17B:30-48

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2005 **CHAPTER:** 352

NJSA: 17B:30-48 ("Health Claims Authorization, Processing and Payment Act")

BILL NO: S2824 (Substituted for A3496/3743)

SPONSOR(S): Vitale and others

DATE INTRODUCED: November 10, 2005

COMMITTEE: **ASSEMBLY:**

SENATE: Commerce

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** January 9, 2006

SENATE: December 15, 2005

DATE OF APPROVAL: January 12, 2006

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (1st reprint enacted)

S2824

SPONSOR'S STATEMENT: (Begins on page 56 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A3496/3743

SPONSOR'S STATEMENT (A3496): (Begins on page 9 of original bill) Yes

SPONSOR'S STATEMENT (A3743): (Begins on page 5 of original bill Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: Yes 5-16-2005
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§§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)***

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

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

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

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

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

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

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

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

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

[1]4. (New section) a. A payer shall provide the following information concerning utilization management and the processing and payment of claims in a clear and conspicuous manner through an Internet website no later than 30 calendar days before the information or policies or any changes in the information or policies take effect:

(1) a description of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the payer or its agent to determine the medical

necessity of health care services;

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

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

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

(5) any other information the commissioner deems necessary.

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

[1][4.] 5.[1] (New section) a. A payer shall respond to a hospital or physician request for authorization of health care services by either approving or denying the request based on the covered person's health benefits plan. Any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a physician under the clinical direction of the medical director who shall be licensed in this State and communicated to the hospital or physician by facsimile, E-mail or any other means of written communication agreed to by the payer and hospital or physician, as follows:

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

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

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

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

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

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

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

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

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

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

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

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

[1] **[**5.**]** 6.**[1]** (New section) a. When a hospital **[1]**or physician**[1]** complies with the provisions set forth in section **[1]** **[**4**]** 5**[1]** of **[1]** **[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill)**[1]**, no

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

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

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

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

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

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

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

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

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

[1][6.] 7.[1] (New section) [1][a.][1] A payer, or [1][its] payer's[1] agent, shall reimburse a hospital or physician according to the provider contract for all medically necessary emergency and urgent care health

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

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

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

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

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

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

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

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

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

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

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

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

subsection.

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

d. An arbitrator's determination shall be:

(1) signed by the arbitrator;

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

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

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

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

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

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

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

[1]8. Section 11 of P.L.1997, c.192 (C.26:2S-11) is amended to read as follows:

11. There is established the Independent Health Care Appeals

Program in the department.

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

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

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

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

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

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

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

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

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

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

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

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

[1]9. Section 12 of P.L.1997, c.192 (C.26:2S-12) shall be amended to read as follows:

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

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

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

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

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

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

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

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

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

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.[1]

(cf: P.L.2001, c.1, s.1)

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

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

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

demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital service corporation [1]<u>,or its agent</u>[1], its subsidiary or its covered persons.

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

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

d. [1]<u>For the purposes of this subsection, "substantiating documentation" means any information specific to the particular health care service provided to a covered person.</u>[1]

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

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

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

(c) there is no dispute regarding the amount claimed;**]** <u>the health care provider is eligible at the date of service;</u>

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

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

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

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

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

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

(a) [the claim is an ineligible claim;

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provider, unless agreed to in writing by the health care provider; or

(iv)] a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

appeal form. If the health care provider is not notified of the payer's determination of the appeal within [1][10] 30[1] days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) [the claim is an ineligible claim;

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

the payer shall notify the [subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits] [1][covered person and][1] health care provider, [1][in writing or][1] by electronic means [1][, as appropriate,] and the covered person in writing[1] within

30 days [1],of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation[, including] or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed][1] [; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject] [1]of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv)] a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

care service provided to a covered person.[1]

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

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

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

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

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

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

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

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

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

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

(a) [the claim is an ineligible claim;

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

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

[1]⟦or⟧[1]

⟦(d)⟧ (c) the payer disputes the amount claimed⟦; or

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[1]or;

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

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

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

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

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

(iv)] a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv)**]** a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

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

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

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

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

(iv) the payer finds there is strong evidence of fraud and has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv)**]** a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

incorrect coding;

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

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

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

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

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

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

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

(a) [the claim is an ineligible claim;

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

the payer shall notify the [enrollee, or that enrollee's agent or assignee if the health maintenance organization coverage for health care services provides for assignment of benefits] [1][covered person and][1] health care provider, [1][in writing or][1] by electronic means [1][, as appropriate,] and the covered person in writing[1] within 30 days [1][,of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation[, including] or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

receipt of a claim submitted by other than electronic means.

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

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

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

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

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

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

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

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

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

section are exhausted; [1]or[1]

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

(iv)[]] a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

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

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

submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the [1]⟦10th⟧ 30th[1] calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within [1]⟦10⟧ 30[1] days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) [the claim is an ineligible claim;

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

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

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

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

(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud[1],

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv)] a monetary penalty against the reimbursement request, including but not limited to, an interest charge or[1] a late fee.

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

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

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

e. (1) A prepaid prescription service organization or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute [1]raised by a health care provider regardless of whether the health care provider is under contract with the payer[1] regarding compliance with the requirements of this section [1]or compliance with the requirements of sections 4 through 7 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[1]18. Section 11 of P.L.1999, c.154 (C.26:1A-15.1) is amended to read as follows:

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

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

[1]19. Section 16 of P.L.1999, c.154 (C.17B:30-25) shall be amended to read as follows:

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

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

to this section.

The college shall report to the Legislature and the Governor from time to time on its findings and recommendations.[1]
(cf: P.L.1999, c.154, s.16)

[1][18.] 20.[1] (New section) The Commissioner of Banking and Insurance shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

[1][19.] 21.[1] (New section) This act shall be liberally construed to effectuate the legislative purposes of the act.

[1][20.] 22.[1] This act shall take effect on the 180th day after enactment, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act.

"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)

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

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

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

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

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

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

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

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

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

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

"Carrier" means an insurance company, health service corporation, 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 <u>thus</u> is new matter.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. An arbitrator's determination shall be:

(1) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) there is no dispute regarding the amount claimed;**]** <u>the health care provider is eligible at the date of service;</u>

<u>(b) the person who received the health care service was covered on the date of service;</u>

<u>(c) the claim is for a service or supply covered under the health benefits plan;</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) in administrative proceedings; or

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

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

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

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

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

(iv) a late fee.

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

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

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

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

Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

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

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

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

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

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the

payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

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

(b) in administrative proceedings; or

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

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

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

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

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

(iv) a late fee.

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

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

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

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a

form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

4. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation**[**,**]** or its agent or a

subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

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

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

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health service corporation or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a **[**subscriber or that subscriber's agent or assignee if the contract provides for assignment of benefits**]** <u>covered person or health care provider</u>, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) **[**the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;**]** the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions distributed in advance to the health care provider or covered person within 120 days of the date of service; and

[(d)**]** (e) the payer has no reason to believe that the claim has been submitted fraudulently**[**; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract**]**.

(2) If all or a portion of the claim is denied by the payer because:

(a) **[**the claim is an ineligible claim;

(b)**]** the claim submission is incomplete because the required substantiating documentation, which is specific to the health care service provided to the covered person, has not been submitted to the payer;

[(c)**]** (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; or

[(d)**]** (c) the payer disputes the amount claimed**[**; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract**]**,

the payer shall notify the **[**subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits**]** covered person and health care provider, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation**[**, including**]** or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed**[**; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject**]**.

(3) If all or a portion of a claim cannot be entered into the claims processing system for any of the following reasons:

(a) the health care provider is not eligible at the time of service;

(b) the person who received the health care service was not a covered person at the time of service;

(c) the premium was not paid by or on the behalf of the covered person; or

(d) the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing,

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

[(4)**]** (5) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**subscriber**]** covered person, no later than two working days following receipt of the transmission of the claim.

[(5)**]** (6) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

[(6)**]** (7) Payment of an eligible claim pursuant to paragraphs (1) and **[**(3)**]** (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph **[**(b)**]** (a) of paragraph (2) or subparagraph (d) of paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the **[**30th**]** 15th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the **[**40th**]** 25th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or information or modification of an initial submission.

(8) (a) No payer shall deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the health care service provided to the covered person.

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

[(7)**]** (9) An overdue payment shall bear simple interest at the rate of **[**10%**]** 20% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings; or

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable.

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request

to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted;

(iii) the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider, unless agreed to in writing by the health care provider; or

(iv) a late fee.

(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than one year from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission.

e. (1) A health service corporation or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this section. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring

the dispute to arbitration as provided by paragraph (2) of this subsection.

The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that individual health care providers may aggregate their own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(c) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

(5) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care provider and the payer requested, but did not receive, this information from the health care provider when the claim was initially processed pursuant to subsection d. of this section or

reviewed under internal appeal pursuant to paragraph (1) of this subsection, the payer shall not be required to pay any accrued interest. In accordance with regulations adopted by the Commissioner of Banking and Insurance, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

(6) If the arbitrator determines that a health care provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 20% per annum.

(7) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

f. As used in this subsection, "insured claim" or "claim" means a claim by a **[**subscriber**]** covered person for payment of benefits under an insured health service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the health service corporation.

g. Any person found in violation of this section with a pattern of frequency as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.4)

13. Section 5 of P.L.1999, c.154 (C.17B:26-9.1) is amended to read as follows:

5. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer**[**,**]** or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all

individual policies issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the policy.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health insurer or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by **[**an insured or that insured's agent or assignee if the policy provides for assignment of benefits**]** a covered person or health care provider, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) **[**the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;**]** the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions distributed in advance to the health care provider or covered person within 120 days of the date of service; and

[(d)**]** (e) the payer has no reason to believe that the claim has been submitted fraudulently**[**; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract**]**.

(2) If all or a portion of the claim is denied by the payer because:

(a) **[**the claim is an ineligible claim;

(b)**]** the claim submission is incomplete because the required substantiating documentation, which is specific to the health care service provided to the covered person, has not been submitted to the payer;

[(c)**]** (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; or

[(d)**]** (c) the payer disputes the amount claimed**[**; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract**]**,

the payer shall notify the **[**subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits**]** covered person and health care provider, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation**[**, including**]** or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed**[**; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject**]**.

(3) If all or a portion of a claim cannot be entered into the claims processing system for any of the following reasons:

(a) the health care provider is not eligible at the time of service;

(b) the person who received the health care service was not a covered person at the time of service;

(c) the premium was not paid by or on the behalf of the covered person; or

(d) the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing,

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

[(4)**]** (5) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**subscriber**]** covered person, no later than two working days following receipt of the transmission of the claim.

[(5)**]** (6) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

[(6)**]** (7) Payment of an eligible claim pursuant to paragraphs (1) and **[**(3)**]** (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph **[**(b)**]** (a) of paragraph (2) or subparagraph (d) of paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the **[**30th**]** 15th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the **[**40th**]** 25th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or information or modification of an initial submission.

(8) (a) No payer shall deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the health care service provided to the covered person.

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

[(7)**]** (9) An overdue payment shall bear simple interest at the rate of **[**10%**]** 20% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings; or

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable.

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted;

(iii) the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider, unless agreed to in writing by the health care provider; or

(iv) a late fee.

(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than one year from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission.

e. (1) A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this section. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection.

The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that individual health care providers may aggregate their own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192

(C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(c) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

(5) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care provider and the payer requested, but did not receive, this information from the health care provider when the claim was initially processed pursuant to subsection d. of this section or reviewed under internal appeal pursuant to paragraph (1) of this subsection, the payer shall not be required to pay any accrued interest. In accordance with regulations adopted by the Commissioner of Banking and Insurance, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

(6) If the arbitrator determines that a health care provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 20% per annum.

(7) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

f. As used in this subsection, "insured claim" or "claim" means a claim by **[**an insured**]** a covered person for payment of benefits under an insured policy for which the financial obligation for the payment of a claim under the policy rests upon the health insurer.

g. Any person found in violation of this section by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.5)

14. Section 6 of P.L.1999, c.154 (C.17B:27-44.2) is amended to read as follows:

6. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer**[**,**]** or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group policies issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the policy.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health insurer or its agent,hereinafter the payer, shall remit payment for every insured claim submitted by **[**an insured or that insured's agent or assignee if the policy provides for assignment of benefits**]** a covered person or-health care provider, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) [the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;] the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions distributed in advance to the health care provider or covered person within 120 days of the date of service; and

[(d)] (e) the payer has no reason to believe that the claim has been submitted fraudulently[; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract].

(2) If all or a portion of the claim is denied by the payer because:

(a) [the claim is an ineligible claim;

(b)] the claim submission is incomplete because the required substantiating documentation, which is specific to the health care service provided to the covered person, has not been submitted to the payer;

[(c)] (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; or

[(d)] (c) the payer disputes the amount claimed[; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract],

the payer shall notify the [subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits] covered person and health care provider, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation[, including] or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed[; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject].

(3) If all or a portion of a claim cannot be entered into the claims processing system for any of the following reasons:

(a) the health care provider is not eligible at the time of service;

(b) the person who received the health care service was not a covered person at the time of service;

(c) the premium was not paid by or on the behalf of the covered person; or

(d) the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing,

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

[(4)**]** (5) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**subscriber**]** covered person, no later than two working days following receipt of the transmission of the claim.

[(5)**]** (6) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

[(6)**]** (7) Payment of an eligible claim pursuant to paragraphs (1) and **[**(3)**]** (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph **[**(b)**]** (a) of paragraph (2) or subparagraph (d) of paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the **[**30th**]** 15th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the **[**40th**]** 25th calendar day for claims submitted by other than electronic means, following receipt

by the payer of the required documentation or information or modification of an initial submission.

(8) (a) No payer shall deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the health care service provided to the covered person.

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

[(7)**]** (9) An overdue payment shall bear simple interest at the rate of **[**10%**]** 20% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings; or

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable.

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted;

(iii) the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider, unless agreed to in writing by the health care provider; or

(iv) a late fee.

(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than one year from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission.

e. (1) A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this section. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form

and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection.

The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that individual health care providers may aggregate their own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(c) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

(5) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care provider and the payer requested, but did not receive, this information from the health care provider when the claim

was initially processed pursuant to subsection d. of this section or reviewed under internal appeal pursuant to paragraph (1) of this subsection, the payer shall not be required to pay any accrued interest. In accordance with regulations adopted by the Commissioner of Banking and Insurance, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

(6) If the arbitrator determines that a health care provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 20% per annum.

(7) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

f. As used in this subsection, "insured claim" or "claim" means a claim by **[**an insured**]** a covered person for payment of benefits under an insured policy for which the financial obligation for the payment of a claim under the policy rests upon the health insurer.

g. Any person found in violation of this section with a pattern of frequency as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.6)

15. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to read as follows:

7. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization**[**,**]** or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health maintenance organization, its subsidiary or its covered **[**enrollees**]** persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization or a subsidiary that processes health care benefits claims as a third party administrator

shall use the standard health care enrollment and claim forms in connection with all group and individual health maintenance organization coverage for health care services issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health maintenance organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by **[**an enrollee or that enrollee's agent or assignee if the health maintenance organization coverage for health care services provides for assignment of benefits**]** a covered person or health care provider, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) **[**the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health maintenance organization coverage for health care services;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;**]** the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions distributed in advance to the health care provider or covered person within 120 days of the date of service; and

[(d)**]** (e) the payer has no reason to believe that the claim has been submitted fraudulently**[**; and

(e) the claim requires no special treatment that prevents timely

payments from being made on the claim under the terms of the health maintenance organization coverage for health care services**]**.

(2) If all or a portion of the claim is denied by the payer because:

(a) **[**the claim is an ineligible claim;

(b)**]** the claim submission is incomplete because the required substantiating documentation, which is specific to the health care service provided to the covered person, has not been submitted to the payer;

[(c)**]** (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; or

[(d)**]** (c) the payer disputes the amount claimed**[**; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the health maintenance organization coverage for health care services**]**,

the payer shall notify the **[**enrollee, or that enrollee's agent or assignee if the health maintenance organization coverage for health care services provides for assignment of benefits**]** covered person and health care provider, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation**[**, including**]** or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed**[**; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject**]**.

(3) If all or a portion of a claim cannot be entered into the claims processing system for any of the following reasons:

(a) the health care provider is not eligible at the time of service;

(b) the person who received the health care service was not a covered person at the time of service;

(c) the premium was not paid by or on the behalf of the covered person; or

(d) the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing,

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

[(4)**]** (5) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**subscriber**]** covered person, no later than two working days following receipt of the transmission of the claim.

[(5)**]** (6) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

[(6)**]** (7) Payment of an eligible claim pursuant to paragraphs (1) and **[**(3)**]** (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph **[**(b)**]** (a) of paragraph (2) or subparagraph (d) of paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the **[**30th**]** 15th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the **[**40th**]** 25th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or information or modification of an initial submission.

(8) (a) No payer shall deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the health care service provided to the covered person.

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

[(7)**]** (9) An overdue payment shall bear simple interest at the rate of **[**10%**]** 20% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings; or

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable.

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted;

(iii) the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider, unless agreed to in writing by the health care provider; or

(iv) a late fee.

(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than one year from the date the first payment on the claim was made, except if the claim is the subject of an appeal

submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission.

e. (1) A health maintenance organization or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this section. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination of the appeal within 10 days, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection.

The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that individual health care providers may aggregate their own disputed claim amounts for the purposes of meeting the threshold requirements

of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(c) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

(5) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care provider and the payer requested, but did not receive, this information from the health care provider when the claim was initially processed pursuant to subsection d. of this section or reviewed under internal appeal pursuant to paragraph (1) of this subsection, the payer shall not be required to pay any accrued interest. In accordance with regulations adopted by the Commissioner of Banking and Insurance, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

(6) If the arbitrator determines that a health care provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 20% per annum.

(7) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

f. As used in this subsection, "insured claim" or "claim" means a claim by **[**an enrollee**]** a covered person for payment of benefits under an insured health maintenance organization contract for which the financial obligation for the payment of a claim under the health maintenance organization coverage for health care services rests upon the health maintenance organization.

g. Any person found in violation of this section with a pattern of frequency as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.7.)

16. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to read as follows:

10. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization[,] or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a prepaid prescription service organization, its subsidiary or its covered enrollees.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a prepaid prescription service organization or its agent,hereinafter the payer, shall remit payment for every insured claim

submitted by [an enrollee or that enrollee's agent or assignee if the contract provides for assignment of benefits] a covered person or health care provider, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) [the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;] the health care provider is eligible at the date of service;

(b) the person who received the health care service was covered on the date of service;

(c) the claim is for a service or supply covered under the health benefits plan;

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions distributed in advance to the health care provider or covered person within 120 days of the date of service; and

[(d)] (e) the payer has no reason to believe that the claim has been submitted fraudulently[; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract].

(2) If all or a portion of the claim is denied by the payer because:

(a) [the claim is an ineligible claim;

(b)] the claim submission is incomplete because the required substantiating documentation, which is specific to the health care service provided to the covered person, has not been submitted to the payer;

[(c)] (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; or

[(d)] (c) the payer disputes the amount claimed[; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract],

the payer shall notify the [subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits] covered person and health care provider, in writing or by electronic means, as

appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation**[**, including**]** or contains incorrect coding, a statement as to what substantiating documentation, specific to the health care service provided to the covered person, or other information, is required to complete adjudication of the claim; and if the amount of the claim is disputed, a statement that it is disputed**[**; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject**]**.

(3) If all or a portion of a claim cannot be entered into the claims processing system for any of the following reasons:

(a) the health care provider is not eligible at the time of service;

(b) the person who received the health care service was not a covered person at the time of service;

(c) the premium was not paid by or on the behalf of the covered person; or

(d) the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing,

the payer shall notify the covered person and health care provider within seven days if the claim was submitted by electronic means, or within 14 days if the claim was submitted by other than electronic means, of that determination of denial, of all the reasons for the denial or any information required to complete adjudication of the claim.

(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

[(4)**]** (5) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**subscriber**]** covered person, no later than two working days following receipt of the transmission of the claim.

[(5)**]** (6) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

[(6)**]** (7) Payment of an eligible claim pursuant to paragraphs (1) and **[**(3)**]** (4) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim

submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph **[**(b)**]** (a) of paragraph (2) or subparagraph (d) of paragraph (3) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the **[**30th**]** 15th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the **[**40th**]** 25th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or information or modification of an initial submission.

(8) (a) No payer shall deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the health care service provided to the covered person.

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

[(7)**]** (9) An overdue payment shall bear simple interest at the rate of **[**10%**]** 20% per annum. The interest shall be paid to the health care provider at the time the overdue payment is made.

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than one year after the date the first payment on the claim was made. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;

(b) in administrative proceedings; or

(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable.

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted;

(iii) the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider, unless agreed to in writing by the health care provider; or

(iv) a late fee.

(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than one year from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission.

e. (1) A prepaid prescription service organization or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute regarding compliance with the requirements of this section. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care provider of its determination on or before the 10th calendar day following the receipt of the appeal form. If the health care provider is not notified of the payer's determination

of the appeal within 10 days, the health care provider may refer the dispute to arbitration0 as provided by paragraph (2) of this subsection.

If the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 20% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If the payer issues a determination against the health care provider, the payer shall notify the health care provider of its findings on or before the 10th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection.

The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that individual health care providers may aggregate their own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.

(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and

(c) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all parties to the dispute.

(5) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care provider and the payer requested, but did not receive, this information from the health care provider when the claim was initially processed pursuant to subsection d. of this section or reviewed under internal appeal pursuant to paragraph (1) of this subsection, the payer shall not be required to pay any accrued interest. In accordance with regulations adopted by the Commissioner of Banking and Insurance, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

(6) If the arbitrator determines that a health care provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 20% per annum.

(7) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

f. As used in this subsection, "insured claim" or "claim" means a claim by **[**an enrollee**]** a covered person for payment of benefits under an insured prepaid prescription service organization contract for which the financial obligation for the payment of a claim under the contract rests upon the prepaid prescription service organization.

g. Any person found in violation of this section with a pattern of frequency as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.10)

17. a. (New section) The Commissioner of Banking and Insurance shall enforce the provisions of sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by this act. A payer found in violation of those sections shall be liable for a civil penalty of not less than $250 and not greater than $10,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the

condition which gave rise to the violation and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

b. If the Commissioner of Banking and Insurance has reason to believe that a person is engaging in a practice or activity, for the purpose of avoiding or circumventing the legislative intent of sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by this act, the Commissioner of Banking and Insurance is authorized to promulgate rules or regulations necessary to prohibit that practice or activity and levy a civil penalty of not less than $250 and not more than $10,000 for each day that person is in violation of that rule or regulation.

c. For the purpose of administering the provisions of sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by this act, 50% of the penalty monies collected pursuant to subsection a. of this section shall be deposited into the General Fund. For the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50% of the penalty monies collected pursuant to subsection a. of this section shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

18. (New section) The Commissioner of Banking and Insurance shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

19. (New section) This act shall be liberally construed to effectuate the legislative purposes of the act.

20. This act shall take effect on the 180th day after enactment, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act.

STATEMENT

This bill, 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. No dispute eligible to be submitted to the Independent Health Care Appeals Program shall be subject to arbitration provided in this bill.

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.

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.

AN ACT concerning health and dental claims authorization, processing and payment and supplementing Title 17B of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. This act shall be known and may be cited as the "Health and Dental Claims Authorization, Processing and Payment Act."

2. The Legislature finds and declares that:

a. Health care services available under health benefits plans must be promptly provided to covered persons under all circumstances, along with timely reimbursement to health care providers for their services rendered.

b. However, confusion still exists among consumers, health care providers and carriers with respect to time frames for communication of determinations by carriers to deny, reduce or terminate benefits under the provisions of a health benefits plan based upon utilization management decisions, which determinations must be communicated as quickly and efficiently as possible.

c. Because both consumers and health care providers have experienced repeated denials or failure by carriers to respond to them in a timely manner with respect to utilization management determinations, many health care providers have found themselves financially uncompensated when carriers have failed to respond to certain requests for authorization of health care services.

d. Because these occurrences reflect negatively on health insurance carriers and because it is fair and reasonable for health care providers to receive reimbursement for health care services delivered to covered persons under their health benefits plans, it is appropriate for the Legislature now to establish uniform procedures and guidelines for health care providers and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers.

3. As used in this act:

"Authorization" means a determination by a carrier that an admission, availability of health care services, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and Medicare+Choice contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only; credit; disability; long-term care; CHAMPUS supplement coverage; coverage arising out of a workers' compensation or similar law; automobile medical payment insurance; personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.); or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Network provider" means a participating health care provider under contract or other agreement with a carrier to furnish health care services to covered persons.

"Payer" means a carrier which requires that utilization management be performed to authorize the approval of a health care service and includes an organized delivery system that is certified by the Commissioner of Health and Senior Services or licensed by the commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer's agent" or "agent" means an intermediary contracted or affiliated with the payer to perform administrative functions including, but not limited to, the payment of claims or the receipt, processing or transfer of claims or claim information.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission

certification; the application of practice guidelines; continued stay review; discharge planning; preauthorization of ambulatory care procedures; and retrospective review.

4. a. A payer shall respond to a health care provider's request for authorization of health care 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 physician licensed in this State and communicated to the provider by facsimile or E-mail, as follows:

(1) In the case of a request for authorization for a covered person who is receiving inpatient hospital services or care rendered in the emergency department of a hospital, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the provider within a time frame appropriate to the medical exigencies of the case but no later than 24 hours following the time the request was made;

(2) In the case of a request for authorization for a covered person who is currently receiving health care services in an outpatient or other setting, including but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the provider within a time frame appropriate to the medical exigencies of the case but no later than three business days following the time the request was made; and

(3) If the payer requires additional information to approve or deny a request for authorization, the payer shall so notify the provider by facsimile or E-mail within the applicable time frame set forth in paragraph (1) or (2) of this subsection and shall identify the specific information needed to approve or deny the request for authorization. If the payer is unable to approve or deny a request for authorization within the applicable time frame set forth in paragraph (1) or (2) of this subsection because of the need for this additional information, the payer shall have an additional period within which to approve or deny the request, as follows:

(a) in the case of a request for authorization for a covered person who is receiving inpatient hospital services or care rendered in the emergency department of a hospital, no more than 12 hours beyond the time of receipt by the payer from the provider of the additional information that the payer has identified as needed to approve or deny the request for authorization; and

(b) in the case of a request for authorization for a covered person who is currently receiving health care services in another setting, no more than two business days beyond the time of receipt by the payer from the provider of the additional information that the payer has identified as needed to approve or deny the request for authorization.

b. Payers and providers shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the time frames established pursuant to subsection a. of this section.

c. If a payer fails to respond to an authorization request within the time frames established pursuant to subsection a. of this section, the health care provider's request shall be deemed approved and the payer shall be responsible to the health care provider for the payment of the requested services at the full contractual rate.

5. a. A payer, or its agent, shall reimburse a hospital if:

(1) the hospital requested authorization from the payer and received approval for the health care services delivered prior to rendering the service; or

(2) the hospital requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the hospital within the time frames established pursuant to subsection a. of section 4 of this act.

b. If the hospital or other health care provider is a network provider of the payer, health care services shall be reimbursed at the provider's contracted rate for the services provided and based on the setting in which the services are delivered.

c. A payer shall reimburse a hospital for all medically necessary services rendered to the covered person at the contracted rate for services provided if it has reimbursed another health care provider for rendering medically necessary care to that same covered person at the hospital.

d. A payer, or its agent, shall not amend a claim by changing the diagnostic code assigned to the services rendered by the health care provider without providing written justification.

e. If a payer has determined that a covered person who is an inpatient in a hospital requires medically necessary health care services that are not available or provided at the hospital or are less than the acute level of care provided at the hospital, the payer shall be responsible for identifying an available contracted health care provider that offers the required covered services and that will accept the covered person. The payer shall pay the hospital in accordance with the contracted rate until an appropriate placement can be made.

6. a. A payer, or its agent, shall reimburse a health care provider for all medically necessary services rendered to a covered person that are covered under the health benefits plan, including emergency and urgent care health care services and all tests necessary, according to nationally recognized treatment protocols as developed by the federal government, to determine the nature of an illness or injury.

b. A payer shall provide each network health care provider with a

copy of all clinical criteria guidelines used by the payer or agent to determine the medical necessity of health care services. These guidelines may be used by the payer only as a screening tool and may not be applied without considering the covered person's individual health care circumstances. The payer or agent shall notify each network provider in writing of any proposed change in the guidelines at least 60 days prior to implementing the change.

7. a. Upon admission to a hospital or prior to receiving health care services, a covered person or a person designated by the covered person may sign a consent form authorizing a health care provider, on the covered person's behalf, to appeal a determination by a payer to deny, reduce or terminate a health care benefit or deny payment for a health care service based upon the payer's determination that the health care benefit or service is not medically necessary, and which consent would be valid for all stages of the payer's informal and formal appeals process and the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11).

b. The health care provider shall provide notice to the covered person whenever the health care provider institutes an appeal of a payer's determination to deny, reduce or terminate a health care benefit or deny payment for a health care service and shall provide additional notice to the covered person each time the health care provider continues that appeal to the next stage of the payer's appeal process, including any appeal to an independent utilization review organization pursuant to section 12 of P.L.1997, c.192 (C.26:2S-12).

c. The covered person shall retain the right to revoke at any time his consent granted pursuant to subsection a. of this section.

8. a. A contract between a payer and any health care provider other than a dentist shall contain a provision, approved by the commissioner, that provides that any dispute regarding the recovery of payments due under the terms of this act, shall, on the initiative of any party to the dispute, be referred to arbitration as provided in this section.

b. Arbitration proceedings shall be conducted by an independent third-party. A party shall initiate an arbitration proceeding within 90 days of receipt of a written determination, on a form prescribed by the commissioner, which is the basis for the arbitration. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that disputed payment amounts may be aggregated for the purposes of meeting the threshold requirements of this section.

c. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)

shall be the subject of arbitration pursuant to this section.

d. An arbitrator may review any records in connection with the payment dispute, including the claims file of the payer, or of the health care provider or the covered person to whom payment is due, subject to confidentiality requirements established by State or federal law.

e. (1) An arbitrator*s determination shall be in writing, in a form prescribed by the commissioner, and shall state the issues in dispute and the findings and conclusions on which the determination is based. The determination shall be signed by the arbitrator and shall be binding on all parties to the dispute.

(2) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this act, the arbitrator shall order the payer to make payment of the claim within 10 business days.

(3) In accordance with regulations adopted by the commissioner, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

9. a. For the purposes of this section:

"Dental care provider" means a dentist or other health care provider licensed pursuant to Title 45 of the Revised Statutes to perform dental care services in this State.

"Dental care service" means a service provided to a covered person under a dental plan.

"Dental carrier" means a dental service corporation established pursuant to the "Dental Service Corporation Act of 1968," P.L.1968, c.305 (C.17:48C-1 et seq.), a dental plan organization established pursuant to the "Dental Plan Organization Act," P.L.1979, c.478 (C.17:48D-1 et seq.) or a carrier authorized to issue dental plans in this State.

"Dental claim" means a request to a third party for payment of a covered dental care service.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Predetermination request" means a request transmitted to a dental carrier in connection with a dental plan to issue an advance determination of coverage, which may include the amount of benefits then available for a dental care service prior to rendering the dental service or services.

b. A dental carrier shall respond to a dental care provider's predetermination request or request for authorization of dental care services by either approving or denying the request based on a utilization management decision. Any denial of a request or limitation imposed on a requested service shall be made by a dentist licensed in this State, and communicated to the provider by facsimile or E-mail,

as follows:

(1) In the case of a predetermination request or request for authorization for a covered person who is receiving care rendered in the emergency department of a hospital, the dental carrier shall communicate the denial of the request or the limitation imposed on the requested service to the provider within a time frame appropriate to the medical exigencies of the case but no later than 24 hours following the time the request was made;

(2) In the case of a predetermination request or request for authorization for a covered person who is currently receiving dental care services in an outpatient setting, the dental carrier shall communicate the denial of the request or the limitation imposed on the requested service to the provider within a time frame appropriate to the medical exigencies of the case but no later than five business days following the time the request was made; and

(3) If the dental carrier requires additional information to approve or deny a request for authorization, the dental carrier shall so notify the provider by facsimile or E-mail within the applicable time frame set forth in paragraph (1) or (2) of this subsection and shall identify the specific information needed to approve or deny the request for predetermination or authorization. If the dental carrier is unable to approve or deny a request for predetermination or authorization within the applicable time frame set forth in paragraph (1) or (2) of this subsection because of the need for this additional information, the dental carrier shall have an additional period within which to approve or deny the request, as follows:

(a) in the case of a request for a predetermination request or authorization for a covered person who is receiving care rendered in the emergency department of a hospital, no more than 12 hours beyond the time of receipt by the dental carrier from the provider of the additional information that the dental carrier has identified as needed to approve or deny the request for predetermination or authorization; and

(b) in the case of a request for predetermination or authorization for a covered person who is currently receiving health care services in another setting, no more than two business days beyond the time of receipt by the dental carrier from the provider of the additional information that the dental carrier has identified as needed to approve or deny the request for authorization.

c. Dental carriers and dental care providers shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., five days a week, to respond to predetermination or authorization requests within the time frames established pursuant to subsection a. of this section.

d. If a dental carrier fails to respond to a predetermination or authorization request within the time frames established pursuant to subsection a. of this section, the dental care provider's request shall be

deemed approved and the dental carrier shall be responsible to the dental care provider for the payment of the requested services at the full contractual rate.

10. The commissioner shall enforce the provisions of this act. A payer or dental carrier found in violation of the provisions of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day that the payer or dental carrier is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer or dental carrier has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

11. The commissioner shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

12. This act shall take effect on the 120th day after enactment, but the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act.

STATEMENT

This bill, the "Health and Dental Claims Authorization, Processing and Payment Act," is intended to ensure that health care providers, including, but not limited to physicians, dentists and other licensed health care professionals, hospitals and other health care facilities, receive reimbursement to which they are entitled from payers for health care services delivered to covered persons under health maintenance organization (HMO) contracts, health, hospital and medical service corporation contracts, health insurance policies and dental plans.

The bill defines "payer" as a carrier (HMO, health, hospital, medical service corporation or commercial insurer) which requires that utilization management be performed to authorize the approval of a health care service, and includes an organized delivery system that is certified by the Commissioner of Health and Senior Services or licensed by the Commissioner of Banking and Insurance.

The bill provides that a payer shall respond to a health care provider'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 on a requested service shall be made by a State licensed physician and shall be communicated to the provider by facsimile or E-mail within a time frame appropriate to the medical exigencies of the case, but no later than 24 hours in the case of a request for authorization for a covered person who is receiving inpatient hospital or emergency room care, and no later than three business days for a covered person who is receiving health care services in another setting. If the payer requires additional information to approve or deny a request for authorization, the payer shall notify the provider by facsimile or E-mail within the applicable time frame and shall identify the specific information needed to approve or deny the request for authorization. If the payer is unable to approve or deny a request for authorization within those time frames because of the need for this additional information, the bill provides that the payer shall have an additional time period within which to approve or deny the request.

If a payer fails to respond to an authorization request within the required time frames, the health care provider's request shall be deemed approved and the payer shall be responsible to the health care provider for the payment of the requested services.

The bill provides that a payer:

- shall reimburse a hospital if the hospital requested authorization from the payer and received approval for the health care services delivered prior to rendering the service or the hospital requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the hospital within the time frames established under the bill;

- shall reimburse a hospital for all medically necessary services rendered to the covered person at the contracted rate for services provided if it has reimbursed another health care provider for rendering medically necessary care to that same covered person at the hospital;

- shall not amend a claim by changing the diagnostic code assigned to the services rendered by the health care provider without providing written justification; and

- shall reimburse a health care provider for all medically necessary services rendered to a covered person that are covered under the health benefits plan, including emergency and urgent care health care services and all tests necessary, in accordance with nationally recognized treatment protocols, to determine the nature of an illness or injury.

The bill also specifies that if a payer has determined that a covered person who is an inpatient in a hospital requires medically necessary health care services that are not available or provided at the hospital or are less than the acute level of care provided at the hospital, the

payer shall be responsible for identifying an available contracted health care provider that offers the required covered services and that will accept the covered person. The payer shall pay the hospital in accordance with the contracted rate until an appropriate placement can be made.

The bill provides that upon admission to a hospital or prior to receiving health care services, a covered person or a person designated by the covered person may sign a consent form authorizing a health care provider, on the covered person's behalf, to appeal a determination by a payer to deny, reduce or terminate a health care benefit or deny payment for a health care service based upon the payer's determination that the health care benefit or service is not medically necessary and which consent would be valid for all stages of the payer's appeals process and the Independent Health Care Appeals Program. The health care provider shall provide notice to the covered person whenever an appeal is initiated and provide additional notice each time the health care provider continues that appeal to the next stage of the payer's appeals process. A covered person retains his right to revoke his consent at any time.

The bill further provides that a contract between a payer and a health care provider other than a dentist shall contain a provision that any dispute regarding the recovery of payments, shall, on the initiative of any party to the dispute, be referred to binding arbitration. The cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

In recognition that dental predetermination requests and requests for authorization for dental services between dentists and dental plans are different from similar requests between other health care providers and insurance carriers, the bill provides for certain procedures with respect to dental claims.

Finally, the bill provides for the imposition of civil monetary 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)

AN ACT concerning reimbursement for overpayment on health care claims and supplementing various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. A hospital service corporation or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 2 of P.L.1999, c.154 (C.17:48-8.4) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the hospital service corporation or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the hospital service corporation or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

2. a. A medical service corporation or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 3 of P.L.1999, c.154 (C.17:48A-7.12) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the medical service corporation or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the medical service corporation or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

3. a. A health service corporation or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 4 of P.L.1999, c.154 (C.17:48E-10.1) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the health service corporation or its agent seeks reimbursement for the overpayment, it

shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the health service corporation or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

4. a. An individual health insurer or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 5 of P.L.1999, c.154 (C.17B:26-9.1) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the insurer or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the insurer or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

5. a. A group health insurer or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 6 of P.L.1999, c.154 (C.17B:27-44.2) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the insurer or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the insurer or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

6. a. A health maintenance organization or its agent shall not seek

reimbursement for overpayment of a claim previously paid pursuant to section 7 of P.L.1999, c.154 (C.26:2J-8.1) for a health care service provided to an enrollee by an eligible health care provider later than 18 months after the date the claim was paid. If the health maintenance organization or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the health maintenance organization or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

7. a. A dental service corporation or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 8 of P.L.1999, c.154 (C.17:48C-8.1) for a health care service provided to a covered person by an eligible health care provider later than 18 months after the date the claim was paid. If the dental service corporation or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the dental service corporation or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

8. a. A dental plan organization or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 9 of P.L.1999, c.154 (C.17:48D-9.4) for a health care service provided to an enrollee by an eligible health care provider later than 18 months after the date the claim was paid. If the dental plan organization or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the dental plan organization or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future

claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

9. a. A prepaid prescription service organization or its agent shall not seek reimbursement for overpayment of a claim previously paid pursuant to section 10 of P.L.1999, c.154 (C.17:48F-13.1) for a prescription provided to an enrollee by an eligible health care provider later than 18 months after the date the claim was paid. If the prepaid prescription service organization or its agent seeks reimbursement for the overpayment, it shall provide written documentation to the health care provider that substantiates the reason for the reimbursement request.

b. In seeking reimbursement for the overpayment, the prepaid prescription service organization or its agent shall not:

(1) require payment earlier than the 60th day following receipt of the documentation by the health care provider;

(2) assess the reimbursement against the payment of any future claims; or

(3) collect or attempt to collect from the health care provider a penalty, including, but not limited to, an interest charge or a late fee.

10. This act shall take effect on the 30th day after enactment.

STATEMENT

This bill limits the time frame in which a health insurance carrier can request reimbursement from a health care provider if the carrier overpaid a previously settled claim. The carrier must submit written documentation substantiating the reason for the reimbursement request and may not require payment on or before the 60th day following the provider's receipt of the documentation. This provision will allow the provider time to examine the reimbursement request, and if necessary, arrange a schedule for paying the carrier. The carrier may not assess the reimbursement against the payment of any future claims or collect or attempt to collect any penalties against the provider, including, but not limited to, interest charges or late fees.

The provisions of this bill apply to hospital, medical, and health service corporations, commercial individual and group insurers, health maintenance organizations, dental service corporations, dental plan 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 furture 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.