ASSEMBLY, No. 1286

STATE OF NEW JERSEY

212th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2006 SESSION

Sponsored by:
Assemblyman LOUIS M. MANZO
District 31 (Hudson)

SYNOPSIS

Limits period for reimbursement for overpayment on health and dental claims to 180 days, establishes claims appeal process, requires examination of claims processing and payment records, and imposes penalties for violations.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

AN ACT concerning payment and review of health and dental 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. 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, 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.

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.

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] 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;

(d) 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 has not been submitted to the payer;

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

(d) 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 or 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in

paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) 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) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the

appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

2. 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 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] <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;

(d) 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 has not been submitted to the payer;

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

(d) 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] <u>covered person or health care provider</u>, 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) 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) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th

calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar

day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

3. 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 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;

(d) 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 has not been submitted to the payer;

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

(d) 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 or 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) 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) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program,

whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

4. 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 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 policy;

(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;

(d) 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 policy.

(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 has not been submitted to the payer;

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

(d) 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 policy, the payer shall notify the [insured, or that insured's agent or assignee if the policy provides for assignment of benefits] covered person or 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

(5) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request,

including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

5. 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 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 policy;

(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;

(d) 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 policy.

(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 has not been submitted to the payer;

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

(d) 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 policy, the payer shall notify the [insured, or that insured's agent or assignee if the policy provides for assignment of benefits] <u>covered person or health provider</u>, 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid <u>in full</u> by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

(5) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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] 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 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

6. 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 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.

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;

(d) 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 has not been submitted to the payer;

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

(d) 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 or 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

(5) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day

following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 12 of P.L. , c. (C.) (now before the Legislature as this bill).

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

7. Section 8 of P.L.1999, c.154 (C.17:48C-8.1) is amended to read as follows:

8. 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 dental service corporation, 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 dental 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 dental 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 dental service corporation shall require that health care providers file all claims for payment for dental services. A covered person who receives dental 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 dental 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;

(d) 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 has not been submitted to the payer;

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

(d) 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 or 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid in full by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) 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) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if the entire eligible amount is 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a

claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

e. (1) A dental 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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued

interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 dental service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the dental service corporation.

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 12 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.1999, c.154, s.8)

8. Section 9 of P.L.1999, c.154 (C.17:48D-9.4) is amended to read as follows:

9. 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 dental plan organization, 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 dental plan organization, 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 dental plan 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 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 dental plan organization shall require that health care providers file all claims for payment for dental services. A covered person who receives dental 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 dental plan organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a covered person or that covered person's agent or assignee if the contract provides for assignment of benefits, 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;

(d) 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 has not been submitted to the payer;

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

(d) 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 covered person, or that covered person's agent or assignee if the contract provides for assignment of benefits, 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid <u>in full</u> by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

(5) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if <u>the entire eligible amount is</u> 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic

means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request, including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

e. (1) A dental plan 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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which

shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care

provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 dental plan organization contract for which the financial obligation for the payment of a claim under the contract rests upon the dental plan organization.

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 12 of P.L. , c. (C.) (now before the Legislature as this bill).

(cf: P.L.2005, c.38, s.7)

9. 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 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] <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;

(d) 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 has not been submitted to the payer;

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

(d) 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 [enrollee, or that enrollee's agent or assignee if the contract provides for assignment of benefits] <u>covered person or health care provider</u>, 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 incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; 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) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid <u>in full</u> by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

(5) 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) Payment of an eligible claim pursuant to paragraphs (1) and (3) 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) of paragraph (2) 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 calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of [10%] 25% per annum. The interest shall be paid at the time the overdue payment is made.

(8) No payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than the 180th calendar day after the date the first payment on the claim was made. At the time of submitting the reimbursement request 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;

(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; or

(d) in which there is clear evidence of fraud by the health care provider.

(9) In seeking reimbursement for overpayment from the health care provider, no payer shall collect or attempt to collect:

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

(b) the funds for the reimbursement request 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 right to appeal set forth under paragraphs (1) and (2) of subsection e. are exhausted;

(c) a monetary penalty against the reimbursement request,

including, but not limited to, an interest charge or late fee; or

(d) the funds for the reimbursement request by assessing them against the payment of any future claim submitted by the health care provider.

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 shall initiate an appeal on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that shall 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 payer shall remit payment of the amount in dispute in full, together with accrued interest at the rate of 25% per annum, on or before the 12th calendar day following the receipt of the appeal form. If the payment is not made in full within the time limit established in this paragraph, the health care provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection.

If at the conclusion of the appeal the payer issues a determination in favor of the health care provider, the payer shall comply with the provisions of this section and pay in full the amount of money in dispute, if applicable, with accrued interest at the rate of 25% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal.

If at the conclusion of the appeal the payer issues a determination in favor of the payer, 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 arbitration, 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 disputed amounts may be aggregated for the purposes of meeting the threshold requirements of this paragraph. 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 paragraph.

(3) An arbitrator may review any records in connection with the dispute, including the claims file of the payer or of the health care provider or the covered person, 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 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 amount in dispute, together with accrued interest, on or before the 10th calendar day following the issuance of the determination. 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 issues a determination in favor of the payer, the health care provider shall reimburse the payer any payment made pursuant to paragraph (1) of this subsection on or before the 10th calendar day following the issuance of the determination.

(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 by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 12 of P.L. , c. (C.) (now

before the Legislature as this bill).
(cf: P.L.1999, c.154, s.10)

10. Section 5 of P.L.1999, c.155 (C.17B:30-30) is amended to read as follows:

5. a. A payer shall maintain a record which shall be audited by a private auditing firm at the expense of the payer, to be submitted to the commissioner[, Governor and the Legislature annually,] in a form established by the commissioner by regulation, of the number of claims [, by category]:

(1) that are submitted to the payer;

(2) that are paid in full after their initial submission;

(3) that are denied because they are for an ineligible service or the health care service was not rendered by an eligible health care provider under the health benefits or dental plan;

[(2)] (4) that are [rejected] denied at their initial submission because of a lack of substantiating documentation;

[(3)] (5) that are [rejected] denied at their initial submission because of incorrect coding or incorrect enrollment information;

[(4)] (6) that are [rejected] denied at their initial submission because of a dispute in the amount claimed;

[(5)] (7) that are not paid in accordance with the time limit established by law because the payer deems the claim to require special treatment that prevents timely payments from being made;

[(6)] (8) that are not paid in accordance with the time limits for payment established by law even though the claims meet the criteria established by law;

[(7)] (9) upon which the [10%] interest penalty established by law has been paid, and the aggregate amount of interest paid for the period covered by the report;

[(8)] (10) that are denied or referred to the payer's fraud investigation unit, if applicable, or 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) because the payer has reason to believe that the claim has been submitted fraudulently; and

[(9)] (11) any other information the commissioner requires.

b. [After reviewing an audit, the commissioner may, if he deems it necessary] Not less frequently than once every five years, the commissioner shall examine the audits of each payer for that time period. Every payer and health care provider shall submit its books and records to such examinations if deemed necessary by the commissioner. For the purpose of the examinations, the commissioner may administer oaths to, and examine the officers

and agents of the payer and the principals of the health care providers concerning processing and payment of claims. The expenses of examinations under this section up to $1,000 shall be assessed against the payer being examined and the amount shall be remitted to the commissioner.

c. If, following the examination, the commissioner determines that a payer has not complied with the provisions sections 2 through 10 of P.L.1999, c.154 (C.17:48-8.4 et al.), the commissioner shall within 180 days of the determination: require the implementation of a plan of remedial action by the payer; require that the payer's claims processing procedures be monitored by a private auditing firm for a time period he deems appropriate; or both.

If, following [an audit,] the commissioner's examination and within one year of the implementation of a plan of remediation or the monitoring of the payer's claims processing procedures, the commissioner determines that:

(1) an unreasonably large or disproportionate number of eligible claims continue to be rejected, denied, or not paid in a timely fashion for the reasons set forth in paragraph [(4), (5) or (6)] (6), (7) or (8) of subsection a. of this section; or

(2) a payer has failed to pay interest as required pursuant to law, the commissioner shall impose a civil penalty of not more than $10,000 upon the payer, to be collected pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

d. The commissioner shall prepare and submit a report annually to the Governor, President of the Senate, Speaker of the General Assembly and the Chairs of the Senate Health, Human Services, and Senior Citizens, Assembly Financial Institutions and Insurance and Assembly Health and Human Services Committees or their successor committees. The report shall include:

(1) the number of examinations conducted in that year by the commissioner pursuant to subsection b. of this section;

(2) the number and names of the payers found by commissioner to have violated provisions of sections 2 through 10 of P.L.1999, c.154 (C.17:48-8.4 et al.) and required to undergo remediation, monitoring or both;

(3) the number and names of the payers fined by the commissioner pursuant to subsection c. of this section; and

(4) the total amount in civil penalties collected pursuant to subsection c. of this section that year by the commissioner.

[c.] e. Every financial examination of a payer performed pursuant to section 11 of P.L.1938, c.366 (C.17:48-11), section 15 of P.L.1940, c.74 (C.17:48A-15), section 26 of P.L.1968, c.305 (C.17:48C-26), section 13 of P.L.1979, c.478 (C.17:48D-13), section 36 of P.L.1985, c.236 (C.17:48E-36), N.J.S.17B:21-1 et seq. or section 9 of P.L.1973, c.337 (C.26:2J-9), as applicable, shall include an examination of the payer's compliance with the

provisions of this section.
(cf: P.L.1999, c.155, s.5)

11. Section 6 of P.L.1999, c.155 (C.17B:30-31) is amended to read as follows:

6. a. In addition to the annual audit required by section 5 of this act, the payer shall maintain and report to the commissioner on no less than a quarterly basis, a record of claims as provided in paragraphs (1) through (9) of subsection a. of section 5 of this act.

b. After reviewing a report, the commissioner may require an immediate audit of the payer by a private audit firm and after reviewing the audit, if [he deems it necessary, may] the commissioner determines that a payer has not complied with the provisions of sections 2 through 10 P.L.1999, c.154 (C.17.48-8.4 et al.) (now pending before the Legislature as this bill), the commissioner shall proceed with a remediation or monitoring procedure as provided by subsection [b.] c. of section 5 of this act.
(cf: P.L.1999, c.155, s.6)

12. (New section) The Commissioner of Banking and Insurance shall enforce the provisions of sections 2 through 10 of P.L.1999, c.154 (C.17:48-8.4 et al.) and P.L.1999, c.155 (C.17B:30-26 et seq.). Except as otherwise provided in subsection c. of section 5 of P.L.1999, c.155 (C.17B:30-30), any person found in violation of the provisions of those sections shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day that the person is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the Commissioner of Banking and Insurance, the person has 30 days, or such additional time as the Commissioner of Banking and Insurance 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 of Banking and Insurance 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.).

13. (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 effectuate the purposes of P.L. , c. (C.) (now pending before the Legislature as this bill).

14. (New section) This act shall take effect on the 120th 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 is intended to ensure that health care providers, or simply "providers," including, but not limited to physicians, dentists and other licensed health care professionals, hospitals and other health care facilities, receive timely and equitable payment of health and dental claims from insurance carriers and have a process for resolving disputes with insurance carriers over claims processing or payment. 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, which are generally referred to in the bill as "payers."

As provided in this bill, the interest rate on an overdue claims payment is increased from 10% per annum to 25% per annum. This rate applies to any overdue claims payment owed to a health care provider by a payer.

This bill also provides that a payer may seek reimbursement for any money overpaid in error to a provider if: the first payment on the claim was made within 180 days of the reimbursement request; the request is accompanied by substantiating documentation; and the request is not based on extrapolation of other claims, except under certain circumstances. The provider has 45 days to review the request prior to payment being due; however, if the provider appeals the request, payment shall not be due until the payer's right to appeal are exhausted. The payer may not assess any monetary penalty against the provider, nor shall the payer collect the reimbursement by assessing it against the payment of any future claims.

The bill establishes a two-part appeals process to resolve any dispute concerning the compliance with the law regarding the processing and prompt payment of claims. A payer must establish an internal appeals process to review any appeal brought forth by a provider within 10 days of its inititation. If following the review, the payer rules in favor of the provider, it must comply with the provisions of the law and pay the disputed amount in full with accrued interest. If a payer rules against the provider, it must communicate its findings in writing, including written instructions for referring the dispute to arbitration. A payer that fails to conduct the review within the allowed time frame must pay the full amount of the money in dispute within 12 days of the appeal's intitiation.

Following an internal appeal, either party can refer the dispute to arbitration conducted by an organization that is under contract with the Department of Banking and Insurance. The arbitrator's determinations shall be binding to all parties in the dispute. If the arbitrator rules in favor of the provider, the payer shall remit payment, including accrued interest, within 10 days. If the arbitrator rules in favor of the payer, the provider shall repay within 10 days any payment that was made to the provider.

Finally, this bill requires the commissioner to examine once every five years the audited records concerning claims payment compiled by payers. If, after review, the commissioner finds that a payer has violated any law regarding the processing and payment of claims, the payer must take certain actions within 180 days of the examination. If within one year of taking such action, the commissioner determines that payer continues to act in violation of the law, the commissioner shall impose a civil penalty of not more than $10,000. The commissioner shall prepare a report detailing the results of that year's examinations and shall submit the report to the Governor, the leaders of the Legislature, and the Chairs of certain Senate and Assembly Committees.

Except as otherwise provided, any person found in violation of this bill is subject to a civil penalty of not less than $250 and not greater than $10,000 for each day that the person is in found in violation by the commissioner.