹the hospital or physician¹:

5 (1) ¹[the hospital] ¹ requested authorization from the payer and
6 received approval for the health care services delivered prior to
7 rendering the service;

8 (2) ¹[the hospital] ¹ requested authorization from the payer for the
9 health care services prior to rendering the services and the payer failed
10 to respond to the hospital ¹or physician¹ within the time frames
11 established pursuant to section ¹[4] ⁵ of ¹[this act] P.L. , c.
12 (C.) (pending before the Legislature as this bill)¹; or

13 (3) ¹[the hospital] ¹ received authorization for the covered service
14 for a patient who is no longer eligible to receive coverage from that
15 payer and it is determined that the patient is covered by another payer,
16 in which case the subsequent payer, based on the subsequent payer's
17 benefits plan, shall accept the authorization and reimburse the hospital
18 ¹or physician¹.

19 b. If the hospital ¹[or other hospital or physician]¹ is a network
20 provider of the payer, health care services shall be reimbursed at the
21 contracted rate for the services provided ¹[except as modified by
22 subsection d. of this section]¹.

23 c. No payer, or payer's agent, shall amend a claim by changing the
24 diagnostic code assigned to the services rendered by ¹[the] ^a hospital
25 or physician without providing written justification.

26 ¹[d. If a payer, in consultation with the covered person's hospital
27 or physician has determined that a covered person, who is an inpatient
28 in a hospital, requires medically necessary, post-acute care services,
29 then the payer shall reimburse the hospital at the agreed upon alternate
30 rate for less than acute care services, which such alternate rate shall be
31 negotiated in good faith.

32 In the event that the covered person's physician determines that the
33 covered person should be discharged to an alternate care facility, the
34 payer shall cooperate fully with the hospital in the hospital's discharge
35 planning.

36 If the payer fails to identify an appropriate network provider for a
37 covered person whose health benefit plan is restricted to network
38 providers, it shall only be entitled to reimburse the hospital at the
39 alternate rate for a period of 48 hours. After 48 hours, if a network
40 placement cannot be identified, the payer shall reimburse the hospital
41 at 65% of the contracted acute care rate for each additional day of
42 stay.]¹

43
44 ¹[6.] 7.¹ (New section) ¹[a.]¹ A payer, or ¹[its] payer's¹ agent,
45 shall reimburse a hospital or physician according to the provider
46 contract for all medically necessary emergency and urgent care health

1 care services that are covered under the health benefits plan, including
2 all tests necessary to determine the nature of an illness or injury.

3 ¹[b. A payer shall provide each network provider with the source
4 of all commercially produced clinical criteria guidelines as well as a
5 copy of all internally produced clinical criteria guidelines used by the
6 payer or its agent to determine the medical necessity of health care
7 services. These guidelines may be used by the payer only as a
8 screening tool and may not be applied without considering the covered
9 person's individual health care circumstances. The payer or its agent
10 shall notify each network provider in writing of any change that is
11 more restrictive in terms of the covered services in the guidelines at
12 least 30 days prior to implementing the change. Notwithstanding the
13 requirements of this subsection, a payer that discloses its internally
14 produced clinical criteria guidelines to network providers on the
15 payer's website shall be deemed in compliance with the disclosure
16 requirements of this subsection for internally produced clinical criteria
17 guidelines. Any changes to the internally produced guidelines that are
18 more restrictive in terms of covered services shall be clearly noted on
19 the website.]¹

20

21 ¹[7. (New section) a. Prior to receiving hospital services, a
22 covered person or a person designated by the covered person may sign
23 a consent form authorizing the hospital, on the covered person's
24 behalf, to appeal a determination by a payer to deny, reduce or
25 terminate a health care benefit or deny payment for a health care
26 service based upon the payer's determination that the health care
27 benefit or service is not medically necessary. An appeal conducted
28 pursuant to this section shall be conducted pursuant to the
29 requirements established in section 11 of P.L.1997, c.192 (C.26:2S-
30 11), provided however, that the hospital shall bear all costs associated
31 with the appeal that are normally paid by the covered person. The
32 consent would be valid for all stages of the payer's informal and formal
33 appeals process and the Independent Health Care Appeals Program
34 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11).

35 b. The hospital shall provide notice to the covered person
36 whenever the hospital institutes an appeal of a payer's determination
37 to deny, reduce or terminate a health care benefit or deny payment for
38 a health care service and shall provide additional notice to the covered
39 person each time the hospital continues that appeal to the next stage
40 of the payer's appeal process, including any appeal to an independent
41 utilization review organization pursuant to section 12 of P.L.1997,
42 c.192 (C.26:2S-12). A hospital acting in accordance with the
43 provisions of this subsection shall bear all costs associated with the
44 appeal that are normally paid by the covered person and comply with
45 the requirements established in section 11 of P.L.1997, c.192
46 (C.26:2S-11).

1 c. The covered person shall retain the right to revoke at any time
2 his consent granted pursuant to subsection a. of this section.]¹

3
4 ¹[8. (New section) a. A payer shall establish an internal appeal
5 mechanism to resolve any dispute regarding the compliance with the
6 requirements of sections 3 through 6 of this act. The payer shall
7 conduct the appeal at no cost to the hospital or physician.

8 A hospital or physician shall initiate an appeal on a form prescribed
9 by the commissioner which shall describe the type of substantiating
10 documentation that must be submitted with the form. The payer shall
11 conduct a review of the appeal and notify the hospital or physician of
12 its determination on or before the 10th calendar day following the
13 payer's receipt of the appeal form. If the hospital or physician is not
14 notified of the payer's determination of the appeal within 10 days, the
15 hospital or physician may refer the dispute to arbitration as provided
16 by subsection b. of this section.

17 If the payer issues a determination in favor of the hospital or
18 physician, the payer shall comply with the provisions of this section
19 and pay the amount of money in dispute, if applicable, with accrued
20 interest at the rate of 20% per annum, on or before the 30th calendar
21 day following the notification of the payer's determination on the
22 appeal.

23 If the payer issues a determination against the hospital or physician,
24 the payer shall notify the hospital or physician of its findings on or
25 before the 10th calendar day following the receipt of the appeal form
26 and shall include in the notification written instructions for referring
27 the dispute to arbitration as provided by subsection b. of this section.

28 The payer shall report annually to the commissioner the number of
29 appeals it has received and the resolution of each appeal.

30 b. Any dispute regarding the determination of an internal appeal
31 conducted pursuant to subsection a. of this section may be referred to
32 arbitration as provided in this subsection. The commissioner shall
33 enter into contract with a nationally recognized, independent
34 organization that specializes in arbitration to conduct the arbitration
35 proceedings.

36 Any party may initiate an arbitration proceeding on or before the
37 90th calendar day following the receipt of the determination, which is
38 the basis of the appeal, on a form prescribed by the commissioner. No
39 dispute shall be accepted for arbitration unless the payment amount in
40 the dispute is \$1,000 or more, except that disputed amounts may be
41 aggregated for the purposes of meeting the threshold requirements of
42 this subsection. No dispute pertaining to medical necessity which is
43 eligible to be submitted to the Independent Health Care Appeals
44 Program established pursuant to section 11 of P.L.1997, c.192
45 (C.26:2S-11) shall be the subject of arbitration pursuant to this

1 subsection.

2 c. An arbitrator may review any records in connection with the
3 dispute, including the claims file of the payer or of the hospital or
4 physician or the covered person, subject to confidentiality
5 requirements established by State or federal law.

6 d. An arbitrator's determination shall be:

7 (1) signed by the arbitrator;

8 (2) issued in writing, in a form prescribed by the commissioner,
9 including a statement of the issues in dispute and the findings and
10 conclusions on which the determination is based; and

11 (3) issued on or before the 30th calendar day following the receipt
12 of the required documentation.

13 The arbitration shall be nonappealable and binding on all parties to
14 the dispute.

15 e. If the arbitrator determines that a payer has withheld or denied
16 payment in violation of the provisions of this section, the arbitrator
17 shall order the payer to make payment of the claim, together with
18 accrued interest, on or before the 10th business day following the
19 issuance of the determination. In accordance with regulations adopted
20 by the commissioner, the cost of the arbitration proceedings, including
21 the payment of reasonable attorney's fees, shall be awarded to the
22 prevailing party.

23 f. If the arbitrator determines that a health care provider has
24 engaged in a pattern and practice of improper billing and a refund is
25 due to the payer, the arbitrator may award the payer a refund,
26 including interest accrued at the rate of 20% per annum.

27 g. The arbitrator shall file a copy of each determination with and
28 in the form prescribed by the commissioner.]¹

29

30 ¹[9. (New section) The commissioner shall enforce the provisions
31 of this act. A payer found in violation of the provisions of this act
32 shall be liable for a civil penalty of not more than \$10,000 for each day
33 that the payer is in violation if reasonable notice in writing is given of
34 the intent to levy the penalty and, at the discretion of the
35 commissioner, the payer has 30 days, or such additional time as the
36 commissioner shall determine to be reasonable, to remedy the
37 condition which gave rise to the violation and fails to do so within the
38 time allowed. The penalty shall be collected by the commissioner in
39 the name of the State in a summary proceeding in accordance with the
40 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
41 seq.).]¹

42

43 ¹8. Section 11 of P.L.1997, c.192 (C.26:2S-11) is amended to read
44 as follows:

45 11. There is established the Independent Health Care Appeals

1 Program in the department.

2 The purpose of the appeals program is to provide an independent
3 medical necessity or appropriateness of services review of final
4 decisions by carriers to deny, reduce or terminate benefits in the event
5 the final decision is contested by the covered person or any health care
6 provider acting on behalf of the covered person but only with the
7 covered person's consent. The appeal review shall not include any
8 decisions regarding benefits not covered by the covered person's health
9 benefits plan.

10 a. A covered person or health care provider may apply to the
11 Independent Health Care Appeals Program for a review of a decision
12 to deny, reduce or terminate a benefit if the person or health care
13 provider has already completed the carrier's appeals process, if any,
14 and the person or health care provider contests the final decision by
15 the carrier. The person or health care provider shall apply to the
16 department within 60 days of the date the final decision was issued by
17 the carrier, in a manner determined by the commissioner.

18 b. As part of the application, the covered person or health care
19 provider shall provide the department with:

20 (1) The name and business address of the carrier;

21 (2) A brief description of the covered person's medical condition for
22 which benefits were denied, reduced or terminated;

23 (3) A copy of any information provided by the carrier regarding its
24 decision to deny, reduce or terminate the benefit; and

25 (4) A written consent to obtain any necessary medical records from
26 the carrier and, in the case of a carrier which offers a managed care
27 plan, any other out-of-network physician the person may have
28 consulted on the matter.

29 c. The covered person shall pay the department an application
30 processing fee of \$25, except that the commissioner may reduce or
31 waive the fee in the case of financial hardship. The health care
32 provider acting on the covered person's behalf shall bear all costs
33 associated with the appeal that are normally paid by the covered
34 person.

35 d. Prior to receiving hospital services, a covered person or a
36 person designated by the covered person may sign a consent form
37 authorizing a health care provider acting on the covered person's
38 behalf to appeal a determination by the carrier to deny, reduce or
39 terminate benefits. The consent is valid for all stages of the carrier's
40 informal and formal appeals process and the Independent Health Care
41 Appeals Program established pursuant to this section. A covered
42 person shall retain the right to revoke his consent at any time.

43 e. A health care provider shall provide notice to the covered person
44 whenever the health care provider initiates an appeal of a carrier's
45 determination to deny, reduce or terminate a benefit or deny payment

1 for a health care service based on a medical necessity determination
2 made by the carrier. The health care provider shall provide additional
3 notice to the covered person each time the health care provider
4 continues the appeal to the next stage of an appeals process, including
5 any appeal to an independent utilization review organization pursuant
6 to this section.¹

7 (cf: P.L.1997, c.192, s.11)

8
9 ^{19.} Section 12 of P.L.1997, c.192 (C.26:2S-12) shall be amended
10 to read as follows:

11 12. a. The commissioner shall contract with one or more
12 independent utilization review organizations in the State that meet the
13 requirements of this act to conduct the appeal reviews. The
14 independent utilization review organization shall be independent of any
15 carrier. The commissioner may establish additional requirements,
16 including conflict of interest standards, consistent with the purposes
17 of this act that an organization shall meet in order to qualify for
18 participation in the Independent Health Care Appeals Program.

19 b. The commissioner shall establish procedures for transmitting the
20 completed application for an appeal review to the independent
21 utilization review organization.

22 c. The independent utilization review organization shall promptly
23 review the pertinent medical records of the covered person to
24 determine the appropriate, medically necessary health care services the
25 person should receive, based on applicable, generally accepted practice
26 guidelines developed by the federal government, national or
27 professional medical societies, boards or associations and any
28 applicable clinical protocols or practice guidelines developed by the
29 carrier. The organization shall complete its review and make its
30 determination within 90 days of receipt of a completed application for
31 an appeal review or within less time, as prescribed by the
32 commissioner.

33 Upon completion of the review, the organization shall state its
34 findings in writing and make a determination of whether the carrier's
35 denial, reduction or termination of benefits deprived the covered
36 person of medically necessary services covered by the person's health
37 benefits plan. If the organization determines that the denial, reduction
38 or termination of benefits deprived the person of medically necessary
39 covered services, it shall convey to the covered person or the health
40 care provider acting on behalf of the covered person and carrier its
41 decision regarding the appropriate, medically necessary health care
42 services that the person should receive, which shall be binding on the
43 carrier. If all or part of the organization's decision is in favor of the
44 covered person, the carrier shall promptly provide coverage for the
45 health care services found by the organization to be medically

1 necessary covered services. If the covered person is not in agreement
2 with the organization's decision, the person may seek the desired
3 health care services outside of his health benefits plan, at his own
4 expense.

5 d. If the commissioner determines that a carrier has failed to
6 comply with the decision of an independent utilization review
7 organization or is otherwise in violation of patient rights and other
8 applicable regulations, the commissioner may impose such penalties
9 and sanctions on the carrier, as provided by regulation, as the
10 commissioner deems appropriate.

11 e. The commissioner shall require the independent utilization
12 review organization to establish procedures to provide for an
13 expedited review of a carrier's denial, reduction or termination of a
14 benefit decision when a delay in receipt of the service could seriously
15 jeopardize the health or well-being of the covered person.

16 f. The covered person's medical records provided to the
17 Independent Health Care Appeals Program and the independent
18 utilization review organization and the findings and recommendations
19 of the organization made pursuant to this act are confidential and shall
20 be used only by the department, the organization and the affected
21 carrier for the purposes of this act. The medical records and findings
22 and recommendations shall not otherwise be divulged or made public
23 so as to disclose the identity of any person to whom they relate, and
24 shall not be included under materials available to public inspection
25 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

26 g. The commissioner shall establish a reasonable, per case
27 reimbursement schedule for the independent utilization review
28 organization.

29 h. The cost of the appeal review shall be borne by the carrier
30 pursuant to a schedule of fees established by the commissioner.¹
31 (cf: P.L.2001, c.1, s.1)

32

33 10. Section 2 of P.L.1999, c.154 (C.17:48-8.4) is amended to read
34 as follows:

35 2. a. Within 180 days of the adoption of a timetable for
36 implementation pursuant to section 1 of P.L.1999, c.154
37 (C.17B:30-23), a hospital service corporation[,] or its agent or a
38 subsidiary that processes health care benefits claims as a third party
39 administrator, shall demonstrate to the satisfaction of the
40 Commissioner of Banking and Insurance that it will adopt and
41 implement all of the standards to receive and transmit health care
42 transactions electronically, according to the corresponding timetable,
43 and otherwise comply with the provisions of this section, as a
44 condition of its continued authorization to do business in this State.

45 The Commissioner of Banking and Insurance may grant extensions
46 or waivers of the implementation requirement when it has been

1 demonstrated to the commissioner's satisfaction that compliance with
2 the timetable for implementation will result in an undue hardship to a
3 hospital service corporation ¹or its agent¹, its subsidiary or its
4 covered persons.

5 b. Within 12 months of the adoption of regulations establishing
6 standard health care enrollment and claim forms by the Commissioner
7 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
8 (C.17B:30-23), a hospital service corporation ¹or its agent¹ or a
9 subsidiary that processes health care benefits claims as a third party
10 administrator shall use the standard health care enrollment and claim
11 forms in connection with all group and individual contracts issued,
12 delivered, executed or renewed in this State.

13 c. Twelve months after the adoption of regulations establishing
14 standard health care enrollment and claim forms by the Commissioner
15 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
16 (C.17B:30-23), a hospital service corporation ¹or its agent¹ shall
17 require that health care providers file all claims for payment for health
18 care services. A covered person who receives health care services
19 shall not be required to submit a claim for payment, but
20 notwithstanding the provisions of this subsection to the contrary, a
21 covered person shall be permitted to submit a claim on his own behalf,
22 at the covered person's option. All claims shall be filed using the
23 standard health care claim form applicable to the contract.

24 d. ¹For the purposes of this subsection, "substantiating
25 documentation" means any information specific to the particular health
26 care service provided to a covered person.¹

27 (1) Effective 180 days after the effective date of P.L.1999, c.154,
28 a hospital service corporation or its agent, hereinafter the payer, shall
29 remit payment for every insured claim submitted by a [subscriber or
30 that subscriber's agent or assignee if the contract provides for
31 assignment of benefits] covered person or health care provider, no
32 later than the 30th calendar day following receipt of the claim by the
33 payer or no later than the time limit established for the payment of
34 claims in the Medicare program pursuant to 42 U.S.C.
35 s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by
36 electronic means, and no later than the 40th calendar day following
37 receipt if the claim is submitted by other than electronic means, if:

38 (a) [the claim is an eligible claim for a health care service provided
39 by an eligible health care provider to a covered person under the
40 contract;

41 (b) the claim has no material defect or impropriety, including, but
42 not limited to, any lack of required substantiating documentation or
43 incorrect coding;

44 (c) there is no dispute regarding the amount claimed;] the health
45 care provider is eligible at the date of service;

1 **(b) the person who received the health care service was covered on**
2 **the date of service;**

3 **(c) the claim is for a service or supply covered under the health**
4 **benefits plan;**

5 **(d) the claim is submitted with all the information requested by the**
6 **payer on the claim form or in other instructions¹ that were¹ distributed**
7 **in advance to the health care provider or covered person¹ [within 120**
8 **days of the date of service] in accordance with the provisions of**
9 **section 4 of P.L. , c. (C.) (pending before the Legislature as this**
10 **bill)¹ ; and**

11 **[(d)] (e) the payer has no reason to believe that the claim has been**
12 **submitted fraudulently[; and**

13 **(e) the claim requires no special treatment that prevents timely**
14 **payments from being made on the claim under the terms of the**
15 **contract].**

16 **(2) If all or a portion of the claim¹ [is denied by the payer] is not**
17 **paid within the time frames provided in paragraph (1) of this**
18 **subsection¹ because:**

19 **(a) [the claim is an ineligible claim;**

20 **(b)] the claim submission is incomplete because the required**
21 **substantiating documentation¹ [, which is specific to the health care**
22 **service provided to the covered person,]¹ has not been submitted to**
23 **the payer;**

24 **[(c)] (b) the diagnosis coding, procedure coding, or any other**
25 **required information to be submitted with the claim is incorrect;**
26 **¹[or]¹**

27 **[(d)] (c) the payer disputes the amount claimed[; or**

28 **(e) the claim requires special treatment that prevents timely**
29 **payments from being made on the claim under the terms of the**
30 **contract] ¹or**

31 **(d) there is strong evidence of fraud by the provider and the payer**
32 **has initiated an investigation into the suspected fraud¹,**

33 the payer shall notify the [subscriber, or that subscriber's agent or
34 assignee if the contract provides for assignment of benefits] ¹[covered
35 person and]¹ health care provider, ¹[in writing or]¹ by electronic
36 means ¹[, as appropriate,] and the covered person in writing¹ within
37 30 days ¹[,of the following: if all or a portion of the claim is denied,
38 all the reasons for the denial; if the claim lacks the required
39 substantiating documentation[, including] or contains incorrect
40 coding, a statement as to what substantiating documentation, specific
41 to the health care service provided to the covered person, or other
42 information, is required to complete adjudication of the claim; and if
43 the amount of the claim is disputed, a statement that it is disputed]¹
44 [; and if the claim requires special treatment that prevents timely

1 payments from being made, a statement of the special treatment to
2 which the claim is subject] ¹of receiving an electronic claim, or notify
3 the covered person and health care provider in writing within 40 days
4 of receiving a claim submitted by other than electronic means, that:

5 (i) the claim is incomplete with a statement as to what
6 substantiating documentation is required for adjudication of the claim;

7 (ii) the claim contains incorrect information with a statement as to
8 what information must be corrected for adjudication of the claim;

9 (iii) the payer disputes the amount claimed in whole or in part with
10 a statement as to the basis of that dispute; or

11 (iv) the payer finds there is strong evidence of fraud and has
12 initiated an investigation into the suspected fraud in accordance with
13 its fraud prevention plan established pursuant to section 1 of P.L.1993,
14 c.362 (C.17:33A-15), or referred the claim, together with supporting
15 documentation, to the Office of the Insurance Fraud Prosecutor in the
16 Department of Law and Public Safety established pursuant to section
17 32 of P.L.1998, c.21 (C.17:33A-16)¹.

18 (3) If all or a portion of ¹[a] an electronically submitted¹ claim
19 cannot be ¹[entered into the claims processing system for any of the
20 following reasons:

21 (a) the health care provider is not eligible at the time of service;

22 (b) the person who received the health care service was not a
23 covered person at the time of service;

24 (c) the premium was not paid by or on the behalf of the covered
25 person; or

26 (d)] adjudicated because¹ the diagnosis coding, procedure coding
27 or any other data required to be submitted with the claim was missing,
28 the payer shall ¹electronically¹ notify the ¹[covered person and]¹
29 health care provider ¹or its agent¹ within seven days ¹[if the claim was
30 submitted by electronic means, or within 14 days if the claim was
31 submitted by other than electronic means,]¹ of that determination¹ [of
32 denial, of all the reasons for the denial or] and request¹ any
33 information required to complete adjudication of the claim.

34 (4) Any portion of a claim that meets the criteria established in
35 paragraph (1) of this subsection shall be paid by the payer in
36 accordance with the time limit established in paragraph (1) of this
37 subsection.

38 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
39 by electronic means from a health care provider ¹[or]¹ [subscriber]
40 ¹[covered person]¹, no later than two working days following receipt
41 of the transmission of the claim.

42 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
43 (C.17:33A-1 et seq.) has reason to believe that a claim has been
44 submitted fraudulently, it shall investigate the claim in accordance with
45 its fraud prevention plan established pursuant to section 1 of P.L.1993,

1 c.362 (C.17:33A-15), or refer the claim, together with supporting
2 documentation, to the Office of the Insurance Fraud Prosecutor in the
3 Department of Law and Public Safety established pursuant to section
4 32 of P.L.1998, c.21 (C.17:33A-16).

5 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
6 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
7 remitted to the claimant or his agent by the payer on or before the 30th
8 calendar day or the time limit established by the Medicare program,
9 whichever is earlier, following receipt by the payer of a claim
10 submitted by electronic means and on or before the 40th calendar day
11 following receipt of a claim submitted by other than electronic means.

12 ¹~~[In the event]~~ If¹ payment is withheld on all or a portion of a
13 claim by a payer pursuant to ¹~~[subparagraph]~~ subparagraphs¹ ~~[(b)]~~
14 ~~(a)~~ ¹~~or (b)~~¹ of paragraph (2) ~~or~~ ¹~~[subparagraph (d) of]~~ paragraph (3)
15 of this subsection, the claims payment shall be overdue if not remitted
16 to the claimant or his agent by the payer on or before the ~~[30th]~~
17 ¹~~[15th]~~ 30th¹ calendar day or the time limit established by the
18 Medicare program, whichever is earlier, for claims submitted by
19 electronic means and the ~~[40th]~~ ¹~~[25th]~~ 40th¹ calendar day for claims
20 submitted by other than electronic means, following receipt by the
21 payer of the required documentation or information or modification of
22 an initial submission.

23 ¹If payment is withheld on all or a portion of a claim by a payer
24 pursuant to paragraphs (2) or (3) of this subsection and the provider
25 is not notified within the time frames provided for in those paragraphs,
26 the claim shall be deemed to be overdue.¹

27 (8) (a) No payer ¹that has reserved the right to change the
28 premium¹ shall deny payment on all or a portion of a claim because the
29 payer requests documentation or information that is not specific to the
30 health care service provided to the covered person.

31 (b) No payer shall deny payment on all or a portion of a claim while
32 seeking coordination of benefits information unless good cause exists
33 for the payer to believe that other insurance is available to the covered
34 person. Good cause shall exist only if the payer's records indicate that
35 other coverage exists. Routine requests to determine whether
36 coordination of benefits exists shall not be considered good cause.

37 (c) In the event payment is withheld on all or a portion of a claim
38 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
39 claims payment shall be deemed to be overdue if not remitted to the
40 claimant or his agent by the payer on or before the 30th calendar day
41 or the time limit established by the Medicare program, whichever is
42 earlier, following receipt by the payer of a claim submitted by
43 electronic means or on or before the 40th calendar day following
44 receipt of a claim submitted by other than electronic means.

45 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
46 of ~~[10%]~~ ¹~~[20%]~~ 12%¹ per annum. The interest shall be paid to the

1 health care provider at the time the overdue payment is made. ¹The
2 amount of interest paid to a health care provider for an overdue claim
3 shall be credited to any civil penalty for late payment of the claim
4 levied by the Department of Human Services against a payer that does
5 not reserve the right to change the premium.¹

6 (10) With the exception of claims that were submitted fraudulently
7 or submitted by health care providers that have a pattern of
8 inappropriate billing or claims that were subject to coordination of
9 benefits, no payer shall seek reimbursement for overpayment of a claim
10 previously paid pursuant to this section later than ¹[one year] 18
11 months¹ after the date the first payment on the claim was made. ¹No
12 payer shall seek more than one reimbursement for overpayment of a
13 particular claim.¹ At the time the reimbursement request is submitted
14 to the health care provider, the payer shall provide written
15 documentation that identifies the error made by the payer in the
16 processing or payment of the claim that justifies the reimbursement
17 request. No payer shall base a reimbursement request for a particular
18 claim on extrapolation of other claims, except under the following
19 circumstances:

20 (a) in judicial or quasi-judicial proceedings, including arbitration;

21 (b) in administrative proceedings; ¹[or]¹

22 (c) in which relevant records required to be maintained by the
23 health care provider have been improperly altered or reconstructed, or
24 a material number of the relevant records are otherwise unavailable
25 ¹or;

26 (d) in which there is clear evidence of fraud by the health care
27 provider and the payer has investigated the claim in accordance with
28 its fraud prevention plan established pursuant to section 1 of P.L.1993,
29 c.362 (C.17:33A-15), and referred the claim, together with supporting
30 documentation, to the Office of the Insurance Fraud Prosecutor in the
31 Department of Law and Public Safety established pursuant to section
32 32 of P.L.1998, c.21 (C.17:33A-16)¹.

33 (11) (a) In seeking reimbursement for the overpayment from the
34 health care provider, except as provided for in subparagraph (b) of this
35 paragraph, no payer shall collect or attempt to collect:

36 (i) the funds for the reimbursement on or before the 45th calendar
37 day following the submission of the reimbursement request to the
38 health care provider;

39 (ii) the funds for the reimbursement if the health care provider
40 disputes the request and initiates an appeal on or before the 45th
41 calendar day following the submission of the reimbursement request
42 to the health care provider and until the health care provider's rights
43 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
44 section are exhausted; ¹or¹

45 (iii) ¹[the funds for the reimbursement request by assessing them
46 against payment of any future claims submitted by the health care

1 provider, unless agreed to in writing by the health care provider; or
2 (iv)] a monetary penalty against the reimbursement request,
3 including but not limited to, an interest charge or¹ a late fee.

4 ¹The payer may collect the funds for the reimbursement request by
5 assessing them against payment of any future claims submitted by the
6 health care provider after the 45th calendar day following the
7 submission of the reimbursement request to the health care provider
8 or after the health care provider's rights to appeal set forth under
9 paragraphs (1) and (2) of subsection e. of this section have been
10 exhausted if the payer submits an explanation in writing to the
11 provider in sufficient detail so that the provider can reconcile each
12 covered person's bill.¹

13 (b) If a payer has determined that the overpayment to the health
14 care provider is a result of fraud committed by the health care provider
15 and the payer has conducted its investigation and reported the fraud
16 to the Office of the Insurance Fraud Prosecutor as required by law, the
17 payer may collect an overpayment by assessing it against payment of
18 any future claim submitted by the health care provider.

19 (12) No health care provider shall seek reimbursement from a payer
20 or covered person for underpayment of a claim submitted pursuant to
21 this section later than ¹[one year] 18 months¹ from the date the first
22 payment on the claim was made, except if the claim is the subject of
23 an appeal submitted pursuant to subsection e. of this section or the
24 claim is subject to continual claims submission. ¹No health care
25 provider shall seek more than one reimbursement for underpayment of
26 a particular claim.¹

27 e. (1) A hospital service corporation or its agent, hereinafter the
28 payer, shall establish an internal appeal mechanism to resolve any
29 dispute ¹raised by a health care provider regardless of whether the
30 health care provider is under contract with the payer¹ regarding
31 compliance with the requirements of this section ¹or compliance with
32 the requirements of sections 4 through 7 of P.L. , c. (C.)
33 (pending before the Legislature as this bill). No dispute pertaining to
34 medical necessity which is eligible to be submitted to the Independent
35 Health Care Appeals Program established pursuant to section 11 of
36 P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal
37 pursuant to this subsection¹. The payer shall conduct the appeal at no
38 cost to the health care provider.

39 A health care provider may initiate an appeal on or before the 90th
40 calendar day following receipt by the health care provider of the
41 payer's claims determination, which is the basis of the appeal, on a
42 form prescribed by the Commissioner of Banking and Insurance which
43 shall describe the type of substantiating documentation that must be
44 submitted with the form. The payer shall conduct a review of the
45 appeal and notify the health care provider of its determination on or
46 before the ¹[10th] 30th¹ calendar day following the receipt of the

1 appeal form. If the health care provider is not notified of the payer's
2 determination of the appeal within ¹[10] ¹30¹ days, the health care
3 provider may refer the dispute to arbitration as provided by paragraph
4 (2) of this subsection.

5 If the payer issues a determination in favor of the health care
6 provider, the payer shall comply with the provisions of this section and
7 pay the amount of money in dispute, if applicable, with accrued
8 interest at the rate of ¹[20%] ¹12%¹ per annum, on or before the 30th
9 calendar day following the notification of the payer's determination on
10 the appeal. ¹Interest shall begin to accrue on the day the appeal was
11 received by the payer.¹

12 If the payer issues a determination against the health care provider,
13 the payer shall notify the health care provider of its findings on or
14 before the ¹[10th] ¹30th¹ calendar day following the receipt of the
15 appeal form and shall include in the notification written instructions for
16 referring the dispute to arbitration as provided by paragraph (2) of this
17 subsection.

18 The payer shall report annually to the Commissioner of Banking and
19 Insurance the number of appeals it has received and the resolution of
20 each appeal.

21 (2) Any dispute regarding the determination of an internal appeal
22 conducted pursuant to paragraph (1) of this subsection may be
23 referred to arbitration as provided in this paragraph. The
24 Commissioner of Banking and Insurance shall contract with a
25 nationally recognized, independent organization that specializes in
26 arbitration to conduct the arbitration proceedings.

27 Any party may initiate an arbitration proceeding on or before the
28 90th calendar day following the receipt of the determination which is
29 the basis of the appeal, on a form prescribed by the Commissioner of
30 Banking and Insurance. No dispute shall be accepted for arbitration
31 unless the payment amount in dispute is \$1,000 or more, except that
32 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
33 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
34 the threshold requirements of this subsection. No dispute pertaining
35 to medical necessity which is eligible to be submitted to the
36 Independent Health Care Appeals Program established pursuant to
37 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
38 arbitration pursuant to this subsection.

39 (3) The arbitrator shall conduct the arbitration proceedings
40 pursuant to the rules of the arbitration entity, including rules of
41 discovery subject to confidentiality requirements established by State
42 or federal law.

43 (4) An arbitrator's determination shall be:

44 (a) signed by the arbitrator;

45 (b) issued in writing, in a form prescribed by the Commissioner of
46 Banking and Insurance, including a statement of the issues in dispute

1 and the findings and conclusions on which the determination is based;
2 and

3 (c) issued on or before the 30th calendar day following the receipt
4 of the required documentation.

5 The arbitration shall be nonappealable and binding on all parties to
6 the dispute.

7 (5) If the arbitrator determines that a payer has withheld or denied
8 payment in violation of the provisions of this section, the arbitrator
9 shall order the payer to make payment of the claim, together with
10 accrued interest, on or before the 10th business day following the
11 issuance of the determination. If the arbitrator determines that a payer
12 has withheld or denied payment on the basis of information submitted
13 by the health care provider and the payer requested, but did not
14 receive, this information from the health care provider when the claim
15 was initially processed pursuant to subsection d. of this section or
16 reviewed under internal appeal pursuant to paragraph (1) of this
17 subsection, the payer shall not be required to pay any accrued interest.

18 ¹[In accordance with regulations adopted by the Commissioner of
19 Banking and Insurance, the cost of the arbitration proceedings,
20 including the payment of reasonable attorney's fees, shall be awarded
21 to the prevailing party.]¹

22 (6) If the arbitrator determines that a health care provider has
23 engaged in a pattern and practice of improper billing and a refund is
24 due to the payer, the arbitrator may award the payer a refund,
25 including interest accrued at the rate of ¹[20%] 12% ¹ per annum.
26 ¹Interest shall begin to accrue on the day the appeal was received by
27 the payer for resolution through the internal appeals process
28 established pursuant to paragraph (1) of this subsection.¹

29 (7) The arbitrator shall file a copy of each determination with and
30 in the form prescribed by the Commissioner of Banking and Insurance.

31 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
32 means a claim by a [subscriber] covered person for payment of
33 benefits under an insured hospital service corporation contract for
34 which the financial obligation for the payment of a claim under the
35 contract rests upon the hospital service corporation.

36 g. Any person found in violation of this section with a pattern ¹[of
37 frequency] and practice¹ as determined by the Commissioner of
38 Banking and Insurance shall be liable to a civil penalty as set forth in
39 section 17 of P.L. , c. (C.) (pending before the Legislature as
40 this bill).

41 (cf: P.L.1999, c.154, s.2)

42

43 11. Section 3 of P.L.1999, c.154 (C.17:48A-7.12) is amended to
44 read as follows:

45 3. a. Within 180 days of the adoption of a timetable for
46 implementation pursuant to section 1 of P.L.1999, c.154

1 (C.17B:30-23), a medical service corporation[, or its agent] or a
2 subsidiary that processes health care benefits claims as a third party
3 administrator, shall demonstrate to the satisfaction of the
4 Commissioner of Banking and Insurance that it will adopt and
5 implement all of the standards to receive and transmit health care
6 transactions electronically, according to the corresponding timetable,
7 and otherwise comply with the provisions of this section, as a
8 condition of its continued authorization to do business in this State.

9 The Commissioner of Banking and Insurance may grant extensions
10 or waivers of the implementation requirement when it has been
11 demonstrated to the commissioner's satisfaction that compliance with
12 the timetable for implementation will result in an undue hardship to a
13 medical service corporation ¹, or its agent ¹, its subsidiary or its
14 covered persons.

15 b. Within 12 months of the adoption of regulations establishing
16 standard health care enrollment and claim forms by the Commissioner
17 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
18 (C.17B:30-23), a medical service corporation ¹or its agent¹ or a
19 subsidiary that processes health care benefits claims as a third party
20 administrator shall use the standard health care enrollment and claim
21 forms in connection with all group and individual contracts issued,
22 delivered, executed or renewed in this State.

23 c. Twelve months after the adoption of regulations establishing
24 standard health care enrollment and claim forms by the Commissioner
25 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
26 (C.17B:30-23), a medical service corporation ¹or its agent¹ shall
27 require that health care providers file all claims for payment for health
28 care services. A covered person who receives health care services
29 shall not be required to submit a claim for payment, but
30 notwithstanding the provisions of this subsection to the contrary, a
31 covered person shall be permitted to submit a claim on his own behalf,
32 at the covered person's option. All claims shall be filed using the
33 standard health care claim form applicable to the contract.

34 d. ¹For the purposes of this subsection, "substantiating
35 documentation" means any information specific to the particular health
36 care service provided to a covered person.¹

37 (1) Effective 180 days after the effective date of P.L.1999, c.154,
38 a medical service corporation or its agent, hereinafter the payer, shall
39 remit payment for every insured claim submitted by a [subscriber or
40 that subscriber's agent or assignee if the contract provides for
41 assignment of benefits] covered person or health care provider, no
42 later than the 30th calendar day following receipt of the claim by the
43 payer or no later than the time limit established for the payment of
44 claims in the Medicare program pursuant to 42 U.S.C.
45 s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by
46 electronic means, and no later than the 40th calendar day following

1 receipt if the claim is submitted by other than electronic means, if:

2 (a) [the claim is an eligible claim for a health care service provided

3 by an eligible health care provider to a covered person under the

4 contract;

5 (b) the claim has no material defect or impropriety, including, but

6 not limited to, any lack of required substantiating documentation or

7 incorrect coding;

8 (c) there is no dispute regarding the amount claimed;] the health

9 care provider is eligible at the date of service;

10 (b) the person who received the health care service was covered on

11 the date of service;

12 (c) the claim is for a service or supply covered under the health

13 benefits plan;

14 (d) the claim is submitted with all the information requested by the

15 payer on the claim form or in other instructions¹ that were¹ distributed

16 in advance to the health care provider or covered person¹ [within 120

17 days of the date of service] in accordance with the provisions of

18 section 4 of P.L. , c. (C.) (pending before the Legislature as this

19 bill)¹ ; and

20 [(d)] (e) the payer has no reason to believe that the claim has

21 been submitted fraudulently]; and

22 (e) the claim requires no special treatment that prevents timely

23 payments from being made on the claim under the terms of the

24 contract].

25 (2) If all or a portion of the claim¹ [is denied by the payer] is not

26 paid within the time frames provided in paragraph (1) of this

27 subsection¹ because:

28 (a) [the claim is an ineligible claim;

29 (b)] the claim submission is incomplete because the required

30 substantiating documentation¹ [, which is specific to the health care

31 service provided to the covered person,]¹ has not been submitted to

32 the payer;

33 [(c)] (b) the diagnosis coding, procedure coding, or any other

34 required information to be submitted with the claim is incorrect;

35 ¹[or]¹

36 [(d)] (c) the payer disputes the amount claimed]; or

37 (e) the claim requires special treatment that prevents timely

38 payments from being made on the claim under the terms of the

39 contract]¹ or

40 (d) there is strong evidence of fraud by the provider and the payer

41 has initiated an investigation into the suspected fraud¹,

42 the payer shall notify the [subscriber, or that subscriber's agent or

43 assignee if the contract provides for assignment of benefits]¹ [covered

44 person and]¹ health care provider,¹ [in writing or]¹ by electronic

45 means¹ [, as appropriate,] and the covered person in writing¹ within

1 30 days ¹[,of the following: if all or a portion of the claim is denied,
2 all the reasons for the denial; if the claim lacks the required
3 substantiating documentation[, including] or contains incorrect
4 coding, a statement as to what substantiating documentation, specific
5 to the health care service provided to the covered person, or other
6 information, is required to complete adjudication of the claim; and if
7 the amount of the claim is disputed, a statement that it is disputed]¹
8 [; and if the claim requires special treatment that prevents timely
9 payments from being made, a statement of the special treatment to
10 which the claim is subject] ¹of receiving an electronic claim, or notify
11 the covered person and health care provider in writing within 40 days
12 of receiving a claim submitted by other than electronic means, that:
13 (i) the claim is incomplete with a statement as to what
14 substantiating documentation is required for adjudication of the claim;
15 (ii) the claim contains incorrect information with a statement as to
16 what information must be corrected for adjudication of the claim;
17 (iii) the payer disputes the amount claimed in whole or in part with
18 a statement as to the basis of that dispute; or
19 (iv) the payer finds there is strong evidence of fraud and has
20 initiated an investigation into the suspected fraud in accordance with
21 its fraud prevention plan established pursuant to section 1 of P.L.1993,
22 c.362 (C.17:33A-15), or referred the claim, together with supporting
23 documentation, to the Office of the Insurance Fraud Prosecutor in the
24 Department of Law and Public Safety established pursuant to section
25 32 of P.L.1998, c.21 (C.17:33A-16)]¹.
26 (3) If all or a portion of ¹[a] an electronically submitted¹ claim
27 cannot be ¹[entered into the claims processing system for any of the
28 following reasons:
29 (a) the health care provider is not eligible at the time of service;
30 (b) the person who received the health care service was not a
31 covered person at the time of service;
32 (c) the premium was not paid by or on the behalf of the covered
33 person; or
34 (d)] adjudicated because¹ the diagnosis coding, procedure coding
35 or any other data required to be submitted with the claim was missing,
36 the payer shall ¹electronically¹ notify the ¹[covered person and]¹
37 health care provider ¹or its agent¹ within seven days ¹[if the claim was
38 submitted by electronic means, or within 14 days if the claim was
39 submitted by other than electronic means,]¹ of that determination ¹[of
40 denial, of all the reasons for the denial or] and request¹ any
41 information required to complete adjudication of the claim.
42 (4) Any portion of a claim that meets the criteria established in
43 paragraph (1) of this subsection shall be paid by the payer in
44 accordance with the time limit established in paragraph (1) of this
45 subsection.

1 ~~[(4)]~~ (5) A payer shall acknowledge receipt of a claim submitted
2 by electronic means from a health care provider ¹[or] ¹[subscriber]
3 ¹[covered person]¹, no later than two working days following receipt
4 of the transmission of the claim.

5 ~~[(5)]~~ (6) If a payer subject to the provisions of P.L.1983, c.320
6 (C.17:33A-1 et seq.) has reason to believe that a claim has been
7 submitted fraudulently, it shall investigate the claim in accordance with
8 its fraud prevention plan established pursuant to section 1 of P.L.1993,
9 c.362 (C.17:33A-15), or refer the claim, together with supporting
10 documentation, to the Office of the Insurance Fraud Prosecutor in the
11 Department of Law and Public Safety established pursuant to section
12 32 of P.L.1998, c.21 (C.17:33A-16).

13 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
14 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
15 remitted to the claimant or his agent by the payer on or before the 30th
16 calendar day or the time limit established by the Medicare program,
17 whichever is earlier, following receipt by the payer of a claim
18 submitted by electronic means and on or before the 40th calendar day
19 following receipt of a claim submitted by other than electronic means.

20 ¹[In the event] If¹ payment is withheld on all or a portion of a
21 claim by a payer pursuant to ¹[subparagraph] subparagraphs¹ [(b)]
22 (a) ¹or (b)¹ of paragraph (2) or ¹[subparagraph (d) of]¹ paragraph (3)
23 of this subsection, the claims payment shall be overdue if not remitted
24 to the claimant or his agent by the payer on or before the ~~[30th]~~
25 ¹[15th] 30th¹ calendar day or the time limit established by the
26 Medicare program, whichever is earlier, for claims submitted by
27 electronic means and the ~~[40th]~~ ¹[25th] 40th¹ calendar day for claims
28 submitted by other than electronic means, following receipt by the
29 payer of the required documentation or information or modification of
30 an initial submission.

31 ¹If payment is withheld on all or a portion of a claim by a payer
32 pursuant to paragraphs (2) or (3) of this subsection and the provider
33 is not notified within the time frames provided for in those paragraphs,
34 the claim shall be deemed to be overdue.¹

35 (8) (a) No payer ¹that has reserved the right to change the
36 premium¹ shall deny payment on all or a portion of a claim because the
37 payer requests documentation or information that is not specific to the
38 health care service provided to the covered person.

39 (b) No payer shall deny payment on all or a portion of a claim while
40 seeking coordination of benefits information unless good cause exists
41 for the payer to believe that other insurance is available to the covered
42 person. Good cause shall exist only if the payer's records indicate that
43 other coverage exists. Routine requests to determine whether
44 coordination of benefits exists shall not be considered good cause.

1 (c) In the event payment is withheld on all or a portion of a claim
2 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
3 claims payment shall be deemed to be overdue if not remitted to the
4 claimant or his agent by the payer on or before the 30th calendar day
5 or the time limit established by the Medicare program, whichever is
6 earlier, following receipt by the payer of a claim submitted by
7 electronic means or on or before the 40th calendar day following
8 receipt of a claim submitted by other than electronic means.

9 [(7)] (9) An overdue payment shall bear simple interest at the rate
10 of [10%] ¹[20%] 12%¹ per annum. The interest shall be paid to the
11 health care provider at the time the overdue payment is made. ¹The
12 amount of interest paid to a health care provider for an overdue claim
13 shall be credited to any civil penalty for late payment of the claim
14 levied by the Department of Human Services against a payer that does
15 not reserve the right to change the premium.¹

16 (10) With the exception of claims that were submitted fraudulently
17 or submitted by health care providers that have a pattern of
18 inappropriate billing or claims that were subject to coordination of
19 benefits, no payer shall seek reimbursement for overpayment of a claim
20 previously paid pursuant to this section later than ¹[one year] 18
21 months¹ after the date the first payment on the claim was made. ¹No
22 payer shall seek more than one reimbursement for overpayment of a
23 particular claim.¹ At the time the reimbursement request is submitted
24 to the health care provider, the payer shall provide written
25 documentation that identifies the error made by the payer in the
26 processing or payment of the claim that justifies the reimbursement
27 request. No payer shall base a reimbursement request for a particular
28 claim on extrapolation of other claims, except under the following
29 circumstances:

30 (a) in judicial or quasi-judicial proceedings, including arbitration;

31 (b) in administrative proceedings; ¹[or]¹

32 (c) in which relevant records required to be maintained by the
33 health care provider have been improperly altered or reconstructed, or
34 a material number of the relevant records are otherwise unavailable
35 ¹or;

36 (d) in which there is clear evidence of fraud by the health care
37 provider and the payer has investigated the claim in accordance with
38 its fraud prevention plan established pursuant to section 1 of P.L.1993,
39 c.362 (C.17:33A-15), and referred the claim, together with supporting
40 documentation, to the Office of the Insurance Fraud Prosecutor in the
41 Department of Law and Public Safety established pursuant to section
42 32 of P.L.1998, c.21 (C.17:33A-16)¹.

43 (11) (a) In seeking reimbursement for the overpayment from the
44 health care provider, except as provided for in subparagraph (b) of this
45 paragraph, no payer shall collect or attempt to collect:

46 (i) the funds for the reimbursement on or before the 45th calendar

1 day following the submission of the reimbursement request to the
2 health care provider;

3 (ii) the funds for the reimbursement if the health care provider
4 disputes the request and initiates an appeal on or before the 45th
5 calendar day following the submission of the reimbursement request
6 to the health care provider and until the health care provider's rights
7 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
8 section are exhausted; ¹or¹

9 (iii) ¹[the funds for the reimbursement request by assessing them
10 against payment of any future claims submitted by the health care
11 provider, unless agreed to in writing by the health care provider; or

12 (iv)] a monetary penalty against the reimbursement request,
13 including but not limited to, an interest charge or¹ a late fee.

14 ¹The payer may collect the funds for the reimbursement request by
15 assessing them against payment of any future claims submitted by the
16 health care provider after the 45th calendar day following the
17 submission of the reimbursement request to the health care provider
18 or after the health care provider's rights to appeal set forth under
19 paragraphs (1) and (2) of subsection e. of this section have been
20 exhausted if the payer submits an explanation in writing to the
21 provider in sufficient detail so that the provider can reconcile each
22 covered person's bill.¹

23 (b) If a payer has determined that the overpayment to the health
24 care provider is a result of fraud committed by the health care provider
25 and the payer has conducted its investigation and reported the fraud
26 to the Office of the Insurance Fraud Prosecutor as required by law, the
27 payer may collect an overpayment by assessing it against payment of
28 any future claim submitted by the health care provider.

29 (12) No health care provider shall seek reimbursement from a payer
30 or covered person for underpayment of a claim submitted pursuant to
31 this section later than ¹[one year] 18 months¹ from the date the first
32 payment on the claim was made, except if the claim is the subject of
33 an appeal submitted pursuant to subsection e. of this section or the
34 claim is subject to continual claims submission. ¹No health care
35 provider shall seek more than one reimbursement for underpayment of
36 a particular claim.¹

37 e. (1) A medical service corporation or its agent, hereinafter the
38 payer, shall establish an internal appeal mechanism to resolve any
39 dispute ¹raised by a health care provider regardless of whether the
40 health care provider is under contract with the payer¹ regarding
41 compliance with the requirements of this section ¹or compliance with
42 the requirements of sections 4 through 7 of P.L. , c. (C.)
43 (pending before the Legislature as this bill). No dispute pertaining to
44 medical necessity which is eligible to be submitted to the Independent
45 Health Care Appeals Program established pursuant to section 11 of

1 P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal
2 pursuant to this subsection¹. The payer shall conduct the appeal at no
3 cost to the health care provider.

4 A health care provider may initiate an appeal on or before the 90th
5 calendar day following receipt by the health care provider of the
6 payer's claims determination, which is the basis of the appeal, on a
7 form prescribed by the Commissioner of Banking and Insurance which
8 shall describe the type of substantiating documentation that must be
9 submitted with the form. The payer shall conduct a review of the
10 appeal and notify the health care provider of its determination on or
11 before the ¹[10th] 30th¹ calendar day following the receipt of the
12 appeal form. If the health care provider is not notified of the payer's
13 determination of the appeal within ¹[10] 30¹ days, the health care
14 provider may refer the dispute to arbitration as provided by paragraph
15 (2) of this subsection.

16 If the payer issues a determination in favor of the health care
17 provider, the payer shall comply with the provisions of this section and
18 pay the amount of money in dispute, if applicable, with accrued
19 interest at the rate of ¹[20%] 12%¹ per annum, on or before the 30th
20 calendar day following the notification of the payer's determination on
21 the appeal. ¹Interest shall begin to accrue on the day the appeal was
22 received by the payer.¹

23 If the payer issues a determination against the health care provider,
24 the payer shall notify the health care provider of its findings on or
25 before the ¹[10th] 30th¹ calendar day following the receipt of the
26 appeal form and shall include in the notification written instructions for
27 referring the dispute to arbitration as provided by paragraph (2) of this
28 subsection.

29 The payer shall report annually to the Commissioner of Banking and
30 Insurance the number of appeals it has received and the resolution of
31 each appeal.

32 (2) Any dispute regarding the determination of an internal appeal
33 conducted pursuant to paragraph (1) of this subsection may be
34 referred to arbitration as provided in this paragraph. The
35 Commissioner of Banking and Insurance shall contract with a
36 nationally recognized, independent organization that specializes in
37 arbitration to conduct the arbitration proceedings.

38 Any party may initiate an arbitration proceeding on or before the
39 90th calendar day following the receipt of the determination which is
40 the basis of the appeal, on a form prescribed by the Commissioner of
41 Banking and Insurance. No dispute shall be accepted for arbitration
42 unless the payment amount in dispute is \$1,000 or more, except that
43 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
44 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
45 the threshold requirements of this subsection. No dispute pertaining
46 to medical necessity which is eligible to be submitted to the

1 Independent Health Care Appeals Program established pursuant to
2 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
3 arbitration pursuant to this subsection.

4 (3) The arbitrator shall conduct the arbitration proceedings
5 pursuant to the rules of the arbitration entity, including rules of
6 discovery subject to confidentiality requirements established by State
7 or federal law.

8 (4) An arbitrator's determination shall be:

9 (a) signed by the arbitrator;

10 (b) issued in writing, in a form prescribed by the Commissioner of
11 Banking and Insurance, including a statement of the issues in dispute
12 and the findings and conclusions on which the determination is based;
13 and

14 (c) issued on or before the 30th calendar day following the receipt
15 of the required documentation.

16 The arbitration shall be nonappealable and binding on all parties to
17 the dispute.

18 (5) If the arbitrator determines that a payer has withheld or denied
19 payment in violation of the provisions of this section, the arbitrator
20 shall order the payer to make payment of the claim, together with
21 accrued interest, on or before the 10th business day following the
22 issuance of the determination. If the arbitrator determines that a payer
23 has withheld or denied payment on the basis of information submitted
24 by the health care provider and the payer requested, but did not
25 receive, this information from the health care provider when the claim
26 was initially processed pursuant to subsection d. of this section or
27 reviewed under internal appeal pursuant to paragraph (1) of this
28 subsection, the payer shall not be required to pay any accrued interest.

29 ¹[In accordance with regulations adopted by the Commissioner of
30 Banking and Insurance, the cost of the arbitration proceedings,
31 including the payment of reasonable attorney's fees, shall be awarded
32 to the prevailing party.]¹

33 (6) If the arbitrator determines that a health care provider has
34 engaged in a pattern and practice of improper billing and a refund is
35 due to the payer, the arbitrator may award the payer a refund,
36 including interest accrued at the rate of ¹~~[20%]~~ 12%¹ per annum.
37 ¹Interest shall begin to accrue on the day the appeal was received by
38 the payer for resolution through the internal appeals process
39 established pursuant to paragraph (1) of this subsection.¹

40 (7) The arbitrator shall file a copy of each determination with and
41 in the form prescribed by the Commissioner of Banking and Insurance.

42 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
43 means a claim by a [subscriber] covered person for payment of
44 benefits under an insured medical service corporation contract for
45 which the financial obligation for the payment of a claim under the
46 contract rests upon the medical service corporation.

1 g. Any person found in violation of this section with a pattern¹ [of
2 frequency] and practice¹ as determined by the Commissioner of
3 Banking and Insurance shall be liable to a civil penalty as set forth in
4 section 17 of P.L. , c. (C.) (pending before the Legislature as
5 this bill).

6 (cf: P.L.1999, c.154, s.3)

7

8 12. Section 4 of P.L.1999, c.154 (C.17:48E-10.1) is amended to
9 read as follows:

10 4. a. Within 180 days of the adoption of a timetable for
11 implementation pursuant to section 1 of P.L.1999, c.154
12 (C.17B:30-23), a health service corporation[,] or its agent or a
13 subsidiary that processes health care benefits claims as a third party
14 administrator, shall demonstrate to the satisfaction of the
15 Commissioner of Banking and Insurance that it will adopt and
16 implement all of the standards to receive and transmit health care
17 transactions electronically, according to the corresponding timetable,
18 and otherwise comply with the provisions of this section, as a
19 condition of its continued authorization to do business in this State.

20 The Commissioner of Banking and Insurance may grant extensions
21 or waivers of the implementation requirement when it has been
22 demonstrated to the commissioner's satisfaction that compliance with
23 the timetable for implementation will result in an undue hardship to a
24 health service corporation ¹, or its agent¹, its subsidiary or its covered
25 persons.

26 b. Within 12 months of the adoption of regulations establishing
27 standard health care enrollment and claim forms by the Commissioner
28 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
29 (C.17B:30-23), a health service corporation ¹or its agent¹ or a
30 subsidiary that processes health care benefits claims as a third party
31 administrator shall use the standard health care enrollment and claim
32 forms in connection with all group and individual contracts issued,
33 delivered, executed or renewed in this State.

34 c. Twelve months after the adoption of regulations establishing
35 standard health care enrollment and claim forms by the Commissioner
36 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
37 (C.17B:30-23), a health service corporation ¹or its agent¹ shall require
38 that health care providers file all claims for payment for health care
39 services. A covered person who receives health care services shall not
40 be required to submit a claim for payment, but notwithstanding the
41 provisions of this subsection to the contrary, a covered person shall be
42 permitted to submit a claim on his own behalf, at the covered person's
43 option. All claims shall be filed using the standard health care claim
44 form applicable to the contract.

45 d. ¹For the purposes of this subsection, "substantiating
46 documentation" means any information specific to the particular health

1 care service provided to a covered person.¹

2 (1) Effective 180 days after the effective date of P.L.1999, c.154,
3 a health service corporation or its agent, hereinafter the payer, shall
4 remit payment for every insured claim submitted by a [subscriber or
5 that subscriber's agent or assignee if the contract provides for
6 assignment of benefits] covered person or health care provider, no
7 later than the 30th calendar day following receipt of the claim by the
8 payer or no later than the time limit established for the payment of
9 claims in the Medicare program pursuant to 42 U.S.C.
10 s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by
11 electronic means, and no later than the 40th calendar day following
12 receipt if the claim is submitted by other than electronic means, if:

13 (a) [the claim is an eligible claim for a health care service provided
14 by an eligible health care provider to a covered person under the
15 contract;

16 (b) the claim has no material defect or impropriety, including, but
17 not limited to, any lack of required substantiating documentation or
18 incorrect coding;

19 (c) there is no dispute regarding the amount claimed;] the health
20 care provider is eligible at the date of service;

21 (b) the person who received the health care service was covered on
22 the date of service;

23 (c) the claim is for a service or supply covered under the health
24 benefits plan;

25 (d) the claim is submitted with all the information requested by the
26 payer on the claim form or in other instructions¹ that were¹ distributed
27 in advance to the health care provider or covered person¹ [within 120
28 days of the date of service] in accordance with the provisions of
29 section 4 of P.L. , c. (C.) (pending before the Legislature as this
30 bill)¹ ; and

31 [(d)] (e) the payer has no reason to believe that the claim has
32 been submitted fraudulently]; and

33 (e) the claim requires no special treatment that prevents timely
34 payments from being made on the claim under the terms of the
35 contract].

36 (2) If all or a portion of the claim¹ [is denied by the payer] is not
37 paid within the time frames provided in paragraph (1) of this
38 subsection¹ because:

39 (a) [the claim is an ineligible claim;

40 (b)] the claim submission is incomplete because the required
41 substantiating documentation¹ [, which is specific to the health care
42 service provided to the covered person,]¹ has not been submitted to
43 the payer;

44 [(c)] (b) the diagnosis coding, procedure coding, or any other
45 required information to be submitted with the claim is incorrect;

1 ¹[or]¹
2 [(d)] (c) the payer disputes the amount claimed[; or
3 (e) the claim requires special treatment that prevents timely
4 payments from being made on the claim under the terms of the
5 contract] ¹or
6 (d) there is strong evidence of fraud by the provider and the payer
7 has initiated an investigation into the suspected fraud¹,
8 the payer shall notify the [subscriber, or that subscriber's agent or
9 assignee if the contract provides for assignment of benefits] ¹[covered
10 person and]¹ health care provider, ¹[in writing or]¹ by electronic
11 means ¹[, as appropriate,] and the covered person in writing¹ within
12 30 days ¹[,of the following: if all or a portion of the claim is denied,
13 all the reasons for the denial; if the claim lacks the required
14 substantiating documentation[, including] or contains incorrect
15 coding, a statement as to what substantiating documentation, specific
16 to the health care service provided to the covered person, or other
17 information, is required to complete adjudication of the claim; and if
18 the amount of the claim is disputed, a statement that it is disputed]¹
19 [; and if the claim requires special treatment that prevents timely
20 payments from being made, a statement of the special treatment to
21 which the claim is subject] ¹of receiving an electronic claim, or notify
22 the covered person and health care provider in writing within 40 days
23 of receiving a claim submitted by other than electronic means, that:
24 (i) the claim is incomplete with a statement as to what
25 substantiating documentation is required for adjudication of the claim;
26 (ii) the claim contains incorrect information with a statement as to
27 what information must be corrected for adjudication of the claim;
28 (iii) the payer disputes the amount claimed in whole or in part with
29 a statement as to the basis of that dispute; or
30 (iv) the payer finds there is strong evidence of fraud and has
31 intitiated an investigation into the suspected fraud in accordance with
32 its fraud prevention plan established pursuant to section 1 of P.L.1993,
33 c.362 (C.17:33A-15), or referred the claim, together with supporting
34 documentation, to the Office of the Insurance Fraud Prosecutor in the
35 Department of Law and Public Safety established pursuant to section
36 32 of P.L.1998, c.21 (C.17:33A-16)¹.
37 (3) If all or a portion of ¹[a] an electronically submitted¹ claim
38 cannot be ¹[entered into the claims processing system for any of the
39 following reasons:
40 (a) the health care provider is not eligible at the time of service;
41 (b) the person who received the health care service was not a
42 covered person at the time of service;
43 (c) the premium was not paid by or on the behalf of the covered
44 person; or

1 ~~(d)~~ adjudicated because¹ the diagnosis coding, procedure coding
2 or any other data required to be submitted with the claim was missing.
3 the payer shall¹ electronically¹ notify the¹ [covered person and]¹
4 health care provider¹ or its agent¹ within seven days¹ [if the claim was
5 submitted by electronic means, or within 14 days if the claim was
6 submitted by other than electronic means,]¹ of that determination¹ [of
7 denial, of all the reasons for the denial or] and request¹ any
8 information required to complete adjudication of the claim.

9 (4) Any portion of a claim that meets the criteria established in
10 paragraph (1) of this subsection shall be paid by the payer in
11 accordance with the time limit established in paragraph (1) of this
12 subsection.

13 ~~[(4)]~~ (5) A payer shall acknowledge receipt of a claim submitted
14 by electronic means from a health care provider¹ [or]¹ [subscriber]
15 ¹[covered person]¹, no later than two working days following receipt
16 of the transmission of the claim.

17 ~~[(5)]~~ (6) If a payer subject to the provisions of P.L.1983, c.320
18 (C.17:33A-1 et seq.) has reason to believe that a claim has been
19 submitted fraudulently, it shall investigate the claim in accordance with
20 its fraud prevention plan established pursuant to section 1 of P.L.1993,
21 c.362 (C.17:33A-15), or refer the claim, together with supporting
22 documentation, to the Office of the Insurance Fraud Prosecutor in the
23 Department of Law and Public Safety established pursuant to section
24 32 of P.L.1998, c.21 (C.17:33A-16).

25 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
26 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
27 remitted to the claimant or his agent by the payer on or before the 30th
28 calendar day or the time limit established by the Medicare program,
29 whichever is earlier, following receipt by the payer of a claim
30 submitted by electronic means and on or before the 40th calendar day
31 following receipt of a claim submitted by other than electronic means.

32 ¹[In the event] If¹ payment is withheld on all or a portion of a
33 claim by a payer pursuant to¹ [subparagraph] subparagraphs¹ [(b)]
34 (a)¹ or (b)¹ of paragraph (2) or¹ [subparagraph (d) of]¹ paragraph (3)
35 of this subsection, the claims payment shall be overdue if not remitted
36 to the claimant or his agent by the payer on or before the [30th]
37 [15th] 30th¹ calendar day or the time limit established by the
38 Medicare program, whichever is earlier, for claims submitted by
39 electronic means and the [40th]¹ [25th] 40th¹ calendar day for claims
40 submitted by other than electronic means, following receipt by the
41 payer of the required documentation or information or modification of
42 an initial submission.

43 ¹If payment is withheld on all or a portion of a claim by a payer
44 pursuant to paragraphs (2) or (3) of this subsection and the provider

1 is not notified within the time frames provided for in those paragraphs,
2 the claim shall be deemed to be overdue.¹

3 (8) (a) No payer ¹that has reserved the right to change the
4 premium¹ shall deny payment on all or a portion of a claim because the
5 payer requests documentation or information that is not specific to the
6 health care service provided to the covered person.

7 (b) No payer shall deny payment on all or a portion of a claim while
8 seeking coordination of benefits information unless good cause exists
9 for the payer to believe that other insurance is available to the covered
10 person. Good cause shall exist only if the payer's records indicate that
11 other coverage exists. Routine requests to determine whether
12 coordination of benefits exists shall not be considered good cause.

13 (c) In the event payment is withheld on all or a portion of a claim
14 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
15 claims payment shall be deemed to be overdue if not remitted to the
16 claimant or his agent by the payer on or before the 30th calendar day
17 or the time limit established by the Medicare program, whichever is
18 earlier, following receipt by the payer of a claim submitted by
19 electronic means or on or before the 40th calendar day following
20 receipt of a claim submitted by other than electronic means.

21 [(7)] (9) An overdue payment shall bear simple interest at the rate
22 of [10%]¹[20%] 12%¹ per annum. The interest shall be paid to the
23 health care provider at the time the overdue payment is made. ¹The
24 amount of interest paid to a health care provider for an overdue claim
25 shall be credited to any civil penalty for late payment of the claim
26 levied by the Department of Human Services against a payer that does
27 not reserve the right to change the premium.¹

28 (10) With the exception of claims that were submitted fraudulently
29 or submitted by health care providers that have a pattern of
30 inappropriate billing or claims that were subject to coordination of
31 benefits, no payer shall seek reimbursement for overpayment of a claim
32 previously paid pursuant to this section later than ¹[one year] 18
33 months¹ after the date the first payment on the claim was made. ¹No
34 payer shall seek more than one reimbursement for overpayment of a
35 particular claim.¹ At the time the reimbursement request is submitted
36 to the health care provider, the payer shall provide written
37 documentation that identifies the error made by the payer in the
38 processing or payment of the claim that justifies the reimbursement
39 request. No payer shall base a reimbursement request for a particular
40 claim on extrapolation of other claims, except under the following
41 circumstances:

42 (a) in judicial or quasi-judicial proceedings, including arbitration;

43 (b) in administrative proceedings; ¹[or]¹

44 (c) in which relevant records required to be maintained by the
45 health care provider have been improperly altered or reconstructed, or
46 a material number of the relevant records are otherwise unavailable

1 ¹or;

2 (d) in which there is clear evidence of fraud by the health care
3 provider and the payer has investigated the claim in accordance with
4 its fraud prevention plan established pursuant to section 1 of P.L.1993,
5 c.362 (C.17:33A-15), and referred the claim, together with supporting
6 documentation, to the Office of the Insurance Fraud Prosecutor in the
7 Department of Law and Public Safety established pursuant to section
8 32 of P.L.1998, c.21 (C.17:33A-16)¹.

9 (11) (a) In seeking reimbursement for the overpayment from the
10 health care provider, except as provided for in subparagraph (b) of this
11 paragraph, no payer shall collect or attempt to collect:

12 (i) the funds for the reimbursement on or before the 45th calendar
13 day following the submission of the reimbursement request to the
14 health care provider;

15 (ii) the funds for the reimbursement if the health care provider
16 disputes the request and initiates an appeal on or before the 45th
17 calendar day following the submission of the reimbursement request
18 to the health care provider and until the health care provider's rights
19 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
20 section are exhausted; ¹or¹

21 (iii) ¹[the funds for the reimbursement request by assessing them
22 against payment of any future claims submitted by the health care
23 provider, unless agreed to in writing by the health care provider; or

24 (iv)] a monetary penalty against the reimbursement request,
25 including but not limited to, an interest charge or¹ a late fee.

26 ¹The payer may collect the funds for the reimbursement request by
27 assessing them against payment of any future claims submitted by the
28 health care provider after the 45th calendar day following the
29 submission of the reimbursement request to the health care provider
30 or after the health care provider's rights to appeal set forth under
31 paragraphs (1) and (2) of subsection e. of this section have been
32 exhausted if the payer submits an explanation in writing to the
33 provider in sufficient detail so that the provider can reconcile each
34 covered person's bill.¹

35 (b) If a payer has determined that the overpayment to the health
36 care provider is a result of fraud committed by the health care provider
37 and the payer has conducted its investigation and reported the fraud
38 to the Office of the Insurance Fraud Prosecutor as required by law, the
39 payer may collect an overpayment by assessing it against payment of
40 any future claim submitted by the health care provider.

41 (12) No health care provider shall seek reimbursement from a payer
42 or covered person for underpayment of a claim submitted pursuant to
43 this section later than ¹[one year] 18 months¹ from the date the first
44 payment on the claim was made, except if the claim is the subject of
45 an appeal submitted pursuant to subsection e. of this section or the
46 claim is subject to continual claims submission. ¹No health care

1 provider shall seek more than one reimbursement for underpayment of
2 a particular claim.¹

3 e. (1) A health service corporation or its agent, hereinafter the
4 payer, shall establish an internal appeal mechanism to resolve any
5 dispute¹ raised by a health care provider regardless of whether the
6 health care provider is under contract with the payer¹ regarding
7 compliance with the requirements of this section¹ or compliance with
8 the requirements of sections 4 through 7 of P.L. , c. (C.)
9 (pending before the Legislature as this bill). No dispute pertaining to
10 medical necessity which is eligible to be submitted to the Independent
11 Health Care Appeals Program established pursuant to section 11 of
12 P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal
13 pursuant to this subsection¹. The payer shall conduct the appeal at no
14 cost to the health care provider.

15 A health care provider may initiate an appeal on or before the 90th
16 calendar day following receipt by the health care provider of the
17 payer's claims determination, which is the basis of the appeal, on a
18 form prescribed by the Commissioner of Banking and Insurance which
19 shall describe the type of substantiating documentation that must be
20 submitted with the form. The payer shall conduct a review of the
21 appeal and notify the health care provider of its determination on or
22 before the¹ [10th] 30th¹ calendar day following the receipt of the
23 appeal form. If the health care provider is not notified of the payer's
24 determination of the appeal within¹ [10] 30¹ days, the health care
25 provider may refer the dispute to arbitration as provided by paragraph
26 (2) of this subsection.

27 If the payer issues a determination in favor of the health care
28 provider, the payer shall comply with the provisions of this section and
29 pay the amount of money in dispute, if applicable, with accrued
30 interest at the rate of¹ [20%] 12%¹ per annum, on or before the 30th
31 calendar day following the notification of the payer's determination on
32 the appeal.¹ Interest shall begin to accrue on the day the appeal was
33 received by the payer.¹

34 If the payer issues a determination against the health care provider,
35 the payer shall notify the health care provider of its findings on or
36 before the¹ [10th] 30th¹ calendar day following the receipt of the
37 appeal form and shall include in the notification written instructions for
38 referring the dispute to arbitration as provided by paragraph (2) of this
39 subsection.

40 The payer shall report annually to the Commissioner of Banking and
41 Insurance the number of appeals it has received and the resolution of
42 each appeal.

43 (2) Any dispute regarding the determination of an internal appeal
44 conducted pursuant to paragraph (1) of this subsection may be
45 referred to arbitration as provided in this paragraph. The
46 Commissioner of Banking and Insurance shall contract with a

1 nationally recognized, independent organization that specializes in
2 arbitration to conduct the arbitration proceedings.

3 Any party may initiate an arbitration proceeding on or before the
4 90th calendar day following the receipt of the determination which is
5 the basis of the appeal, on a form prescribed by the Commissioner of
6 Banking and Insurance. No dispute shall be accepted for arbitration
7 unless the payment amount in dispute is \$1,000 or more, except that
8 ¹[individual] a¹ health care ¹[providers] provider ¹may aggregate
9 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
10 the threshold requirements of this subsection. No dispute pertaining
11 to medical necessity which is eligible to be submitted to the
12 Independent Health Care Appeals Program established pursuant to
13 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
14 arbitration pursuant to this subsection.

15 (3) The arbitrator shall conduct the arbitration proceedings
16 pursuant to the rules of the arbitration entity, including rules of
17 discovery subject to confidentiality requirements established by State
18 or federal law.

19 (4) An arbitrator's determination shall be:

20 (a) signed by the arbitrator;

21 (b) issued in writing, in a form prescribed by the Commissioner of
22 Banking and Insurance, including a statement of the issues in dispute
23 and the findings and conclusions on which the determination is based;
24 and

25 (c) issued on or before the 30th calendar day following the receipt
26 of the required documentation.

27 The arbitration shall be nonappealable and binding on all parties to
28 the dispute.

29 (5) If the arbitrator determines that a payer has withheld or denied
30 payment in violation of the provisions of this section, the arbitrator
31 shall order the payer to make payment of the claim, together with
32 accrued interest, on or before the 10th business day following the
33 issuance of the determination. If the arbitrator determines that a payer
34 has withheld or denied payment on the basis of information submitted
35 by the health care provider and the payer requested, but did not
36 receive, this information from the health care provider when the claim
37 was initially processed pursuant to subsection d. of this section or
38 reviewed under internal appeal pursuant to paragraph (1) of this
39 subsection, the payer shall not be required to pay any accrued interest.
40 ¹[In accordance with regulations adopted by the Commissioner of
41 Banking and Insurance, the cost of the arbitration proceedings,
42 including the payment of reasonable attorney's fees, shall be awarded
43 to the prevailing party.]¹

44 (6) If the arbitrator determines that a health care provider has
45 engaged in a pattern and practice of improper billing and a refund is
46 due to the payer, the arbitrator may award the payer a refund,
47 including interest accrued at the rate of ¹[20%] 12%¹ per annum.

1 ¹Interest shall begin to accrue on the day the appeal was received by
2 the payer for resolution through the internal appeals process
3 established pursuant to paragraph (1) of this subsection.¹

4 (7) The arbitrator shall file a copy of each determination with and
5 in the form prescribed by the Commissioner of Banking and Insurance.

6 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
7 means a claim by a [subscriber] covered person for payment of
8 benefits under an insured health service corporation contract for which
9 the financial obligation for the payment of a claim under the contract
10 rests upon the health service corporation.

11 g. Any person found in violation of this section with a pattern ¹[of
12 frequency] and practice¹ as determined by the Commissioner of
13 Banking and Insurance shall be liable to a civil penalty as set forth in
14 section 17 of P.L. , c. (C.) (pending before the Legislature as
15 this bill).

16 (cf: P.L.1999, c.154, s.4)

17
18 13. Section 5 of P.L.1999, c.154 (C.17B:26-9.1) is amended to
19 read as follows:

20 5. a. Within 180 days of the adoption of a timetable for
21 implementation pursuant to section 1 of P.L.1999, c.154
22 (C.17B:30-23), a health insurer[,] or its agent or a subsidiary that
23 processes health care benefits claims as a third party administrator,
24 shall demonstrate to the satisfaction of the Commissioner of Banking
25 and Insurance that it will adopt and implement all of the standards to
26 receive and transmit health care transactions electronically, according
27 to the corresponding timetable, and otherwise comply with the
28 provisions of this section, as a condition of its continued authorization
29 to do business in this State.

30 The Commissioner of Banking and Insurance may grant extensions
31 or waivers of the implementation requirement when it has been
32 demonstrated to the commissioner's satisfaction that compliance with
33 the timetable for implementation will result in an undue hardship to a
34 health insurer ¹, or its agent¹, its subsidiary or its covered persons.

35 b. Within 12 months of the adoption of regulations establishing
36 standard health care enrollment and claim forms by the Commissioner
37 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
38 (C.17B:30-23), a health insurer ¹or its agent¹ or a subsidiary that
39 processes health care benefits claims as a third party administrator
40 shall use the standard health care enrollment and claim forms in
41 connection with all individual policies issued, delivered, executed or
42 renewed in this State.

43 c. Twelve months after the adoption of regulations establishing
44 standard health care enrollment and claim forms by the Commissioner
45 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154

1 (C.17B:30-23), a health insurer ¹or its agent¹ shall require that health
2 care providers file all claims for payment for health care services. A
3 covered person who receives health care services shall not be required
4 to submit a claim for payment, but notwithstanding the provisions of
5 this subsection to the contrary, a covered person shall be permitted to
6 submit a claim on his own behalf, at the covered person's option. All
7 claims shall be filed using the standard health care claim form
8 applicable to the policy.

9 d. ¹For the purposes of this subsection, "substantiating
10 documentation" means any information specific to the particular health
11 care service provided to a covered person.¹

12 (1) Effective 180 days after the effective date of P.L.1999, c.154,
13 a health insurer or its agent, hereinafter the payer, shall remit payment
14 for every insured claim submitted by [an insured or that insured's
15 agent or assignee if the policy provides for assignment of benefits] a
16 covered person or health care provider, no later than the 30th calendar
17 day following receipt of the claim by the payer or no later than the
18 time limit established for the payment of claims in the Medicare
19 program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier,
20 if the claim is submitted by electronic means, and no later than the
21 40th calendar day following receipt if the claim is submitted by other
22 than electronic means, if:

23 (a) [the claim is an eligible claim for a health care service provided
24 by an eligible health care provider to a covered person under the
25 contract;

26 (b) the claim has no material defect or impropriety, including, but
27 not limited to, any lack of required substantiating documentation or
28 incorrect coding;

29 (c) there is no dispute regarding the amount claimed;] the health
30 care provider is eligible at the date of service;

31 (b) the person who received the health care service was covered on
32 the date of service;

33 (c) the claim is for a service or supply covered under the health
34 benefits plan;

35 (d) the claim is submitted with all the information requested by the
36 payer on the claim form or in other instructions ¹that were¹ distributed
37 in advance to the health care provider or covered person ¹[within 120
38 days of the date of service] in accordance with the provisions of
39 section 4 of P.L. , c. (C.) (pending before the Legislature as this
40 bill)¹ ; and

41 [(d)] (e) the payer has no reason to believe that the claim has
42 been submitted fraudulently[; and

43 (e) the claim requires no special treatment that prevents timely
44 payments from being made on the claim under the terms of the
45 contract].

1 (2) If all or a portion of the claim ¹[is denied by the payer] is not
2 paid within the time frames provided in paragraph (1) of this
3 subsection¹ because:

4 (a) [the claim is an ineligible claim;

5 (b)] the claim submission is incomplete because the required
6 substantiating documentation ¹[, which is specific to the health care
7 service provided to the covered person,]¹ has not been submitted to
8 the payer;

9 [(c)] (b) the diagnosis coding, procedure coding, or any other
10 required information to be submitted with the claim is incorrect;
11 ¹[or]¹

12 [(d)] (c) the payer disputes the amount claimed[; or

13 (e) the claim requires special treatment that prevents timely
14 payments from being made on the claim under the terms of the
15 contract] ¹or

16 (d) there is strong evidence of fraud by the provider and the payer
17 has initiated an investigation into the suspected fraud¹,

18 the payer shall notify the [subscriber, or that subscriber's agent or
19 assignee if the contract provides for assignment of benefits] ¹[covered
20 person and]¹ health care provider,¹[in writing or]¹ by electronic
21 means ¹[, as appropriate,] and the covered person in writing¹ within
22 30 days ¹[,of the following: if all or a portion of the claim is denied,
23 all the reasons for the denial; if the claim lacks the required
24 substantiating documentation[, including] or contains incorrect
25 coding, a statement as to what substantiating documentation, specific
26 to the health care service provided to the covered person, or other
27 information, is required to complete adjudication of the claim; and if
28 the amount of the claim is disputed, a statement that it is disputed]¹

29 [; and if the claim requires special treatment that prevents timely
30 payments from being made, a statement of the special treatment to
31 which the claim is subject] ¹of receiving an electronic claim, or notify
32 the covered person and health care provider in writing within 40 days
33 of receiving a claim submitted by other than electronic means, that:

34 (i) the claim is incomplete with a statement as to what
35 substantiating documentation is required for adjudication of the claim;

36 (ii) the claim contains incorrect information with a statement as to
37 what information must be corrected for adjudication of the claim;

38 (iii) the payer disputes the amount claimed in whole or in part with
39 a statement as to the basis of that dispute; or

40 (iv) the payer finds there is strong evidence of fraud and has
41 initiated an investigation into the suspected fraud in accordance with
42 its fraud prevention plan established pursuant to section 1 of P.L.1993,
43 c.362 (C.17:33A-15), or referred the claim, together with supporting
44 documentation, to the Office of the Insurance Fraud Prosecutor in the
45 Department of Law and Public Safety established pursuant to section

1 32 of P.L.1998, c.21 (C.17:33A-16)¹.

2 (3) If all or a portion of ¹[a] an electronically submitted¹ claim
3 cannot be ¹[entered into the claims processing system for any of the
4 following reasons:

5 (a) the health care provider is not eligible at the time of service;

6 (b) the person who received the health care service was not a
7 covered person at the time of service;

8 (c) the premium was not paid by or on the behalf of the covered
9 person; or

10 (d)] adjudicated because¹ the diagnosis coding, procedure coding
11 or any other data required to be submitted with the claim was missing,
12 the payer shall ¹electronically ¹notify the [covered person and] ¹
13 health care provider ¹or its agent¹ within seven days ¹[if the claim was
14 submitted by electronic means, or within 14 days if the claim was
15 submitted by other than electronic means,]¹ of that determination¹ [of
16 denial, of all the reasons for the denial or] and request¹ any
17 information required to complete adjudication of the claim.

18 (4) Any portion of a claim that meets the criteria established in
19 paragraph (1) of this subsection shall be paid by the payer in
20 accordance with the time limit established in paragraph (1) of this
21 subsection.

22 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
23 by electronic means from a health care provider ¹[or]¹ [subscriber]
24 ¹[covered person]¹, no later than two working days following receipt
25 of the transmission of the claim.

26 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
27 (C.17:33A-1 et seq.) has reason to believe that a claim has been
28 submitted fraudulently, it shall investigate the claim in accordance with
29 its fraud prevention plan established pursuant to section 1 of P.L.1993,
30 c.362 (C.17:33A-15), or refer the claim, together with supporting
31 documentation, to the Office of the Insurance Fraud Prosecutor in the
32 Department of Law and Public Safety established pursuant to section
33 32 of P.L.1998, c.21 (C.17:33A-16).

34 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
35 and [(3)] (4) of this subsection shall be deemed to be overdue if not
36 remitted to the claimant or his agent by the payer on or before the 30th
37 calendar day or the time limit established by the Medicare program,
38 whichever is earlier, following receipt by the payer of a claim
39 submitted by electronic means and on or before the 40th calendar day
40 following receipt of a claim submitted by other than electronic means.

41 ¹[In the event] If ¹payment is withheld on all or a portion of a
42 claim by a payer pursuant to ¹[subparagraph] subparagraphs¹ [(b)]
43 (a) ¹or (b)¹ of paragraph (2) or ¹[subparagraph (d) of]¹ paragraph (3)
44 of this subsection, the claims payment shall be overdue if not remitted
45 to the claimant or his agent by the payer on or before the [30th]

1 ~~1~~¹[15th] 30th¹ calendar day or the time limit established by the
2 Medicare program, whichever is earlier, for claims submitted by
3 electronic means and the [40th] ~~1~~¹[25th] 40th¹ calendar day for claims
4 submitted by other than electronic means, following receipt by the
5 payer of the required documentation or information or modification of
6 an initial submission.

7 ¹If payment is withheld on all or a portion of a claim by a payer
8 pursuant to paragraphs (2) or (3) of this subsection and the provider
9 is not notified within the time frames provided for in those paragraphs,
10 the claim shall be deemed to be overdue.¹

11 (8) (a) No payer ¹that has reserved the right to change the
12 premium¹ shall deny payment on all or a portion of a claim because the
13 payer requests documentation or information that is not specific to the
14 health care service provided to the covered person.

15 (b) No payer shall deny payment on all or a portion of a claim while
16 seeking coordination of benefits information unless good cause exists
17 for the payer to believe that other insurance is available to the covered
18 person. Good cause shall exist only if the payer's records indicate that
19 other coverage exists. Routine requests to determine whether
20 coordination of benefits exists shall not be considered good cause.

21 (c) In the event payment is withheld on all or a portion of a claim
22 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
23 claims payment shall be deemed to be overdue if not remitted to the
24 claimant or his agent by the payer on or before the 30th calendar day
25 or the time limit established by the Medicare program, whichever is
26 earlier, following receipt by the payer of a claim submitted by
27 electronic means or on or before the 40th calendar day following
28 receipt of a claim submitted by other than electronic means.

29 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
30 of [10%]¹[20%] 12%¹ per annum. The interest shall be paid to the
31 health care provider at the time the overdue payment is made. ¹The
32 amount of interest paid to a health care provider for an overdue claim
33 shall be credited to any civil penalty for late payment of the claim
34 levied by the Department of Human Services against a payer that does
35 not reserve the right to change the premium.¹

36 (10) With the exception of claims that were submitted fraudulently
37 or submitted by health care providers that have a pattern of
38 inappropriate billing or claims that were subject to coordination of
39 benefits, no payer shall seek reimbursement for overpayment of a claim
40 previously paid pursuant to this section later than ¹[one year] 18
41 months¹ after the date the first payment on the claim was made. ¹No
42 payer shall seek more than one reimbursement for overpayment of a
43 particular claim.¹ At the time the reimbursement request is submitted
44 to the health care provider, the payer shall provide written
45 documentation that identifies the error made by the payer in the
46 processing or payment of the claim that justifies the reimbursement

1 request. No payer shall base a reimbursement request for a particular
2 claim on extrapolation of other claims, except under the following
3 circumstances:

4 (a) in judicial or quasi-judicial proceedings, including arbitration;

5 (b) in administrative proceedings; ¹[or]¹

6 (c) in which relevant records required to be maintained by the
7 health care provider have been improperly altered or reconstructed, or
8 a material number of the relevant records are otherwise unavailable
9 ¹or;

10 (d) in which there is clear evidence of fraud by the health care
11 provider and the payer has investigated the claim in accordance with
12 its fraud prevention plan established pursuant to section 1 of P.L.1993,
13 c.362 (C.17:33A-15), and referred the claim, together with supporting
14 documentation, to the Office of the Insurance Fraud Prosecutor in the
15 Department of Law and Public Safety established pursuant to section
16 32 of P.L.1998, c.21 (C.17:33A-16)¹.

17 (11) (a) In seeking reimbursement for the overpayment from the
18 health care provider, except as provided for in subparagraph (b) of this
19 paragraph, no payer shall collect or attempt to collect:

20 (i) the funds for the reimbursement on or before the 45th calendar
21 day following the submission of the reimbursement request to the
22 health care provider;

23 (ii) the funds for the reimbursement if the health care provider
24 disputes the request and initiates an appeal on or before the 45th
25 calendar day following the submission of the reimbursement request
26 to the health care provider and until the health care provider's rights
27 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
28 section are exhausted; ¹or¹

29 (iii) ¹[the funds for the reimbursement request by assessing them
30 against payment of any future claims submitted by the health care
31 provider, unless agreed to in writing by the health care provider; or

32 (iv)] a monetary penalty against the reimbursement request,
33 including but not limited to, an interest charge or¹ a late fee.

34 ¹The payer may collect the funds for the reimbursement request by
35 assessing them against payment of any future claims submitted by the
36 health care provider after the 45th calendar day following the
37 submission of the reimbursement request to the health care provider
38 or after the health care provider's rights to appeal set forth under
39 paragraphs (1) and (2) of subsection e. of this section have been
40 exhausted if the payer submits an explanation in writing to the
41 provider in sufficient detail so that the provider can reconcile each
42 covered person's bill.¹

43 (b) If a payer has determined that the overpayment to the health
44 care provider is a result of fraud committed by the health care provider
45 and the payer has conducted its investigation and reported the fraud
46 to the Office of the Insurance Fraud Prosecutor as required by law, the

1 payer may collect an overpayment by assessing it against payment of
2 any future claim submitted by the health care provider.

3 (12) No health care provider shall seek reimbursement from a payer
4 or covered person for underpayment of a claim submitted pursuant to
5 this section later than ¹[one year] 18 months¹ from the date the first
6 payment on the claim was made, except if the claim is the subject of
7 an appeal submitted pursuant to subsection e. of this section or the
8 claim is subject to continual claims submission. ¹No health care
9 provider shall seek more than one reimbursement for underpayment of
10 a particular claim.¹

11 e. (1) A health insurer or its agent, hereinafter the payer, shall
12 establish an internal appeal mechanism to resolve any dispute ¹raised
13 by a health care provider regardless of whether the health care
14 provider is under contract with the payer¹ regarding compliance with
15 the requirements of this section ¹or compliance with the requirements
16 of sections 4 through 7 of P.L. , c. (C.) (pending before the
17 Legislature as this bill). No dispute pertaining to medical necessity
18 which is eligible to be submitted to the Independent Health Care
19 Appeals Program established pursuant to section 11 of P.L.1997,
20 c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this
21 subsection¹. The payer shall conduct the appeal at no cost to the
22 health care provider.

23 A health care provider may initiate an appeal on or before the 90th
24 calendar day following receipt by the health care provider of the
25 payer's claims determination, which is the basis of the appeal, on a
26 form prescribed by the Commissioner of Banking and Insurance which
27 shall describe the type of substantiating documentation that must be
28 submitted with the form. The payer shall conduct a review of the
29 appeal and notify the health care provider of its determination on or
30 before the ¹[10th] 30th¹ calendar day following the receipt of the
31 appeal form. If the health care provider is not notified of the payer's
32 determination of the appeal within ¹[10] 30¹ days, the health care
33 provider may refer the dispute to arbitration as provided by paragraph
34 (2) of this subsection.

35 If the payer issues a determination in favor of the health care
36 provider, the payer shall comply with the provisions of this section and
37 pay the amount of money in dispute, if applicable, with accrued
38 interest at the rate of ¹[20%] 12%¹ per annum, on or before the 30th
39 calendar day following the notification of the payer's determination on
40 the appeal. ¹Interest shall begin to accrue on the day the appeal was
41 received by the payer.¹

42 If the payer issues a determination against the health care provider,
43 the payer shall notify the health care provider of its findings on or
44 before the ¹[10th] 30th¹ calendar day following the receipt of the
45 appeal form and shall include in the notification written instructions for
46 referring the dispute to arbitration as provided by paragraph (2) of this
47 subsection.

1 The payer shall report annually to the Commissioner of Banking and
2 Insurance the number of appeals it has received and the resolution of
3 each appeal.

4 (2) Any dispute regarding the determination of an internal appeal
5 conducted pursuant to paragraph (1) of this subsection may be
6 referred to arbitration as provided in this paragraph. The
7 Commissioner of Banking and Insurance shall contract with a
8 nationally recognized, independent organization that specializes in
9 arbitration to conduct the arbitration proceedings.

10 Any party may initiate an arbitration proceeding on or before the
11 90th calendar day following the receipt of the determination which is
12 the basis of the appeal, on a form prescribed by the Commissioner of
13 Banking and Insurance. No dispute shall be accepted for arbitration
14 unless the payment amount in dispute is \$1,000 or more, except that
15 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
16 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
17 the threshold requirements of this subsection. No dispute pertaining
18 to medical necessity which is eligible to be submitted to the
19 Independent Health Care Appeals Program established pursuant to
20 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
21 arbitration pursuant to this subsection.

22 (3) The arbitrator shall conduct the arbitration proceedings
23 pursuant to the rules of the arbitration entity, including rules of
24 discovery subject to confidentiality requirements established by State
25 or federal law.

26 (4) An arbitrator's determination shall be:

27 (a) signed by the arbitrator;

28 (b) issued in writing, in a form prescribed by the Commissioner of
29 Banking and Insurance, including a statement of the issues in dispute
30 and the findings and conclusions on which the determination is based;
31 and

32 (c) issued on or before the 30th calendar day following the receipt
33 of the required documentation.

34 The arbitration shall be nonappealable and binding on all parties to
35 the dispute.

36 (5) If the arbitrator determines that a payer has withheld or denied
37 payment in violation of the provisions of this section, the arbitrator
38 shall order the payer to make payment of the claim, together with
39 accrued interest, on or before the 10th business day following the
40 issuance of the determination. If the arbitrator determines that a payer
41 has withheld or denied payment on the basis of information submitted
42 by the health care provider and the payer requested, but did not
43 receive, this information from the health care provider when the claim
44 was initially processed pursuant to subsection d. of this section or
45 reviewed under internal appeal pursuant to paragraph (1) of this
46 subsection, the payer shall not be required to pay any accrued interest.

1 ¹[In accordance with regulations adopted by the Commissioner of
 2 Banking and Insurance, the cost of the arbitration proceedings,
 3 including the payment of reasonable attorney's fees, shall be awarded
 4 to the prevailing party.]¹

5 (6) If the arbitrator determines that a health care provider has
 6 engaged in a pattern and practice of improper billing and a refund is
 7 due to the payer, the arbitrator may award the payer a refund,
 8 including interest accrued at the rate of ¹[20%] 12%¹ per annum.
 9 ¹Interest shall begin to accrue on the day the appeal was received by
 10 the payer for resolution through the internal appeals process
 11 established pursuant to paragraph (1) of this subsection.¹

12 (7) The arbitrator shall file a copy of each determination with and
 13 in the form prescribed by the Commissioner of Banking and Insurance.

14 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
 15 means a claim by [an insured] a covered person for payment of
 16 benefits under an insured policy for which the financial obligation for
 17 the payment of a claim under the policy rests upon the health insurer.

18 g. Any person found in violation of this section with a pattern ¹[of
 19 frequency] and practice¹ as determined by the Commissioner of
 20 Banking and Insurance shall be liable to a civil penalty as set forth in
 21 section 17 of P.L. , c. (C.) (pending before the Legislature as
 22 this bill).

23 (cf: P.L.1999, c.154, s.5)

24
 25 14. Section 6 of P.L.1999, c.154 (C.17B:27-44.2) is amended to
 26 read as follows:

27 6. a. Within 180 days of the adoption of a timetable for
 28 implementation pursuant to section 1 of P.L.1999, c.154
 29 (C.17B:30-23), a health insurer[,] or its agent or a subsidiary that
 30 processes health care benefits claims as a third party administrator,
 31 shall demonstrate to the satisfaction of the Commissioner of Banking
 32 and Insurance that it will adopt and implement all of the standards to
 33 receive and transmit health care transactions electronically, according
 34 to the corresponding timetable, and otherwise comply with the
 35 provisions of this section, as a condition of its continued authorization
 36 to do business in this State.

37 The Commissioner of Banking and Insurance may grant extensions
 38 or waivers of the implementation requirement when it has been
 39 demonstrated to the commissioner's satisfaction that compliance with
 40 the timetable for implementation will result in an undue hardship to a
 41 health insurer ¹or its agent¹, its subsidiary or its covered persons.

42 b. Within 12 months of the adoption of regulations establishing
 43 standard health care enrollment and claim forms by the Commissioner
 44 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
 45 (C.17B:30-23), a health insurer ¹or its agent¹ or a subsidiary that
 46 processes health care benefits claims as a third party administrator

1 shall use the standard health care enrollment and claim forms in
2 connection with all group policies issued, delivered, executed or
3 renewed in this State.

4 c. Twelve months after the adoption of regulations establishing
5 standard health care enrollment and claim forms by the Commissioner
6 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
7 (C.17B:30-23), a health insurer ¹or its agent¹ shall require that health
8 care providers file all claims for payment for health care services. A
9 covered person who receives health care services shall not be required
10 to submit a claim for payment, but notwithstanding the provisions of
11 this subsection to the contrary, a covered person shall be permitted to
12 submit a claim on his own behalf, at the covered person's option. All
13 claims shall be filed using the standard health care claim form
14 applicable to the policy.

15 d. ¹For the purposes of this subsection, "substantiating
16 documentation" means any information specific to the particular health
17 care service provided to a covered person.¹

18 (1) Effective 180 days after the effective date of P.L.1999, c.154,
19 a health insurer or its agent, hereinafter the payer, shall remit payment
20 for every insured claim submitted by [an insured or that insured's
21 agent or assignee if the policy provides for assignment of benefits] a
22 covered person or health care provider, no later than the 30th calendar
23 day following receipt of the claim by the payer or no later than the
24 time limit established for the payment of claims in the Medicare
25 program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier,
26 if the claim is submitted by electronic means, and no later than the
27 40th calendar day following receipt if the claim is submitted by other
28 than electronic means, if:

29 (a) [the claim is an eligible claim for a health care service provided
30 by an eligible health care provider to a covered person under the
31 contract;

32 (b) the claim has no material defect or impropriety, including, but
33 not limited to, any lack of required substantiating documentation or
34 incorrect coding;

35 (c) there is no dispute regarding the amount claimed;] the health
36 care provider is eligible at the date of service;

37 (b) the person who received the health care service was covered on
38 the date of service;

39 (c) the claim is for a service or supply covered under the health
40 benefits plan;

41 (d) the claim is submitted with all the information requested by the
42 payer on the claim form or in other instructions ¹that were¹ distributed
43 in advance to the health care provider or covered person ¹[within 120
44 days of the date of service] in accordance with the provisions of
45 section 4 of P.L. , c. (C.) (pending before the Legislature as this
46 bill)¹ ; and

1 [(d)] (e) the payer has no reason to believe that the claim has
2 been submitted fraudulently[; and
3 (e) the claim requires no special treatment that prevents timely
4 payments from being made on the claim under the terms of the
5 contract].
6 (2) If all or a portion of the claim ¹[is denied by the payer] is not
7 paid within the time frames provided in paragraph (1) of this
8 subsection¹ because:
9 (a) [the claim is an ineligible claim;
10 (b)] the claim submission is incomplete because the required
11 substantiating documentation ¹[, which is specific to the health care
12 service provided to the covered person,]¹ has not been submitted to
13 the payer;
14 [(c)] (b) the diagnosis coding, procedure coding, or any other
15 required information to be submitted with the claim is incorrect;
16 ¹[or]¹
17 [(d)] (c) the payer disputes the amount claimed[; or
18 (e) the claim requires special treatment that prevents timely
19 payments from being made on the claim under the terms of the
20 contract] ¹or
21 (d) there is strong evidence of fraud by the provider and the payer
22 has initiated an investigation into the suspected fraud¹,
23 the payer shall notify the [subscriber, or that subscriber's agent or
24 assignee if the contract provides for assignment of benefits] ¹[covered
25 person and]¹ health care provider, ¹[in writing or]¹ by electronic
26 means ¹[, as appropriate,] and the covered person in writing¹ within
27 30 days ¹[,of the following: if all or a portion of the claim is denied,
28 all the reasons for the denial; if the claim lacks the required
29 substantiating documentation[, including] or contains incorrect
30 coding, a statement as to what substantiating documentation, specific
31 to the health care service provided to the covered person, or other
32 information, is required to complete adjudication of the claim; and if
33 the amount of the claim is disputed, a statement that it is disputed]¹
34 [; and if the claim requires special treatment that prevents timely
35 payments from being made, a statement of the special treatment to
36 which the claim is subject] ¹of receiving an electronic claim, or notify
37 the covered person and health care provider in writing within 40 days
38 of receiving a claim submitted by other than electronic means, that:
39 (i) the claim is incomplete with a statement as to what
40 substantiating documentation is required for adjudication of the claim;
41 (ii) the claim contains incorrect information with a statement as to
42 what information must be corrected for adjudication of the claim;
43 (iii) the payer disputes the amount claimed in whole or in part with
44 a statement as to the basis of that dispute; or
45 (iv) the payer finds there is strong evidence of fraud and has

1 intitiated an investigation into the suspected fraud in accordance with
2 its fraud prevention plan established pursuant to section 1 of P.L.1993,
3 c.362 (C.17:33A-15), or referred the claim, together with supporting
4 documentation, to the Office of the Insurance Fraud Prosecutor in the
5 Department of Law and Public Safety established pursuant to section
6 32 of P.L.1998, c.21 (C.17:33A-16)¹.

7 (3) If all or a portion of ¹[a] an electronically submitted ¹claim
8 cannot be ¹[entered into the claims processing system for any of the
9 following reasons:

10 (a) the health care provider is not eligible at the time of service;

11 (b) the person who received the health care service was not a
12 covered person at the time of service;

13 (c) the premium was not paid by or on the behalf of the covered
14 person; or

15 (d)] adjudicated because ¹the diagnosis coding, procedure coding
16 or any other data required to be submitted with the claim was missing,
17 the payer shall ¹electronically ¹notify the ¹[covered person and] ¹
18 health care provider ¹or its agent ¹within seven days ¹[if the claim was
19 submitted by electronic means, or within 14 days if the claim was
20 submitted by other than electronic means,] ¹of that determination ¹[of
21 denial, of all the reasons for the denial or] and request ¹any
22 information required to complete adjudication of the claim.

23 (4) Any portion of a claim that meets the criteria established in
24 paragraph (1) of this subsection shall be paid by the payer in
25 accordance with the time limit established in paragraph (1) of this
26 subsection.

27 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
28 by electronic means from a health care provider ¹[or] ¹[subscriber]
29 ¹[covered person] ¹, no later than two working days following receipt
30 of the transmission of the claim.

31 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
32 (C.17:33A-1 et seq.) has reason to believe that a claim has been
33 submitted fraudulently, it shall investigate the claim in accordance with
34 its fraud prevention plan established pursuant to section 1 of P.L.1993,
35 c.362 (C.17:33A-15), or refer the claim, together with supporting
36 documentation, to the Office of the Insurance Fraud Prosecutor in the
37 Department of Law and Public Safety established pursuant to section
38 32 of P.L.1998, c.21 (C.17:33A-16).

39 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
40 and [(3)] (4) of this subsection shall be deemed to be overdue if not
41 remitted to the claimant or his agent by the payer on or before the 30th
42 calendar day or the time limit established by the Medicare program,
43 whichever is earlier, following receipt by the payer of a claim
44 submitted by electronic means and on or before the 40th calendar day
45 following receipt of a claim submitted by other than electronic means.

1 ¹[In the event] If¹ payment is withheld on all or a portion of a
2 claim by a payer pursuant to ¹[subparagraph] subparagraphs¹ [(b)]
3 (a) ¹or (b)¹ of paragraph (2) or ¹[subparagraph (d) of]¹ paragraph (3)
4 of this subsection, the claims payment shall be overdue if not remitted
5 to the claimant or his agent by the payer on or before the [30th]
6 ¹[15th] 30th¹ calendar day or the time limit established by the
7 Medicare program, whichever is earlier, for claims submitted by
8 electronic means and the [40th] ¹[25th] 40th¹ calendar day for claims
9 submitted by other than electronic means, following receipt by the
10 payer of the required documentation or information or modification of
11 an initial submission.

12 ¹If payment is withheld on all or a portion of a claim by a payer
13 pursuant to paragraphs (2) or (3) of this subsection and the provider
14 is not notified within the time frames provided for in those paragraphs,
15 the claim shall be deemed to be overdue.¹

16 (8) (a) No payer¹ that has reserved the right to change the
17 premium¹ shall deny payment on all or a portion of a claim because the
18 payer requests documentation or information that is not specific to the
19 health care service provided to the covered person.

20 (b) No payer shall deny payment on all or a portion of a claim while
21 seeking coordination of benefits information unless good cause exists
22 for the payer to believe that other insurance is available to the covered
23 person. Good cause shall exist only if the payer's records indicate that
24 other coverage exists. Routine requests to determine whether
25 coordination of benefits exists shall not be considered good cause.

26 (c) In the event payment is withheld on all or a portion of a claim
27 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
28 claims payment shall be deemed to be overdue if not remitted to the
29 claimant or his agent by the payer on or before the 30th calendar day
30 or the time limit established by the Medicare program, whichever is
31 earlier, following receipt by the payer of a claim submitted by
32 electronic means or on or before the 40th calendar day following
33 receipt of a claim submitted by other than electronic means.

34 [(7)] (9) An overdue payment shall bear simple interest at the rate
35 of [10%]¹[20%] 12%¹ per annum. The interest shall be paid to the
36 health care provider at the time the overdue payment is made. ¹The
37 amount of interest paid to a health care provider for an overdue claim
38 shall be credited to any civil penalty for late payment of the claim
39 levied by the Department of Human Services against a payer that does
40 not reserve the right to change the premium.¹

41 (10) With the exception of claims that were submitted fraudulently
42 or submitted by health care providers that have a pattern of
43 inappropriate billing or claims that were subject to coordination of
44 benefits, no payer shall seek reimbursement for overpayment of a claim
45 previously paid pursuant to this section later than ¹[one year] 18

1 months¹ after the date the first payment on the claim was made. ¹No
2 payer shall seek more than one reimbursement for overpayment of a
3 particular claim.¹ At the time the reimbursement request is submitted
4 to the health care provider, the payer shall provide written
5 documentation that identifies the error made by the payer in the
6 processing or payment of the claim that justifies the reimbursement
7 request. No payer shall base a reimbursement request for a particular
8 claim on extrapolation of other claims, except under the following
9 circumstances:

10 (a) in judicial or quasi-judicial proceedings, including arbitration;

11 (b) in administrative proceedings; ¹[or]¹

12 (c) in which relevant records required to be maintained by the
13 health care provider have been improperly altered or reconstructed, or
14 a material number of the relevant records are otherwise unavailable
15 ¹or;

16 (d) in which there is clear evidence of fraud by the health care
17 provider and the payer has investigated the claim in accordance with
18 its fraud prevention plan established pursuant to section 1 of P.L.1993,
19 c.362 (C.17:33A-15), and referred the claim, together with supporting
20 documentation, to the Office of the Insurance Fraud Prosecutor in the
21 Department of Law and Public Safety established pursuant to section
22 32 of P.L.1998, c.21 (C.17:33A-16)¹.

23 (11) (a) In seeking reimbursement for the overpayment from the
24 health care provider, except as provided for in subparagraph (b) of this
25 paragraph, no payer shall collect or attempt to collect:

26 (i) the funds for the reimbursement on or before the 45th calendar
27 day following the submission of the reimbursement request to the
28 health care provider;

29 (ii) the funds for the reimbursement if the health care provider
30 disputes the request and initiates an appeal on or before the 45th
31 calendar day following the submission of the reimbursement request
32 to the health care provider and until the health care provider's rights
33 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
34 section are exhausted; ¹or¹

35 (iii) ¹[the funds for the reimbursement request by assessing them
36 against payment of any future claims submitted by the health care
37 provider, unless agreed to in writing by the health care provider; or

38 (iv)] a monetary penalty against the reimbursement request,
39 including but not limited to, an interest charge or¹ a late fee.

40 ¹The payer may collect the funds for the reimbursement request by
41 assessing them against payment of any future claims submitted by the
42 health care provider after the 45th calendar day following the
43 submission of the reimbursement request to the health care provider
44 or after the health care provider's rights to appeal set forth under
45 paragraphs (1) and (2) of subsection e. of this section have been

1 exhausted if the payer submits an explanation in writing to the
2 provider in sufficient detail so that the provider can reconcile each
3 covered person's bill.¹

4 (b) If a payer has determined that the overpayment to the health
5 care provider is a result of fraud committed by the health care provider
6 and the payer has conducted its investigation and reported the fraud
7 to the Office of the Insurance Fraud Prosecutor as required by law, the
8 payer may collect an overpayment by assessing it against payment of
9 any future claim submitted by the health care provider.

10 (12) No health care provider shall seek reimbursement from a payer
11 or covered person for underpayment of a claim submitted pursuant to
12 this section later than ¹[one year] 18 months¹ from the date the first
13 payment on the claim was made, except if the claim is the subject of
14 an appeal submitted pursuant to subsection e. of this section or the
15 claim is subject to continual claims submission. ¹No health care
16 provider shall seek more than one reimbursement for underpayment of
17 a particular claim.¹

18 e. (1) A health insurer or its agent, hereinafter the payer, shall
19 establish an internal appeal mechanism to resolve any dispute ¹raised
20 by a health care provider regardless of whether the health care
21 provider is under contract with the payer¹ regarding compliance with
22 the requirements of this section ¹or compliance with the requirements
23 of sections 4 through 7 of P.L. , c. (C.) (pending before the
24 Legislature as this bill). No dispute pertaining to medical necessity
25 which is eligible to be submitted to the Independent Health Care
26 Appeals Program established pursuant to section 11 of P.L.1997,
27 c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this
28 subsection¹. The payer shall conduct the appeal at no cost to the
29 health care provider.

30 A health care provider may initiate an appeal on or before the 90th
31 calendar day following receipt by the health care provider of the
32 payer's claims determination, which is the basis of the appeal, on a
33 form prescribed by the Commissioner of Banking and Insurance which
34 shall describe the type of substantiating documentation that must be
35 submitted with the form. The payer shall conduct a review of the
36 appeal and notify the health care provider of its determination on or
37 before the ¹[10th] 30th¹ calendar day following the receipt of the
38 appeal form. If the health care provider is not notified of the payer's
39 determination of the appeal within ¹[10] 30¹ days, the health care
40 provider may refer the dispute to arbitration as provided by paragraph
41 (2) of this subsection.

42 If the payer issues a determination in favor of the health care
43 provider, the payer shall comply with the provisions of this section and
44 pay the amount of money in dispute, if applicable, with accrued
45 interest at the rate of ¹[20%] 12%¹ per annum, on or before the 30th
46 calendar day following the notification of the payer's determination on

1 the appeal. ¹Interest shall begin to accrue on the day the appeal was
2 received by the payer.¹

3 If the payer issues a determination against the health care provider,
4 the payer shall notify the health care provider of its findings on or
5 before the ¹[10th] 30th¹ calendar day following the receipt of the
6 appeal form and shall include in the notification written instructions for
7 referring the dispute to arbitration as provided by paragraph (2) of this
8 subsection.

9 The payer shall report annually to the Commissioner of Banking and
10 Insurance the number of appeals it has received and the resolution of
11 each appeal.

12 (2) Any dispute regarding the determination of an internal appeal
13 conducted pursuant to paragraph (1) of this subsection may be
14 referred to arbitration as provided in this paragraph. The
15 Commissioner of Banking and Insurance shall contract with a
16 nationally recognized, independent organization that specializes in
17 arbitration to conduct the arbitration proceedings.

18 Any party may initiate an arbitration proceeding on or before the
19 90th calendar day following the receipt of the determination which is
20 the basis of the appeal, on a form prescribed by the Commissioner of
21 Banking and Insurance. No dispute shall be accepted for arbitration
22 unless the payment amount in dispute is \$1,000 or more, except that
23 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
24 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
25 the threshold requirements of this subsection. No dispute pertaining
26 to medical necessity which is eligible to be submitted to the
27 Independent Health Care Appeals Program established pursuant to
28 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
29 arbitration pursuant to this subsection.

30 (3) The arbitrator shall conduct the arbitration proceedings
31 pursuant to the rules of the arbitration entity, including rules of
32 discovery subject to confidentiality requirements established by State
33 or federal law.

34 (4) An arbitrator's determination shall be:

35 (a) signed by the arbitrator;

36 (b) issued in writing, in a form prescribed by the Commissioner of
37 Banking and Insurance, including a statement of the issues in dispute
38 and the findings and conclusions on which the determination is based;
39 and

40 (c) issued on or before the 30th calendar day following the receipt
41 of the required documentation.

42 The arbitration shall be nonappealable and binding on all parties to
43 the dispute.

44 (5) If the arbitrator determines that a payer has withheld or denied
45 payment in violation of the provisions of this section, the arbitrator

1 shall order the payer to make payment of the claim, together with
 2 accrued interest, on or before the 10th business day following the
 3 issuance of the determination. If the arbitrator determines that a payer
 4 has withheld or denied payment on the basis of information submitted
 5 by the health care provider and the payer requested, but did not
 6 receive, this information from the health care provider when the claim
 7 was initially processed pursuant to subsection d. of this section or
 8 reviewed under internal appeal pursuant to paragraph (1) of this
 9 subsection, the payer shall not be required to pay any accrued interest.
 10 ¹[In accordance with regulations adopted by the Commissioner of
 11 Banking and Insurance, the cost of the arbitration proceedings,
 12 including the payment of reasonable attorney's fees, shall be awarded
 13 to the prevailing party.]¹

14 (6) If the arbitrator determines that a health care provider has
 15 engaged in a pattern and practice of improper billing and a refund is
 16 due to the payer, the arbitrator may award the payer a refund,
 17 including interest accrued at the rate of ¹[20%] 12%¹ per annum.
 18 ¹Interest shall begin to accrue on the day the appeal was received by
 19 the payer for resolution through the internal appeals process
 20 established pursuant to paragraph (1) of this subsection.¹

21 (7) The arbitrator shall file a copy of each determination with and
 22 in the form prescribed by the Commissioner of Banking and Insurance.

23 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
 24 means a claim by [an insured] a covered person for payment of
 25 benefits under an insured policy for which the financial obligation for
 26 the payment of a claim under the policy rests upon the health insurer.

27 g. Any person found in violation of this section with a pattern ¹[of
 28 frequency] and practice¹ as determined by the Commissioner of
 29 Banking and Insurance shall be liable to a civil penalty as set forth in
 30 section 17 of P.L. , c. (C.) (pending before the Legislature as
 31 this bill).

32 (cf: P.L.1999, c.154, s.6)

33

34 15. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to read
 35 as follows:

36 7. a. Within 180 days of the adoption of a timetable for
 37 implementation pursuant to section 1 of P.L.1999, c.154
 38 (C.17B:30-23), a health maintenance organization[,] or its agent or
 39 a subsidiary that processes health care benefits claims as a third party
 40 administrator, shall demonstrate to the satisfaction of the
 41 Commissioner of Banking and Insurance that it will adopt and
 42 implement all of the standards to receive and transmit health care
 43 transactions electronically, according to the corresponding timetable,
 44 and otherwise comply with the provisions of this section, as a
 45 condition of its continued authorization to do business in this State.

1 The Commissioner of Banking and Insurance may grant extensions
2 or waivers of the implementation requirement when it has been
3 demonstrated to the commissioner's satisfaction that compliance with
4 the timetable for implementation will result in an undue hardship to a
5 health maintenance organization ¹, or its agent¹, its subsidiary or its
6 covered [enrollees] persons.

7 b. Within 12 months of the adoption of regulations establishing
8 standard health care enrollment and claim forms by the Commissioner
9 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
10 (C.17B:30-23), a health maintenance organization ¹or its agent¹ or a
11 subsidiary that processes health care benefits claims as a third party
12 administrator shall use the standard health care enrollment and claim
13 forms in connection with all group and individual health maintenance
14 organization coverage for health care services issued, delivered,
15 executed or renewed in this State.

16 c. Twelve months after the adoption of regulations establishing
17 standard health care enrollment and claim forms by the Commissioner
18 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
19 (C.17B:30-23), a health maintenance organization ¹or its agent¹ shall
20 require that health care providers file all claims for payment for health
21 care services. A covered person who receives health care services
22 shall not be required to submit a claim for payment, but
23 notwithstanding the provisions of this subsection to the contrary, a
24 covered person shall be permitted to submit a claim on his own behalf,
25 at the covered person's option. All claims shall be filed using the
26 standard health care claim form applicable to the contract.

27 d. ¹For the purposes of this subsection, "substantiating
28 documentation" means any information specific to the particular health
29 care service provided to a covered person.¹

30 (1) Effective 180 days after the effective date of P.L.1999, c.154,
31 a health maintenance organization or its agent, hereinafter the payer,
32 shall remit payment for every insured claim submitted by [an enrollee
33 or that enrollee's agent or assignee if the health maintenance
34 organization coverage for health care services provides for assignment
35 of benefits] a covered person or health care provider, no later than the
36 30th calendar day following receipt of the claim by the payer or no
37 later than the time limit established for the payment of claims in the
38 Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever
39 is earlier, if the claim is submitted by electronic means, and no later
40 than the 40th calendar day following receipt if the claim is submitted
41 by other than electronic means, if:

42 (a) [the claim is an eligible claim for a health care service provided
43 by an eligible health care provider to a covered person under the health
44 maintenance organization coverage for health care services;

45 (b) the claim has no material defect or impropriety, including, but
46 not limited to, any lack of required substantiating documentation or

1 incorrect coding;

2 (c) there is no dispute regarding the amount claimed;] the health
3 care provider is eligible at the date of service;

4 (b) the person who received the health care service was covered on
5 the date of service;

6 (c) the claim is for a service or supply covered under the health
7 benefits plan;

8 (d) the claim is submitted with all the information requested by the
9 payer on the claim form or in other instructions¹ that were¹ distributed
10 in advance to the health care provider or covered person¹ [within 120
11 days of the date of service] in accordance with the provisions of
12 section 4 of P.L. , c. (C.) (pending before the Legislature as this
13 bill)¹ ; and

14 [(d)] (e) the payer has no reason to believe that the claim has
15 been submitted fraudulently[; and

16 (e) the claim requires no special treatment that prevents timely
17 payments from being made on the claim under the terms of the
18 contract].

19 (2) If all or a portion of the claim¹ [is denied by the payer] is not
20 paid within the time frames provided in paragraph (1) of this
21 subsection¹ because:

22 (a) [(the claim is an ineligible claim;

23 (b)] the claim submission is incomplete because the required
24 substantiating documentation¹ [, which is specific to the health care
25 service provided to the covered person,]¹ has not been submitted to
26 the payer;

27 [(c)] (b) the diagnosis coding, procedure coding, or any other
28 required information to be submitted with the claim is incorrect;
29 ¹[or]¹

30 [(d)] (c) the payer disputes the amount claimed[; or

31 (e) the claim requires special treatment that prevents timely
32 payments from being made on the claim under the terms of the health
33 maintenance organization coverage for health care services]¹ or

34 (d) there is strong evidence of fraud by the provider and the payer
35 has initiated an investigation into the suspected fraud¹,
36 the payer shall notify the [enrollee, or that enrollee's agent or
37 assignee if the health maintenance organization coverage for health
38 care services provides for assignment of benefits]¹ [covered person
39 and]¹ health care provider,¹ [in writing or]¹ by electronic means¹ [,
40 as appropriate,] and the covered person in writing¹ within 30 days
41 ¹[,of the following: if all or a portion of the claim is denied, all the
42 reasons for the denial; if the claim lacks the required substantiating
43 documentation[, including] or contains incorrect coding, a statement
44 as to what substantiating documentation, specific to the health care
45 service provided to the covered person, or other information, is

1 required to complete adjudication of the claim; and if the amount of
2 the claim is disputed, a statement that it is disputed]¹ [; and if the
3 claim requires special treatment that prevents timely payments from
4 being made, a statement of the special treatment to which the claim is
5 subject] ¹of receiving an electronic claim, or notify the covered person
6 and health care provider in writing within 40 days of receiving a claim
7 submitted by other than electronic means, that:

8 (i) the claim is incomplete with a statement as to what
9 substantiating documentation is required for adjudication of the claim;

10 (ii) the claim contains incorrect information with a statement as to
11 what information must be corrected for adjudication of the claim;

12 (iii) the payer disputes the amount claimed in whole or in part with
13 a statement as to the basis of that dispute; or

14 (iv) the payer finds there is strong evidence of fraud and has
15 initiated an investigation into the suspected fraud in accordance with
16 its fraud prevention plan established pursuant to section 1 of P.L.1993,
17 c.362 (C.17:33A-15), or referred the claim, together with supporting
18 documentation, to the Office of the Insurance Fraud Prosecutor in the
19 Department of Law and Public Safety established pursuant to section
20 32 of P.L.1998, c.21 (C.17:33A-16)]¹.

21 (3) If all or a portion of]¹[a] an electronically submitted¹ claim
22 cannot be]¹[entered into the claims processing system for any of the
23 following reasons:

24 (a) the health care provider is not eligible at the time of service;

25 (b) the person who received the health care service was not a
26 covered person at the time of service;

27 (c) the premium was not paid by or on the behalf of the covered
28 person; or

29 (d)] adjudicated because¹ the diagnosis coding, procedure coding
30 or any other data required to be submitted with the claim was missing,
31 the payer shall]¹electronically¹ notify the]¹[covered person and]¹
32 health care provider]¹or its agent¹ within seven days]¹[if the claim was
33 submitted by electronic means, or within 14 days if the claim was
34 submitted by other than electronic means,]¹ of that determination]¹[of
35 denial, of all the reasons for the denial or] and request¹ any
36 information required to complete adjudication of the claim.

37 (4) Any portion of a claim that meets the criteria established in
38 paragraph (1) of this subsection shall be paid by the payer in
39 accordance with the time limit established in paragraph (1) of this
40 subsection.

41 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
42 by electronic means from a health care provider]¹[or]¹ [subscriber]
43]¹[covered person]¹, no later than two working days following receipt
44 of the transmission of the claim.

45 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320

1 (C.17:33A-1 et seq.) has reason to believe that a claim has been
2 submitted fraudulently, it shall investigate the claim in accordance with
3 its fraud prevention plan established pursuant to section 1 of P.L.1993,
4 c.362 (C.17:33A-15), or refer the claim, together with supporting
5 documentation, to the Office of the Insurance Fraud Prosecutor in the
6 Department of Law and Public Safety established pursuant to section
7 32 of P.L.1998, c.21 (C.17:33A-16).

8 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
9 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
10 remitted to the claimant or his agent by the payer on or before the 30th
11 calendar day or the time limit established by the Medicare program,
12 whichever is earlier, following receipt by the payer of a claim
13 submitted by electronic means and on or before the 40th calendar day
14 following receipt of a claim submitted by other than electronic means.

15 ¹~~[In the event]~~ If¹ payment is withheld on all or a portion of a
16 claim by a payer pursuant to ¹~~[subparagraph]~~ subparagraphs¹ ~~[(b)]~~
17 (a)¹ or (b)¹ of paragraph (2) or ¹~~[subparagraph (d) of]~~¹ paragraph (3)
18 of this subsection, the claims payment shall be overdue if not remitted
19 to the claimant or his agent by the payer on or before the ~~[30th]~~
20 ¹[15th] 30th¹ calendar day or the time limit established by the
21 Medicare program, whichever is earlier, for claims submitted by
22 electronic means and the ~~[40th]~~ ¹[25th] 40th¹ calendar day for claims
23 submitted by other than electronic means, following receipt by the
24 payer of the required documentation or information or modification of
25 an initial submission.

26 ¹If payment is withheld on all or a portion of a claim by a payer
27 pursuant to paragraphs (2) or (3) of this subsection and the provider
28 is not notified within the time frames provided for in those paragraphs,
29 the claim shall be deemed to be overdue.¹

30 (8) (a) No payer¹ that has reserved the right to change the
31 premium¹ shall deny payment on all or a portion of a claim because the
32 payer requests documentation or information that is not specific to the
33 health care service provided to the covered person.

34 (b) No payer shall deny payment on all or a portion of a claim while
35 seeking coordination of benefits information unless good cause exists
36 for the payer to believe that other insurance is available to the covered
37 person. Good cause shall exist only if the payer's records indicate that
38 other coverage exists. Routine requests to determine whether
39 coordination of benefits exists shall not be considered good cause.

40 (c) In the event payment is withheld on all or a portion of a claim
41 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
42 claims payment shall be deemed to be overdue if not remitted to the
43 claimant or his agent by the payer on or before the 30th calendar day
44 or the time limit established by the Medicare program, whichever is
45 earlier, following receipt by the payer of a claim submitted by
46 electronic means or on or before the 40th calendar day following

1 receipt of a claim submitted by other than electronic means.

2 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
3 of ~~[10%]~~¹~~[20%]~~ 12%¹ per annum. The interest shall be paid to the
4 health care provider at the time the overdue payment is made. ¹The
5 amount of interest paid to a health care provider for an overdue claim
6 shall be credited to any civil penalty for late payment of the claim
7 levied by the Department of Human Services against a payer that does
8 not reserve the right to change the premium.¹

9 (10) With the exception of claims that were submitted fraudulently
10 or submitted by health care providers that have a pattern of
11 inappropriate billing or claims that were subject to coordination of
12 benefits, no payer shall seek reimbursement for overpayment of a claim
13 previously paid pursuant to this section later than ¹[one year] 18
14 months¹ after the date the first payment on the claim was made. ¹No
15 payer shall seek more than one reimbursement for overpayment of a
16 particular claim.¹ At the time the reimbursement request is submitted
17 to the health care provider, the payer shall provide written
18 documentation that identifies the error made by the payer in the
19 processing or payment of the claim that justifies the reimbursement
20 request. No payer shall base a reimbursement request for a particular
21 claim on extrapolation of other claims, except under the following
22 circumstances:

23 (a) in judicial or quasi-judicial proceedings, including arbitration;

24 (b) in administrative proceedings; ¹[or]¹

25 (c) in which relevant records required to be maintained by the
26 health care provider have been improperly altered or reconstructed, or
27 a material number of the relevant records are otherwise unavailable
28 ¹or;

29 (d) in which there is clear evidence of fraud by the health care
30 provider and the payer has investigated the claim in accordance with
31 its fraud prevention plan established pursuant to section 1 of P.L.1993,
32 c.362 (C.17:33A-15), and referred the claim, together with supporting
33 documentation, to the Office of the Insurance Fraud Prosecutor in the
34 Department of Law and Public Safety established pursuant to section
35 32 of P.L.1998, c.21 (C.17:33A-16)¹.

36 (11) (a) In seeking reimbursement for the overpayment from the
37 health care provider, except as provided for in subparagraph (b) of this
38 paragraph, no payer shall collect or attempt to collect:

39 (i) the funds for the reimbursement on or before the 45th calendar
40 day following the submission of the reimbursement request to the
41 health care provider;

42 (ii) the funds for the reimbursement if the health care provider
43 disputes the request and initiates an appeal on or before the 45th
44 calendar day following the submission of the reimbursement request
45 to the health care provider and until the health care provider's rights
46 to appeal set forth under paragraphs (1) and (2) of subsection e. of this

1 section are exhausted; ¹or¹

2 (iii) ¹[the funds for the reimbursement request by assessing them
3 against payment of any future claims submitted by the health care
4 provider, unless agreed to in writing by the health care provider; or

5 (iv)] a monetary penalty against the reimbursement request,
6 including but not limited to, an interest charge or¹ a late fee.

7 ¹The payer may collect the funds for the reimbursement request by
8 assessing them against payment of any future claims submitted by the
9 health care provider after the 45th calendar day following the
10 submission of the reimbursement request to the health care provider
11 or after the health care provider's rights to appeal set forth under
12 paragraphs (1) and (2) of subsection e. of this section have been
13 exhausted if the payer submits an explanation in writing to the
14 provider in sufficient detail so that the provider can reconcile each
15 covered person's bill.¹

16 (b) If a payer has determined that the overpayment to the health
17 care provider is a result of fraud committed by the health care provider
18 and the payer has conducted its investigation and reported the fraud
19 to the Office of the Insurance Fraud Prosecutor as required by law, the
20 payer may collect an overpayment by assessing it against payment of
21 any future claim submitted by the health care provider.

22 (12) No health care provider shall seek reimbursement from a payer
23 or covered person for underpayment of a claim submitted pursuant to
24 this section later than ¹[one year] 18 months¹ from the date the first
25 payment on the claim was made, except if the claim is the subject of
26 an appeal submitted pursuant to subsection e. of this section or the
27 claim is subject to continual claims submission. ¹No health care
28 provider shall seek more than one reimbursement for underpayment of
29 a particular claim.¹

30 e. (1) A health maintenance organization or its agent, hereinafter
31 the payer, shall establish an internal appeal mechanism to resolve any
32 dispute ¹raised by a health care provider regardless of whether the
33 health care provider is under contract with the payer¹ regarding
34 compliance with the requirements of this section ¹or compliance with
35 the requirements of sections 4 through 7 of P.L. , c. (C.)
36 (pending before the Legislature as this bill). No dispute pertaining to
37 medical necessity which is eligible to be submitted to the Independent
38 Health Care Appeals Program established pursuant to section 11 of
39 P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal
40 pursuant to this subsection¹. The payer shall conduct the appeal at no
41 cost to the health care provider.

42 A health care provider may initiate an appeal on or before the 90th
43 calendar day following receipt by the health care provider of the
44 payer's claims determination, which is the basis of the appeal, on a
45 form prescribed by the Commissioner of Banking and Insurance which
46 shall describe the type of substantiating documentation that must be

1 submitted with the form. The payer shall conduct a review of the
2 appeal and notify the health care provider of its determination on or
3 before the ¹[10th] ¹30th¹ calendar day following the receipt of the
4 appeal form. If the health care provider is not notified of the payer's
5 determination of the appeal within ¹[10] ¹30¹ days, the health care
6 provider may refer the dispute to arbitration as provided by paragraph
7 (2) of this subsection.

8 If the payer issues a determination in favor of the health care
9 provider, the payer shall comply with the provisions of this section and
10 pay the amount of money in dispute, if applicable, with accrued
11 interest at the rate of ¹[20%] ¹12%¹ per annum, on or before the 30th
12 calendar day following the notification of the payer's determination on
13 the appeal. ¹Interest shall begin to accrue on the day the appeal was
14 received by the payer.¹

15 If the payer issues a determination against the health care provider,
16 the payer shall notify the health care provider of its findings on or
17 before the ¹[10th] ¹30th¹ calendar day following the receipt of the
18 appeal form and shall include in the notification written instructions for
19 referring the dispute to arbitration as provided by paragraph (2) of this
20 subsection.

21 The payer shall report annually to the Commissioner of Banking and
22 Insurance the number of appeals it has received and the resolution of
23 each appeal.

24 (2) Any dispute regarding the determination of an internal appeal
25 conducted pursuant to paragraph (1) of this subsection may be
26 referred to arbitration as provided in this paragraph. The
27 Commissioner of Banking and Insurance shall contract with a
28 nationally recognized, independent organization that specializes in
29 arbitration to conduct the arbitration proceedings.

30 Any party may initiate an arbitration proceeding on or before the
31 90th calendar day following the receipt of the determination which is
32 the basis of the appeal, on a form prescribed by the Commissioner of
33 Banking and Insurance. No dispute shall be accepted for arbitration
34 unless the payment amount in dispute is \$1,000 or more, except that
35 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
36 ¹[their] his¹ own disputed claim amounts for the purposes of meeting
37 the threshold requirements of this subsection. No dispute pertaining
38 to medical necessity which is eligible to be submitted to the
39 Independent Health Care Appeals Program established pursuant to
40 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
41 arbitration pursuant to this subsection.

42 (3) The arbitrator shall conduct the arbitration proceedings
43 pursuant to the rules of the arbitration entity, including rules of
44 discovery subject to confidentiality requirements established by State
45 or federal law.

46 (4) An arbitrator's determination shall be:

1 (a) signed by the arbitrator;

2 (b) issued in writing, in a form prescribed by the Commissioner of
3 Banking and Insurance, including a statement of the issues in dispute
4 and the findings and conclusions on which the determination is based;
5 and

6 (c) issued on or before the 30th calendar day following the receipt
7 of the required documentation.

8 The arbitration shall be nonappealable and binding on all parties to
9 the dispute.

10 (5) If the arbitrator determines that a payer has withheld or denied
11 payment in violation of the provisions of this section, the arbitrator
12 shall order the payer to make payment of the claim, together with
13 accrued interest, on or before the 10th business day following the
14 issuance of the determination. If the arbitrator determines that a payer
15 has withheld or denied payment on the basis of information submitted
16 by the health care provider and the payer requested, but did not
17 receive, this information from the health care provider when the claim
18 was initially processed pursuant to subsection d. of this section or
19 reviewed under internal appeal pursuant to paragraph (1) of this
20 subsection, the payer shall not be required to pay any accrued interest.
21 ¹[In accordance with regulations adopted by the Commissioner of
22 Banking and Insurance, the cost of the arbitration proceedings,
23 including the payment of reasonable attorney's fees, shall be awarded
24 to the prevailing party.]¹

25 (6) If the arbitrator determines that a health care provider has
26 engaged in a pattern and practice of improper billing and a refund is
27 due to the payer, the arbitrator may award the payer a refund,
28 including interest accrued at the rate of ¹[20%] 12%¹ per annum.
29 ¹Interest shall begin to accrue on the day the appeal was received by
30 the payer for resolution through the internal appeals process
31 established pursuant to paragraph (1) of this subsection.¹

32 (7) The arbitrator shall file a copy of each determination with and
33 in the form prescribed by the Commissioner of Banking and Insurance.

34 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
35 means a claim by [an enrollee] a covered person for payment of
36 benefits under an insured health maintenance organization contract for
37 which the financial obligation for the payment of a claim under the
38 health maintenance organization coverage for health care services rests
39 upon the health maintenance organization.

40 g. Any person found in violation of this section with a pattern ¹[of
41 frequency] and practice¹ as determined by the Commissioner of
42 Banking and Insurance shall be liable to a civil penalty as set forth in
43 section 17 of P.L. , c. (C.) (pending before the Legislature as
44 this bill).

45 (cf: P.L.1999, c.154, s.7)

1 16. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to
2 read as follows:

3 10. a. Within 180 days of the adoption of a timetable for
4 implementation pursuant to section 1 of P.L.1999, c.154
5 (C.17B:30-23), a prepaid prescription service organization[,] or its
6 agent or a subsidiary that processes health care benefits claims as a
7 third party administrator, shall demonstrate to the satisfaction of the
8 Commissioner of Banking and Insurance that it will adopt and
9 implement all of the standards to receive and transmit health care
10 transactions electronically, according to the corresponding timetable,
11 and otherwise comply with the provisions of this section, as a
12 condition of its continued authorization to do business in this State.

13 The Commissioner of Banking and Insurance may grant extensions
14 or waivers of the implementation requirement when it has been
15 demonstrated to the commissioner's satisfaction that compliance with
16 the timetable for implementation will result in an undue hardship to a
17 prepaid prescription service organization ¹, or its agent¹, its subsidiary
18 or its covered enrollees.

19 b. Within 12 months of the adoption of regulations establishing
20 standard health care enrollment and claim forms by the Commissioner
21 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
22 (C.17B:30-23), a prepaid prescription service organization ¹or its
23 agent¹ or a subsidiary that processes health care benefits claims as a
24 third party administrator shall use the standard health care enrollment
25 and claim forms in connection with all contracts issued, delivered,
26 executed or renewed in this State.

27 c. Twelve months after the adoption of regulations establishing
28 standard health care enrollment and claim forms by the Commissioner
29 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
30 (C.17B:30-23), a prepaid prescription service organization ¹or its
31 agent¹ shall require that health care providers file all claims for
32 payment for health care services. A covered person who receives
33 health care services shall not be required to submit a claim for
34 payment, but notwithstanding the provisions of this subsection to the
35 contrary, a covered person shall be permitted to submit a claim on his
36 own behalf, at the covered person's option. All claims shall be filed
37 using the standard health care claim form applicable to the contract.

38 d. ¹For the purposes of this subsection, "substantiating
39 documentation" means any information specific to the particular health
40 care service provided to a covered person.¹

41 (1) Effective 180 days after the effective date of P.L.1999, c.154,
42 a prepaid prescription service organization or its agent, hereinafter the
43 payer, shall remit payment for every insured claim submitted by [an
44 enrollee or that enrollee's agent or assignee if the contract provides for
45 assignment of benefits] covered person or health care provider, no
46 later than the 30th calendar day following receipt of the claim by the

1 payer or no later than the time limit established for the payment of
2 claims in the Medicare program pursuant to 42 U.S.C.
3 s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by
4 electronic means, and no later than the 40th calendar day following
5 receipt if the claim is submitted by other than electronic means, if:

6 (a) [the claim is an eligible claim for a health care service provided
7 by an eligible health care provider to a covered person under the
8 contract;

9 (b) the claim has no material defect or impropriety, including, but
10 not limited to, any lack of required substantiating documentation or
11 incorrect coding;

12 (c) there is no dispute regarding the amount claimed;] the health
13 care provider is eligible at the date of service;

14 (b) the person who received the health care service was covered on
15 the date of service;

16 (c) the claim is for a service or supply covered under the health
17 benefits plan;

18 (d) the claim is submitted with all the information requested by the
19 payer on the claim form or in other instructions¹ that were¹ distributed
20 in advance to the health care provider or covered person¹ [within 120
21 days of the date of service] in accordance with the provisions of
22 section 4 of P.L. , c. (C.) (pending before the Legislature as this
23 bill)¹ ; and

24 [(d)] (e) the payer has no reason to believe that the claim has
25 been submitted fraudulently]; and

26 (e) the claim requires no special treatment that prevents timely
27 payments from being made on the claim under the terms of the
28 contract].

29 (2) If all or a portion of the claim¹ [is denied by the payer] is not
30 paid within the time frames provided in paragraph (1) of this
31 subsection¹ because:

32 (a) [the claim is an ineligible claim;

33 (b)] the claim submission is incomplete because the required
34 substantiating documentation¹ [, which is specific to the health care
35 service provided to the covered person,]¹ has not been submitted to
36 the payer;

37 [(c)] (b) the diagnosis coding, procedure coding, or any other
38 required information to be submitted with the claim is incorrect;
39 ¹[or]¹

40 [(d)] (c) the payer disputes the amount claimed]; or

41 (e) the claim requires special treatment that prevents timely
42 payments from being made on the claim under the terms of the
43 contract]¹ or

44 (d) there is strong evidence of fraud by the provider and the payer
45 has initiated an investigation into the suspected fraud¹,

1 the payer shall notify the [subscriber, or that subscriber's agent or
2 assignee if the contract provides for assignment of benefits] ¹[covered
3 person and] ¹ health care provider, [in writing or] ¹by electronic
4 means ¹[, as appropriate,] and the covered person in writing ¹ within
5 30 days ¹[,of the following: if all or a portion of the claim is denied,
6 all the reasons for the denial; if the claim lacks the required
7 substantiating documentation[, including] or contains incorrect
8 coding, a statement as to what substantiating documentation, specific
9 to the health care service provided to the covered person, or other
10 information, is required to complete adjudication of the claim; and if
11 the amount of the claim is disputed, a statement that it is disputed] ¹
12 [; and if the claim requires special treatment that prevents timely
13 payments from being made, a statement of the special treatment to
14 which the claim is subject] ¹of receiving an electronic claim, or notify
15 the covered person and health care provider in writing within 40 days
16 of receiving a claim submitted by other than electronic means, that:

17 (i) the claim is incomplete with a statement as to what
18 substantiating documentation is required for adjudication of the claim;
19 (ii) the claim contains incorrect information with a statement as to
20 what information must be corrected for adjudication of the claim;
21 (iii) the payer disputes the amount claimed in whole or in part with
22 a statement as to the basis of that dispute; or
23 (iv) the payer finds there is strong evidence of fraud and has
24 initiated an investigation into the suspected fraud in accordance with
25 its fraud prevention plan established pursuant to section 1 of P.L.1993,
26 c.362 (C.17:33A-15), or referred the claim, together with supporting
27 documentation, to the Office of the Insurance Fraud Prosecutor in the
28 Department of Law and Public Safety established pursuant to section
29 32 of P.L.1998, c.21 (C.17:33A-16) ¹.

30 (3) If all or a portion of ¹[a] an electronically submitted ¹ claim
31 cannot be ¹[entered into the claims processing system for any of the
32 following reasons:

33 (a) the health care provider is not eligible at the time of service;
34 (b) the person who received the health care service was not a
35 covered person at the time of service;
36 (c) the premium was not paid by or on the behalf of the covered
37 person; or
38 (d) adjudicated because ¹ the diagnosis coding, procedure coding
39 or any other data required to be submitted with the claim was missing,
40 the payer shall ¹electronically notify the [covered person and] ¹
41 health care provider ¹or its agent ¹ within seven days ¹[if the claim was
42 submitted by electronic means, or within 14 days if the claim was
43 submitted by other than electronic means,] ¹ of that determination ¹[of
44 denial, of all the reasons for the denial or] and request ¹ any
45 information required to complete adjudication of the claim.

1 (4) Any portion of a claim that meets the criteria established in
2 paragraph (1) of this subsection shall be paid by the payer in
3 accordance with the time limit established in paragraph (1) of this
4 subsection.

5 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
6 by electronic means from a health care provider ¹[or]¹ [subscriber]
7 ¹[covered person]¹, no later than two working days following receipt
8 of the transmission of the claim.

9 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
10 (C.17:33A-1 et seq.) has reason to believe that a claim has been
11 submitted fraudulently, it shall investigate the claim in accordance with
12 its fraud prevention plan established pursuant to section 1 of P.L.1993,
13 c.362 (C.17:33A-15), or refer the claim, together with supporting
14 documentation, to the Office of the Insurance Fraud Prosecutor in the
15 Department of Law and Public Safety established pursuant to section
16 32 of P.L.1998, c.21 (C.17:33A-16).

17 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
18 and [(3)] (4) of this subsection shall be deemed to be overdue if not
19 remitted to the claimant or his agent by the payer on or before the 30th
20 calendar day or the time limit established by the Medicare program,
21 whichever is earlier, following receipt by the payer of a claim
22 submitted by electronic means and on or before the 40th calendar day
23 following receipt of a claim submitted by other than electronic means.

24 ¹[In the event] if¹ payment is withheld on all or a portion of a
25 claim by a payer pursuant to ¹[subparagraph] subparagraphs¹ [(b)]
26 (a) ¹or (b)¹ of paragraph (2) or ¹[subparagraph (d) of]¹ paragraph (3)
27 of this subsection, the claims payment shall be overdue if not remitted
28 to the claimant or his agent by the payer on or before the [30th]
29 ¹[15th] 30th¹ calendar day or the time limit established by the
30 Medicare program, whichever is earlier, for claims submitted by
31 electronic means and the [40th] ¹[25th] 40th¹ calendar day for claims
32 submitted by other than electronic means, following receipt by the
33 payer of the required documentation or information or modification of
34 an initial submission.

35 ¹If payment is withheld on all or a portion of a claim by a payer
36 pursuant to paragraphs (2) or (3) of this subsection and the provider
37 is not notified within the time frames provided for in those paragraphs,
38 the claim shall be deemed to be overdue.¹

39 (8) (a) No payer ¹that has reserved the right to change the
40 premium¹ shall deny payment on all or a portion of a claim because the
41 payer requests documentation or information that is not specific to the
42 health care service provided to the covered person.

43 (b) No payer shall deny payment on all or a portion of a claim while
44 seeking coordination of benefits information unless good cause exists
45 for the payer to believe that other insurance is available to the covered

1 person. Good cause shall exist only if the payer's records indicate that
2 other coverage exists. Routine requests to determine whether
3 coordination of benefits exists shall not be considered good cause.

4 (c) In the event payment is withheld on all or a portion of a claim
5 by a payer pursuant to subparagraphs (a) or (b) of this paragraph, the
6 claims payment shall be deemed to be overdue if not remitted to the
7 claimant or his agent by the payer on or before the 30th calendar day
8 or the time limit established by the Medicare program, whichever is
9 earlier, following receipt by the payer of a claim submitted by
10 electronic means or on or before the 40th calendar day following
11 receipt of a claim submitted by other than electronic means.

12 [(7)] (9) An overdue payment shall bear simple interest at the rate
13 of [10%]¹[20%] 12%¹ per annum. The interest shall be paid to the
14 health care provider at the time the overdue payment is made. ¹The
15 amount of interest paid to a health care provider for an overdue claim
16 shall be credited to any civil penalty for late payment of the claim
17 levied by the Department of Human Services against a payer that does
18 not reserve the right to change the premium.¹

19 (10) With the exception of claims that were submitted fraudulently
20 or submitted by health care providers that have a pattern of
21 inappropriate billing or claims that were subject to coordination of
22 benefits, no payer shall seek reimbursement for overpayment of a claim
23 previously paid pursuant to this section later than ¹[one year] 18
24 months¹ after the date the first payment on the claim was made. ¹No
25 payer shall seek more than one reimbursement for overpayment of a
26 particular claim.¹ At the time the reimbursement request is submitted
27 to the health care provider, the payer shall provide written
28 documentation that identifies the error made by the payer in the
29 processing or payment of the claim that justifies the reimbursement
30 request. No payer shall base a reimbursement request for a particular
31 claim on extrapolation of other claims, except under the following
32 circumstances:

33 (a) in judicial or quasi-judicial proceedings, including arbitration;

34 (b) in administrative proceedings; ¹[or]¹

35 (c) in which relevant records required to be maintained by the
36 health care provider have been improperly altered or reconstructed, or
37 a material number of the relevant records are otherwise unavailable
38 ¹or;

39 (d) in which there is clear evidence of fraud by the health care
40 provider and the payer has investigated the claim in accordance with
41 its fraud prevention plan established pursuant to section 1 of P.L.1993,
42 c.362 (C.17:33A-15), and referred the claim, together with supporting
43 documentation, to the Office of the Insurance Fraud Prosecutor in the
44 Department of Law and Public Safety established pursuant to section
45 32 of P.L.1998, c.21 (C.17:33A-16)¹.

46 (11) (a) In seeking reimbursement for the overpayment from the

1 health care provider, except as provided for in subparagraph (b) of this
 2 paragraph, no payer shall collect or attempt to collect:

3 (i) the funds for the reimbursement on or before the 45th calendar
 4 day following the submission of the reimbursement request to the
 5 health care provider;

6 (ii) the funds for the reimbursement if the health care provider
 7 disputes the request and initiates an appeal on or before the 45th
 8 calendar day following the submission of the reimbursement request
 9 to the health care provider and until the health care provider's rights
 10 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
 11 section are exhausted; ¹or¹

12 (iii) ¹[the funds for the reimbursement request by assessing them
 13 against payment of any future claims submitted by the health care
 14 provider, unless agreed to in writing by the health care provider; or

15 (iv)] a monetary penalty against the reimbursement request,
 16 including but not limited to, an interest charge or¹ a late fee.

17 ¹The payer may collect the funds for the reimbursement request by
 18 assessing them against payment of any future claims submitted by the
 19 health care provider after the 45th calendar day following the
 20 submission of the reimbursement request to the health care provider
 21 or after the health care provider's rights to appeal set forth under
 22 paragraphs (1) and (2) of subsection e. of this section have been
 23 exhausted if the payer submits an explanation in writing to the
 24 provider in sufficient detail so that the provider can reconcile each
 25 covered person's bill.¹

26 (b) If a payer has determined that the overpayment to the health
 27 care provider is a result of fraud committed by the health care provider
 28 and the payer has conducted its investigation and reported the fraud
 29 to the Office of the Insurance Fraud Prosecutor as required by law, the
 30 payer may collect an overpayment by assessing it against payment of
 31 any future claim submitted by the health care provider.

32 (12) No health care provider shall seek reimbursement from a payer
 33 or covered person for underpayment of a claim submitted pursuant to
 34 this section later than ¹[one year] 18 months¹ from the date the first
 35 payment on the claim was made, except if the claim is the subject of
 36 an appeal submitted pursuant to subsection e. of this section or the
 37 claim is subject to continual claims submission. ¹No health care
 38 provider shall seek more than one reimbursement for underpayment of
 39 a particular claim.¹

40 e. (1) A prepaid prescription service organization or its agent,
 41 hereinafter the payer, shall establish an internal appeal mechanism to
 42 resolve any dispute ¹raised by a health care provider regardless of
 43 whether the health care provider is under contract with the payer¹
 44 regarding compliance with the requirements of this section ¹or
 45 compliance with the requirements of sections 4 through 7 of P.L. . . .

46 c. (C. . .) (pending before the Legislature as this bill). No dispute

1 pertaining to medical necessity which is eligible to be submitted to the
2 Independent Health Care Appeals Program established pursuant to
3 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an
4 appeal pursuant to this subsection¹. The payer shall conduct the
5 appeal at no cost to the health care provider.

6 A health care provider may initiate an appeal on or before the 90th
7 calendar day following receipt by the health care provider of the
8 payer's claims determination, which is the basis of the appeal, on a
9 form prescribed by the Commissioner of Banking and Insurance which
10 shall describe the type of substantiating documentation that must be
11 submitted with the form. The payer shall conduct a review of the
12 appeal and notify the health care provider of its determination on or
13 before the ¹[10th] 30th¹ calendar day following the receipt of the
14 appeal form. If the health care provider is not notified of the payer's
15 determination of the appeal within ¹[10] 30¹ days, the health care
16 provider may refer the dispute to arbitration as provided by paragraph
17 (2) of this subsection.

18 If the payer issues a determination in favor of the health care
19 provider, the payer shall comply with the provisions of this section and
20 pay the amount of money in dispute, if applicable, with accrued
21 interest at the rate of ¹[20%] 12%¹ per annum, on or before the 30th
22 calendar day following the notification of the payer's determination on
23 the appeal. ¹Interest shall begin to accrue on the day the appeal was
24 received by the payer.¹

25 If the payer issues a determination against the health care provider,
26 the payer shall notify the health care provider of its findings on or
27 before the ¹[10th] 30th¹ calendar day following the receipt of the
28 appeal form and shall include in the notification written instructions for
29 referring the dispute to arbitration as provided by paragraph (2) of this
30 subsection.

31 The payer shall report annually to the Commissioner of Banking and
32 Insurance the number of appeals it has received and the resolution of
33 each appeal.

34 (2) Any dispute regarding the determination of an internal appeal
35 conducted pursuant to paragraph (1) of this subsection may be
36 referred to arbitration as provided in this paragraph. The
37 Commissioner of Banking and Insurance shall contract with a
38 nationally recognized, independent organization that specializes in
39 arbitration to conduct the arbitration proceedings.

40 Any party may initiate an arbitration proceeding on or before the
41 90th calendar day following the receipt of the determination which is
42 the basis of the appeal, on a form prescribed by the Commissioner of
43 Banking and Insurance. No dispute shall be accepted for arbitration
44 unless the payment amount in dispute is \$1,000 or more, except that
45 ¹[individual] a¹ health care ¹[providers] provider¹ may aggregate
46 ¹[their] his¹ own disputed claim amounts for the purposes of meeting

1 the threshold requirements of this subsection. No dispute pertaining
2 to medical necessity which is eligible to be submitted to the
3 Independent Health Care Appeals Program established pursuant to
4 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
5 arbitration pursuant to this subsection.

6 (3) The arbitrator shall conduct the arbitration proceedings
7 pursuant to the rules of the arbitration entity, including rules of
8 discovery subject to confidentiality requirements established by State
9 or federal law.

10 (4) An arbitrator's determination shall be:

11 (a) signed by the arbitrator;

12 (b) issued in writing, in a form prescribed by the Commissioner of
13 Banking and Insurance, including a statement of the issues in dispute
14 and the findings and conclusions on which the determination is based;
15 and

16 (c) issued on or before the 30th calendar day following the receipt
17 of the required documentation.

18 The arbitration shall be nonappealable and binding on all parties to
19 the dispute.

20 (5) If the arbitrator determines that a payer has withheld or denied
21 payment in violation of the provisions of this section, the arbitrator
22 shall order the payer to make payment of the claim, together with
23 accrued interest, on or before the 10th business day following the
24 issuance of the determination. If the arbitrator determines that a payer
25 has withheld or denied payment on the basis of information submitted
26 by the health care provider and the payer requested, but did not
27 receive, this information from the health care provider when the claim
28 was initially processed pursuant to subsection d. of this section or
29 reviewed under internal appeal pursuant to paragraph (1) of this
30 subsection, the payer shall not be required to pay any accrued interest.

31 ¹[In accordance with regulations adopted by the Commissioner of
32 Banking and Insurance, the cost of the arbitration proceedings,
33 including the payment of reasonable attorney's fees, shall be awarded
34 to the prevailing party.]¹

35 (6) If the arbitrator determines that a health care provider has
36 engaged in a pattern and practice of improper billing and a refund is
37 due to the payer, the arbitrator may award the payer a refund,
38 including interest accrued at the rate of ¹[20%] 12%¹ per annum.
39 ¹Interest shall begin to accrue on the day the appeal was received by
40 the payer for resolution through the internal appeals process
41 established pursuant to paragraph (1) of this subsection.¹

42 (7) The arbitrator shall file a copy of each determination with and
43 in the form prescribed by the Commissioner of Banking and Insurance.

44 f. As used in this ¹[subsection] section¹, "insured claim" or "claim"
45 means a claim by [an enrollee] a covered person for payment of
46 benefits under an insured prepaid prescription service organization

1 contract for which the financial obligation for the payment of a claim
2 under the contract rests upon the prepaid prescription service
3 organization.

4 g. Any person found in violation of this section with a pattern¹ [of
5 frequency] and practice¹ as determined by the Commissioner of
6 Banking and Insurance shall be liable to a civil penalty as set forth in
7 section 17 of P.L. , c. (C.) (pending before the Legislature as
8 this bill).

9 (cf: P.L.1999, c.154, s.10)

10

11 17. a. (New section) The Commissioner of Banking and Insurance
12 shall enforce the provisions of ¹sections 2 through 7 of P.L. , c.
13 (C.) (pending before the Legislature as this bill) and¹ sections 2, 3,
14 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12,
15 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1)
16 as amended by ¹[this act] P.L. , c. (C.) (pending before the
17 Legislature as this bill)¹. A payer found in violation of those sections
18 shall be liable for a civil penalty of ¹[not less than \$250 and] ¹ not
19 ¹[greater] more¹ than \$10,000 for each day that the payer is in
20 violation if reasonable notice in writing is given of the intent to levy
21 the penalty and, at the discretion of the commissioner, the payer has
22 30 days, or such additional time as the commissioner shall determine
23 to be reasonable, to remedy the condition which gave rise to the
24 violation and fails to do so within the time allowed. The penalty shall
25 be collected by the commissioner in the name of the State in a
26 summary proceeding in accordance with the "Penalty Enforcement
27 Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). ¹The
28 commissioner's determination shall be a final agency decision subject
29 to review by the Appellate Division of the Superior Court.¹

30 b. If the Commissioner of Banking and Insurance has reason to
31 believe that a person is engaging in a practice or activity, for the
32 purpose of avoiding or circumventing the legislative intent of sections
33 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12,
34 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1)
35 as amended by ¹[this act] P.L. , c. (C.) (pending before the
36 Legislature as this bill)¹, the Commissioner of Banking and Insurance
37 is authorized to promulgate rules or regulations necessary to prohibit
38 that practice or activity and levy a civil penalty of ¹[not less than \$250
39 and] ¹ not more than \$10,000 for each day that person is in violation
40 of that rule or regulation.

41 c. For the purpose of administering the provisions of ¹sections 2
42 through 7 of P.L. , c. (C.) (pending before the Legislature as
43 this bill) and¹ sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
44 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,
45 26:2J-8.1 and 17:48F-13.1) as amended by ¹[this act] P.L. , c.

1 (C. _____) (pending before the Legislature as this bill)¹, 50% of the
2 penalty monies collected pursuant to ¹[subsection] subsections ¹a.
3 ¹and b.¹ of this section shall be deposited into the General Fund. For
4 the purpose of providing payments to hospitals in accordance with the
5 formula used for the distribution of charity care subsidies that are
6 provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50%
7 of the penalty monies collected pursuant to ¹[subsection] subsections¹
8 a. ¹and b.¹ of this section shall be deposited into the Health Care
9 Subsidy Fund established pursuant to section 8 of P.L.1992, c.160
10 (C.26:2H-18.58).

11 ¹d. A penalty levied pursuant to this section against a payer that
12 does not reserve the right to change the premium shall be credited
13 towards a penalty levied against the payer by the Department of
14 Human Services for the same violation.¹

15

16 ¹18. Section 11 of P.L.1999, c.154 (C.26:1A-15.1) is amended to
17 read as follows:

18 11. The Commissioner of Health and Senior Services, in
19 consultation with the Commissioner of Banking and Insurance, shall
20 establish an advisory board to make recommendations to the
21 commissioners on health information electronic data interchange
22 technology policy , including a Statewide policy on electronic health
23 records, and measures to protect the confidentiality of medical
24 information. The members of the board shall include, at a minimum,
25 representation from health insurance carriers, health care professionals
26 and facilities, higher education, business and organized labor, **[and]**
27 health care consumers and the commissioner of each department in the
28 State that uses individuals' medical records or processes claims for
29 health care services. The members of the board shall serve without
30 compensation but shall be entitled to reimbursement for reasonable
31 expenses incurred in the performance of their duties.¹

32 (cf: P.L.1999, c.154, s.11)

33

34 ¹19. Section 16 of P.L.1999, c.154 (C.17B:30-25) shall be
35 amended to read as follows:

36 16. Thomas A. Edison State College shall study and monitor the
37 effectiveness of electronic data interchange technology and electronic
38 health records in reducing administrative costs, identify means by
39 which new electronic data interchange technology and electronic
40 health records can be implemented to effect health care system cost
41 savings, and determine the extent of electronic data interchange
42 technology and electronic health records use in the State's health care
43 system.

44 The Departments of Health and Senior Services and Banking and
45 Insurance or any other department upon request shall cooperate with
46 and provide assistance to the college in carrying out its study pursuant

1 to this section.

2

3 The college shall report to the Legislature and the Governor from
4 time to time on its findings and recommendations.¹

5 (cf: P.L.1999, c.154, s.16)

6

7 ¹[18.] 20.¹ (New section) The Commissioner of Banking and
8 Insurance shall promulgate rules and regulations pursuant to the
9 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.)
10 necessary to carry out the purposes of this act.

11

12 ¹[19.] 21.¹ (New section) This act shall be liberally construed to
13 effectuate the legislative purposes of the act.

14

15 ¹[20.] 22.¹ This act shall take effect on the 180th day after
16 enactment, but the Commissioner of Banking and Insurance may take
17 such anticipatory administrative action in advance as shall be necessary
18 for the implementation of this act.

19

20

21

22

23 "Health Claims Authorization, Processing and Payment Act."

SENATE, No. 2824

STATE OF NEW JERSEY
211th LEGISLATURE

INTRODUCED NOVEMBER 10, 2005

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator BARBARA BUONO

District 18 (Middlesex)

Co-Sponsored by:

Senator Asselta

SYNOPSIS

"Health Claims Authorization, Processing and Payment Act."

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 12/6/2005)

1 AN ACT concerning health claims and amending and supplementing
2 various parts of the statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. (New section) This act shall be known and may be cited as the
8 "Health Claims Authorization, Processing and Payment Act."

9

10 2. (New section) The Legislature finds and declares that:

11 a. Health care services available under health benefits plans must
12 be promptly provided to covered persons under all circumstances,
13 along with timely reimbursement to hospital and physicians for their
14 services rendered;

15 b. However, confusion still exists among consumers, hospitals,
16 physicians and carriers with respect to time frames for communication
17 of determinations by carriers to deny, reduce or terminate benefits
18 under the provisions of a health benefits plan based upon utilization
19 management decisions;

20 c. Since it is the declared public policy of the State that hospital
21 and related health care services be of the highest quality and
22 demonstrated need and be efficiently provided and properly utilized at
23 a reasonable cost, the hospital care and related health care services
24 must be appropriate to the condition of the patient and payment must
25 be for services that were rendered to the patient;

26 d. Because it is fair and reasonable for hospitals and physicians to
27 receive reimbursement for health care services delivered to covered
28 persons under their health benefits plans and inefficiencies in any area
29 of the health care delivery system reflect poorly on all aspects of the
30 health care delivery system, and because those inefficiencies can harm
31 the consumers of health care, it is appropriate for the Legislature now
32 to establish uniform procedures and guidelines for hospitals, physicians
33 and health insurance carriers to follow in communicating and following
34 utilization management decisions and determinations on behalf of
35 consumers.

36

37 3. (New section) As used in sections 3 through 9 of this act:

38 "Authorization" means a determination required under a health
39 benefits plan, that based on the information provided, satisfies the
40 requirements under the member's health benefits plan for medical
41 necessity.

42 "Carrier" means an insurance company, health service corporation,
43 hospital service corporation, medical service corporation or health

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 maintenance organization authorized to issue health benefits plans in
2 this State.

3 "Commissioner" means the Commissioner of Banking and
4 Insurance.

5 "Covered person" means a person on whose behalf a carrier offering
6 the plan is obligated to pay benefits or provide services pursuant to the
7 health benefits plan.

8 "Covered service" means a health care service provided to a
9 covered person under a health benefits plan for which the carrier is
10 obligated to pay benefits or provide services.

11 "Health benefits plan" means a benefits plan which pays or provides
12 hospital and medical expense benefits for covered services, and is
13 delivered or issued for delivery in this State by or through a carrier.
14 Health benefits plan includes, but is not limited to, Medicare
15 supplement coverage and Medicare+Choice contracts to the extent not
16 otherwise prohibited by federal law. For the purposes of sections 3
17 through 9 of this act, health benefits plan shall not include the
18 following plans, policies or contracts: accident only, credit, disability,
19 long-term care, Civilian Health and Medical Program for the
20 Uniformed Services, CHAMPUS supplement coverage, coverage
21 arising out of a workers' compensation or similar law, automobile
22 medical payment insurance, personal injury protection insurance issued
23 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital
24 confinement indemnity coverage.

25 "Hospital" means a general acute care facility licensed by the
26 Commissioner of Health and Senior Services pursuant to P.L.1971,
27 c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and
28 long-term acute facilities.

29 "Network provider" means a participating hospital or physician
30 under contract or other agreement with a carrier to furnish health care
31 services to covered persons.

32 "Payer" means a carrier which requires that utilization management
33 be performed to authorize the approval of a health care service and
34 includes an organized delivery system that is certified by the
35 Commissioner of Health and Senior Services or licensed by the
36 commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

37 "Payer's agent" or "agent" means an intermediary contracted or
38 affiliated with the payer to provide authorization for service or
39 perform administrative functions including, but not limited to, the
40 payment of claims or the receipt, processing or transfer of claims or
41 claim information.

42 "Physician" means a physician licensed pursuant to Title 45 of the
43 Revised Statutes.

44 "Utilization management" means a system for reviewing the
45 appropriate and efficient allocation of health care services under a
46 health benefits plan according to specified guidelines, in order to

1 recommend or determine whether, or to what extent, a health care
2 service given or proposed to be given to a covered person should or
3 will be reimbursed, covered, paid for, or otherwise provided under the
4 health benefits plan. The system may include, but shall not be limited
5 to: preadmission certification, the application of practice guidelines,
6 continued stay review, discharge planning, preauthorization of
7 ambulatory care procedures and retrospective review.

8

9 4. (New section) a. A payer shall respond to a hospital or
10 physician request for authorization of health care services by either
11 approving or denying the request based on the covered person's health
12 benefits plan. Any denial of a request for authorization or limitation
13 imposed by a payer on a requested service shall be made by a physician
14 under the clinical direction of the medical director who shall be
15 licensed in this State and communicated to the hospital or physician by
16 facsimile, E-mail or any other means of written communication agreed
17 to by the payer and hospital or physician, as follows:

18 (1) in the case of a request for prior authorization for a covered
19 person who will be receiving inpatient hospital services, the payer shall
20 communicate the denial of the request or the limitation imposed on the
21 requested service to the hospital or physician within a time frame
22 appropriate to the medical exigencies of the case but no later than 15
23 days following the time the request was made;

24 (2) in the case of a request for authorization for a covered person
25 who is currently receiving inpatient hospital services or care rendered
26 in the emergency department of a hospital, the payer shall
27 communicate the denial of the request or the limitation imposed on the
28 requested service to the hospital or physician within a time frame
29 appropriate to the medical exigencies of the case but no later than 24
30 hours following the time the request was made;

31 (3) in the case of a request for prior authorization for a covered
32 person who will be receiving health care services in an outpatient or
33 other setting, including, but not limited to, a clinic, rehabilitation
34 facility or nursing home, the payer shall communicate the denial of the
35 request or the limitation imposed on the requested service to the
36 hospital or physician within a time frame appropriate to the medical
37 exigencies of the case but no later than 15 days following the time the
38 request was made; and

39 (4) if the payer requires additional information to approve or deny
40 a request for authorization, the payer shall so notify the hospital or
41 physician by facsimile, E-mail or any other means of written
42 communication agreed to by the payer and hospital or physician within
43 the applicable time frame set forth in paragraphs (1), (2) or (3) of this
44 subsection and shall identify the specific information needed to
45 approve or deny the request for authorization.

1 If the payer is unable to approve or deny a request for authorization
2 within the applicable time frame set forth in paragraphs (1), (2) or (3)
3 of this subsection because of the need for this additional information,
4 the payer shall have an additional period within which to approve or
5 deny the request, as follows:

6 (a) in the case of a request for prior authorization for a covered
7 person who will be receiving inpatient hospital services, within a time
8 frame appropriate to the medical exigencies of the case but no later
9 than 15 days beyond the time of receipt by the payer from the hospital
10 or physician of the additional information that the payer has identified
11 as needed to approve or deny the request for authorization;

12 (b) in the case of a request for authorization for a covered person
13 who is currently receiving inpatient hospital services or care rendered
14 in the emergency department of a hospital, no more than 24 hours
15 beyond the time of receipt by the payer from the hospital or physician
16 of the additional information that the payer has identified as needed to
17 approve or deny the request for authorization; and

18 (c) in the case of a request for authorization for a covered person
19 who will be receiving health care services in another setting, within a
20 time frame appropriate to the medical exigencies of the case but no
21 more than 15 days beyond the time of receipt by the payer from the
22 hospital or physician of the additional information that the payer has
23 identified as needed to approve or deny the request for authorization.

24 b. Payers and hospitals shall have appropriate staff available
25 between the hours of 9 a.m. and 5 p.m., seven days a week, to respond
26 to authorization requests within the time frames established pursuant
27 to subsection a. of this section.

28 c. If a payer fails to respond to an authorization request within the
29 time frames established pursuant to subsection a. of this section, the
30 hospital or physician's request shall be deemed approved and the payer
31 shall be responsible to the hospital or physician for the payment of the
32 covered services delivered pursuant to the hospital or physician's
33 contract with the payer.

34 d. If a hospital or physician fails to respond to a payer's request for
35 additional information necessary to render an authorization decision
36 within 72 hours, the hospital or physician's request for authorization
37 shall be deemed withdrawn.

38
39 5. (New section) a. When a hospital complies with the provisions
40 set forth in section 4 of this act, no payer, or payer's agent, shall deny
41 reimbursement to a hospital for covered services rendered to a covered
42 person on grounds of medical necessity in the absence of fraud or
43 misrepresentation if:

44 (1) the hospital requested authorization from the payer and received
45 approval for the health care services delivered prior to rendering the
46 service;

1 (2) the hospital requested authorization from the payer for the
2 health care services prior to rendering the services and the payer failed
3 to respond to the hospital within the time frames established pursuant
4 to section 4 of this act; or

5 (3) the hospital received authorization for the covered service for
6 a patient who is no longer eligible to receive coverage from that payer
7 and it is determined that the patient is covered by another payer, in
8 which case the subsequent payer, based on the subsequent payer's
9 benefits plan, shall accept the authorization and reimburse the hospital.

10 b. If the hospital or other hospital or physician is a network
11 provider of the payer, health care services shall be reimbursed at the
12 contracted rate for the services provided except as modified by
13 subsection d. of this section.

14 c. No payer, or payer's agent, shall amend a claim by changing the
15 diagnostic code assigned to the services rendered by the hospital or
16 physician without providing written justification.

17 d. If a payer, in consultation with the covered person's hospital or
18 physician has determined that a covered person, who is an inpatient in
19 a hospital, requires medically necessary, post-acute care services, then
20 the payer shall reimburse the hospital at the agreed upon alternate rate
21 for less than acute care services, which such alternate rate shall be
22 negotiated in good faith.

23 In the event that the covered person's physician determines that the
24 covered person should be discharged to an alternate care facility, the
25 payer shall cooperate fully with the hospital in the hospital's discharge
26 planning.

27 If the payer fails to identify an appropriate network provider for a
28 covered person whose health benefits plan is restricted to network
29 providers, it shall only be entitled to reimburse the hospital at the
30 alternate rate for a period of 48 hours. After 48 hours, if a network
31 placement cannot be identified, the payer shall reimburse the hospital
32 at 65% of the contracted acute care rate for each additional day of
33 stay.

34
35 6. (New section) a. A payer, or its agent, shall reimburse a
36 hospital or physician according to the provider contract for all
37 medically necessary emergency and urgent care health care services
38 that are covered under the health benefits plan, including all tests
39 necessary to determine the nature of an illness or injury.

40 b. A payer shall provide each network provider with the source of
41 all commercially produced clinical criteria guidelines as well as a copy
42 of all internally produced clinical criteria guidelines used by the payer
43 or its agent to determine the medical necessity of health care services.
44 These guidelines may be used by the payer only as a screening tool and
45 may not be applied without considering the covered person's individual
46 health care circumstances. The payer or its agent shall notify each

1 network provider in writing of any change that is more restrictive in
2 terms of the covered services in the guidelines at least 30 days prior to
3 implementing the change. Notwithstanding the requirements of this
4 subsection, a payer that discloses its internally produced clinical
5 criteria guidelines to network providers on the payer's website shall be
6 deemed in compliance with the disclosure requirements of this
7 subsection for internally produced clinical criteria guidelines. Any
8 changes to the internally produced guidelines that are more restrictive
9 in terms of covered services shall be clearly noted on the website.

10
11 7. (New section) a. Prior to receiving hospital services, a covered
12 person or a person designated by the covered person may sign a
13 consent form authorizing the hospital, on the covered person's behalf,
14 to appeal a determination by a payer to deny, reduce or terminate a
15 health care benefit or deny payment for a health care service based
16 upon the payer's determination that the health care benefit or service
17 is not medically necessary. An appeal conducted pursuant to this
18 section shall be conducted pursuant to the requirements established in
19 section 11 of P.L.1997, c.192 (C.26:2S-11), provided however, that
20 the hospital shall bear all costs associated with the appeal that are
21 normally paid by the covered person. The consent would be valid for
22 all stages of the payer's informal and formal appeals process and the
23 Independent Health Care Appeals Program established pursuant to
24 section 11 of P.L.1997, c.192 (C.26:2S-11).

25 b. The hospital shall provide notice to the covered person
26 whenever the hospital institutes an appeal of a payer's determination
27 to deny, reduce or terminate a health care benefit or deny payment for
28 a health care service and shall provide additional notice to the covered
29 person each time the hospital continues that appeal to the next stage
30 of the payer's appeal process, including any appeal to an independent
31 utilization review organization pursuant to section 12 of P.L.1997,
32 c.192 (C.26:2S-12). A hospital acting in accordance with the
33 provisions of this subsection shall bear all costs associated with the
34 appeal that are normally paid by the covered person and comply with
35 the requirements established in section 11 of P.L.1997, c.192
36 (C.26:2S-11).

37 c. The covered person shall retain the right to revoke at any time
38 his consent granted pursuant to subsection a. of this section.

39
40 8. (New section) a. A payer shall establish an internal appeal
41 mechanism to resolve any dispute regarding the compliance with the
42 requirements of sections 3 through 6 of this act. The payer shall
43 conduct the appeal at no cost to the hospital or physician.

44 A hospital or physician shall initiate an appeal on a form prescribed
45 by the commissioner which shall describe the type of substantiating
46 documentation that must be submitted with the form. The payer shall

1 conduct a review of the appeal and notify the hospital or physician of
2 its determination on or before the 10th calendar day following the
3 payer's receipt of the appeal form. If the hospital or physician is not
4 notified of the payer's determination of the appeal within 10 days, the
5 hospital or physician may refer the dispute to arbitration as provided
6 by subsection b. of this section.

7 If the payer issues a determination in favor of the hospital or
8 physician, the payer shall comply with the provisions of this section
9 and pay the amount of money in dispute, if applicable, with accrued
10 interest at the rate of 20% per annum, on or before the 30th calendar
11 day following the notification of the payer's determination on the
12 appeal.

13 If the payer issues a determination against the hospital or physician,
14 the payer shall notify the hospital or physician of its findings on or
15 before the 10th calendar day following the receipt of the appeal form
16 and shall include in the notification written instructions for referring
17 the dispute to arbitration as provided by subsection b. of this section.

18 The payer shall report annually to the commissioner the number of
19 appeals it has received and the resolution of each appeal.

20 b. Any dispute regarding the determination of an internal appeal
21 conducted pursuant to subsection a. of this section may be referred to
22 arbitration as provided in this subsection. The commissioner shall
23 enter into contract with a nationally recognized, independent
24 organization that specializes in arbitration to conduct the arbitration
25 proceedings.

26 Any party may initiate an arbitration proceeding on or before the
27 90th calendar day following the receipt of the determination, which is
28 the basis of the appeal, on a form prescribed by the commissioner. No
29 dispute shall be accepted for arbitration unless the payment amount in
30 the dispute is \$1,000 or more, except that disputed amounts may be
31 aggregated for the purposes of meeting the threshold requirements of
32 this subsection. No dispute pertaining to medical necessity which is
33 eligible to be submitted to the Independent Health Care Appeals
34 Program established pursuant to section 11 of P.L.1997, c.192
35 (C.26:2S-11) shall be the subject of arbitration pursuant to this
36 subsection.

37 c. An arbitrator may review any records in connection with the
38 dispute, including the claims file of the payer or of the hospital or
39 physician or the covered person, subject to confidentiality
40 requirements established by State or federal law.

41 d. An arbitrator's determination shall be:

42 (1) signed by the arbitrator;

43 (2) issued in writing, in a form prescribed by the commissioner,
44 including a statement of the issues in dispute and the findings and
45 conclusions on which the determination is based; and

1 (3) issued on or before the 30th calendar day following the receipt
2 of the required documentation.

3 The arbitration shall be nonappealable and binding on all parties to
4 the dispute.

5 e. If the arbitrator determines that a payer has withheld or denied
6 payment in violation of the provisions of this section, the arbitrator
7 shall order the payer to make payment of the claim, together with
8 accrued interest, on or before the 10th business day following the
9 issuance of the determination. In accordance with regulations adopted
10 by the commissioner, the cost of the arbitration proceedings, including
11 the payment of reasonable attorney's fees, shall be awarded to the
12 prevailing party.

13 f. If the arbitrator determines that a health care provider has
14 engaged in a pattern and practice of improper billing and a refund is
15 due to the payer, the arbitrator may award the payer a refund,
16 including interest accrued at the rate of 20% per annum.

17 g. The arbitrator shall file a copy of each determination with and
18 in the form prescribed by the commissioner.

19
20 9. (New section) The commissioner shall enforce the provisions
21 of this act. A payer found in violation of the provisions of this act
22 shall be liable for a civil penalty of not more than \$10,000 for each day
23 that the payer is in violation if reasonable notice in writing is given of
24 the intent to levy the penalty and, at the discretion of the
25 commissioner, the payer has 30 days, or such additional time as the
26 commissioner shall determine to be reasonable, to remedy the
27 condition which gave rise to the violation and fails to do so within the
28 time allowed. The penalty shall be collected by the commissioner in
29 the name of the State in a summary proceeding in accordance with the
30 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
31 seq.).

32
33 10. Section 2 of P.L.1999, c.154 (C.17:48-8.4) is amended to read
34 as follows:

35 2. a. Within 180 days of the adoption of a timetable for
36 implementation pursuant to section 1 of P.L.1999, c.154
37 (C.17B:30-23), a hospital service corporation[,] or its agent or a
38 subsidiary that processes health care benefits claims as a third party
39 administrator, shall demonstrate to the satisfaction of the
40 Commissioner of Banking and Insurance that it will adopt and
41 implement all of the standards to receive and transmit health care
42 transactions electronically, according to the corresponding timetable,
43 and otherwise comply with the provisions of this section, as a
44 condition of its continued authorization to do business in this State.

45 The Commissioner of Banking and Insurance may grant extensions
46 or waivers of the implementation requirement when it has been

1 demonstrated to the commissioner's satisfaction that compliance with
2 the timetable for implementation will result in an undue hardship to a
3 hospital service corporation, its subsidiary or its covered persons.

4 b. Within 12 months of the adoption of regulations establishing
5 standard health care enrollment and claim forms by the Commissioner
6 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
7 (C.17B:30-23), a hospital service corporation or a subsidiary that
8 processes health care benefits claims as a third party administrator
9 shall use the standard health care enrollment and claim forms in
10 connection with all group and individual contracts issued, delivered,
11 executed or renewed in this State.

12 c. Twelve months after the adoption of regulations establishing
13 standard health care enrollment and claim forms by the Commissioner
14 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
15 (C.17B:30-23), a hospital service corporation shall require that health
16 care providers file all claims for payment for health care services. A
17 covered person who receives health care services shall not be required
18 to submit a claim for payment, but notwithstanding the provisions of
19 this subsection to the contrary, a covered person shall be permitted to
20 submit a claim on his own behalf, at the covered person's option. All
21 claims shall be filed using the standard health care claim form
22 applicable to the contract.

23 d. (1) Effective 180 days after the effective date of P.L.1999,
24 c.154, a hospital service corporation or its agent, hereinafter the payer,
25 shall remit payment for every insured claim submitted by a [subscriber
26 or that subscriber's agent or assignee if the contract provides for
27 assignment of benefits] covered person or health care provider, no
28 later than the 30th calendar day following receipt of the claim by the
29 payer or no later than the time limit established for the payment of
30 claims in the Medicare program pursuant to
31 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
32 submitted by electronic means, and no later than the 40th calendar day
33 following receipt if the claim is submitted by other than electronic
34 means, if:

35 (a) [the claim is an eligible claim for a health care service provided
36 by an eligible health care provider to a covered person under the
37 contract;

38 (b) the claim has no material defect or impropriety, including, but
39 not limited to, any lack of required substantiating documentation or
40 incorrect coding;

41 (c) there is no dispute regarding the amount claimed;] the health
42 care provider is eligible at the date of service;

43 (b) the person who received the health care service was covered on
44 the date of service;

45 (c) the claim is for a service or supply covered under the health
46 benefits plan;

1 (d) the claim is submitted with all the information requested by the
2 payer on the claim form or in other instructions distributed in advance
3 to the health care provider or covered person within 120 days of the
4 date of service; and

5 ~~[(d)]~~ (e) the payer has no reason to believe that the claim has been
6 submitted fraudulently]; and

7 (e) the claim requires no special treatment that prevents timely
8 payments from being made on the claim under the terms of the
9 contract].

10 (2) If all or a portion of the claim is denied by the payer because:

11 (a) ~~the claim is an ineligible claim;~~

12 ~~(b)]~~ (b) the claim submission is incomplete because the required
13 substantiating documentation, which is specific to the health care
14 service provided to the covered person, has not been submitted to the
15 payer;

16 ~~(c)]~~ (b) the diagnosis coding, procedure coding, or any other
17 required information to be submitted with the claim is incorrect; or

18 ~~(d)]~~ (c) the payer disputes the amount claimed]; or

19 (e) the claim requires special treatment that prevents timely
20 payments from being made on the claim under the terms of the
21 contract],

22 the payer shall notify the ~~subscriber, or that subscriber's agent or~~
23 assignee if the contract provides for assignment of benefits covered
24 person and health care provider, in writing or by electronic means, as
25 appropriate, within 30 days, of the following: if all or a portion of the
26 claim is denied, all the reasons for the denial; if the claim lacks the
27 required substantiating documentation[, including] or contains
28 incorrect coding, a statement as to what substantiating documentation,
29 specific to the health care service provided to the covered person, or
30 other information, is required to complete adjudication of the claim;
31 and if the amount of the claim is disputed, a statement that it is
32 disputed]; and if the claim requires special treatment that prevents
33 timely payments from being made, a statement of the special treatment
34 to which the claim is subject].

35 (3) If all or a portion of a claim cannot be entered into the claims
36 processing system for any of the following reasons:

37 (a) the health care provider is not eligible at the time of service;

38 (b) the person who received the health care service was not a
39 covered person at the time of service;

40 (c) the premium was not paid by or on the behalf of the covered
41 person; or

42 (d) the diagnosis coding, procedure coding or any other data
43 required to be submitted with the claim was missing.

44 the payer shall notify the covered person and health care provider
45 within seven days if the claim was submitted by electronic means, or

1 within 14 days if the claim was submitted by other than electronic
2 means, of that determination of denial, of all the reasons for the denial
3 or any information required to complete adjudication of the claim.

4 (4) Any portion of a claim that meets the criteria established in
5 paragraph (1) of this subsection shall be paid by the payer in
6 accordance with the time limit established in paragraph (1) of this
7 subsection.

8 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
9 by electronic means from a health care provider or [subscriber]
10 covered person, no later than two working days following receipt of
11 the transmission of the claim.

12 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
13 (C.17:33A-1 et seq.) has reason to believe that a claim has been
14 submitted fraudulently, it shall investigate the claim in accordance with
15 its fraud prevention plan established pursuant to section 1 of P.L.1993,
16 c.362 (C.17:33A-15), or refer the claim, together with supporting
17 documentation, to the Office of the Insurance Fraud Prosecutor in the
18 Department of Law and Public Safety established pursuant to section
19 32 of P.L.1998, c.21 (C.17:33A-16).

20 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
21 and [(3)] (4) of this subsection shall be deemed to be overdue if not
22 remitted to the claimant or his agent by the payer on or before the 30th
23 calendar day or the time limit established by the Medicare program,
24 whichever is earlier, following receipt by the payer of a claim
25 submitted by electronic means and on or before the 40th calendar day
26 following receipt of a claim submitted by other than electronic means.

27 In the event payment is withheld on all or a portion of a claim by a
28 payer pursuant to subparagraph [(b)] (a) of paragraph (2) or
29 subparagraph (d) of paragraph (3) of this subsection, the claims
30 payment shall be overdue if not remitted to the claimant or his agent
31 by the payer on or before the [(30th)] 15th calendar day or the time
32 limit established by the Medicare program, whichever is earlier, for
33 claims submitted by electronic means and the [(40th)] 25th calendar day
34 for claims submitted by other than electronic means, following receipt
35 by the payer of the required documentation or information or
36 modification of an initial submission.

37 (8) (a) No payer shall deny payment on all or a portion of a claim
38 because the payer requests documentation or information that is not
39 specific to the health care service provided to the covered person.

40 (b) No payer shall deny payment on all or a portion of a claim while
41 seeking coordination of benefits information unless good cause exists
42 for the payer to believe that other insurance is available to the covered
43 person. Good cause shall exist only if the payer's records indicate that
44 other coverage exists. Routine requests to determine whether
45 coordination of benefits exists shall not be considered good cause.

1 (c) In the event payment is withheld on all or a portion of a claim
2 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
3 claims payment shall be deemed to be overdue if not remitted to the
4 claimant or his agent by the payer on or before the 30th calendar day
5 or the time limit established by the Medicare program, whichever is
6 earlier, following receipt by the payer of a claim submitted by
7 electronic means or on or before the 40th calendar day following
8 receipt of a claim submitted by other than electronic means.

9 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
10 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
11 care provider at the time the overdue payment is made.

12 (10) With the exception of claims that were submitted fraudulently
13 or submitted by health care providers that have a pattern of
14 inappropriate billing or claims that were subject to coordination of
15 benefits, no payer shall seek reimbursement for overpayment of a claim
16 previously paid pursuant to this section later than one year after the
17 date the first payment on the claim was made. At the time the
18 reimbursement request is submitted to the health care provider, the
19 payer shall provide written documentation that identifies the error
20 made by the payer in the processing or payment of the claim that
21 justifies the reimbursement request. No payer shall base a
22 reimbursement request for a particular claim on extrapolation of other
23 claims, except under the following circumstances:

24 (a) in judicial or quasi-judicial proceedings, including arbitration;

25 (b) in administrative proceedings; or

26 (c) in which relevant records required to be maintained by the
27 health care provider have been improperly altered or reconstructed, or
28 a material number of the relevant records are otherwise unavailable.

29 (11) (a) In seeking reimbursement for the overpayment from the
30 health care provider, except as provided for in subparagraph (b) of this
31 paragraph, no payer shall collect or attempt to collect:

32 (i) the funds for the reimbursement on or before the 45th calendar
33 day following the submission of the reimbursement request to the
34 health care provider;

35 (ii) the funds for the reimbursement if the health care provider
36 disputes the request and initiates an appeal on or before the 45th
37 calendar day following the submission of the reimbursement request
38 to the health care provider and until the health care provider's rights
39 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
40 section are exhausted;

41 (iii) the funds for the reimbursement request by assessing them
42 against payment of any future claims submitted by the health care
43 provider, unless agreed to in writing by the health care provider; or

44 (iv) a late fee.

45 (b) If a payer has determined that the overpayment to the health
46 care provider is a result of fraud committed by the health care provider

1 and the payer has conducted its investigation and reported the fraud
2 to the Office of the Insurance Fraud Prosecutor as required by law, the
3 payer may collect an overpayment by assessing it against payment of
4 any future claim submitted by the health care provider.

5 (12) No health care provider shall seek reimbursement from a payer
6 or covered person for underpayment of a claim submitted pursuant to
7 this section later than one year from the date the first payment on the
8 claim was made, except if the claim is the subject of an appeal
9 submitted pursuant to subsection e. of this section or the claim is
10 subject to continual claims submission.

11 e. (1) A hospital service corporation or its agent, hereinafter the
12 payer, shall establish an internal appeal mechanism to resolve any
13 dispute regarding compliance with the requirements of this section.
14 The payer shall conduct the appeal at no cost to the health care
15 provider.

16 A health care provider may initiate an appeal on or before the 90th
17 calendar day following receipt by the health care provider of the
18 payer's claims determination, which is the basis of the appeal, on a
19 form prescribed by the Commissioner of Banking and Insurance which
20 shall describe the type of substantiating documentation that must be
21 submitted with the form. The payer shall conduct a review of the
22 appeal and notify the health care provider of its determination on or
23 before the 10th calendar day following the receipt of the appeal form.
24 If the health care provider is not notified of the payer's determination
25 of the appeal within 10 days, the health care provider may refer the
26 dispute to arbitration as provided by paragraph (2) of this subsection.

27 If the payer issues a determination in favor of the health care
28 provider, the payer shall comply with the provisions of this section and
29 pay the amount of money in dispute, if applicable, with accrued
30 interest at the rate of 20% per annum, on or before the 30th calendar
31 day following the notification of the payer's determination on the
32 appeal.

33 If the payer issues a determination against the health care provider,
34 the payer shall notify the health care provider of its findings on or
35 before the 10th calendar day following the receipt of the appeal form
36 and shall include in the notification written instructions for referring
37 the dispute to arbitration as provided by paragraph (2) of this
38 subsection.

39 The payer shall report annually to the Commissioner of Banking and
40 Insurance the number of appeals it has received and the resolution of
41 each appeal.

42 (2) Any dispute regarding the determination of an internal appeal
43 conducted pursuant to paragraph (1) of this subsection may be
44 referred to arbitration as provided in this paragraph. The
45 Commissioner of Banking and Insurance shall contract with a

1 nationally recognized, independent organization that specializes in
2 arbitration to conduct the arbitration proceedings.

3 Any party may initiate an arbitration proceeding on or before the
4 90th calendar day following the receipt of the determination which is
5 the basis of the appeal, on a form prescribed by the Commissioner of
6 Banking and Insurance. No dispute shall be accepted for arbitration
7 unless the payment amount in dispute is \$1,000 or more, except that
8 individual health care providers may aggregate their own disputed
9 claim amounts for the purposes of meeting the threshold requirements
10 of this subsection. No dispute pertaining to medical necessity which
11 is eligible to be submitted to the Independent Health Care Appeals
12 Program established pursuant to section 11 of P.L.1997, c.192
13 (C.26:2S-11) shall be the subject of arbitration pursuant to this
14 subsection.

15 (3) The arbitrator shall conduct the arbitration proceedings
16 pursuant to the rules of the arbitration entity, including rules of
17 discovery subject to confidentiality requirements established by State
18 or federal law.

19 (4) An arbitrator's determination shall be:

20 (a) signed by the arbitrator;

21 (b) issued in writing, in a form prescribed by the Commissioner of
22 Banking and Insurance, including a statement of the issues in dispute
23 and the findings and conclusions on which the determination is based;
24 and

25 (c) issued on or before the 30th calendar day following the receipt
26 of the required documentation.

27 The arbitration shall be nonappealable and binding on all parties to
28 the dispute.

29 (5) If the arbitrator determines that a payer has withheld or denied
30 payment in violation of the provisions of this section, the arbitrator
31 shall order the payer to make payment of the claim, together with
32 accrued interest, on or before the 10th business day following the
33 issuance of the determination. If the arbitrator determines that a payer
34 has withheld or denied payment on the basis of information submitted
35 by the health care provider and the payer requested, but did not
36 receive, this information from the health care provider when the claim
37 was initially processed pursuant to subsection d. of this section or
38 reviewed under internal appeal pursuant to paragraph (1) of this
39 subsection, the payer shall not be required to pay any accrued interest.
40 In accordance with regulations adopted by the Commissioner of
41 Banking and Insurance, the cost of the arbitration proceedings,
42 including the payment of reasonable attorney's fees, shall be awarded
43 to the prevailing party.

44 (6) If the arbitrator determines that a health care provider has
45 engaged in a pattern and practice of improper billing and a refund is

1 due to the payer, the arbitrator may award the payer a refund,
2 including interest accrued at the rate of 20% per annum.

3 (7) The arbitrator shall file a copy of each determination with and
4 in the form prescribed by the Commissioner of Banking and Insurance.

5 f. As used in this subsection, "insured claim" or "claim" means a
6 claim by a [subscriber] covered person for payment of benefits under
7 an insured hospital service corporation contract for which the financial
8 obligation for the payment of a claim under the contract rests upon the
9 hospital service corporation.

10 g. Any person found in violation of this section with a pattern of
11 frequency as determined by the Commissioner of Banking and
12 Insurance shall be liable to a civil penalty as set forth in section 17 of
13 P.L. , c. (C.) (now before the Legislature as this bill).

14 (cf: P.L.1999, c.154, s.2)

15

16 11. Section 3 of P.L.1999, c.154 (C.17:48A-7.12) is amended to
17 read as follows:

18 3. a. Within 180 days of the adoption of a timetable for
19 implementation pursuant to section 1 of P.L.1999, c.154
20 (C.17B:30-23), a medical service corporation[,] or its agent or a
21 subsidiary that processes health care benefits claims as a third party
22 administrator, shall demonstrate to the satisfaction of the
23 Commissioner of Banking and Insurance that it will adopt and
24 implement all of the standards to receive and transmit health care
25 transactions electronically, according to the corresponding timetable,
26 and otherwise comply with the provisions of this section, as a
27 condition of its continued authorization to do business in this State.

28 The Commissioner of Banking and Insurance may grant extensions
29 or waivers of the implementation requirement when it has been
30 demonstrated to the commissioner's satisfaction that compliance with
31 the timetable for implementation will result in an undue hardship to a
32 medical service corporation, its subsidiary or its covered persons.

33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
36 (C.17B:30-23), a medical service corporation or a subsidiary that
37 processes health care benefits claims as a third party administrator
38 shall use the standard health care enrollment and claim forms in
39 connection with all group and individual contracts issued, delivered,
40 executed or renewed in this State.

41 c. Twelve months after the adoption of regulations establishing
42 standard health care enrollment and claim forms by the Commissioner
43 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
44 (C.17B:30-23), a medical service corporation shall require that health
45 care providers file all claims for payment for health care services. A
46 covered person who receives health care services shall not be required

1 to submit a claim for payment, but notwithstanding the provisions of
2 this subsection to the contrary, a covered person shall be permitted to
3 submit a claim on his own behalf, at the covered person's option. All
4 claims shall be filed using the standard health care claim form
5 applicable to the contract.

6 d. (1) Effective 180 days after the effective date of P.L.1999,
7 c.154, a medical service corporation or its agent, hereinafter the payer,
8 shall remit payment for every insured claim submitted by a [subscriber
9 or that subscriber's agent or assignee if the contract provides for
10 assignment of benefits] covered person or health care provider, no
11 later than the 30th calendar day following receipt of the claim by the
12 payer or no later than the time limit established for the payment of
13 claims in the Medicare program pursuant to
14 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
15 submitted by electronic means, and no later than the 40th calendar day
16 following receipt if the claim is submitted by other than electronic
17 means, if:

18 (a) [the claim is an eligible claim for a health care service provided
19 by an eligible health care provider to a covered person under the
20 contract;

21 (b) the claim has no material defect or impropriety, including, but
22 not limited to, any lack of required substantiating documentation or
23 incorrect coding;

24 (c) there is no dispute regarding the amount claimed;] the health
25 care provider is eligible at the date of service;

26 (b) the person who received the health care service was covered on
27 the date of service;

28 (c) the claim is for a service or supply covered under the health
29 benefits plan;

30 (d) the claim is submitted with all the information requested by the
31 payer on the claim form or in other instructions distributed in advance
32 to the health care provider or covered person within 120 days of the
33 date of service; and

34 [(d)] (e) the payer has no reason to believe that the claim has been
35 submitted fraudulently[; and

36 (e) the claim requires no special treatment that prevents timely
37 payments from being made on the claim under the terms of the
38 contract].

39 (2) If all or a portion of the claim is denied by the payer because:

40 (a) [the claim is an ineligible claim;

41 (b)] the claim submission is incomplete because the required
42 substantiating documentation, which is specific to the health care
43 service provided to the covered person, has not been submitted to the
44 payer;

45 [(c)] (b) the diagnosis coding, procedure coding, or any other
46 required information to be submitted with the claim is incorrect; or

1 [(d)] (c) the payer disputes the amount claimed[; or
2 (e) the claim requires special treatment that prevents timely
3 payments from being made on the claim under the terms of the
4 contract],
5 the payer shall notify the [subscriber, or that subscriber's agent or
6 assignee if the contract provides for assignment of benefits] covered
7 person and health care provider, in writing or by electronic means, as
8 appropriate, within 30 days, of the following: if all or a portion of the
9 claim is denied, all the reasons for the denial; if the claim lacks the
10 required substantiating documentation[, including] or contains
11 incorrect coding, a statement as to what substantiating documentation,
12 specific to the health care service provided to the covered person, or
13 other information, is required to complete adjudication of the claim;
14 and if the amount of the claim is disputed, a statement that it is
15 disputed[; and if the claim requires special treatment that prevents
16 timely payments from being made, a statement of the special treatment
17 to which the claim is subject].

18 (3) If all or a portion of a claim cannot be entered into the claims
19 processing system for any of the following reasons:
20 (a) the health care provider is not eligible at the time of service;
21 (b) the person who received the health care service was not a
22 covered person at the time of service;
23 (c) the premium was not paid by or on the behalf of the covered
24 person; or
25 (d) the diagnosis coding, procedure coding or any other data
26 required to be submitted with the claim was missing.
27 the payer shall notify the covered person and health care provider
28 within seven days if the claim was submitted by electronic means, or
29 within 14 days if the claim was submitted by other than electronic
30 means, of that determination of denial, of all the reasons for the denial
31 or any information required to complete adjudication of the claim.

32 (4) Any portion of a claim that meets the criteria established in
33 paragraph (1) of this subsection shall be paid by the payer in
34 accordance with the time limit established in paragraph (1) of this
35 subsection.

36 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
37 by electronic means from a health care provider or [subscriber]
38 covered person, no later than two working days following receipt of
39 the transmission of the claim.

40 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
41 (C.17:33A-1 et seq.) has reason to believe that a claim has been
42 submitted fraudulently, it shall investigate the claim in accordance with
43 its fraud prevention plan established pursuant to section 1 of P.L.1993,
44 c.362 (C.17:33A-15), or refer the claim, together with supporting
45 documentation, to the Office of the Insurance Fraud Prosecutor in the

1 Department of Law and Public Safety established pursuant to section
2 32 of P.L.1998, c.21 (C.17:33A-16).

3 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
4 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
5 remitted to the claimant or his agent by the payer on or before the 30th
6 calendar day or the time limit established by the Medicare program,
7 whichever is earlier, following receipt by the payer of a claim
8 submitted by electronic means and on or before the 40th calendar day
9 following receipt of a claim submitted by other than electronic means.

10 In the event payment is withheld on all or a portion of a claim by a
11 payer pursuant to subparagraph ~~[(b)]~~ (a) of paragraph (2) or
12 subparagraph (d) of paragraph (3) of this subsection, the claims
13 payment shall be overdue if not remitted to the claimant or his agent
14 by the payer on or before the ~~[30th]~~ 15th calendar day or the time
15 limit established by the Medicare program, whichever is earlier, for
16 claims submitted by electronic means and the ~~[40th]~~ 25th calendar day
17 for claims submitted by other than electronic means, following receipt
18 by the payer of the required documentation or information or
19 modification of an initial submission.

20 (8) (a) No payer shall deny payment on all or a portion of a claim
21 because the payer requests documentation or information that is not
22 specific to the health care service provided to the covered person.

23 (b) No payer shall deny payment on all or a portion of a claim while
24 seeking coordination of benefits information unless good cause exists
25 for the payer to believe that other insurance is available to the covered
26 person. Good cause shall exist only if the payer's records indicate that
27 other coverage exists. Routine requests to determine whether
28 coordination of benefits exists shall not be considered good cause.

29 (c) In the event payment is withheld on all or a portion of a claim
30 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
31 claims payment shall be deemed to be overdue if not remitted to the
32 claimant or his agent by the payer on or before the 30th calendar day
33 or the time limit established by the Medicare program, whichever is
34 earlier, following receipt by the payer of a claim submitted by
35 electronic means or on or before the 40th calendar day following
36 receipt of a claim submitted by other than electronic means.

37 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
38 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
39 care provider at the time the overdue payment is made.

40 (10) With the exception of claims that were submitted fraudulently
41 or submitted by health care providers that have a pattern of
42 inappropriate billing or claims that were subject to coordination of
43 benefits, no payer shall seek reimbursement for overpayment of a claim
44 previously paid pursuant to this section later than one year after the
45 date the first payment on the claim was made. At the time the
46 reimbursement request is submitted to the health care provider, the

1 payer shall provide written documentation that identifies the error
2 made by the payer in the processing or payment of the claim that
3 justifies the reimbursement request. No payer shall base a
4 reimbursement request for a particular claim on extrapolation of other
5 claims, except under the following circumstances:

6 (a) in judicial or quasi-judicial proceedings, including arbitration;

7 (b) in administrative proceedings; or

8 (c) in which relevant records required to be maintained by the
9 health care provider have been improperly altered or reconstructed, or
10 a material number of the relevant records are otherwise unavailable.

11 (11) (a) In seeking reimbursement for the overpayment from the
12 health care provider, except as provided for in subparagraph (b) of this
13 paragraph, no payer shall collect or attempt to collect:

14 (i) the funds for the reimbursement on or before the 45th calendar
15 day following the submission of the reimbursement request to the
16 health care provider;

17 (ii) the funds for the reimbursement if the health care provider
18 disputes the request and initiates an appeal on or before the 45th
19 calendar day following the submission of the reimbursement request
20 to the health care provider and until the health care provider's rights
21 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
22 section are exhausted;

23 (iii) the funds for the reimbursement request by assessing them
24 against payment of any future claims submitted by the health care
25 provider, unless agreed to in writing by the health care provider; or

26 (iv) a late fee.

27 (b) If a payer has determined that the overpayment to the health
28 care provider is a result of fraud committed by the health care provider
29 and the payer has conducted its investigation and reported the fraud
30 to the Office of the Insurance Fraud Prosecutor as required by law, the
31 payer may collect an overpayment by assessing it against payment of
32 any future claim submitted by the health care provider.

33 (12) No health care provider shall seek reimbursement from a payer
34 or covered person for underpayment of a claim submitted pursuant to
35 this section later than one year from the date the first payment on the
36 claim was made, except if the claim is the subject of an appeal
37 submitted pursuant to subsection e. of this section or the claim is
38 subject to continual claims submission.

39 e. (1) A medical service corporation or its agent, hereinafter the
40 payer, shall establish an internal appeal mechanism to resolve any
41 dispute regarding compliance with the requirements of this section.
42 The payer shall conduct the appeal at no cost to the health care
43 provider.

44 A health care provider may initiate an appeal on or before the 90th
45 calendar day following receipt by the health care provider of the
46 payer's claims determination, which is the basis of the appeal, on a

1 form prescribed by the Commissioner of Banking and Insurance which
2 shall describe the type of substantiating documentation that must be
3 submitted with the form. The payer shall conduct a review of the
4 appeal and notify the health care provider of its determination on or
5 before the 10th calendar day following the receipt of the appeal form.
6 If the health care provider is not notified of the payer's determination
7 of the appeal within 10 days, the health care provider may refer the
8 dispute to arbitration as provided by paragraph (2) of this subsection.

9 If the payer issues a determination in favor of the health care
10 provider, the payer shall comply with the provisions of this section and
11 pay the amount of money in dispute, if applicable, with accrued
12 interest at the rate of 20% per annum, on or before the 30th calendar
13 day following the notification of the payer's determination on the
14 appeal.

15 If the payer issues a determination against the health care provider,
16 the payer shall notify the health care provider of its findings on or
17 before the 10th calendar day following the receipt of the appeal form
18 and shall include in the notification written instructions for referring
19 the dispute to arbitration as provided by paragraph (2) of this
20 subsection.

21 The payer shall report annually to the Commissioner of Banking and
22 Insurance the number of appeals it has received and the resolution of
23 each appeal.

24 (2) Any dispute regarding the determination of an internal appeal
25 conducted pursuant to paragraph (1) of this subsection may be
26 referred to arbitration as provided in this paragraph. The
27 Commissioner of Banking and Insurance shall contract with a
28 nationally recognized, independent organization that specializes in
29 arbitration to conduct the arbitration proceedings.

30 Any party may initiate an arbitration proceeding on or before the
31 90th calendar day following the receipt of the determination which is
32 the basis of the appeal, on a form prescribed by the Commissioner of
33 Banking and Insurance. No dispute shall be accepted for arbitration
34 unless the payment amount in dispute is \$1,000 or more, except that
35 individual health care providers may aggregate their own disputed
36 claim amounts for the purposes of meeting the threshold requirements
37 of this subsection. No dispute pertaining to medical necessity which
38 is eligible to be submitted to the Independent Health Care Appeals
39 Program established pursuant to section 11 of P.L.1997, c.192
40 (C.26:2S-11) shall be the subject of arbitration pursuant to this
41 subsection.

42 (3) The arbitrator shall conduct the arbitration proceedings
43 pursuant to the rules of the arbitration entity, including rules of
44 discovery subject to confidentiality requirements established by State
45 or federal law.

46 (4) An arbitrator's determination shall be:

1 (a) signed by the arbitrator;

2 (b) issued in writing, in a form prescribed by the Commissioner of
3 Banking and Insurance, including a statement of the issues in dispute
4 and the findings and conclusions on which the determination is based;
5 and

6 (c) issued on or before the 30th calendar day following the receipt
7 of the required documentation.

8 The arbitration shall be nonappealable and binding on all parties to
9 the dispute.

10 (5) If the arbitrator determines that a payer has withheld or denied
11 payment in violation of the provisions of this section, the arbitrator
12 shall order the payer to make payment of the claim, together with
13 accrued interest, on or before the 10th business day following the
14 issuance of the determination. If the arbitrator determines that a payer
15 has withheld or denied payment on the basis of information submitted
16 by the health care provider and the payer requested, but did not
17 receive, this information from the health care provider when the claim
18 was initially processed pursuant to subsection d. of this section or
19 reviewed under internal appeal pursuant to paragraph (1) of this
20 subsection, the payer shall not be required to pay any accrued interest.
21 In accordance with regulations adopted by the Commissioner of
22 Banking and Insurance, the cost of the arbitration proceedings,
23 including the payment of reasonable attorney's fees, shall be awarded
24 to the prevailing party.

25 (6) If the arbitrator determines that a health care provider has
26 engaged in a pattern and practice of improper billing and a refund is
27 due to the payer, the arbitrator may award the payer a refund,
28 including interest accrued at the rate of 20% per annum.

29 (7) The arbitrator shall file a copy of each determination with and
30 in the form prescribed by the Commissioner of Banking and Insurance.

31 f. As used in this subsection, "insured claim" or "claim" means a
32 claim by a [subscriber] covered person for payment of benefits under
33 an insured medical service corporation contract for which the financial
34 obligation for the payment of a claim under the contract rests upon the
35 medical service corporation.

36 g. Any person found in violation of this section with a pattern of
37 frequency as determined by the Commissioner of Banking and
38 Insurance shall be liable to a civil penalty as set forth in section 17 of
39 P.L. , c. (C.) (now before the Legislature as this bill).

40 (cf: P.L.1999, c.154, s.3)

41

42 12. Section 4 of P.L.1999, c.154 (C.17:48E-10.1) is amended to
43 read as follows:

44 4. a. Within 180 days of the adoption of a timetable for
45 implementation pursuant to section 1 of P.L.1999, c.154
46 (C.17B:30-23), a health service corporation[,] or its agent or a

1 subsidiary that processes health care benefits claims as a third party
2 administrator, shall demonstrate to the satisfaction of the
3 Commissioner of Banking and Insurance that it will adopt and
4 implement all of the standards to receive and transmit health care
5 transactions electronically, according to the corresponding timetable,
6 and otherwise comply with the provisions of this section, as a
7 condition of its continued authorization to do business in this State.

8 The Commissioner of Banking and Insurance may grant extensions
9 or waivers of the implementation requirement when it has been
10 demonstrated to the commissioner's satisfaction that compliance with
11 the timetable for implementation will result in an undue hardship to a
12 health service corporation, its subsidiary or its covered persons.

13 b. Within 12 months of the adoption of regulations establishing
14 standard health care enrollment and claim forms by the Commissioner
15 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
16 (C.17B:30-23), a health service corporation or a subsidiary that
17 processes health care benefits claims as a third party administrator
18 shall use the standard health care enrollment and claim forms in
19 connection with all group and individual contracts issued, delivered,
20 executed or renewed in this State.

21 c. Twelve months after the adoption of regulations establishing
22 standard health care enrollment and claim forms by the Commissioner
23 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
24 (C.17B:30-23), a health service corporation shall require that health
25 care providers file all claims for payment for health care services. A
26 covered person who receives health care services shall not be required
27 to submit a claim for payment, but notwithstanding the provisions of
28 this subsection to the contrary, a covered person shall be permitted to
29 submit a claim on his own behalf, at the covered person's option. All
30 claims shall be filed using the standard health care claim form
31 applicable to the contract.

32 d. (1) Effective 180 days after the effective date of P.L.1999,
33 c.154, a health service corporation or its agent, hereinafter the payer,
34 shall remit payment for every insured claim submitted by a [subscriber
35 or that subscriber's agent or assignee if the contract provides for
36 assignment of benefits] covered person or health care provider, no
37 later than the 30th calendar day following receipt of the claim by the
38 payer or no later than the time limit established for the payment of
39 claims in the Medicare program pursuant to
40 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
41 submitted by electronic means, and no later than the 40th calendar day
42 following receipt if the claim is submitted by other than electronic
43 means, if:

44 (a) [the claim is an eligible claim for a health care service provided
45 by an eligible health care provider to a covered person under the
46 contract;

1 (b) the claim has no material defect or impropriety, including, but
2 not limited to, any lack of required substantiating documentation or
3 incorrect coding;

4 (c) there is no dispute regarding the amount claimed;] the health
5 care provider is eligible at the date of service;

6 (b) the person who received the health care service was covered on
7 the date of service;

8 (c) the claim is for a service or supply covered under the health
9 benefits plan;

10 (d) the claim is submitted with all the information requested by the
11 payer on the claim form or in other instructions distributed in advance
12 to the health care provider or covered person within 120 days of the
13 date of service; and

14 [(d)] (e) the payer has no reason to believe that the claim has been
15 submitted fraudulently[; and

16 (e) the claim requires no special treatment that prevents timely
17 payments from being made on the claim under the terms of the
18 contract].

19 (2) If all or a portion of the claim is denied by the payer because:

20 (a) [the claim is an ineligible claim;

21 (b)] the claim submission is incomplete because the required
22 substantiating documentation, which is specific to the health care
23 service provided to the covered person, has not been submitted to the
24 payer;

25 [(c)] (b) the diagnosis coding, procedure coding, or any other
26 required information to be submitted with the claim is incorrect; or

27 [(d)] (c) the payer disputes the amount claimed[; or

28 (e) the claim requires special treatment that prevents timely
29 payments from being made on the claim under the terms of the
30 contract],

31 the payer shall notify the [subscriber, or that subscriber's agent or
32 assignee if the contract provides for assignment of benefits] covered
33 person and health care provider, in writing or by electronic means, as
34 appropriate, within 30 days, of the following: if all or a portion of the
35 claim is denied, all the reasons for the denial; if the claim lacks the
36 required substantiating documentation[, including] or contains
37 incorrect coding, a statement as to what substantiating documentation,
38 specific to the health care service provided to the covered person, or
39 other information, is required to complete adjudication of the claim;
40 and if the amount of the claim is disputed, a statement that it is
41 disputed[; and if the claim requires special treatment that prevents
42 timely payments from being made, a statement of the special treatment
43 to which the claim is subject].

44 (3) If all or a portion of a claim cannot be entered into the claims
45 processing system for any of the following reasons:

1 (a) the health care provider is not eligible at the time of service;

2 (b) the person who received the health care service was not a
3 covered person at the time of service;

4 (c) the premium was not paid by or on the behalf of the covered
5 person; or

6 (d) the diagnosis coding, procedure coding or any other data
7 required to be submitted with the claim was missing.

8 the payer shall notify the covered person and health care provider
9 within seven days if the claim was submitted by electronic means, or
10 within 14 days if the claim was submitted by other than electronic
11 means, of that determination of denial, of all the reasons for the denial
12 or any information required to complete adjudication of the claim.

13 (4) Any portion of a claim that meets the criteria established in
14 paragraph (1) of this subsection shall be paid by the payer in
15 accordance with the time limit established in paragraph (1) of this
16 subsection.

17 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
18 by electronic means from a health care provider or [subscriber]
19 covered person, no later than two working days following receipt of
20 the transmission of the claim.

21 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
22 (C.17:33A-1 et seq.) has reason to believe that a claim has been
23 submitted fraudulently, it shall investigate the claim in accordance with
24 its fraud prevention plan established pursuant to section 1 of P.L.1993,
25 c.362 (C.17:33A-15), or refer the claim, together with supporting
26 documentation, to the Office of the Insurance Fraud Prosecutor in the
27 Department of Law and Public Safety established pursuant to section
28 32 of P.L.1998, c.21 (C.17:33A-16).

29 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
30 and [(3)] (4) of this subsection shall be deemed to be overdue if not
31 remitted to the claimant or his agent by the payer on or before the 30th
32 calendar day or the time limit established by the Medicare program,
33 whichever is earlier, following receipt by the payer of a claim
34 submitted by electronic means and on or before the 40th calendar day
35 following receipt of a claim submitted by other than electronic means.

36 In the event payment is withheld on all or a portion of a claim by a
37 payer pursuant to subparagraph [(b)] (a) of paragraph (2) or
38 subparagraph (d) of paragraph (3) of this subsection, the claims
39 payment shall be overdue if not remitted to the claimant or his agent
40 by the payer on or before the [30th] 15th calendar day or the time
41 limit established by the Medicare program, whichever is earlier, for
42 claims submitted by electronic means and the [40th] 25th calendar day
43 for claims submitted by other than electronic means, following receipt
44 by the payer of the required documentation or information or
45 modification of an initial submission.

1 (8) (a) No payer shall deny payment on all or a portion of a claim
2 because the payer requests documentation or information that is not
3 specific to the health care service provided to the covered person.

4 (b) No payer shall deny payment on all or a portion of a claim while
5 seeking coordination of benefits information unless good cause exists
6 for the payer to believe that other insurance is available to the covered
7 person. Good cause shall exist only if the payer's records indicate that
8 other coverage exists. Routine requests to determine whether
9 coordination of benefits exists shall not be considered good cause.

10 (c) In the event payment is withheld on all or a portion of a claim
11 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
12 claims payment shall be deemed to be overdue if not remitted to the
13 claimant or his agent by the payer on or before the 30th calendar day
14 or the time limit established by the Medicare program, whichever is
15 earlier, following receipt by the payer of a claim submitted by
16 electronic means or on or before the 40th calendar day following
17 receipt of a claim submitted by other than electronic means.

18 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
19 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
20 care provider at the time the overdue payment is made.

21 (10) With the exception of claims that were submitted fraudulently
22 or submitted by health care providers that have a pattern of
23 inappropriate billing or claims that were subject to coordination of
24 benefits, no payer shall seek reimbursement for overpayment of a claim
25 previously paid pursuant to this section later than one year after the
26 date the first payment on the claim was made. At the time the
27 reimbursement request is submitted to the health care provider, the
28 payer shall provide written documentation that identifies the error
29 made by the payer in the processing or payment of the claim that
30 justifies the reimbursement request. No payer shall base a
31 reimbursement request for a particular claim on extrapolation of other
32 claims, except under the following circumstances:

33 (a) in judicial or quasi-judicial proceedings, including arbitration;

34 (b) in administrative proceedings; or

35 (c) in which relevant records required to be maintained by the
36 health care provider have been improperly altered or reconstructed, or
37 a material number of the relevant records are otherwise unavailable.

38 (11) (a) In seeking reimbursement for the overpayment from the
39 health care provider, except as provided for in subparagraph (b) of this
40 paragraph, no payer shall collect or attempt to collect:

41 (i) the funds for the reimbursement on or before the 45th calendar
42 day following the submission of the reimbursement request to the
43 health care provider;

44 (ii) the funds for the reimbursement if the health care provider
45 disputes the request and initiates an appeal on or before the 45th
46 calendar day following the submission of the reimbursement request

1 to the health care provider and until the health care provider's rights
2 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
3 section are exhausted;

4 (iii) the funds for the reimbursement request by assessing them
5 against payment of any future claims submitted by the health care
6 provider, unless agreed to in writing by the health care provider; or

7 (iv) a late fee.

8 (b) If a payer has determined that the overpayment to the health
9 care provider is a result of fraud committed by the health care provider
10 and the payer has conducted its investigation and reported the fraud
11 to the Office of the Insurance Fraud Prosecutor as required by law, the
12 payer may collect an overpayment by assessing it against payment of
13 any future claim submitted by the health care provider.

14 (12) No health care provider shall seek reimbursement from a payer
15 or covered person for underpayment of a claim submitted pursuant to
16 this section later than one year from the date the first payment on the
17 claim was made, except if the claim is the subject of an appeal
18 submitted pursuant to subsection e. of this section or the claim is
19 subject to continual claims submission.

20 e. (1) A health service corporation or its agent, hereinafter the
21 payer, shall establish an internal appeal mechanism to resolve any
22 dispute regarding compliance with the requirements of this section.
23 The payer shall conduct the appeal at no cost to the health care
24 provider.

25 A health care provider may initiate an appeal on or before the 90th
26 calendar day following receipt by the health care provider of the
27 payer's claims determination, which is the basis of the appeal, on a
28 form prescribed by the Commissioner of Banking and Insurance which
29 shall describe the type of substantiating documentation that must be
30 submitted with the form. The payer shall conduct a review of the
31 appeal and notify the health care provider of its determination on or
32 before the 10th calendar day following the receipt of the appeal form.
33 If the health care provider is not notified of the payer's determination
34 of the appeal within 10 days, the health care provider may refer the
35 dispute to arbitration as provided by paragraph (2) of this subsection.

36 If the payer issues a determination in favor of the health care
37 provider, the payer shall comply with the provisions of this section and
38 pay the amount of money in dispute, if applicable, with accrued
39 interest at the rate of 20% per annum, on or before the 30th calendar
40 day following the notification of the payer's determination on the
41 appeal.

42 If the payer issues a determination against the health care provider,
43 the payer shall notify the health care provider of its findings on or
44 before the 10th calendar day following the receipt of the appeal form
45 and shall include in the notification written instructions for referring

1 the dispute to arbitration as provided by paragraph (2) of this
2 subsection.

3 The payer shall report annually to the Commissioner of Banking and
4 Insurance the number of appeals it has received and the resolution of
5 each appeal.

6 (2) Any dispute regarding the determination of an internal appeal
7 conducted pursuant to paragraph (1) of this subsection may be
8 referred to arbitration as provided in this paragraph. The
9 Commissioner of Banking and Insurance shall contract with a
10 nationally recognized, independent organization that specializes in
11 arbitration to conduct the arbitration proceedings.

12 Any party may initiate an arbitration proceeding on or before the
13 90th calendar day following the receipt of the determination which is
14 the basis of the appeal, on a form prescribed by the Commissioner of
15 Banking and Insurance. No dispute shall be accepted for arbitration
16 unless the payment amount in dispute is \$1,000 or more, except that
17 individual health care providers may aggregate their own disputed
18 claim amounts for the purposes of meeting the threshold requirements
19 of this subsection. No dispute pertaining to medical necessity which
20 is eligible to be submitted to the Independent Health Care Appeals
21 Program established pursuant to section 11 of P.L.1997, c.192
22 (C.26:2S-11) shall be the subject of arbitration pursuant to this
23 subsection.

24 (3) The arbitrator shall conduct the arbitration proceedings
25 pursuant to the rules of the arbitration entity, including rules of
26 discovery subject to confidentiality requirements established by State
27 or federal law.

28 (4) An arbitrator's determination shall be:

29 (a) signed by the arbitrator;

30 (b) issued in writing, in a form prescribed by the Commissioner of
31 Banking and Insurance, including a statement of the issues in dispute
32 and the findings and conclusions on which the determination is based;
33 and

34 (c) issued on or before the 30th calendar day following the receipt
35 of the required documentation.

36 The arbitration shall be nonappealable and binding on all parties to
37 the dispute.

38 (5) If the arbitrator determines that a payer has withheld or denied
39 payment in violation of the provisions of this section, the arbitrator
40 shall order the payer to make payment of the claim, together with
41 accrued interest, on or before the 10th business day following the
42 issuance of the determination. If the arbitrator determines that a payer
43 has withheld or denied payment on the basis of information submitted
44 by the health care provider and the payer requested, but did not
45 receive, this information from the health care provider when the claim
46 was initially processed pursuant to subsection d. of this section or

1 reviewed under internal appeal pursuant to paragraph (1) of this
2 subsection, the payer shall not be required to pay any accrued interest.
3 In accordance with regulations adopted by the Commissioner of
4 Banking and Insurance, the cost of the arbitration proceedings,
5 including the payment of reasonable attorney's fees, shall be awarded
6 to the prevailing party.

7 (6) If the arbitrator determines that a health care provider has
8 engaged in a pattern and practice of improper billing and a refund is
9 due to the payer, the arbitrator may award the payer a refund,
10 including interest accrued at the rate of 20% per annum.

11 (7) The arbitrator shall file a copy of each determination with and
12 in the form prescribed by the Commissioner of Banking and Insurance.

13 f. As used in this subsection, "insured claim" or "claim" means a
14 claim by a [subscriber] covered person for payment of benefits under
15 an insured health service corporation contract for which the financial
16 obligation for the payment of a claim under the contract rests upon the
17 health service corporation.

18 g. Any person found in violation of this section with a pattern of
19 frequency as determined by the Commissioner of Banking and
20 Insurance shall be liable to a civil penalty as set forth in section 17 of
21 P.L. , c. (C.) (now before the Legislature as this bill).

22 (cf: P.L.1999, c.154, s.4)

23

24 13. Section 5 of P.L.1999, c.154 (C.17B:26-9.1) is amended to
25 read as follows:

26 5. a. Within 180 days of the adoption of a timetable for
27 implementation pursuant to section 1 of P.L.1999, c.154
28 (C.17B:30-23), a health insurer[,] or its agent or a subsidiary that
29 processes health care benefits claims as a third party administrator,
30 shall demonstrate to the satisfaction of the Commissioner of Banking
31 and Insurance that it will adopt and implement all of the standards to
32 receive and transmit health care transactions electronically, according
33 to the corresponding timetable, and otherwise comply with the
34 provisions of this section, as a condition of its continued authorization
35 to do business in this State.

36 The Commissioner of Banking and Insurance may grant extensions
37 or waivers of the implementation requirement when it has been
38 demonstrated to the commissioner's satisfaction that compliance with
39 the timetable for implementation will result in an undue hardship to a
40 health insurer, its subsidiary or its covered persons.

41 b. Within 12 months of the adoption of regulations establishing
42 standard health care enrollment and claim forms by the Commissioner
43 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
44 (C.17B:30-23), a health insurer or a subsidiary that processes health
45 care benefits claims as a third party administrator shall use the
46 standard health care enrollment and claim forms in connection with all

1 individual policies issued, delivered, executed or renewed in this State.
2 c. Twelve months after the adoption of regulations establishing
3 standard health care enrollment and claim forms by the Commissioner
4 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
5 (C.17B:30-23), a health insurer shall require that health care providers
6 file all claims for payment for health care services. A covered person
7 who receives health care services shall not be required to submit a
8 claim for payment, but notwithstanding the provisions of this
9 subsection to the contrary, a covered person shall be permitted to
10 submit a claim on his own behalf, at the covered person's option. All
11 claims shall be filed using the standard health care claim form
12 applicable to the policy.

13 d. (1) Effective 180 days after the effective date of P.L.1999,
14 c.154, a health insurer or its agent, hereinafter the payer, shall remit
15 payment for every insured claim submitted by [an insured or that
16 insured's agent or assignee if the policy provides for assignment of
17 benefits] a covered person or health care provider, no later than the
18 30th calendar day following receipt of the claim by the payer or no
19 later than the time limit established for the payment of claims in the
20 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
21 is earlier, if the claim is submitted by electronic means, and no later
22 than the 40th calendar day following receipt if the claim is submitted
23 by other than electronic means, if:

24 (a) [the claim is an eligible claim for a health care service provided
25 by an eligible health care provider to a covered person under the
26 contract;

27 (b) the claim has no material defect or impropriety, including, but
28 not limited to, any lack of required substantiating documentation or
29 incorrect coding;

30 (c) there is no dispute regarding the amount claimed;] the health
31 care provider is eligible at the date of service;

32 (b) the person who received the health care service was covered on
33 the date of service;

34 (c) the claim is for a service or supply covered under the health
35 benefits plan;

36 (d) the claim is submitted with all the information requested by the
37 payer on the claim form or in other instructions distributed in advance
38 to the health care provider or covered person within 120 days of the
39 date of service; and

40 [(d)] (e) the payer has no reason to believe that the claim has been
41 submitted fraudulently[]; and

42 (e) the claim requires no special treatment that prevents timely
43 payments from being made on the claim under the terms of the
44 contract].

45 (2) If all or a portion of the claim is denied by the payer because:

46 (a) [the claim is an ineligible claim;

1 (b)] the claim submission is incomplete because the required
2 substantiating documentation, which is specific to the health care
3 service provided to the covered person, has not been submitted to the
4 payer;

5 [(c)] (b) the diagnosis coding, procedure coding, or any other
6 required information to be submitted with the claim is incorrect; or

7 [(d)] (c) the payer disputes the amount claimed[; or

8 (e) the claim requires special treatment that prevents timely
9 payments from being made on the claim under the terms of the
10 contract],

11 the payer shall notify the [subscriber, or that subscriber's agent or
12 assignee if the contract provides for assignment of benefits] covered
13 person and health care provider, in writing or by electronic means, as
14 appropriate, within 30 days, of the following: if all or a portion of the
15 claim is denied, all the reasons for the denial; if the claim lacks the
16 required substantiating documentation[, including] or contains
17 incorrect coding, a statement as to what substantiating documentation,
18 specific to the health care service provided to the covered person, or
19 other information, is required to complete adjudication of the claim;
20 and if the amount of the claim is disputed, a statement that it is
21 disputed[; and if the claim requires special treatment that prevents
22 timely payments from being made, a statement of the special treatment
23 to which the claim is subject].

24 (3) If all or a portion of a claim cannot be entered into the claims
25 processing system for any of the following reasons:

26 (a) the health care provider is not eligible at the time of service;

27 (b) the person who received the health care service was not a
28 covered person at the time of service;

29 (c) the premium was not paid by or on the behalf of the covered
30 person; or

31 (d) the diagnosis coding, procedure coding or any other data
32 required to be submitted with the claim was missing.

33 the payer shall notify the covered person and health care provider
34 within seven days if the claim was submitted by electronic means, or
35 within 14 days if the claim was submitted by other than electronic
36 means, of that determination of denial, of all the reasons for the denial
37 or any information required to complete adjudication of the claim.

38 (4) Any portion of a claim that meets the criteria established in
39 paragraph (1) of this subsection shall be paid by the payer in
40 accordance with the time limit established in paragraph (1) of this
41 subsection.

42 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
43 by electronic means from a health care provider or [subscriber]
44 covered person, no later than two working days following receipt of
45 the transmission of the claim.

1 ~~[(5)]~~ (6) If a payer subject to the provisions of P.L.1983, c.320
2 (C.17:33A-1 et seq.) has reason to believe that a claim has been
3 submitted fraudulently, it shall investigate the claim in accordance with
4 its fraud prevention plan established pursuant to section 1 of P.L.1993,
5 c.362 (C.17:33A-15), or refer the claim, together with supporting
6 documentation, to the Office of the Insurance Fraud Prosecutor in the
7 Department of Law and Public Safety established pursuant to section
8 32 of P.L.1998, c.21 (C.17:33A-16).

9 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
10 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
11 remitted to the claimant or his agent by the payer on or before the 30th
12 calendar day or the time limit established by the Medicare program,
13 whichever is earlier, following receipt by the payer of a claim
14 submitted by electronic means and on or before the 40th calendar day
15 following receipt of a claim submitted by other than electronic means.

16 In the event payment is withheld on all or a portion of a claim by a
17 payer pursuant to subparagraph ~~[(b)]~~ (a) of paragraph (2) or
18 subparagraph (d) of paragraph (3) of this subsection, the claims
19 payment shall be overdue if not remitted to the claimant or his agent
20 by the payer on or before the ~~[30th]~~ 15th calendar day or the time
21 limit established by the Medicare program, whichever is earlier, for
22 claims submitted by electronic means and the ~~[40th]~~ 25th calendar day
23 for claims submitted by other than electronic means, following receipt
24 by the payer of the required documentation or information or
25 modification of an initial submission.

26 (8) (a) No payer shall deny payment on all or a portion of a claim
27 because the payer requests documentation or information that is not
28 specific to the health care service provided to the covered person.

29 (b) No payer shall deny payment on all or a portion of a claim while
30 seeking coordination of benefits information unless good cause exists
31 for the payer to believe that other insurance is available to the covered
32 person. Good cause shall exist only if the payer's records indicate that
33 other coverage exists. Routine requests to determine whether
34 coordination of benefits exists shall not be considered good cause.

35 (c) In the event payment is withheld on all or a portion of a claim
36 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
37 claims payment shall be deemed to be overdue if not remitted to the
38 claimant or his agent by the payer on or before the 30th calendar day
39 or the time limit established by the Medicare program, whichever is
40 earlier, following receipt by the payer of a claim submitted by
41 electronic means or on or before the 40th calendar day following
42 receipt of a claim submitted by other than electronic means.

43 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
44 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
45 care provider at the time the overdue payment is made.

1 (10) With the exception of claims that were submitted fraudulently
2 or submitted by health care providers that have a pattern of
3 inappropriate billing or claims that were subject to coordination of
4 benefits, no payer shall seek reimbursement for overpayment of a claim
5 previously paid pursuant to this section later than one year after the
6 date the first payment on the claim was made. At the time the
7 reimbursement request is submitted to the health care provider, the
8 payer shall provide written documentation that identifies the error
9 made by the payer in the processing or payment of the claim that
10 justifies the reimbursement request. No payer shall base a
11 reimbursement request for a particular claim on extrapolation of other
12 claims, except under the following circumstances:

13 (a) in judicial or quasi-judicial proceedings, including arbitration;

14 (b) in administrative proceedings; or

15 (c) in which relevant records required to be maintained by the
16 health care provider have been improperly altered or reconstructed, or
17 a material number of the relevant records are otherwise unavailable.

18 (11) (a) In seeking reimbursement for the overpayment from the
19 health care provider, except as provided for in subparagraph (b) of this
20 paragraph, no payer shall collect or attempt to collect:

21 (i) the funds for the reimbursement on or before the 45th calendar
22 day following the submission of the reimbursement request to the
23 health care provider;

24 (ii) the funds for the reimbursement if the health care provider
25 disputes the request and initiates an appeal on or before the 45th
26 calendar day following the submission of the reimbursement request
27 to the health care provider and until the health care provider's rights
28 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
29 section are exhausted;

30 (iii) the funds for the reimbursement request by assessing them
31 against payment of any future claims submitted by the health care
32 provider, unless agreed to in writing by the health care provider; or

33 (iv) a late fee.

34 (b) If a payer has determined that the overpayment to the health
35 care provider is a result of fraud committed by the health care provider
36 and the payer has conducted its investigation and reported the fraud
37 to the Office of the Insurance Fraud Prosecutor as required by law, the
38 payer may collect an overpayment by assessing it against payment of
39 any future claim submitted by the health care provider.

40 (12) No health care provider shall seek reimbursement from a payer
41 or covered person for underpayment of a claim submitted pursuant to
42 this section later than one year from the date the first payment on the
43 claim was made, except if the claim is the subject of an appeal
44 submitted pursuant to subsection e. of this section or the claim is
45 subject to continual claims submission.

1 e. (1) A health insurer or its agent, hereinafter the payer, shall
2 establish an internal appeal mechanism to resolve any dispute
3 regarding compliance with the requirements of this section. The payer
4 shall conduct the appeal at no cost to the health care provider.

5 A health care provider may initiate an appeal on or before the 90th
6 calendar day following receipt by the health care provider of the
7 payer's claims determination, which is the basis of the appeal, on a
8 form prescribed by the Commissioner of Banking and Insurance which
9 shall describe the type of substantiating documentation that must be
10 submitted with the form. The payer shall conduct a review of the
11 appeal and notify the health care provider of its determination on or
12 before the 10th calendar day following the receipt of the appeal form.
13 If the health care provider is not notified of the payer's determination
14 of the appeal within 10 days, the health care provider may refer the
15 dispute to arbitration as provided by paragraph (2) of this subsection.

16 If the payer issues a determination in favor of the health care
17 provider, the payer shall comply with the provisions of this section and
18 pay the amount of money in dispute, if applicable, with accrued
19 interest at the rate of 20% per annum, on or before the 30th calendar
20 day following the notification of the payer's determination on the
21 appeal.

22 If the payer issues a determination against the health care provider,
23 the payer shall notify the health care provider of its findings on or
24 before the 10th calendar day following the receipt of the appeal form
25 and shall include in the notification written instructions for referring
26 the dispute to arbitration as provided by paragraph (2) of this
27 subsection.

28 The payer shall report annually to the Commissioner of Banking and
29 Insurance the number of appeals it has received and the resolution of
30 each appeal.

31 (2) Any dispute regarding the determination of an internal appeal
32 conducted pursuant to paragraph (1) of this subsection may be
33 referred to arbitration as provided in this paragraph. The
34 Commissioner of Banking and Insurance shall contract with a
35 nationally recognized, independent organization that specializes in
36 arbitration to conduct the arbitration proceedings.

37 Any party may initiate an arbitration proceeding on or before the
38 90th calendar day following the receipt of the determination which is
39 the basis of the appeal, on a form prescribed by the Commissioner of
40 Banking and Insurance. No dispute shall be accepted for arbitration
41 unless the payment amount in dispute is \$1,000 or more, except that
42 individual health care providers may aggregate their own disputed
43 claim amounts for the purposes of meeting the threshold requirements
44 of this subsection. No dispute pertaining to medical necessity which
45 is eligible to be submitted to the Independent Health Care Appeals
46 Program established pursuant to section 11 of P.L.1997, c.192

1 (C.26:2S-11) shall be the subject of arbitration pursuant to this
2 subsection.

3 (3) The arbitrator shall conduct the arbitration proceedings
4 pursuant to the rules of the arbitration entity, including rules of
5 discovery subject to confidentiality requirements established by State
6 or federal law.

7 (4) An arbitrator's determination shall be:

8 (a) signed by the arbitrator;

9 (b) issued in writing, in a form prescribed by the Commissioner of
10 Banking and Insurance, including a statement of the issues in dispute
11 and the findings and conclusions on which the determination is based;
12 and

13 (c) issued on or before the 30th calendar day following the receipt
14 of the required documentation.

15 The arbitration shall be nonappealable and binding on all parties to
16 the dispute.

17 (5) If the arbitrator determines that a payer has withheld or denied
18 payment in violation of the provisions of this section, the arbitrator
19 shall order the payer to make payment of the claim, together with
20 accrued interest, on or before the 10th business day following the
21 issuance of the determination. If the arbitrator determines that a payer
22 has withheld or denied payment on the basis of information submitted
23 by the health care provider and the payer requested, but did not
24 receive, this information from the health care provider when the claim
25 was initially processed pursuant to subsection d. of this section or
26 reviewed under internal appeal pursuant to paragraph (1) of this
27 subsection, the payer shall not be required to pay any accrued interest.
28 In accordance with regulations adopted by the Commissioner of
29 Banking and Insurance, the cost of the arbitration proceedings,
30 including the payment of reasonable attorney's fees, shall be awarded
31 to the prevailing party.

32 (6) If the arbitrator determines that a health care provider has
33 engaged in a pattern and practice of improper billing and a refund is
34 due to the payer, the arbitrator may award the payer a refund,
35 including interest accrued at the rate of 20% per annum.

36 (7) The arbitrator shall file a copy of each determination with and
37 in the form prescribed by the Commissioner of Banking and Insurance.

38 f. As used in this subsection, "insured claim" or "claim" means a
39 claim by [an insured] a covered person for payment of benefits under
40 an insured policy for which the financial obligation for the payment of
41 a claim under the policy rests upon the health insurer.

42 g. Any person found in violation of this section by the
43 Commissioner of Banking and Insurance shall be liable to a civil
44 penalty as set forth in section 17 of P.L. , c. (C.) (now before
45 the Legislature as this bill).

46 (cf: P.L.1999, c.154, s.5)

1 14. Section 6 of P.L.1999, c.154 (C.17B:27-44.2) is amended to
2 read as follows:

3 6. a. Within 180 days of the adoption of a timetable for
4 implementation pursuant to section 1 of P.L.1999, c.154
5 (C.17B:30-23), a health insurer[,] or its agent or a subsidiary that
6 processes health care benefits claims as a third party administrator,
7 shall demonstrate to the satisfaction of the Commissioner of Banking
8 and Insurance that it will adopt and implement all of the standards to
9 receive and transmit health care transactions electronically, according
10 to the corresponding timetable, and otherwise comply with the
11 provisions of this section, as a condition of its continued authorization
12 to do business in this State.

13 The Commissioner of Banking and Insurance may grant extensions
14 or waivers of the implementation requirement when it has been
15 demonstrated to the commissioner's satisfaction that compliance with
16 the timetable for implementation will result in an undue hardship to a
17 health insurer, its subsidiary or its covered persons.

18 b. Within 12 months of the adoption of regulations establishing
19 standard health care enrollment and claim forms by the Commissioner
20 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
21 (C.17B:30-23), a health insurer or a subsidiary that processes health
22 care benefits claims as a third party administrator shall use the
23 standard health care enrollment and claim forms in connection with all
24 group policies issued, delivered, executed or renewed in this State.

25 c. Twelve months after the adoption of regulations establishing
26 standard health care enrollment and claim forms by the Commissioner
27 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
28 (C.17B:30-23), a health insurer shall require that health care providers
29 file all claims for payment for health care services. A covered person
30 who receives health care services shall not be required to submit a
31 claim for payment, but notwithstanding the provisions of this
32 subsection to the contrary, a covered person shall be permitted to
33 submit a claim on his own behalf, at the covered person's option. All
34 claims shall be filed using the standard health care claim form
35 applicable to the policy.

36 d. (1) Effective 180 days after the effective date of P.L.1999,
37 c.154, a health insurer or its agent, hereinafter the payer, shall remit
38 payment for every insured claim submitted by [an insured or that
39 insured's agent or assignee if the policy provides for assignment of
40 benefits] a covered person or health care provider, no later than the
41 30th calendar day following receipt of the claim by the payer or no
42 later than the time limit established for the payment of claims in the
43 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
44 is earlier, if the claim is submitted by electronic means, and no later
45 than the 40th calendar day following receipt if the claim is submitted
46 by other than electronic means, if:

1 (a) [the claim is an eligible claim for a health care service provided
2 by an eligible health care provider to a covered person under the
3 contract;
4 (b) the claim has no material defect or impropriety, including, but
5 not limited to, any lack of required substantiating documentation or
6 incorrect coding;
7 (c) there is no dispute regarding the amount claimed;] the health
8 care provider is eligible at the date of service;
9 (b) the person who received the health care service was covered on
10 the date of service;
11 (c) the claim is for a service or supply covered under the health
12 benefits plan;
13 (d) the claim is submitted with all the information requested by the
14 payer on the claim form or in other instructions distributed in advance
15 to the health care provider or covered person within 120 days of the
16 date of service; and
17 [(d)] (e) the payer has no reason to believe that the claim has been
18 submitted fraudulently[; and
19 (e) the claim requires no special treatment that prevents timely
20 payments from being made on the claim under the terms of the
21 contract].
22 (2) If all or a portion of the claim is denied by the payer because:
23 (a) [the claim is an ineligible claim;
24 (b)] the claim submission is incomplete because the required
25 substantiating documentation, which is specific to the health care
26 service provided to the covered person, has not been submitted to the
27 payer;
28 [(c)] (b) the diagnosis coding, procedure coding, or any other
29 required information to be submitted with the claim is incorrect; or
30 [(d)] (c) the payer disputes the amount claimed[; or
31 (e) the claim requires special treatment that prevents timely
32 payments from being made on the claim under the terms of the
33 contract],
34 the payer shall notify the [subscriber, or that subscriber's agent or
35 assignee if the contract provides for assignment of benefits] covered
36 person and health care provider, in writing or by electronic means, as
37 appropriate, within 30 days, of the following: if all or a portion of the
38 claim is denied, all the reasons for the denial; if the claim lacks the
39 required substantiating documentation[, including] or contains
40 incorrect coding, a statement as to what substantiating documentation,
41 specific to the health care service provided to the covered person, or
42 other information, is required to complete adjudication of the claim;
43 and if the amount of the claim is disputed, a statement that it is
44 disputed[; and if the claim requires special treatment that prevents
45 timely payments from being made, a statement of the special treatment
46 to which the claim is subject].

1 (3) If all or a portion of a claim cannot be entered into the claims
2 processing system for any of the following reasons:

3 (a) the health care provider is not eligible at the time of service;

4 (b) the person who received the health care service was not a
5 covered person at the time of service;

6 (c) the premium was not paid by or on the behalf of the covered
7 person; or

8 (d) the diagnosis coding, procedure coding or any other data
9 required to be submitted with the claim was missing.

10 the payer shall notify the covered person and health care provider
11 within seven days if the claim was submitted by electronic means, or
12 within 14 days if the claim was submitted by other than electronic
13 means, of that determination of denial, of all the reasons for the denial
14 or any information required to complete adjudication of the claim.

15 (4) Any portion of a claim that meets the criteria established in
16 paragraph (1) of this subsection shall be paid by the payer in
17 accordance with the time limit established in paragraph (1) of this
18 subsection.

19 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
20 by electronic means from a health care provider or [subscriber]
21 covered person, no later than two working days following receipt of
22 the transmission of the claim.

23 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
24 (C.17:33A-1 et seq.) has reason to believe that a claim has been
25 submitted fraudulently, it shall investigate the claim in accordance with
26 its fraud prevention plan established pursuant to section 1 of P.L.1993,
27 c.362 (C.17:33A-15), or refer the claim, together with supporting
28 documentation, to the Office of the Insurance Fraud Prosecutor in the
29 Department of Law and Public Safety established pursuant to section
30 32 of P.L.1998, c.21 (C.17:33A-16).

31 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
32 and [(3)] (4) of this subsection shall be deemed to be overdue if not
33 remitted to the claimant or his agent by the payer on or before the 30th
34 calendar day or the time limit established by the Medicare program,
35 whichever is earlier, following receipt by the payer of a claim
36 submitted by electronic means and on or before the 40th calendar day
37 following receipt of a claim submitted by other than electronic means.

38 In the event payment is withheld on all or a portion of a claim by a
39 payer pursuant to subparagraph [(b)] (a) of paragraph (2) or
40 subparagraph (d) of paragraph (3) of this subsection, the claims
41 payment shall be overdue if not remitted to the claimant or his agent
42 by the payer on or before the [(30th)] 15th calendar day or the time
43 limit established by the Medicare program, whichever is earlier, for
44 claims submitted by electronic means and the [(40th)] 25th calendar day
45 for claims submitted by other than electronic means, following receipt

1 by the payer of the required documentation or information or
2 modification of an initial submission.

3 (8) (a) No payer shall deny payment on all or a portion of a claim
4 because the payer requests documentation or information that is not
5 specific to the health care service provided to the covered person.

6 (b) No payer shall deny payment on all or a portion of a claim while
7 seeking coordination of benefits information unless good cause exists
8 for the payer to believe that other insurance is available to the covered
9 person. Good cause shall exist only if the payer's records indicate that
10 other coverage exists. Routine requests to determine whether
11 coordination of benefits exists shall not be considered good cause.

12 (c) In the event payment is withheld on all or a portion of a claim
13 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
14 claims payment shall be deemed to be overdue if not remitted to the
15 claimant or his agent by the payer on or before the 30th calendar day
16 or the time limit established by the Medicare program, whichever is
17 earlier, following receipt by the payer of a claim submitted by
18 electronic means or on or before the 40th calendar day following
19 receipt of a claim submitted by other than electronic means.

20 [(7)] (9) An overdue payment shall bear simple interest at the rate
21 of [10%] 20% per annum. The interest shall be paid to the health
22 care provider at the time the overdue payment is made.

23 (10) With the exception of claims that were submitted fraudulently
24 or submitted by health care providers that have a pattern of
25 inappropriate billing or claims that were subject to coordination of
26 benefits, no payer shall seek reimbursement for overpayment of a claim
27 previously paid pursuant to this section later than one year after the
28 date the first payment on the claim was made. At the time the
29 reimbursement request is submitted to the health care provider, the
30 payer shall provide written documentation that identifies the error
31 made by the payer in the processing or payment of the claim that
32 justifies the reimbursement request. No payer shall base a
33 reimbursement request for a particular claim on extrapolation of other
34 claims, except under the following circumstances:

35 (a) in judicial or quasi-judicial proceedings, including arbitration;

36 (b) in administrative proceedings; or

37 (c) in which relevant records required to be maintained by the
38 health care provider have been improperly altered or reconstructed, or
39 a material number of the relevant records are otherwise unavailable.

40 (11) (a) In seeking reimbursement for the overpayment from the
41 health care provider, except as provided for in subparagraph (b) of this
42 paragraph, no payer shall collect or attempt to collect:

43 (i) the funds for the reimbursement on or before the 45th calendar
44 day following the submission of the reimbursement request to the
45 health care provider;

1 (ii) the funds for the reimbursement if the health care provider
2 disputes the request and initiates an appeal on or before the 45th
3 calendar day following the submission of the reimbursement request
4 to the health care provider and until the health care provider's rights
5 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
6 section are exhausted;

7 (iii) the funds for the reimbursement request by assessing them
8 against payment of any future claims submitted by the health care
9 provider, unless agreed to in writing by the health care provider; or

10 (iv) a late fee.

11 (b) If a payer has determined that the overpayment to the health
12 care provider is a result of fraud committed by the health care provider
13 and the payer has conducted its investigation and reported the fraud
14 to the Office of the Insurance Fraud Prosecutor as required by law, the
15 payer may collect an overpayment by assessing it against payment of
16 any future claim submitted by the health care provider.

17 (12) No health care provider shall seek reimbursement from a payer
18 or covered person for underpayment of a claim submitted pursuant to
19 this section later than one year from the date the first payment on the
20 claim was made, except if the claim is the subject of an appeal
21 submitted pursuant to subsection e. of this section or the claim is
22 subject to continual claims submission.

23 e. (1) A health insurer or its agent, hereinafter the payer, shall
24 establish an internal appeal mechanism to resolve any dispute
25 regarding compliance with the requirements of this section. The payer
26 shall conduct the appeal at no cost to the health care provider.

27 A health care provider may initiate an appeal on or before the 90th
28 calendar day following receipt by the health care provider of the
29 payer's claims determination, which is the basis of the appeal, on a
30 form prescribed by the Commissioner of Banking and Insurance which
31 shall describe the type of substantiating documentation that must be
32 submitted with the form. The payer shall conduct a review of the
33 appeal and notify the health care provider of its determination on or
34 before the 10th calendar day following the receipt of the appeal form.
35 If the health care provider is not notified of the payer's determination
36 of the appeal within 10 days, the health care provider may refer the
37 dispute to arbitration as provided by paragraph (2) of this subsection.

38 If the payer issues a determination in favor of the health care
39 provider, the payer shall comply with the provisions of this section and
40 pay the amount of money in dispute, if applicable, with accrued
41 interest at the rate of 20% per annum, on or before the 30th calendar
42 day following the notification of the payer's determination on the
43 appeal.

44 If the payer issues a determination against the health care provider,
45 the payer shall notify the health care provider of its findings on or
46 before the 10th calendar day following the receipt of the appeal form

1 and shall include in the notification written instructions for referring
2 the dispute to arbitration as provided by paragraph (2) of this
3 subsection.

4 The payer shall report annually to the Commissioner of Banking and
5 Insurance the number of appeals it has received and the resolution of
6 each appeal.

7 (2) Any dispute regarding the determination of an internal appeal
8 conducted pursuant to paragraph (1) of this subsection may be
9 referred to arbitration as provided in this paragraph. The
10 Commissioner of Banking and Insurance shall contract with a
11 nationally recognized, independent organization that specializes in
12 arbitration to conduct the arbitration proceedings.

13 Any party may initiate an arbitration proceeding on or before the
14 90th calendar day following the receipt of the determination which is
15 the basis of the appeal, on a form prescribed by the Commissioner of
16 Banking and Insurance. No dispute shall be accepted for arbitration
17 unless the payment amount in dispute is \$1,000 or more, except that
18 individual health care providers may aggregate their own disputed
19 claim amounts for the purposes of meeting the threshold requirements
20 of this subsection. No dispute pertaining to medical necessity which
21 is eligible to be submitted to the Independent Health Care Appeals
22 Program established pursuant to section 11 of P.L.1997, c.192
23 (C.26:2S-11) shall be the subject of arbitration pursuant to this
24 subsection.

25 (3) The arbitrator shall conduct the arbitration proceedings
26 pursuant to the rules of the arbitration entity, including rules of
27 discovery subject to confidentiality requirements established by State
28 or federal law.

29 (4) An arbitrator's determination shall be:

30 (a) signed by the arbitrator;

31 (b) issued in writing, in a form prescribed by the Commissioner of
32 Banking and Insurance, including a statement of the issues in dispute
33 and the findings and conclusions on which the determination is based;
34 and

35 (c) issued on or before the 30th calendar day following the receipt
36 of the required documentation.

37 The arbitration shall be nonappealable and binding on all parties to
38 the dispute.

39 (5) If the arbitrator determines that a payer has withheld or denied
40 payment in violation of the provisions of this section, the arbitrator
41 shall order the payer to make payment of the claim, together with
42 accrued interest, on or before the 10th business day following the
43 issuance of the determination. If the arbitrator determines that a payer
44 has withheld or denied payment on the basis of information submitted
45 by the health care provider and the payer requested, but did not
46 receive, this information from the health care provider when the claim

1 was initially processed pursuant to subsection d. of this section or
2 reviewed under internal appeal pursuant to paragraph (1) of this
3 subsection, the payer shall not be required to pay any accrued interest.
4 In accordance with regulations adopted by the Commissioner of
5 Banking and Insurance, the cost of the arbitration proceedings,
6 including the payment of reasonable attorney's fees, shall be awarded
7 to the prevailing party.

8 (6) If the arbitrator determines that a health care provider has
9 engaged in a pattern and practice of improper billing and a refund is
10 due to the payer, the arbitrator may award the payer a refund,
11 including interest accrued at the rate of 20% per annum.

12 (7) The arbitrator shall file a copy of each determination with and
13 in the form prescribed by the Commissioner of Banking and Insurance.

14 f. As used in this subsection, "insured claim" or "claim" means a
15 claim by [an insured] a covered person for payment of benefits under
16 an insured policy for which the financial obligation for the payment of
17 a claim under the policy rests upon the health insurer.

18 g. Any person found in violation of this section with a pattern of
19 frequency as determined by the Commissioner of Banking and
20 Insurance shall be liable to a civil penalty as set forth in section 17 of
21 P.L. , c. (C.) (now before the Legislature as this bill).

22 (cf: P.L.1999, c.154, s.6)

23
24 15. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to read
25 as follows:

26 7. a. Within 180 days of the adoption of a timetable for
27 implementation pursuant to section 1 of P.L.1999, c.154
28 (C.17B:30-23), a health maintenance organization[,] or its agent or
29 a subsidiary that processes health care benefits claims as a third party
30 administrator, shall demonstrate to the satisfaction of the
31 Commissioner of Banking and Insurance that it will adopt and
32 implement all of the standards to receive and transmit health care
33 transactions electronically, according to the corresponding timetable,
34 and otherwise comply with the provisions of this section, as a
35 condition of its continued authorization to do business in this State.

36 The Commissioner of Banking and Insurance may grant extensions
37 or waivers of the implementation requirement when it has been
38 demonstrated to the commissioner's satisfaction that compliance with
39 the timetable for implementation will result in an undue hardship to a
40 health maintenance organization, its subsidiary or its covered
41 [enrollees] persons.

42 b. Within 12 months of the adoption of regulations establishing
43 standard health care enrollment and claim forms by the Commissioner
44 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
45 (C.17B:30-23), a health maintenance organization or a subsidiary that
46 processes health care benefits claims as a third party administrator

1 shall use the standard health care enrollment and claim forms in
2 connection with all group and individual health maintenance
3 organization coverage for health care services issued, delivered,
4 executed or renewed in this State.

5 c. Twelve months after the adoption of regulations establishing
6 standard health care enrollment and claim forms by the Commissioner
7 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
8 (C.17B:30-23), a health maintenance organization shall require that
9 health care providers file all claims for payment for health care
10 services. A covered person who receives health care services shall not
11 be required to submit a claim for payment, but notwithstanding the
12 provisions of this subsection to the contrary, a covered person shall be
13 permitted to submit a claim on his own behalf, at the covered person's
14 option. All claims shall be filed using the standard health care claim
15 form applicable to the contract.

16 d. (1) Effective 180 days after the effective date of P.L.1999,
17 c.154, a health maintenance organization or its agent, hereinafter the
18 payer, shall remit payment for every insured claim submitted by [an
19 enrollee or that enrollee's agent or assignee if the health maintenance
20 organization coverage for health care services provides for assignment
21 of benefits] a covered person or health care provider, no later than the
22 30th calendar day following receipt of the claim by the payer or no
23 later than the time limit established for the payment of claims in the
24 Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever
25 is earlier, if the claim is submitted by electronic means, and no later
26 than the 40th calendar day following receipt if the claim is submitted
27 by other than electronic means, if:

28 (a) [the claim is an eligible claim for a health care service provided
29 by an eligible health care provider to a covered person under the health
30 maintenance organization coverage for health care services;

31 (b) the claim has no material defect or impropriety, including, but
32 not limited to, any lack of required substantiating documentation or
33 incorrect coding;

34 (c) there is no dispute regarding the amount claimed;] the health
35 care provider is eligible at the date of service;

36 (b) the person who received the health care service was covered on
37 the date of service;

38 (c) the claim is for a service or supply covered under the health
39 benefits plan;

40 (d) the claim is submitted with all the information requested by the
41 payer on the claim form or in other instructions distributed in advance
42 to the health care provider or covered person within 120 days of the
43 date of service; and

44 [(d)] (e) the payer has no reason to believe that the claim has been
45 submitted fraudulently[]; and

46 (e) the claim requires no special treatment that prevents timely

1 payments from being made on the claim under the terms of the health
2 maintenance organization coverage for health care services].

3 (2) If all or a portion of the claim is denied by the payer because:
4 (a) [the claim is an ineligible claim;
5 (b)] the claim submission is incomplete because the required
6 substantiating documentation, which is specific to the health care
7 service provided to the covered person, has not been submitted to the
8 payer;

9 [(c)] (b) the diagnosis coding, procedure coding, or any other
10 required information to be submitted with the claim is incorrect; or
11 [(d)] (c) the payer disputes the amount claimed[; or
12 (e) the claim requires special treatment that prevents timely
13 payments from being made on the claim under the terms of the health
14 maintenance organization coverage for health care services],
15 the payer shall notify the [enrollee, or that enrollee's agent or
16 assignee if the health maintenance organization coverage for health
17 care services provides for assignment of benefits] covered person and
18 health care provider, in writing or by electronic means, as appropriate,
19 within 30 days, of the following: if all or a portion of the claim is
20 denied, all the reasons for the denial; if the claim lacks the required
21 substantiating documentation[, including] or contains incorrect
22 coding, a statement as to what substantiating documentation, specific
23 to the health care service provided to the covered person, or other
24 information, is required to complete adjudication of the claim; and if
25 the amount of the claim is disputed, a statement that it is disputed[;
26 and if the claim requires special treatment that prevents timely
27 payments from being made, a statement of the special treatment to
28 which the claim is subject].

29 (3) If all or a portion of a claim cannot be entered into the claims
30 processing system for any of the following reasons:
31 (a) the health care provider is not eligible at the time of service;
32 (b) the person who received the health care service was not a
33 covered person at the time of service;
34 (c) the premium was not paid by or on the behalf of the covered
35 person; or
36 (d) the diagnosis coding, procedure coding or any other data
37 required to be submitted with the claim was missing.
38 the payer shall notify the covered person and health care provider
39 within seven days if the claim was submitted by electronic means, or
40 within 14 days if the claim was submitted by other than electronic
41 means, of that determination of denial, of all the reasons for the denial
42 or any information required to complete adjudication of the claim.

43 (4) Any portion of a claim that meets the criteria established in
44 paragraph (1) of this subsection shall be paid by the payer in
45 accordance with the time limit established in paragraph (1) of this
46 subsection.

1 ~~[(4)]~~ (5) A payer shall acknowledge receipt of a claim submitted
2 by electronic means from a health care provider or ~~[subscriber]~~
3 covered person, no later than two working days following receipt of
4 the transmission of the claim.

5 ~~[(5)]~~ (6) If a payer subject to the provisions of P.L.1983, c.320
6 (C.17:33A-1 et seq.) has reason to believe that a claim has been
7 submitted fraudulently, it shall investigate the claim in accordance with
8 its fraud prevention plan established pursuant to section 1 of P.L.1993,
9 c.362 (C.17:33A-15), or refer the claim, together with supporting
10 documentation, to the Office of the Insurance Fraud Prosecutor in the
11 Department of Law and Public Safety established pursuant to section
12 32 of P.L.1998, c.21 (C.17:33A-16).

13 ~~[(6)]~~ (7) Payment of an eligible claim pursuant to paragraphs (1)
14 and ~~[(3)]~~ (4) of this subsection shall be deemed to be overdue if not
15 remitted to the claimant or his agent by the payer on or before the 30th
16 calendar day or the time limit established by the Medicare program,
17 whichever is earlier, following receipt by the payer of a claim
18 submitted by electronic means and on or before the 40th calendar day
19 following receipt of a claim submitted by other than electronic means.

20 In the event payment is withheld on all or a portion of a claim by a
21 payer pursuant to subparagraph ~~[(b)]~~ (a) of paragraph (2) ~~or~~
22 subparagraph (d) of paragraph (3) of this subsection, the claims
23 payment shall be overdue if not remitted to the claimant or his agent
24 by the payer on or before the ~~[30th]~~ 15th calendar day or the time
25 limit established by the Medicare program, whichever is earlier, for
26 claims submitted by electronic means and the ~~[40th]~~ 25th calendar day
27 for claims submitted by other than electronic means, following receipt
28 by the payer of the required documentation or information or
29 modification of an initial submission.

30 (8) (a) No payer shall deny payment on all or a portion of a claim
31 because the payer requests documentation or information that is not
32 specific to the health care service provided to the covered person.

33 (b) No payer shall deny payment on all or a portion of a claim while
34 seeking coordination of benefits information unless good cause exists
35 for the payer to believe that other insurance is available to the covered
36 person. Good cause shall exist only if the payer's records indicate that
37 other coverage exists. Routine requests to determine whether
38 coordination of benefits exists shall not be considered good cause.

39 (c) In the event payment is withheld on all or a portion of a claim
40 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
41 claims payment shall be deemed to be overdue if not remitted to the
42 claimant or his agent by the payer on or before the 30th calendar day
43 or the time limit established by the Medicare program, whichever is
44 earlier, following receipt by the payer of a claim submitted by
45 electronic means or on or before the 40th calendar day following
46 receipt of a claim submitted by other than electronic means.

1 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
2 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
3 care provider at the time the overdue payment is made.

4 (10) With the exception of claims that were submitted fraudulently
5 or submitted by health care providers that have a pattern of
6 inappropriate billing or claims that were subject to coordination of
7 benefits, no payer shall seek reimbursement for overpayment of a claim
8 previously paid pursuant to this section later than one year after the
9 date the first payment on the claim was made. At the time the
10 reimbursement request is submitted to the health care provider, the
11 payer shall provide written documentation that identifies the error
12 made by the payer in the processing or payment of the claim that
13 justifies the reimbursement request. No payer shall base a
14 reimbursement request for a particular claim on extrapolation of other
15 claims, except under the following circumstances:

16 (a) in judicial or quasi-judicial proceedings, including arbitration;

17 (b) in administrative proceedings; or

18 (c) in which relevant records required to be maintained by the
19 health care provider have been improperly altered or reconstructed, or
20 a material number of the relevant records are otherwise unavailable.

21 (11) (a) In seeking reimbursement for the overpayment from the
22 health care provider, except as provided for in subparagraph (b) of this
23 paragraph, no payer shall collect or attempt to collect:

24 (i) the funds for the reimbursement on or before the 45th calendar
25 day following the submission of the reimbursement request to the
26 health care provider;

27 (ii) the funds for the reimbursement if the health care provider
28 disputes the request and initiates an appeal on or before the 45th
29 calendar day following the submission of the reimbursement request
30 to the health care provider and until the health care provider's rights
31 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
32 section are exhausted;

33 (iii) the funds for the reimbursement request by assessing them
34 against payment of any future claims submitted by the health care
35 provider, unless agreed to in writing by the health care provider; or

36 (iv) a late fee.

37 (b) If a payer has determined that the overpayment to the health
38 care provider is a result of fraud committed by the health care provider
39 and the payer has conducted its investigation and reported the fraud
40 to the Office of the Insurance Fraud Prosecutor as required by law, the
41 payer may collect an overpayment by assessing it against payment of
42 any future claim submitted by the health care provider.

43 (12) No health care provider shall seek reimbursement from a payer
44 or covered person for underpayment of a claim submitted pursuant to
45 this section later than one year from the date the first payment on the
46 claim was made, except if the claim is the subject of an appeal

1 submitted pursuant to subsection e. of this section or the claim is
2 subject to continual claims submission.

3 e. (1) A health maintenance organization or its agent, hereinafter
4 the payer, shall establish an internal appeal mechanism to resolve any
5 dispute regarding compliance with the requirements of this section.
6 The payer shall conduct the appeal at no cost to the health care
7 provider.

8 A health care provider may initiate an appeal on or before the 90th
9 calendar day following receipt by the health care provider of the
10 payer's claims determination, which is the basis of the appeal, on a
11 form prescribed by the Commissioner of Banking and Insurance which
12 shall describe the type of substantiating documentation that must be
13 submitted with the form. The payer shall conduct a review of the
14 appeal and notify the health care provider of its determination on or
15 before the 10th calendar day following the receipt of the appeal form.
16 If the health care provider is not notified of the payer's determination
17 of the appeal within 10 days, the health care provider may refer the
18 dispute to arbitration as provided by paragraph (2) of this subsection.

19 If the payer issues a determination in favor of the health care
20 provider, the payer shall comply with the provisions of this section and
21 pay the amount of money in dispute, if applicable, with accrued
22 interest at the rate of 20% per annum, on or before the 30th calendar
23 day following the notification of the payer's determination on the
24 appeal.

25 If the payer issues a determination against the health care provider,
26 the payer shall notify the health care provider of its findings on or
27 before the 10th calendar day following the receipt of the appeal form
28 and shall include in the notification written instructions for referring
29 the dispute to arbitration as provided by paragraph (2) of this
30 subsection.

31 The payer shall report annually to the Commissioner of Banking and
32 Insurance the number of appeals it has received and the resolution of
33 each appeal.

34 (2) Any dispute regarding the determination of an internal appeal
35 conducted pursuant to paragraph (1) of this subsection may be
36 referred to arbitration as provided in this paragraph. The
37 Commissioner of Banking and Insurance shall contract with a
38 nationally recognized, independent organization that specializes in
39 arbitration to conduct the arbitration proceedings.

40 Any party may initiate an arbitration proceeding on or before the
41 90th calendar day following the receipt of the determination which is
42 the basis of the appeal, on a form prescribed by the Commissioner of
43 Banking and Insurance. No dispute shall be accepted for arbitration
44 unless the payment amount in dispute is \$1,000 or more, except that
45 individual health care providers may aggregate their own disputed
46 claim amounts for the purposes of meeting the threshold requirements

1 of this subsection. No dispute pertaining to medical necessity which
2 is eligible to be submitted to the Independent Health Care Appeals
3 Program established pursuant to section 11 of P.L.1997, c.192
4 (C.26:2S-11) shall be the subject of arbitration pursuant to this
5 subsection.

6 (3) The arbitrator shall conduct the arbitration proceedings
7 pursuant to the rules of the arbitration entity, including rules of
8 discovery subject to confidentiality requirements established by State
9 or federal law.

10 (4) An arbitrator's determination shall be:

11 (a) signed by the arbitrator;

12 (b) issued in writing, in a form prescribed by the Commissioner of
13 Banking and Insurance, including a statement of the issues in dispute
14 and the findings and conclusions on which the determination is based;
15 and

16 (c) issued on or before the 30th calendar day following the receipt
17 of the required documentation.

18 The arbitration shall be nonappealable and binding on all parties to
19 the dispute.

20 (5) If the arbitrator determines that a payer has withheld or denied
21 payment in violation of the provisions of this section, the arbitrator
22 shall order the payer to make payment of the claim, together with
23 accrued interest, on or before the 10th business day following the
24 issuance of the determination. If the arbitrator determines that a payer
25 has withheld or denied payment on the basis of information submitted
26 by the health care provider and the payer requested, but did not
27 receive, this information from the health care provider when the claim
28 was initially processed pursuant to subsection d. of this section or
29 reviewed under internal appeal pursuant to paragraph (1) of this
30 subsection, the payer shall not be required to pay any accrued interest.
31 In accordance with regulations adopted by the Commissioner of
32 Banking and Insurance, the cost of the arbitration proceedings,
33 including the payment of reasonable attorney's fees, shall be awarded
34 to the prevailing party.

35 (6) If the arbitrator determines that a health care provider has
36 engaged in a pattern and practice of improper billing and a refund is
37 due to the payer, the arbitrator may award the payer a refund,
38 including interest accrued at the rate of 20% per annum.

39 (7) The arbitrator shall file a copy of each determination with and
40 in the form prescribed by the Commissioner of Banking and Insurance.

41 f. As used in this subsection, "insured claim" or "claim" means a
42 claim by [an enrollee] a covered person for payment of benefits under
43 an insured health maintenance organization contract for which the
44 financial obligation for the payment of a claim under the health
45 maintenance organization coverage for health care services rests upon
46 the health maintenance organization.

1 g. Any person found in violation of this section with a pattern of
2 frequency as determined by the Commissioner of Banking and
3 Insurance shall be liable to a civil penalty as set forth in section 17 of
4 P.L. , c. (C.) (now before the Legislature as this bill).
5 (cf: P.L.1999, c.154, s.7.)

6
7 16. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to
8 read as follows:

9 10. a. Within 180 days of the adoption of a timetable for
10 implementation pursuant to section 1 of P.L.1999, c.154
11 (C.17B:30-23), a prepaid prescription service organization[,] or its
12 agent or a subsidiary that processes health care benefits claims as a
13 third party administrator, shall demonstrate to the satisfaction of the
14 Commissioner of Banking and Insurance that it will adopt and
15 implement all of the standards to receive and transmit health care
16 transactions electronically, according to the corresponding timetable,
17 and otherwise comply with the provisions of this section, as a
18 condition of its continued authorization to do business in this State.

19 The Commissioner of Banking and Insurance may grant extensions
20 or waivers of the implementation requirement when it has been
21 demonstrated to the commissioner's satisfaction that compliance with
22 the timetable for implementation will result in an undue hardship to a
23 prepaid prescription service organization, its subsidiary or its covered
24 enrollees.

25 b. Within 12 months of the adoption of regulations establishing
26 standard health care enrollment and claim forms by the Commissioner
27 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
28 (C.17B:30-23), a prepaid prescription service organization or a
29 subsidiary that processes health care benefits claims as a third party
30 administrator shall use the standard health care enrollment and claim
31 forms in connection with all contracts issued, delivered, executed or
32 renewed in this State.

33 c. Twelve months after the adoption of regulations establishing
34 standard health care enrollment and claim forms by the Commissioner
35 of Banking and Insurance pursuant to section 1 of P.L.1999, c.154
36 (C.17B:30-23), a prepaid prescription service organization shall
37 require that health care providers file all claims for payment for health
38 care services. A covered person who receives health care services
39 shall not be required to submit a claim for payment, but
40 notwithstanding the provisions of this subsection to the contrary, a
41 covered person shall be permitted to submit a claim on his own behalf,
42 at the covered person's option. All claims shall be filed using the
43 standard health care claim form applicable to the contract.

44 d. (1) Effective 180 days after the effective date of P.L.1999,
45 c.154, a prepaid prescription service organization or its
46 agent, hereinafter the payer, shall remit payment for every insured claim

1 submitted by [an enrollee or that enrollee's agent or assignee if the
2 contract provides for assignment of benefits] a covered person or
3 health care provider, no later than the 30th calendar day following
4 receipt of the claim by the payer or no later than the time limit
5 established for the payment of claims in the Medicare program
6 pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the
7 claim is submitted by electronic means, and no later than the 40th
8 calendar day following receipt if the claim is submitted by other than
9 electronic means, if:

10 (a) [the claim is an eligible claim for a health care service provided
11 by an eligible health care provider to a covered person under the
12 contract;

13 (b) the claim has no material defect or impropriety, including, but
14 not limited to, any lack of required substantiating documentation or
15 incorrect coding;

16 (c) there is no dispute regarding the amount claimed;] the health
17 care provider is eligible at the date of service;

18 (b) the person who received the health care service was covered on
19 the date of service;

20 (c) the claim is for a service or supply covered under the health
21 benefits plan;

22 (d) the claim is submitted with all the information requested by the
23 payer on the claim form or in other instructions distributed in advance
24 to the health care provider or covered person within 120 days of the
25 date of service; and

26 [(d)] (e) the payer has no reason to believe that the claim has been
27 submitted fraudulently[; and

28 (e) the claim requires no special treatment that prevents timely
29 payments from being made on the claim under the terms of the
30 contract].

31 (2) If all or a portion of the claim is denied by the payer because:

32 (a) [the claim is an ineligible claim;

33 (b)] the claim submission is incomplete because the required
34 substantiating documentation, which is specific to the health care
35 service provided to the covered person, has not been submitted to the
36 payer;

37 [(c)] (b) the diagnosis coding, procedure coding, or any other
38 required information to be submitted with the claim is incorrect; or

39 [(d)] (c) the payer disputes the amount claimed[; or

40 (e) the claim requires special treatment that prevents timely
41 payments from being made on the claim under the terms of the
42 contract],

43 the payer shall notify the [subscriber, or that subscriber's agent or
44 assignee if the contract provides for assignment of benefits] covered
45 person and health care provider, in writing or by electronic means, as

1 appropriate, within 30 days, of the following: if all or a portion of the
2 claim is denied, all the reasons for the denial; if the claim lacks the
3 required substantiating documentation[, including] or contains
4 incorrect coding, a statement as to what substantiating documentation,
5 specific to the health care service provided to the covered person, or
6 other information, is required to complete adjudication of the claim;
7 and if the amount of the claim is disputed, a statement that it is
8 disputed[; and if the claim requires special treatment that prevents
9 timely payments from being made, a statement of the special treatment
10 to which the claim is subject].

11 (3) If all or a portion of a claim cannot be entered into the claims
12 processing system for any of the following reasons:

13 (a) the health care provider is not eligible at the time of service;

14 (b) the person who received the health care service was not a
15 covered person at the time of service;

16 (c) the premium was not paid by or on the behalf of the covered
17 person; or

18 (d) the diagnosis coding, procedure coding or any other data
19 required to be submitted with the claim was missing.

20 the payer shall notify the covered person and health care provider
21 within seven days if the claim was submitted by electronic means, or
22 within 14 days if the claim was submitted by other than electronic
23 means, of that determination of denial, of all the reasons for the denial
24 or any information required to complete adjudication of the claim.

25 (4) Any portion of a claim that meets the criteria established in
26 paragraph (1) of this subsection shall be paid by the payer in
27 accordance with the time limit established in paragraph (1) of this
28 subsection.

29 [(4)] (5) A payer shall acknowledge receipt of a claim submitted
30 by electronic means from a health care provider or [subscriber]
31 covered person, no later than two working days following receipt of
32 the transmission of the claim.

33 [(5)] (6) If a payer subject to the provisions of P.L.1983, c.320
34 (C.17:33A-1 et seq.) has reason to believe that a claim has been
35 submitted fraudulently, it shall investigate the claim in accordance with
36 its fraud prevention plan established pursuant to section 1 of P.L.1993,
37 c.362 (C.17:33A-15), or refer the claim, together with supporting
38 documentation, to the Office of the Insurance Fraud Prosecutor in the
39 Department of Law and Public Safety established pursuant to section
40 32 of P.L.1998, c.21 (C.17:33A-16).

41 [(6)] (7) Payment of an eligible claim pursuant to paragraphs (1)
42 and [(3)] (4) of this subsection shall be deemed to be overdue if not
43 remitted to the claimant or his agent by the payer on or before the 30th
44 calendar day or the time limit established by the Medicare program,
45 whichever is earlier, following receipt by the payer of a claim

1 submitted by electronic means and on or before the 40th calendar day
2 following receipt of a claim submitted by other than electronic means.

3 In the event payment is withheld on all or a portion of a claim by a
4 payer pursuant to subparagraph ~~[(b)] (a)~~ of paragraph (2) or
5 subparagraph (d) of paragraph (3) of this subsection, the claims
6 payment shall be overdue if not remitted to the claimant or his agent
7 by the payer on or before the ~~[30th]~~ 15th calendar day or the time
8 limit established by the Medicare program, whichever is earlier, for
9 claims submitted by electronic means and the ~~[40th]~~ 25th calendar day
10 for claims submitted by other than electronic means, following receipt
11 by the payer of the required documentation or information or
12 modification of an initial submission.

13 (8) (a) No payer shall deny payment on all or a portion of a claim
14 because the payer requests documentation or information that is not
15 specific to the health care service provided to the covered person.

16 (b) No payer shall deny payment on all or a portion of a claim while
17 seeking coordination of benefits information unless good cause exists
18 for the payer to believe that other insurance is available to the covered
19 person. Good cause shall exist only if the payer's records indicate that
20 other coverage exists. Routine requests to determine whether
21 coordination of benefits exists shall not be considered good cause.

22 (c) In the event payment is withheld on all or a portion of a claim
23 by a payer pursuant to subparagraph (a) or (b) of this paragraph, the
24 claims payment shall be deemed to be overdue if not remitted to the
25 claimant or his agent by the payer on or before the 30th calendar day
26 or the time limit established by the Medicare program, whichever is
27 earlier, following receipt by the payer of a claim submitted by
28 electronic means or on or before the 40th calendar day following
29 receipt of a claim submitted by other than electronic means.

30 ~~[(7)]~~ (9) An overdue payment shall bear simple interest at the rate
31 of ~~[10%]~~ 20% per annum. The interest shall be paid to the health
32 care provider at the time the overdue payment is made.

33 (10) With the exception of claims that were submitted fraudulently
34 or submitted by health care providers that have a pattern of
35 inappropriate billing or claims that were subject to coordination of
36 benefits, no payer shall seek reimbursement for overpayment of a claim
37 previously paid pursuant to this section later than one year after the
38 date the first payment on the claim was made. At the time the
39 reimbursement request is submitted to the health care provider, the
40 payer shall provide written documentation that identifies the error
41 made by the payer in the processing or payment of the claim that
42 justifies the reimbursement request. No payer shall base a
43 reimbursement request for a particular claim on extrapolation of other
44 claims, except under the following circumstances:

45 (a) in judicial or quasi-judicial proceedings, including arbitration;

46 (b) in administrative proceedings; or

1 (c) in which relevant records required to be maintained by the
2 health care provider have been improperly altered or reconstructed, or
3 a material number of the relevant records are otherwise unavailable.

4 (11) (a) In seeking reimbursement for the overpayment from the
5 health care provider, except as provided for in subparagraph (b) of this
6 paragraph, no payer shall collect or attempt to collect:

7 (i) the funds for the reimbursement on or before the 45th calendar
8 day following the submission of the reimbursement request to the
9 health care provider;

10 (ii) the funds for the reimbursement if the health care provider
11 disputes the request and initiates an appeal on or before the 45th
12 calendar day following the submission of the reimbursement request
13 to the health care provider and until the health care provider's rights
14 to appeal set forth under paragraphs (1) and (2) of subsection e. of this
15 section are exhausted;

16 (iii) the funds for the reimbursement request by assessing them
17 against payment of any future claims submitted by the health care
18 provider, unless agreed to in writing by the health care provider; or

19 (iv) a late fee.

20 (b) If a payer has determined that the overpayment to the health
21 care provider is a result of fraud committed by the health care provider
22 and the payer has conducted its investigation and reported the fraud
23 to the Office of the Insurance Fraud Prosecutor as required by law, the
24 payer may collect an overpayment by assessing it against payment of
25 any future claim submitted by the health care provider.

26 (12) No health care provider shall seek reimbursement from a payer
27 or covered person for underpayment of a claim submitted pursuant to
28 this section later than one year from the date the first payment on the
29 claim was made, except if the claim is the subject of an appeal
30 submitted pursuant to subsection e. of this section or the claim is
31 subject to continual claims submission.

32 e. (1) A prepaid prescription service organization or its agent,
33 hereinafter the payer, shall establish an internal appeal mechanism to
34 resolve any dispute regarding compliance with the requirements of this
35 section. The payer shall conduct the appeal at no cost to the health
36 care provider.

37 A health care provider may initiate an appeal on or before the 90th
38 calendar day following receipt by the health care provider of the
39 payer's claims determination, which is the basis of the appeal, on a
40 form prescribed by the Commissioner of Banking and Insurance which
41 shall describe the type of substantiating documentation that must be
42 submitted with the form. The payer shall conduct a review of the
43 appeal and notify the health care provider of its determination on or
44 before the 10th calendar day following the receipt of the appeal form.
45 If the health care provider is not notified of the payer's determination

1 of the appeal within 10 days, the health care provider may refer the
2 dispute to arbitration⁰ as provided by paragraph (2) of this subsection.

3 If the payer issues a determination in favor of the health care
4 provider, the payer shall comply with the provisions of this section and
5 pay the amount of money in dispute, if applicable, with accrued
6 interest at the rate of 20% per annum, on or before the 30th calendar
7 day following the notification of the payer's determination on the
8 appeal.

9 If the payer issues a determination against the health care provider,
10 the payer shall notify the health care provider of its findings on or
11 before the 10th calendar day following the receipt of the appeal form
12 and shall include in the notification written instructions for referring
13 the dispute to arbitration as provided by paragraph (2) of this
14 subsection.

15 The payer shall report annually to the Commissioner of Banking and
16 Insurance the number of appeals it has received and the resolution of
17 each appeal.

18 (2) Any dispute regarding the determination of an internal appeal
19 conducted pursuant to paragraph (1) of this subsection may be
20 referred to arbitration as provided in this paragraph. The
21 Commissioner of Banking and Insurance shall contract with a
22 nationally recognized, independent organization that specializes in
23 arbitration to conduct the arbitration proceedings.

24 Any party may initiate an arbitration proceeding on or before the
25 90th calendar day following the receipt of the determination which is
26 the basis of the appeal, on a form prescribed by the Commissioner of
27 Banking and Insurance. No dispute shall be accepted for arbitration
28 unless the payment amount in dispute is \$1,000 or more, except that
29 individual health care providers may aggregate their own disputed
30 claim amounts for the purposes of meeting the threshold requirements
31 of this subsection. No dispute pertaining to medical necessity which
32 is eligible to be submitted to the Independent Health Care Appeals
33 Program established pursuant to section 11 of P.L.1997, c.192
34 (C.26:2S-11) shall be the subject of arbitration pursuant to this
35 subsection.

36 (3) The arbitrator shall conduct the arbitration proceedings
37 pursuant to the rules of the arbitration entity, including rules of
38 discovery subject to confidentiality requirements established by State
39 or federal law.

40 (4) An arbitrator's determination shall be:

41 (a) signed by the arbitrator;

42 (b) issued in writing, in a form prescribed by the Commissioner of
43 Banking and Insurance, including a statement of the issues in dispute
44 and the findings and conclusions on which the determination is based;
45 and

1 (c) issued on or before the 30th calendar day following the receipt
2 of the required documentation.

3 The arbitration shall be nonappealable and binding on all parties to
4 the dispute.

5 (5) If the arbitrator determines that a payer has withheld or denied
6 payment in violation of the provisions of this section, the arbitrator
7 shall order the payer to make payment of the claim, together with
8 accrued interest, on or before the 10th business day following the
9 issuance of the determination. If the arbitrator determines that a payer
10 has withheld or denied payment on the basis of information submitted
11 by the health care provider and the payer requested, but did not
12 receive, this information from the health care provider when the claim
13 was initially processed pursuant to subsection d. of this section or
14 reviewed under internal appeal pursuant to paragraph (1) of this
15 subsection, the payer shall not be required to pay any accrued interest.
16 In accordance with regulations adopted by the Commissioner of
17 Banking and Insurance, the cost of the arbitration proceedings,
18 including the payment of reasonable attorney's fees, shall be awarded
19 to the prevailing party.

20 (6) If the arbitrator determines that a health care provider has
21 engaged in a pattern and practice of improper billing and a refund is
22 due to the payer, the arbitrator may award the payer a refund,
23 including interest accrued at the rate of 20% per annum.

24 (7) The arbitrator shall file a copy of each determination with and
25 in the form prescribed by the Commissioner of Banking and Insurance.

26 f. As used in this subsection, "insured claim" or "claim" means a
27 claim by [an enrollee] a covered person for payment of benefits under
28 an insured prepaid prescription service organization contract for which
29 the financial obligation for the payment of a claim under the contract
30 rests upon the prepaid prescription service organization.

31 g. Any person found in violation of this section with a pattern of
32 frequency as determined by the Commissioner of Banking and
33 Insurance shall be liable to a civil penalty as set forth in section 17 of
34 P.L. , c. (C.) (now before the Legislature as this bill).

35 (cf: P.L.1999, c.154, s.10)

36
37 17. a. (New section) The Commissioner of Banking and Insurance
38 shall enforce the provisions of sections 2, 3, 4, 5, 6, 7 and 10 of
39 P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1,
40 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by this act. A
41 payer found in violation of those sections shall be liable for a civil
42 penalty of not less than \$250 and not greater than \$10,000 for each
43 day that the payer is in violation if reasonable notice in writing is given
44 of the intent to levy the penalty and, at the discretion of the
45 commissioner, the payer has 30 days, or such additional time as the
46 commissioner shall determine to be reasonable, to remedy the

1 condition which gave rise to the violation and fails to do so within the
2 time allowed. The penalty shall be collected by the commissioner in
3 the name of the State in a summary proceeding in accordance with the
4 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
5 seq.).

6 b. If the Commissioner of Banking and Insurance has reason to
7 believe that a person is engaging in a practice or activity, for the
8 purpose of avoiding or circumventing the legislative intent of sections
9 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12,
10 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1)
11 as amended by this act, the Commissioner of Banking and Insurance
12 is authorized to promulgate rules or regulations necessary to prohibit
13 that practice or activity and levy a civil penalty of not less than \$250
14 and not more than \$10,000 for each day that person is in violation of
15 that rule or regulation.

16 c. For the purpose of administering the provisions of sections 2, 3,
17 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12,
18 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1)
19 as amended by this act, 50% of the penalty monies collected pursuant
20 to subsection a. of this section shall be deposited into the General
21 Fund. For the purpose of providing payments to hospitals in
22 accordance with the formula used for the distribution of charity care
23 subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-
24 18.51 et seq.), 50% of the penalty monies collected pursuant to
25 subsection a. of this section shall be deposited into the Health Care
26 Subsidy Fund established pursuant to section 8 of P.L.1992, c.160
27 (C.26:2H-18.58).

28

29 18. (New section) The Commissioner of Banking and Insurance
30 shall promulgate rules and regulations pursuant to the "Administrative
31 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to
32 carry out the purposes of this act.

33

34 19. (New section) This act shall be liberally construed to
35 effectuate the legislative purposes of the act.

36

37 20. This act shall take effect on the 180th day after enactment, but
38 the Commissioner of Banking and Insurance may take such
39 anticipatory administrative action in advance as shall be necessary for
40 the implementation of this act.

41

42

43

STATEMENT

44

45 This bill, entitled the "Health Claims Authorization, Processing and
46 Payment Act," is intended to ensure that health care providers receive

1 timely reimbursement to which they are entitled from insurance
2 carriers for services delivered to persons covered under health
3 insurance policies. Specifically, the bill: requires that utilization
4 management be performed in authorizing the delivery of health care
5 services; makes changes to the law regarding the processing and
6 payment of health care claims; and provides for an arbitration process
7 to resolve claims disputes.

8 As provided in the bill, a payer is required to respond to a hospital
9 or physician's request for authorization of services by either approving
10 or denying the request based on a utilization management decision.
11 Any denial of a request or limitation imposed by a payer on a
12 requested service shall be made by a State licensed physician and shall
13 be communicated to the hospital or physician within the time frames
14 provided in the bill. As used in the bill, a "payer" means a health
15 maintenance organization, health, hospital, or medical service
16 corporation, or commercial insurer which requires that utilization
17 management be performed to authorize the approval of a health care
18 service and includes a certified or licensed organized delivery system.

19 The bill further provides that upon admission to a hospital or prior
20 to receiving health care services, the hospital may obtain written
21 consent from the covered person, authorizing the hospital to appeal to
22 the Independent Health Care Appeals Program a payer's determination
23 that a benefit or service is not medically necessary.

24 This bill provides a separate two-step appeals process to resolve
25 any dispute regarding the compliance with the provisions of the bill
26 concerning the authorization of services by payers. The process
27 involves an internal appeals mechanism, and may involve
28 nonappealable and binding arbitration. No dispute eligible to be
29 submitted to the Independent Health Care Appeals Program shall be
30 subject to arbitration provided in this bill.

31 The bill also makes several changes to current law regarding the
32 processing and prompt payment of claims for health care services
33 rendered by health care providers including, but not limited to,
34 physicians and other licensed health care professionals and hospitals
35 and other health care facilities. These provisions apply to hospital,
36 medical, and health service corporations, commercial individual and
37 group insurers, health maintenance organizations, and prepaid
38 prescription service organizations.

39 The bill increases the interest for overdue, eligible claims from 10%
40 to 20% per annum and requires the interest payment to be included in
41 the overdue payment.

42 The bill describes a class of claims that must be handled differently
43 because they cannot be entered into the claims processing system, and
44 provides a process for handling this class of claims.

45 This bill limits the time frame in which a payer can seek
46 reimbursement from a provider for an overpayment made on a claim

1 to one year from the date the first payment was made. Providers have
2 45 days after they have received the required documentation
3 substantiating the request, to pay the requested reimbursement or
4 initiate an appeal to dispute the request. Payment shall not be due
5 until the providers' rights to appeal set forth under the bill are
6 exhausted. Payers may not collect the funds for the reimbursement by
7 assessing them against the payment of future claims or assess a
8 monetary penalty against providers.

9 The bill provides a two-part appeals process to resolve disputes
10 regarding the processing and payment of claims. The process
11 involves an internal appeals mechanism and may involve nonappealable
12 and binding arbitration.

13 Finally, this bill requires the Commissioner of the Department of
14 Banking and Insurance to enforce this bill and sets forth civil penalties
15 for violation of the bill's provisions.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 2824

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 5, 2005

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 2824.

As amended, this bill requires that utilization management be performed by health insurers in authorizing the delivery of health care services; makes changes to the law regarding the processing and payment of claims for reimbursement of health care services; provides for an arbitration process to resolve disputes concerning compliance with the provisions of the bill; and directs an advisory board established under current law to make recommendations to State agencies regarding the Statewide policy on electronic health records.

The bill requires that a health insurer, herein a "payer," shall respond to a hospital or physician's request for authorization of service by either approving or denying the request based on a utilization management decision. Any denial of a request or limitation imposed by a payer on a requested service shall be made by a State-licensed physician and shall be communicated within the time frames provided in the bill. If the payer does not respond to the request within the applicable time frame, the request shall be deemed approved, and the payer shall be responsible for payment of the covered services. Payment of services provided by a network hospital shall be based on the contracted rate.

The bill requires payers to provide, through an Internet website, information that describes the payers' utilization management and claims processing and payment policies. The information or changes in the information must be posted 30 days before becoming effective.

Health care providers are authorized to appeal on behalf of a covered person, only with the covered person's consent, a payer's utilization management decision to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:25-11). The consent may be obtained at any time and may be revoked by the covered person at any time. Currently under regulation, health care providers are authorized to appeal on a covered person's behalf with his consent. The provider shall notify the covered person as to the progress of the appeal and shall bear all costs

associated with the appeal that are normally paid by the covered person. These do not change the type of appeals that can be accepted into the appeals process.

The bill makes various changes to the current law regarding the processing and prompt payment of claims for health care services. The bill requires that a claim, so long as it meets the standards set forth in the bill, be paid within 30 days, if the claim was submitted electronically, or 40 days, if it was submitted by means other than electronic form. If a claim is not paid within 30 or 40 days, as applicable, the payer shall communicate to the health care provider the reasons, as enumerated in the bill, the claim will not be paid.

However, with respect to claims that cannot be adjudicated because of missing diagnosis coding or any other missing data, the bill requires early notification of nonpayment. The payer shall electronically notify a health care provider or its agent within 7 days if an electronically submitted claim is missing various technical data. After receiving the data, the payer has 30 days to pay the claim or notify the provider of nonpayment.

A claim shall be considered overdue if the submitting health care provider is not paid or notified of nonpayment within the time frames established in the bill. Overdue claims shall accrue interest at 12% per annum.

Except in cases of fraud, the bill limits to 18 months the time frame in which a payer can seek reimbursement from a provider for overpayment of a claim. Likewise, a health care provider shall only seek reimbursement for underpayment of a claim within 18 months from the date the first payment was received. The bill describes the circumstances in which the payer may seek reimbursement and the procedures through which the payer may collect the reimbursement funds.

The bill establishes a two-part appeals process to resolve disputes concerning compliance with the provisions regarding utilization management and the processing and payment of claims. No dispute concerning medical necessity, which is eligible to be submitted to the Independent Health Care Appeals Program, shall be subject to the appeal process established by the bill. The process involves an internal appeals mechanism, and if applicable, is followed by nonappealable, binding arbitration conducted by an independent arbitrator contracted by the Commissioner of Banking and Insurance.

The bill requires the commissioner to enforce the provisions of the bill concerning utilization management and claims processing and payment, and sets forth civil penalties for violation of the bill's provisions.

Finally, to increase the efficiency of claims processing and payment, the bill requires an advisory board already established under law to make recommendations to include a Statewide policy on electronic health records with the State's health information electronic data interchange technology policy. Further, any State department

that uses medical records or health care claims shall participate on the board, and if asked, provide assistance to Thomas Edison State College in its project to monitor the effectiveness of the State's health information technology policy.

ASSEMBLY, No. 3496

STATE OF NEW JERSEY
211th LEGISLATURE

INTRODUCED NOVEMBER 8, 2004

Sponsored by:

Assemblyman NEIL M. COHEN

District 20 (Union)

SYNOPSIS

"Health and Dental Claims Authorization, Processing and Payment Act."

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning health and dental claims authorization, processing
2 and payment and supplementing Title 17B of the New Jersey
3 Statutes.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. This act shall be known and may be cited as the "Health and
9 Dental Claims Authorization, Processing and Payment Act."

10
11 2. The Legislature finds and declares that:

12 a. Health care services available under health benefits plans must
13 be promptly provided to covered persons under all circumstances,
14 along with timely reimbursement to health care providers for their
15 services rendered.

16 b. However, confusion still exists among consumers, health care
17 providers and carriers with respect to time frames for communication
18 of determinations by carriers to deny, reduce or terminate benefits
19 under the provisions of a health benefits plan based upon utilization
20 management decisions, which determinations must be communicated
21 as quickly and efficiently as possible.

22 c. Because both consumers and health care providers have
23 experienced repeated denials or failure by carriers to respond to them
24 in a timely manner with respect to utilization management
25 determinations, many health care providers have found themselves
26 financially uncompensated when carriers have failed to respond to
27 certain requests for authorization of health care services.

28 d. Because these occurrences reflect negatively on health insurance
29 carriers and because it is fair and reasonable for health care providers
30 to receive reimbursement for health care services delivered to covered
31 persons under their health benefits plans, it is appropriate for the
32 Legislature now to establish uniform procedures and guidelines for
33 health care providers and health insurance carriers to follow in
34 communicating and following utilization management decisions and
35 determinations on behalf of consumers.

36
37 3. As used in this act:

38 "Authorization" means a determination by a carrier that an
39 admission, availability of health care services, continued stay or other
40 health care service has been reviewed and, based on the information
41 provided, satisfies the carrier's requirements for medical necessity,
42 appropriateness, health care setting, level of care and effectiveness.

43 "Carrier" means an insurance company, health service corporation,
44 hospital service corporation, medical service corporation or health
45 maintenance organization authorized to issue health benefits plans in
46 this State.

1 "Commissioner" means the Commissioner of Banking and
2 Insurance.

3 "Covered person" means a person on whose behalf a carrier offering
4 the plan is obligated to pay benefits or provide services pursuant to the
5 health benefits plan.

6 "Covered service" means a health care service provided to a
7 covered person under a health benefits plan for which the carrier is
8 obligated to pay benefits or provide services.

9 "Health benefits plan" means a benefits plan which pays or provides
10 hospital and medical expense benefits for covered services, and is
11 delivered or issued for delivery in this State by or through a carrier.
12 Health benefits plan includes, but is not limited to, Medicare
13 supplement coverage and Medicare+Choice contracts to the extent not
14 otherwise prohibited by federal law. For the purposes of this act,
15 health benefits plan shall not include the following plans, policies or
16 contracts: accident only; credit; disability; long-term care; CHAMPUS
17 supplement coverage; coverage arising out of a workers' compensation
18 or similar law; automobile medical payment insurance; personal injury
19 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et
20 seq.); or hospital confinement indemnity coverage.

21 "Health care provider" means an individual or entity which, acting
22 within the scope of its licensure or certification, provides a covered
23 service defined by the health benefits plan. Health care provider
24 includes, but is not limited to, a physician and other health care
25 professionals licensed pursuant to Title 45 of the Revised Statutes, and
26 a hospital and other health care facilities licensed pursuant to Title 26
27 of the Revised Statutes.

28 "Network provider" means a participating health care provider
29 under contract or other agreement with a carrier to furnish health care
30 services to covered persons.

31 "Payer" means a carrier which requires that utilization management
32 be performed to authorize the approval of a health care service and
33 includes an organized delivery system that is certified by the
34 Commissioner of Health and Senior Services or licensed by the
35 commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

36 "Payer's agent" or "agent" means an intermediary contracted or
37 affiliated with the payer to perform administrative functions including,
38 but not limited to, the payment of claims or the receipt, processing or
39 transfer of claims or claim information.

40 "Utilization management" means a system for reviewing the
41 appropriate and efficient allocation of health care services under a
42 health benefits plan according to specified guidelines, in order to
43 recommend or determine whether, or to what extent, a health care
44 service given or proposed to be given to a covered person should or
45 will be reimbursed, covered, paid for, or otherwise provided under the
46 health benefits plan. The system may include: preadmission

1 certification; the application of practice guidelines; continued stay
2 review; discharge planning; preauthorization of ambulatory care
3 procedures; and retrospective review.

4
5 4. a. A payer shall respond to a health care provider's request for
6 authorization of health care services by either approving or denying
7 the request based on a utilization management decision. Any denial of
8 a request or limitation imposed by a payer on a requested service shall
9 be made by a physician licensed in this State and communicated to the
10 provider by facsimile or E-mail, as follows:

11 (1) In the case of a request for authorization for a covered person
12 who is receiving inpatient hospital services or care rendered in the
13 emergency department of a hospital, the payer shall communicate the
14 denial of the request or the limitation imposed on the requested service
15 to the provider within a time frame appropriate to the medical
16 exigencies of the case but no later than 24 hours following the time the
17 request was made;

18 (2) In the case of a request for authorization for a covered person
19 who is currently receiving health care services in an outpatient or other
20 setting, including but not limited to, a clinic, rehabilitation facility or
21 nursing home, the payer shall communicate the denial of the request
22 or the limitation imposed on the requested service to the provider
23 within a time frame appropriate to the medical exigencies of the case
24 but no later than three business days following the time the request
25 was made; and

26 (3) If the payer requires additional information to approve or deny
27 a request for authorization, the payer shall so notify the provider by
28 facsimile or E-mail within the applicable time frame set forth in
29 paragraph (1) or (2) of this subsection and shall identify the specific
30 information needed to approve or deny the request for authorization.
31 If the payer is unable to approve or deny a request for authorization
32 within the applicable time frame set forth in paragraph (1) or (2) of
33 this subsection because of the need for this additional information, the
34 payer shall have an additional period within which to approve or deny
35 the request, as follows:

36 (a) in the case of a request for authorization for a covered person
37 who is receiving inpatient hospital services or care rendered in the
38 emergency department of a hospital, no more than 12 hours beyond
39 the time of receipt by the payer from the provider of the additional
40 information that the payer has identified as needed to approve or deny
41 the request for authorization; and

42 (b) in the case of a request for authorization for a covered person
43 who is currently receiving health care services in another setting, no
44 more than two business days beyond the time of receipt by the payer
45 from the provider of the additional information that the payer has
46 identified as needed to approve or deny the request for authorization.

1 b. Payers and providers shall have appropriate staff available
2 between the hours of 9 a.m. and 5 p.m., seven days a week, to respond
3 to authorization requests within the time frames established pursuant
4 to subsection a. of this section.

5 c. If a payer fails to respond to an authorization request within the
6 time frames established pursuant to subsection a. of this section, the
7 health care provider's request shall be deemed approved and the payer
8 shall be responsible to the health care provider for the payment of the
9 requested services at the full contractual rate.

10
11 5. a. A payer, or its agent, shall reimburse a hospital if:

12 (1) the hospital requested authorization from the payer and
13 received approval for the health care services delivered prior to
14 rendering the service; or

15 (2) the hospital requested authorization from the payer for the
16 health care services prior to rendering the services and the payer failed
17 to respond to the hospital within the time frames established pursuant
18 to subsection a. of section 4 of this act.

19 b. If the hospital or other health care provider is a network
20 provider of the payer, health care services shall be reimbursed at the
21 provider's contracted rate for the services provided and based on the
22 setting in which the services are delivered.

23 c. A payer shall reimburse a hospital for all medically necessary
24 services rendered to the covered person at the contracted rate for
25 services provided if it has reimbursed another health care provider for
26 rendering medically necessary care to that same covered person at the
27 hospital.

28 d. A payer, or its agent, shall not amend a claim by changing the
29 diagnostic code assigned to the services rendered by the health care
30 provider without providing written justification.

31 e. If a payer has determined that a covered person who is an
32 inpatient in a hospital requires medically necessary health care services
33 that are not available or provided at the hospital or are less than the
34 acute level of care provided at the hospital, the payer shall be
35 responsible for identifying an available contracted health care provider
36 that offers the required covered services and that will accept the
37 covered person. The payer shall pay the hospital in accordance with
38 the contracted rate until an appropriate placement can be made.

39
40 6. a. A payer, or its agent, shall reimburse a health care provider
41 for all medically necessary services rendered to a covered person that
42 are covered under the health benefits plan, including emergency and
43 urgent care health care services and all tests necessary, according to
44 nationally recognized treatment protocols as developed by the federal
45 government, to determine the nature of an illness or injury.

46 b. A payer shall provide each network health care provider with a

1 copy of all clinical criteria guidelines used by the payer or agent to
2 determine the medical necessity of health care services. These
3 guidelines may be used by the payer only as a screening tool and may
4 not be applied without considering the covered person's individual
5 health care circumstances. The payer or agent shall notify each
6 network provider in writing of any proposed change in the guidelines
7 at least 60 days prior to implementing the change.

8
9 7. a. Upon admission to a hospital or prior to receiving health care
10 services, a covered person or a person designated by the covered
11 person may sign a consent form authorizing a health care provider, on
12 the covered person's behalf, to appeal a determination by a payer to
13 deny, reduce or terminate a health care benefit or deny payment for a
14 health care service based upon the payer's determination that the health
15 care benefit or service is not medically necessary, and which consent
16 would be valid for all stages of the payer's informal and formal appeals
17 process and the Independent Health Care Appeals Program established
18 pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11).

19 b. The health care provider shall provide notice to the covered
20 person whenever the health care provider institutes an appeal of a
21 payer's determination to deny, reduce or terminate a health care benefit
22 or deny payment for a health care service and shall provide additional
23 notice to the covered person each time the health care provider
24 continues that appeal to the next stage of the payer's appeal process,
25 including any appeal to an independent utilization review organization
26 pursuant to section 12 of P.L.1997, c.192 (C.26:2S-12).

27 c. The covered person shall retain the right to revoke at any time
28 his consent granted pursuant to subsection a. of this section.

29
30 8. a. A contract between a payer and any health care provider
31 other than a dentist shall contain a provision, approved by the
32 commissioner, that provides that any dispute regarding the recovery
33 of payments due under the terms of this act, shall, on the initiative of
34 any party to the dispute, be referred to arbitration as provided in this
35 section.

36 b. Arbitration proceedings shall be conducted by an independent
37 third-party. A party shall initiate an arbitration proceeding within 90
38 days of receipt of a written determination, on a form prescribed by the
39 commissioner, which is the basis for the arbitration. No dispute shall
40 be accepted for arbitration unless the payment amount in dispute is
41 \$1,000 or more, except that disputed payment amounts may be
42 aggregated for the purposes of meeting the threshold requirements of
43 this section.

44 c. No dispute pertaining to medical necessity which is eligible to be
45 submitted to the Independent Health Care Appeals Program
46 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)

1 shall be the subject of arbitration pursuant to this section.

2 d. An arbitrator may review any records in connection with the
3 payment dispute, including the claims file of the payer, or of the health
4 care provider or the covered person to whom payment is due, subject
5 to confidentiality requirements established by State or federal law.

6 e. (1) An arbitrator*s determination shall be in writing, in a form
7 prescribed by the commissioner, and shall state the issues in dispute
8 and the findings and conclusions on which the determination is based.
9 The determination shall be signed by the arbitrator and shall be binding
10 on all parties to the dispute.

11 (2) If the arbitrator determines that a payer has withheld or denied
12 payment in violation of the provisions of this act, the arbitrator shall
13 order the payer to make payment of the claim within 10 business days.

14 (3) In accordance with regulations adopted by the commissioner,
15 the cost of the arbitration proceedings, including the payment of
16 reasonable attorney's fees, shall be awarded to the prevailing party.

17

18 9. a. For the purposes of this section:

19 "Dental care provider" means a dentist or other health care provider
20 licensed pursuant to Title 45 of the Revised Statutes to perform dental
21 care services in this State.

22 "Dental care service" means a service provided to a covered person
23 under a dental plan.

24 "Dental carrier" means a dental service corporation established
25 pursuant to the "Dental Service Corporation Act of 1968," P.L.1968,
26 c.305 (C.17:48C-1 et seq.), a dental plan organization established
27 pursuant to the "Dental Plan Organization Act," P.L.1979, c.478
28 (C.17:48D-1 et seq.) or a carrier authorized to issue dental plans in
29 this State.

30 "Dental claim" means a request to a third party for payment of a
31 covered dental care service.

32 "Dental plan" means a benefits plan which pays or provides dental
33 expense benefits for covered services and is delivered or issued for
34 delivery in this State by or through a dental service corporation or
35 dental plan organization authorized to issue dental plans in this State.

36 "Predetermination request" means a request transmitted to a dental
37 carrier in connection with a dental plan to issue an advance
38 determination of coverage, which may include the amount of benefits
39 then available for a dental care service prior to rendering the dental
40 service or services.

41 b. A dental carrier shall respond to a dental care provider's
42 predetermination request or request for authorization of dental care
43 services by either approving or denying the request based on a
44 utilization management decision. Any denial of a request or limitation
45 imposed on a requested service shall be made by a dentist licensed in
46 this State, and communicated to the provider by facsimile or E-mail,

1 as follows:

2 (1) In the case of a predetermination request or request for
3 authorization for a covered person who is receiving care rendered in
4 the emergency department of a hospital, the dental carrier shall
5 communicate the denial of the request or the limitation imposed on the
6 requested service to the provider within a time frame appropriate to
7 the medical exigencies of the case but no later than 24 hours following
8 the time the request was made;

9 (2) In the case of a predetermination request or request for
10 authorization for a covered person who is currently receiving dental
11 care services in an outpatient setting, the dental carrier shall
12 communicate the denial of the request or the limitation imposed on the
13 requested service to the provider within a time frame appropriate to
14 the medical exigencies of the case but no later than five business days
15 following the time the request was made; and

16 (3) If the dental carrier requires additional information to approve
17 or deny a request for authorization, the dental carrier shall so notify
18 the provider by facsimile or E-mail within the applicable time frame set
19 forth in paragraph (1) or (2) of this subsection and shall identify the
20 specific information needed to approve or deny the request for
21 predetermination or authorization. If the dental carrier is unable to
22 approve or deny a request for predetermination or authorization within
23 the applicable time frame set forth in paragraph (1) or (2) of this
24 subsection because of the need for this additional information, the
25 dental carrier shall have an additional period within which to approve
26 or deny the request, as follows:

27 (a) in the case of a request for a predetermination request or
28 authorization for a covered person who is receiving care rendered in
29 the emergency department of a hospital, no more than 12 hours
30 beyond the time of receipt by the dental carrier from the provider of
31 the additional information that the dental carrier has identified as
32 needed to approve or deny the request for predetermination or
33 authorization; and

34 (b) in the case of a request for predetermination or authorization
35 for a covered person who is currently receiving health care services in
36 another setting, no more than two business days beyond the time of
37 receipt by the dental carrier from the provider of the additional
38 information that the dental carrier has identified as needed to approve
39 or deny the request for authorization.

40 c. Dental carriers and dental care providers shall have appropriate
41 staff available between the hours of 9 a.m. and 5 p.m., five days a
42 week, to respond to predetermination or authorization requests within
43 the time frames established pursuant to subsection a. of this section.

44 d. If a dental carrier fails to respond to a predetermination or
45 authorization request within the time frames established pursuant to
46 subsection a. of this section, the dental care provider's request shall be

1 deemed approved and the dental carrier shall be responsible to the
2 dental care provider for the payment of the requested services at the
3 full contractual rate.

4
5 10. The commissioner shall enforce the provisions of this act. A
6 payer or dental carrier found in violation of the provisions of this act
7 shall be liable to a civil penalty of not less than \$250 and not greater
8 than \$10,000 for each day that the payer or dental carrier is in
9 violation of the act if reasonable notice in writing is given of the intent
10 to levy the penalty and, at the discretion of the commissioner, the
11 payer or dental carrier has 30 days, or such additional time as the
12 commissioner shall determine to be reasonable, to remedy the
13 condition which gave rise to the violation, and fails to do so within the
14 time allowed. The penalty shall be collected by the commissioner in
15 the name of the State in a summary proceeding in accordance with the
16 "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et
17 seq.).

18
19 11. The commissioner shall promulgate rules and regulations
20 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
21 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

22
23 12. This act shall take effect on the 120th day after enactment, but
24 the commissioner may take such anticipatory administrative action in
25 advance as shall be necessary for the implementation of this act.

26
27
28 STATEMENT

29
30 This bill, the "Health and Dental Claims Authorization, Processing
31 and Payment Act," is intended to ensure that health care providers,
32 including, but not limited to physicians, dentists and other licensed
33 health care professionals, hospitals and other health care facilities,
34 receive reimbursement to which they are entitled from payers for
35 health care services delivered to covered persons under health
36 maintenance organization (HMO) contracts, health, hospital and
37 medical service corporation contracts, health insurance policies and
38 dental plans.

39 The bill defines "payer" as a carrier (HMO, health, hospital, medical
40 service corporation or commercial insurer) which requires that
41 utilization management be performed to authorize the approval of a
42 health care service, and includes an organized delivery system that is
43 certified by the Commissioner of Health and Senior Services or
44 licensed by the Commissioner of Banking and Insurance.

45 The bill provides that a payer shall respond to a health care
46 provider's request for authorization of services by either approving or

1 denying the request based on a utilization management decision. Any
2 denial of a request or limitation imposed on a requested service shall
3 be made by a State licensed physician and shall be communicated to
4 the provider by facsimile or E-mail within a time frame appropriate to
5 the medical exigencies of the case, but no later than 24 hours in the
6 case of a request for authorization for a covered person who is
7 receiving inpatient hospital or emergency room care, and no later than
8 three business days for a covered person who is receiving health care
9 services in another setting. If the payer requires additional information
10 to approve or deny a request for authorization, the payer shall notify
11 the provider by facsimile or E-mail within the applicable time frame
12 and shall identify the specific information needed to approve or deny
13 the request for authorization. If the payer is unable to approve or
14 deny a request for authorization within those time frames because of
15 the need for this additional information, the bill provides that the payer
16 shall have an additional time period within which to approve or deny
17 the request.

18 If a payer fails to respond to an authorization request within the
19 required time frames, the health care provider's request shall be
20 deemed approved and the payer shall be responsible to the health care
21 provider for the payment of the requested services.

22 The bill provides that a payer:

23 - shall reimburse a hospital if the hospital requested authorization
24 from the payer and received approval for the health care services
25 delivered prior to rendering the service or the hospital requested
26 authorization from the payer for the health care services prior to
27 rendering the services and the payer failed to respond to the hospital
28 within the time frames established under the bill;

29 - shall reimburse a hospital for all medically necessary services
30 rendered to the covered person at the contracted rate for services
31 provided if it has reimbursed another health care provider for
32 rendering medically necessary care to that same covered person at the
33 hospital;

34 - shall not amend a claim by changing the diagnostic code assigned
35 to the services rendered by the health care provider without providing
36 written justification; and

37 - shall reimburse a health care provider for all medically necessary
38 services rendered to a covered person that are covered under the
39 health benefits plan, including emergency and urgent care health care
40 services and all tests necessary, in accordance with nationally
41 recognized treatment protocols, to determine the nature of an illness
42 or injury.

43 The bill also specifies that if a payer has determined that a covered
44 person who is an inpatient in a hospital requires medically necessary
45 health care services that are not available or provided at the hospital
46 or are less than the acute level of care provided at the hospital, the

1 payer shall be responsible for identifying an available contracted health
2 care provider that offers the required covered services and that will
3 accept the covered person. The payer shall pay the hospital in
4 accordance with the contracted rate until an appropriate placement can
5 be made.

6 The bill provides that upon admission to a hospital or prior to
7 receiving health care services, a covered person or a person designated
8 by the covered person may sign a consent form authorizing a health
9 care provider, on the covered person's behalf, to appeal a
10 determination by a payer to deny, reduce or terminate a health care
11 benefit or deny payment for a health care service based upon the
12 payer's determination that the health care benefit or service is not
13 medically necessary and which consent would be valid for all stages of
14 the payer's appeals process and the Independent Health Care Appeals
15 Program. The health care provider shall provide notice to the covered
16 person whenever an appeal is initiated and provide additional notice
17 each time the health care provider continues that appeal to the next
18 stage of the payer's appeals process. A covered person retains his
19 right to revoke his consent at any time.

20 The bill further provides that a contract between a payer and a
21 health care provider other than a dentist shall contain a provision that
22 any dispute regarding the recovery of payments, shall, on the initiative
23 of any party to the dispute, be referred to binding arbitration. The
24 cost of the arbitration proceedings, including the payment of
25 reasonable attorney's fees, shall be awarded to the prevailing party.

26 In recognition that dental predetermination requests and requests
27 for authorization for dental services between dentists and dental plans
28 are different from similar requests between other health care providers
29 and insurance carriers, the bill provides for certain procedures with
30 respect to dental claims.

31 Finally, the bill provides for the imposition of civil monetary
32 penalties for violations of the bill's provisions.

ASSEMBLY, No. 3743

STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED JANUARY 24, 2005

Sponsored by:

Assemblywoman LORETTA WEINBERG

District 37 (Bergen)

Assemblyman NEIL M. COHEN

District 20 (Union)

Co-Sponsored by:

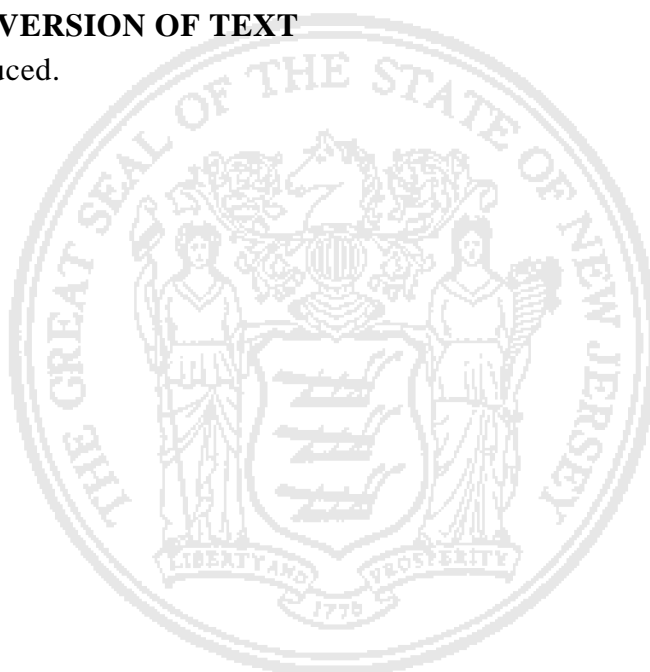
Assemblyman Conaway

SYNOPSIS

Limits period for reimbursement from providers for overpayment on health care claims to 18 months.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 5/3/2005)

1 AN ACT concerning reimbursement for overpayment on health care
2 claims and supplementing various parts of the statutory law.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. a. A hospital service corporation or its agent shall not seek
8 reimbursement for overpayment of a claim previously paid pursuant to
9 section 2 of P.L.1999, c.154 (C.17:48-8.4) for a health care service
10 provided to a covered person by an eligible health care provider later
11 than 18 months after the date the claim was paid. If the hospital
12 service corporation or its agent seeks reimbursement for the
13 overpayment, it shall provide written documentation to the health care
14 provider that substantiates the reason for the reimbursement request.

15 b. In seeking reimbursement for the overpayment, the hospital
16 service corporation or its agent shall not:

17 (1) require payment earlier than the 60th day following receipt of
18 the documentation by the health care provider;

19 (2) assess the reimbursement against the payment of any future
20 claims; or

21 (3) collect or attempt to collect from the health care provider a
22 penalty, including, but not limited to, an interest charge or a late fee.

23
24 2. a. A medical service corporation or its agent shall not seek
25 reimbursement for overpayment of a claim previously paid pursuant to
26 section 3 of P.L.1999, c.154 (C.17:48A-7.12) for a health care service
27 provided to a covered person by an eligible health care provider later
28 than 18 months after the date the claim was paid. If the medical
29 service corporation or its agent seeks reimbursement for the
30 overpayment, it shall provide written documentation to the health care
31 provider that substantiates the reason for the reimbursement request.

32 b. In seeking reimbursement for the overpayment, the medical
33 service corporation or its agent shall not:

34 (1) require payment earlier than the 60th day following receipt of
35 the documentation by the health care provider;

36 (2) assess the reimbursement against the payment of any future
37 claims; or

38 (3) collect or attempt to collect from the health care provider a
39 penalty, including, but not limited to, an interest charge or a late fee.

40
41 3. a. A health service corporation or its agent shall not seek
42 reimbursement for overpayment of a claim previously paid pursuant to
43 section 4 of P.L.1999, c.154 (C.17:48E-10.1) for a health care service
44 provided to a covered person by an eligible health care provider later
45 than 18 months after the date the claim was paid. If the health service
46 corporation or its agent seeks reimbursement for the overpayment, it

1 shall provide written documentation to the health care provider that
2 substantiates the reason for the reimbursement request.

3 b. In seeking reimbursement for the overpayment, the health
4 service corporation or its agent shall not:

5 (1) require payment earlier than the 60th day following receipt of
6 the documentation by the health care provider;

7 (2) assess the reimbursement against the payment of any future
8 claims; or

9 (3) collect or attempt to collect from the health care provider a
10 penalty, including, but not limited to, an interest charge or a late fee.

11

12 4. a. An individual health insurer or its agent shall not seek
13 reimbursement for overpayment of a claim previously paid pursuant to
14 section 5 of P.L.1999, c.154 (C.17B:26-9.1) for a health care service
15 provided to a covered person by an eligible health care provider later
16 than 18 months after the date the claim was paid. If the insurer or its
17 agent seeks reimbursement for the overpayment, it shall provide
18 written documentation to the health care provider that substantiates
19 the reason for the reimbursement request.

20 b. In seeking reimbursement for the overpayment, the insurer or its
21 agent shall not:

22 (1) require payment earlier than the 60th day following receipt of
23 the documentation by the health care provider;

24 (2) assess the reimbursement against the payment of any future
25 claims; or

26 (3) collect or attempt to collect from the health care provider a
27 penalty, including, but not limited to, an interest charge or a late fee.

28

29 5. a. A group health insurer or its agent shall not seek
30 reimbursement for overpayment of a claim previously paid pursuant to
31 section 6 of P.L.1999, c.154 (C.17B:27-44.2) for a health care service
32 provided to a covered person by an eligible health care provider later
33 than 18 months after the date the claim was paid. If the insurer or its
34 agent seeks reimbursement for the overpayment, it shall provide
35 written documentation to the health care provider that substantiates
36 the reason for the reimbursement request.

37 b. In seeking reimbursement for the overpayment, the insurer or its
38 agent shall not:

39 (1) require payment earlier than the 60th day following receipt of
40 the documentation by the health care provider;

41 (2) assess the reimbursement against the payment of any future
42 claims; or

43 (3) collect or attempt to collect from the health care provider a
44 penalty, including, but not limited to, an interest charge or a late fee.

45

46 6. a. A health maintenance organization or its agent shall not seek

1 reimbursement for overpayment of a claim previously paid pursuant to
2 section 7 of P.L.1999, c.154 (C.26:2J-8.1) for a health care service
3 provided to an enrollee by an eligible health care provider later than 18
4 months after the date the claim was paid. If the health maintenance
5 organization or its agent seeks reimbursement for the overpayment, it
6 shall provide written documentation to the health care provider that
7 substantiates the reason for the reimbursement request.

8 b. In seeking reimbursement for the overpayment, the health
9 maintenance organization or its agent shall not:

10 (1) require payment earlier than the 60th day following receipt of
11 the documentation by the health care provider;

12 (2) assess the reimbursement against the payment of any future
13 claims; or

14 (3) collect or attempt to collect from the health care provider a
15 penalty, including, but not limited to, an interest charge or a late fee.

16

17 7. a. A dental service corporation or its agent shall not seek
18 reimbursement for overpayment of a claim previously paid pursuant to
19 section 8 of P.L.1999, c.154 (C.17:48C-8.1) for a health care service
20 provided to a covered person by an eligible health care provider later
21 than 18 months after the date the claim was paid. If the dental service
22 corporation or its agent seeks reimbursement for the overpayment, it
23 shall provide written documentation to the health care provider that
24 substantiates the reason for the reimbursement request.

25 b. In seeking reimbursement for the overpayment, the dental
26 service corporation or its agent shall not:

27 (1) require payment earlier than the 60th day following receipt of
28 the documentation by the health care provider;

29 (2) assess the reimbursement against the payment of any future
30 claims; or

31 (3) collect or attempt to collect from the health care provider a
32 penalty, including, but not limited to, an interest charge or a late fee.

33

34 8. a. A dental plan organization or its agent shall not seek
35 reimbursement for overpayment of a claim previously paid pursuant to
36 section 9 of P.L.1999, c.154 (C.17:48D-9.4) for a health care service
37 provided to an enrollee by an eligible health care provider later than 18
38 months after the date the claim was paid. If the dental plan
39 organization or its agent seeks reimbursement for the overpayment, it
40 shall provide written documentation to the health care provider that
41 substantiates the reason for the reimbursement request.

42 b. In seeking reimbursement for the overpayment, the dental plan
43 organization or its agent shall not:

44 (1) require payment earlier than the 60th day following receipt of
45 the documentation by the health care provider;

46 (2) assess the reimbursement against the payment of any future

1 claims; or

2 (3) collect or attempt to collect from the health care provider a
3 penalty, including, but not limited to, an interest charge or a late fee.

4

5 9. a. A prepaid prescription service organization or its agent shall
6 not seek reimbursement for overpayment of a claim previously paid
7 pursuant to section 10 of P.L.1999, c.154 (C.17:48F-13.1) for a
8 prescription provided to an enrollee by an eligible health care provider
9 later than 18 months after the date the claim was paid. If the prepaid
10 prescription service organization or its agent seeks reimbursement for
11 the overpayment, it shall provide written documentation to the health
12 care provider that substantiates the reason for the reimbursement
13 request.

14 b. In seeking reimbursement for the overpayment, the prepaid
15 prescription service organization or its agent shall not:

16 (1) require payment earlier than the 60th day following receipt of
17 the documentation by the health care provider;

18 (2) assess the reimbursement against the payment of any future
19 claims; or

20 (3) collect or attempt to collect from the health care provider a
21 penalty, including, but not limited to, an interest charge or a late fee.

22

23 10. This act shall take effect on the 30th day after enactment.

24

25

26

STATEMENT

27

28 This bill limits the time frame in which a health insurance carrier can
29 request reimbursement from a health care provider if the carrier
30 overpaid a previously settled claim. The carrier must submit written
31 documentation substantiating the reason for the reimbursement request
32 and may not require payment on or before the 60th day following the
33 provider's receipt of the documentation. This provision will allow the
34 provider time to examine the reimbursement request, and if necessary,
35 arrange a schedule for paying the carrier. The carrier may not assess
36 the reimbursement against the payment of any future claims or collect
37 or attempt to collect any penalties against the provider, including, but
38 not limited to, interest charges or late fees.

39 The provisions of this bill apply to hospital, medical, and health
40 service corporations, commercial individual and group insurers, health
41 maintenance organizations, dental service corporations, dental plan
42 organizations, and prepaid prescription service organizations.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3496 and 3743

STATE OF NEW JERSEY

DATED: MAY 2, 2005

The Assembly Financial Institutions and Insurance Committee reports favorably an Assembly Committee Substitute for Assembly Bill Nos. 3496 and 3743.

This bill, the Assembly Committee Substitute for Assembly Bill Nos. 3496 and 3743, entitled the "Health Claims Authorization, Processing and Payment Act," is intended to ensure that health care providers receive timely reimbursement to which they are entitled from insurance carriers for services delivered to persons covered under health insurance policies. Specifically, the bill: requires that utilization management be performed in authorizing the delivery of health care services; makes changes to the law regarding the processing and payment of health care claims; and provides for an arbitration process to resolve claims disputes.

As provided in the bill, a payer is required to respond to a hospital or physician's request for authorization of services by either approving or denying the request based on a utilization management decision. Any denial of a request or limitation imposed by a payer on a requested service shall be made by a State licensed physician and shall be communicated to the hospital or physician within the time frames provided in the bill. As used in the bill, a "payer" means a health maintenance organization, health, hospital, or medical service corporation, or commercial insurer which requires that utilization management be performed to authorize the approval of a health care service and includes a certified or licensed organized delivery system.

The bill further provides that upon admission to a hospital or prior to receiving health care services, the hospital may obtain written consent from the covered person, authorizing the hospital to appeal to the Independent Health Care Appeals Program a payer's determination that a benefit or service is not medically necessary.

This bill provides a separate two-step appeals process to resolve any dispute regarding the compliance with the provisions of the bill concerning the authorization of services by payers. The process involves an internal appeals mechanism, and may involve

nonappealable and binding arbitration.

The bill also makes several changes to current law regarding the processing and prompt payment of claims for health care services rendered by health care providers including, but not limited to, physicians and other licensed health care professionals and hospitals and other health care facilities. These provisions apply to hospital, medical, and health service corporations, commercial individual and group insurers, health maintenance organizations, and prepaid prescription service organizations.

The bill increases the interest for overdue, eligible claims from 10% to 20% per annum and requires the interest payment to be included in the overdue payment.

The bill describes a class of claims that must be handled differently because they cannot be entered into the claims processing system, and provides a process for handling this class of claims.

This bill limits the time frame in which a payer can seek reimbursement from a provider for an overpayment made on a claim to one year from the date the first payment was made. Providers have 45 days after they have received the required documentation substantiating the request, to pay the requested reimbursement or initiate an appeal to dispute the request. Payment shall not be due until the providers' rights to appeal set forth under the bill are exhausted. Payers may not collect the funds for the reimbursement by assessing them against the payment of future claims or assess a monetary penalty against providers.

The bill provides a two-part appeals process to resolve disputes regarding the processing and payment of claims. The process involves an internal appeals mechanism and may involve nonappealable and binding arbitration.

Finally, this bill requires the Commissioner of the Department of Banking and Insurance to enforce this bill and sets forth civil penalties for violation of the bill's provisions.

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3496 and 3743

with Assembly Floor Amendments
(Proposed By Assemblyman COHEN)

ADOPTED: MAY 16, 2005

These amendments make various revisions to the Assembly Committee Substitute for Nos. 3496 and 3743, the "Health Claims Authorization, Processing and Payment Act."

Specifically, the amendments:

1. Allow insurance carriers, herein referred to as "payers," to deny payment of a health care claim on the grounds that coordination of benefits information is being sought when the payers' records indicate that other insurance is available to the covered person;
2. Allow payers to collect a reimbursement, and to assess against future claims in certain circumstances, for monies paid to health care providers on claims that were submitted fraudulently; and
3. Increase the penalties against health care providers that are found by an arbitrator under contract with the Department of Banking and Insurance to have engaged in a pattern and practice of improper billing.

STATEMENT TO

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR **ASSEMBLY, Nos. 3496 and 3743**

with Assembly Floor Amendments
(Proposed By Assemblyman COHEN)

ADOPTED: DECEMBER 12, 2005

These amendments make various revisions to the Assembly Committee Substitute for Assembly Nos. 3496 and 3743, the "Health Claims Authorization, Processing and Payment Act."

Specifically, the amendments:

1. Require payers to disclose on a website information concerning their utilization management and claims processing and payment policies;

2. Clarify that a health care provider can obtain a covered person's written consent, allowing the provider to act on the person's behalf in appealing a dispute to the Independent Health Care Appeals Program. The consent may be given at any point prior to or following the delivery of health care services and may be revoked at any time;

3. Require payers to pay a claim or provide notification of reasons for nonpayment within 30 or 40 days of receiving an electronic or written claim, respectively, and set aside a category of electronically submitted claims that require faster notification if technical data are missing;

4. Change the interest rate for overdue claims from 20% to 12%;

5. Permit payers that do not reserve the right to change the premiums (payers that provide health coverage for the State's Medicaid enrollees) to credit interest or penalty payments against similar payments for the same violation that were made to the Department of Human Services;

6. Extend the amount of time that a payer or health care provider can seek reimbursement for an overpayment or underpayment, respectively, of a claim from one year to 18 months and clarify the provisions concerning collection by a payer of an overpayment;

7. Clarify that any dispute concerning compliance with utilization management or processing and payment of claims may be resolved through a two-step appeals process;

8. Clarify that the Commissioner of Banking and Insurance shall enforce the bill and sets forth penalties for non-compliance; and

9. Require an advisory board already established under law to make recommendations to include a State-wide policy on electronic health records with the State's health information electronic data

interchange technology policy, require any department that uses medical records or health care claims to participate on the board, and if asked, provide assistance to Thomas Edison State College in its project to monitor the effectiveness of the State's health information technology policy.