

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



1 AN ACT concerning payment and review of health and dental claims
2 and amending and supplementing various parts of the statutory
3 law.
4

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

7
8 1. Section 2 of P.L.1999, c.154 (C.17:48-8.4) is amended to read
9 as follows:

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

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

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

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

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

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

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

19 (c) there is no dispute regarding the amount claimed;

20 (d) the payer has no reason to believe that the claim has been
21 submitted fraudulently; and

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

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

26 (a) the claim is an ineligible claim;

27 (b) the claim submission is incomplete because the required
28 substantiating documentation has not been submitted to the payer;

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

31 (d) the payer disputes the amount claimed; or

32 (e) the claim requires special treatment that prevents timely
33 payments from being made on the claim under the terms of the
34 contract, the payer shall notify the [subscriber, or that subscriber's
35 agent or assignee if the contract provides for assignment of
36 benefits] covered person or health care provider, in writing or by
37 electronic means, as appropriate, within 30 days, of the following:
38 if all or a portion of the claim is denied, all the reasons for the
39 denial; if the claim lacks the required substantiating documentation,
40 including incorrect coding, a statement as to what substantiating
41 documentation or other information is required to complete
42 adjudication of the claim; if the amount of the claim is disputed, a
43 statement that it is disputed; and if the claim requires special
44 treatment that prevents timely payments from being made, a
45 statement of the special treatment to which the claim is subject.

46 (3) Any portion of a claim that meets the criteria established in

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

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

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

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

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

33 (7) An overdue payment shall bear simple interest at the rate of
34 [10%] 25% per annum. The interest shall be paid at the time the
35 overdue payment is made.

36 (8) No payer shall seek reimbursement for overpayment of a
37 claim previously paid pursuant to this section later than the 180th
38 calendar day after the date the first payment on the claim was made.
39 At the time of submitting the reimbursement request to the health
40 care provider, the payer shall provide written documentation that
41 identifies the error made by the payer in the processing or payment
42 of the claim that justifies the reimbursement request. No payer
43 shall base a reimbursement request for a particular claim on
44 extrapolation of other claims, except under the following
45 circumstances:

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

- 1 (b) in administrative proceedings;
2 (c) in which relevant records required to be maintained by the
3 health care provider have been improperly altered or reconstructed,
4 or a material number of the relevant records are otherwise
5 unavailable; or
6 (d) in which there is clear evidence of fraud by the health care
7 provider.
8 (9) In seeking reimbursement for overpayment from the health
9 care provider, no payer shall collect or attempt to collect:
10 (a) the funds for reimbursement on or before the 45th calendar
11 day following the submission of the reimbursement request to the
12 health care provider;
13 (b) the funds for the reimbursement request if the health care
14 provider disputes the request and initiates an appeal on or before the
15 45th calendar day following the submission of the reimbursement
16 request to the health care provider and until the health care
17 provider's right to appeal set forth under paragraphs (1) and (2) of
18 subsection e. are exhausted;
19 (c) a monetary penalty against the reimbursement request,
20 including, but not limited to, an interest charge or late fee; or
21 (d) the funds for the reimbursement request by assessing them
22 against the payment of any future claim submitted by the health
23 care provider.
24 e. (1) A hospital service corporation or its agent, hereinafter the
25 payer, shall establish an internal appeal mechanism to resolve any
26 dispute regarding compliance with the requirements of this section.
27 The payer shall conduct the appeal at no cost to the health care
28 provider.
29 A health care provider shall initiate an appeal on a form
30 prescribed by the Commissioner of Banking and Insurance which
31 shall describe the type of substantiating documentation that shall be
32 submitted with the form. The payer shall conduct a review of the
33 appeal and notify the health care provider of its determination on or
34 before the 10th calendar day following the receipt of the appeal
35 form. If the health care provider is not notified of the payer's
36 determination of the appeal within 10 days, the payer shall remit
37 payment of the amount in dispute in full, together with accrued
38 interest at the rate of 25% per annum, on or before the 12th calendar
39 day following the receipt of the appeal form. If the payment is not
40 made in full within the time limit established in this paragraph, the
41 health care provider may refer the dispute to arbitration as provided
42 by paragraph (2) of this subsection.
43 If at the conclusion of the appeal the payer issues a
44 determination in favor of the health care provider, the payer shall
45 comply with the provisions of this section and pay in full the
46 amount of money in dispute, if applicable, with accrued interest at
47 the rate of 25% per annum, on or before the 30th calendar day
48 following the notification of the payer's determination on the

1 appeal.

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

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

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

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

29 (3) An arbitrator may review any records in connection with the
30 dispute, including the claims file of the payer or of the health care
31 provider or the covered person, subject to confidentiality
32 requirements established by State or federal law.

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

34 (a) signed by the arbitrator;

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

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

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

42 (5) If the arbitrator determines that a payer has withheld or
43 denied payment in violation of the provisions of this section, the
44 arbitrator shall order the payer to make payment of the amount in
45 dispute, together with accrued interest, on or before the 10th
46 calendar day following the issuance of the determination. In
47 accordance with regulations adopted by the Commissioner of
48 Banking and Insurance, the cost of the arbitration proceedings,

1 including the payment of reasonable attorney's fees, shall be
2 awarded to the prevailing party.

3 (6) If the arbitrator issues a determination in favor of the payer,
4 the health care provider shall reimburse the payer any payment
5 made pursuant to paragraph (1) of this subsection on or before the
6 10th calendar day following the issuance of the determination.

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

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

15 g. Any person found in violation of this section by the
16 Commissioner of Banking and Insurance shall be liable to a civil
17 penalty as set forth in section 12 of P.L. , c. (C.) (now
18 before the Legislature as this bill).

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

20

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

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

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

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

47 c. Twelve months after the adoption of regulations establishing

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

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

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

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

29 (c) there is no dispute regarding the amount claimed;

30 (d) the payer has no reason to believe that the claim has been
31 submitted fraudulently; and

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

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

36 (a) the claim is an ineligible claim;

37 (b) the claim submission is incomplete because the required
38 substantiating documentation has not been submitted to the payer;

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

41 (d) the payer disputes the amount claimed; or

42 (e) the claim requires special treatment that prevents timely
43 payments from being made on the claim under the terms of the
44 contract, the payer shall notify the [subscriber, or that subscriber's
45 agent or assignee if the contract provides for assignment of
46 benefits] covered person or health care provider, in writing or by

1 electronic means, as appropriate, within 30 days, of the following:
2 if all or a portion of the claim is denied, all the reasons for the
3 denial; if the claim lacks the required substantiating documentation,
4 including incorrect coding, a statement as to what substantiating
5 documentation or other information is required to complete
6 adjudication of the claim; if the amount of the claim is disputed, a
7 statement that it is disputed; and if the claim requires special
8 treatment that prevents timely payments from being made, a
9 statement of the special treatment to which the claim is subject.

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

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

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

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

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

43 (7) An overdue payment shall bear simple interest at the rate of
44 ~~[10%]~~ 25% per annum. The interest shall be paid at the time the
45 overdue payment is made.

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

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

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

11 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

39 A health care provider shall initiate an appeal on a form
40 prescribed by the Commissioner of Banking and Insurance which
41 shall describe the type of substantiating documentation that shall be
42 submitted with the form. The payer shall conduct a review of the
43 appeal and notify the health care provider of its determination on or
44 before the 10th calendar day following the receipt of the appeal
45 form. If the health care provider is not notified of the payer's
46 determination of the appeal within 10 days, the payer shall remit
47 payment of the amount in dispute in full, together with accrued
48 interest at the rate of 25% per annum, on or before the 12th calendar

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

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

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

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

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

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

39 (3) An arbitrator may review any records in connection with the
40 dispute, including the claims file of the payer or of the health care
41 provider or the covered person, subject to confidentiality
42 requirements established by State or federal law.

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

44 (a) signed by the arbitrator;

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

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

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

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

13 (6) If the arbitrator issues a determination in favor of the payer,
14 the health care provider shall reimburse the payer any payment
15 made pursuant to paragraph (1) of this subsection on or before the
16 10th calendar day following the issuance of the determination.

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

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

25 g. Any person found in violation of this section by the
26 Commissioner of Banking and Insurance shall be liable to a civil
27 penalty as set forth in section 12 of P.L. , c. (C.) (now
28 before the Legislature as this bill).

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

30

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

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

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

1 covered persons.

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

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

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

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

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

39 (c) there is no dispute regarding the amount claimed;

40 (d) the payer has no reason to believe that the claim has been
41 submitted fraudulently; and

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

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

46 (a) the claim is an ineligible claim;

47 (b) the claim submission is incomplete because the required

1 substantiating documentation has not been submitted to the payer;
2 (c) the diagnosis coding, procedure coding, or any other required
3 information to be submitted with the claim is incorrect;
4 (d) the payer disputes the amount claimed; or
5 (e) the claim requires special treatment that prevents timely
6 payments from being made on the claim under the terms of the
7 contract, the payer shall notify the [subscriber, or that subscriber's
8 agent or assignee if the contract provides for assignment of
9 benefits] covered person or health care provider, in writing or by
10 electronic means, as appropriate, within 30 days, of the following:
11 if all or a portion of the claim is denied, all the reasons for the
12 denial; if the claim lacks the required substantiating documentation,
13 including incorrect coding, a statement as to what substantiating
14 documentation or other information is required to complete
15 adjudication of the claim; if the amount of the claim is disputed, a
16 statement that it is disputed; and if the claim requires special
17 treatment that prevents timely payments from being made, a
18 statement of the special treatment to which the claim is subject.

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

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

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

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

43 In the event payment is withheld on all or a portion of a claim by
44 a payer pursuant to subparagraph (b) of paragraph (2) of this
45 subsection, the claims payment shall be overdue if not remitted to
46 the claimant or his agent by the payer on or before the 30th calendar
47 day or the time limit established by the Medicare program,

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

5 (7) An overdue payment shall bear simple interest at the rate of
6 [10%] 25% per annum. The interest shall be paid at the time the
7 overdue payment is made.

8 (8) No payer shall seek reimbursement for overpayment of a
9 claim previously paid pursuant to this section later than the 180th
10 calendar day after the date the first payment on the claim was made.
11 At the time of submitting the reimbursement request to the health
12 care provider, the payer shall provide written documentation that
13 identifies the error made by the payer in the processing or payment
14 of the claim that justifies the reimbursement request. No payer
15 shall base a reimbursement request for a particular claim on
16 extrapolation of other claims, except under the following
17 circumstances:

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

20 (b) in administrative proceedings;

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

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

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

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

32 (b) the funds for the reimbursement request if the health care
33 provider disputes the request and initiates an appeal on or before the
34 45th calendar day following the submission of the reimbursement
35 request to the health care provider and until the health care
36 provider's right to appeal set forth under paragraphs (1) and (2) of
37 subsection e. are exhausted;

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

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

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

1 A health care provider shall initiate an appeal on a form
2 prescribed by the Commissioner of Banking and Insurance which
3 shall describe the type of substantiating documentation that shall be
4 submitted with the form. The payer shall conduct a review of the
5 appeal and notify the health care provider of its determination on or
6 before the 10th calendar day following the receipt of the appeal
7 form. If the health care provider is not notified of the payer's
8 determination of the appeal within 10 days, the payer shall remit
9 payment of the amount in dispute in full, together with accrued
10 interest at the rate of 25% per annum, on or before the 12th calendar
11 day following the receipt of the appeal form. If the payment is not
12 made in full within the time limit established in this paragraph, the
13 health care provider may refer the dispute to arbitration as provided
14 by paragraph (2) of this subsection.

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

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

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

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

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

1 (3) An arbitrator may review any records in connection with the
2 dispute, including the claims file of the payer or of the health care
3 provider or the covered person, subject to confidentiality
4 requirements established by State or federal law.

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

6 (a) signed by the arbitrator;

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

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

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

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

23 (6) If the arbitrator issues a determination in favor of the payer,
24 the health care provider shall reimburse the payer any payment
25 made pursuant to paragraph (1) of this subsection on or before the
26 10th calendar day following the issuance of the determination.

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

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

35 g. Any person found in violation of this section by the
36 Commissioner of Banking and Insurance shall be liable to a civil
37 penalty as set forth in section 12 of P.L. , c. (C.) (now
38 before the Legislature as this bill).

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

40

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

43 5. a. Within 180 days of the adoption of a timetable for
44 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
45 23), a health insurer, or a subsidiary that processes health care
46 benefits claims as a third party administrator, shall demonstrate to
47 the satisfaction of the Commissioner of Banking and Insurance that

1 it will adopt and implement all of the standards to receive and
2 transmit health care transactions electronically, according to the
3 corresponding timetable, and otherwise comply with the provisions
4 of this section, as a condition of its continued authorization to do
5 business in this State.

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

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

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

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

42 (a) the claim is an eligible claim for a health care service
43 provided by an eligible health care provider to a covered person
44 under the policy;

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

- 1 (c) there is no dispute regarding the amount claimed;
- 2 (d) the payer has no reason to believe that the claim has been
3 submitted fraudulently; and
- 4 (e) the claim requires no special treatment that prevents timely
5 payments from being made on the claim under the terms of the
6 policy.
- 7 (2) If all or a portion of the claim is denied by the payer because:
- 8 (a) the claim is an ineligible claim;
- 9 (b) the claim submission is incomplete because the required
10 substantiating documentation has not been submitted to the payer;
- 11 (c) the diagnosis coding, procedure coding, or any other required
12 information to be submitted with the claim is incorrect;
- 13 (d) the payer disputes the amount claimed; or
- 14 (e) the claim requires special treatment that prevents timely
15 payments from being made on the claim under the terms of the
16 policy, the payer shall notify the [insured, or that insured's agent or
17 assignee if the policy provides for assignment of benefits] covered
18 person or health care provider, in writing or by electronic means, as
19 appropriate, within 30 days, of the following: if all or a portion of
20 the claim is denied, all the reasons for the denial; if the claim lacks
21 the required substantiating documentation, including incorrect
22 coding, a statement as to what substantiating documentation or
23 other information is required to complete adjudication of the claim;
24 if the amount of the claim is disputed, a statement that it is
25 disputed; and if the claim requires special treatment that prevents
26 timely payments from being made, a statement of the special
27 treatment to which the claim is subject.
- 28 (3) Any portion of a claim that meets the criteria established in
29 paragraph (1) of this subsection shall be paid in full by the payer in
30 accordance with the time limit established in paragraph (1) of this
31 subsection.
- 32 (4) A payer shall acknowledge receipt of a claim submitted by
33 electronic means from a health care provider or [insured] covered
34 person, no later than two working days following receipt of the
35 transmission of the claim.
- 36 (5) If a payer subject to the provisions of P.L.1983, c.320
37 (C.17:33A-1 et seq.) has reason to believe that a claim has been
38 submitted fraudulently, it shall investigate the claim in accordance
39 with its fraud prevention plan established pursuant to section 1 of
40 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
41 supporting documentation, to the Office of the Insurance Fraud
42 Prosecutor in the Department of Law and Public Safety established
43 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 44 (6) Payment of an eligible claim pursuant to paragraphs (1) and
45 (3) of this subsection shall be deemed to be overdue if the entire
46 eligible amount is not remitted to the claimant or his agent by the
47 payer on or before the 30th calendar day or the time limit

1 established by the Medicare program, whichever is earlier,
2 following receipt by the payer of a claim submitted by electronic
3 means and on or before the 40th calendar day following receipt of a
4 claim submitted by other than electronic means.

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

14 (7) An overdue payment shall bear simple interest at the rate of
15 ~~[10%]~~ 25% per annum. The interest shall be paid at the time the
16 overdue payment is made.

17 (8) No payer shall seek reimbursement for overpayment of a
18 claim previously paid pursuant to this section later than the 180th
19 calendar day after the date the first payment on the claim was made.
20 At the time of submitting the reimbursement request to the health
21 care provider, the payer shall provide written documentation that
22 identifies the error made by the payer in the processing or payment
23 of the claim that justifies the reimbursement request. No payer
24 shall base a reimbursement request for a particular claim on
25 extrapolation of other claims, except under the following
26 circumstances:

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

29 (b) in administrative proceedings;

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

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

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

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

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

47 (c) a monetary penalty against the reimbursement request,

1 including, but not limited to, an interest charge or late fee; or
2 (d) the funds for the reimbursement request by assessing them
3 against the payment of any future claim submitted by the health
4 care provider.

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

9 A health care provider shall initiate an appeal on a form
10 prescribed by the Commissioner of Banking and Insurance which
11 shall describe the type of substantiating documentation that shall be
12 submitted with the form. The payer shall conduct a review of the
13 appeal and notify the health care provider of its determination on or
14 before the 10th calendar day following the receipt of the appeal
15 form. If the health care provider is not notified of the payer's
16 determination of the appeal within 10 days, the payer shall remit
17 payment of the amount in dispute in full, together with accrued
18 interest at the rate of 25% per annum, on or before the 12th calendar
19 day following the receipt of the appeal form. If the payment is not
20 made in full within the time limit established in this paragraph, the
21 health care provider may refer the dispute to arbitration as provided
22 by paragraph (2) of this subsection.

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

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

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

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

45 Any party may initiate an arbitration proceeding on or before the
46 90th calendar day following the receipt of the determination which
47 is the basis of the arbitration, on a form prescribed by the
48 Commissioner of Banking and Insurance. No dispute shall be

1 accepted for arbitration unless the payment amount in dispute is
2 \$1,000 or more, except that disputed amounts may be aggregated
3 for the purposes of meeting the threshold requirements of this
4 paragraph. No dispute pertaining to medical necessity which is
5 eligible to be submitted to the Independent Health Care Appeals
6 Program established pursuant to section 11 of P.L.1997, c.192
7 (C.26:2S-11) shall be the subject of arbitration pursuant to this
8 paragraph.

9 (3) An arbitrator may review any records in connection with the
10 dispute, including the claims file of the payer or of the health care
11 provider or the covered person, subject to confidentiality
12 requirements established by State or federal law.

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

14 (a) signed by the arbitrator;

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

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

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

22 (5) If the arbitrator determines that a payer has withheld or
23 denied payment in violation of the provisions of this section, the
24 arbitrator shall order the payer to make payment of the amount in
25 dispute, together with accrued interest, on or before the 10th
26 calendar day following the issuance of the determination. In
27 accordance with regulations adopted by the Commissioner of
28 Banking and Insurance, the cost of the arbitration proceedings,
29 including the payment of reasonable attorney's fees, shall be
30 awarded to the prevailing party.

31 (6) If the arbitrator issues a determination in favor of the payer,
32 the health care provider shall reimburse the payer any payment
33 made pursuant to paragraph (1) of this subsection on or before the
34 10th calendar day following the issuance of the determination.

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

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

42 g. Any person found in violation of this section by the
43 Commissioner of Banking and Insurance shall be liable to a civil
44 penalty as set forth in section 12 of P.L. , c. (C.) (now
45 before the Legislature as this bill).

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

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

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

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

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

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

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

- 1 claim is submitted by other than electronic means, if:
- 2 (a) the claim is an eligible claim for a health care service
3 provided by an eligible health care provider to a covered person
4 under the policy;
- 5 (b) the claim has no material defect or impropriety, including,
6 but not limited to, any lack of required substantiating
7 documentation or incorrect coding;
- 8 (c) there is no dispute regarding the amount claimed;
- 9 (d) the payer has no reason to believe that the claim has been
10 submitted fraudulently; and
- 11 (e) the claim requires no special treatment that prevents timely
12 payments from being made on the claim under the terms of the
13 policy.
- 14 (2) If all or a portion of the claim is denied by the payer because:
- 15 (a) the claim is an ineligible claim;
- 16 (b) the claim submission is incomplete because the required
17 substantiating documentation has not been submitted to the payer;
- 18 (c) the diagnosis coding, procedure coding, or any other required
19 information to be submitted with the claim is incorrect;
- 20 (d) the payer disputes the amount claimed; or
- 21 (e) the claim requires special treatment that prevents timely
22 payments from being made on the claim under the terms of the
23 policy, the payer shall notify the [insured, or that insured's agent or
24 assignee if the policy provides for assignment of benefits] covered
25 person or health provider, in writing or by electronic means, as
26 appropriate, within 30 days, of the following: if all or a portion of
27 the claim is denied, all the reasons for the denial; if the claim lacks
28 the required substantiating documentation, including incorrect
29 coding, a statement as to what substantiating documentation or
30 other information is required to complete adjudication of the claim;
31 if the amount of the claim is disputed, a statement that it is
32 disputed; and if the claim requires special treatment that prevents
33 timely payments from being made, a statement of the special
34 treatment to which the claim is subject.
- 35 (3) Any portion of a claim that meets the criteria established in
36 paragraph (1) of this subsection shall be paid in full by the payer in
37 accordance with the time limit established in paragraph (1) of this
38 subsection.
- 39 (4) A payer shall acknowledge receipt of a claim submitted by
40 electronic means from a health care provider or [insured] covered
41 person, no later than two working days following receipt of the
42 transmission of the claim.
- 43 (5) If a payer subject to the provisions of P.L.1983, c.320
44 (C.17:33A-1 et seq.) has reason to believe that a claim has been
45 submitted fraudulently, it shall investigate the claim in accordance
46 with its fraud prevention plan established pursuant to section 1 of
47 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with

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

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

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

21 (7) An overdue payment shall bear simple interest at the rate of
22 [~~10%~~] 25% per annum. The interest shall be paid at the time the
23 overdue payment is made.

24 (8) No payer shall seek reimbursement for overpayment of a
25 claim previously paid pursuant to this section later than the 180th
26 calendar day after the date the first payment on the claim was made.
27 At the time of submitting the reimbursement request to the health
28 care provider, the payer shall provide written documentation that
29 identifies the error made by the payer in the processing or payment
30 of the claim that justifies the reimbursement request. No payer
31 shall base a reimbursement request for a particular claim on
32 extrapolation of other claims, except under the following
33 circumstances:

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

36 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

16 A health care provider shall initiate an appeal on a form
17 prescribed by the Commissioner of Banking and Insurance which
18 shall describe the type of substantiating documentation that shall be
19 submitted with the form. The payer shall conduct a review of the
20 appeal and notify the health care provider of its determination on or
21 before the 10th calendar day following the receipt of the appeal
22 form. If the health care provider is not notified of the payer's
23 determination of the appeal within 10 days, the payer shall remit
24 payment of the amount in dispute in full, together with accrued
25 interest at the rate of 25% per annum, on or before the 12th calendar
26 day following the receipt of the appeal form. If the payment is not
27 made in full within the time limit established in this paragraph, the
28 health care provider may refer the dispute to arbitration as provided
29 by paragraph (2) of this subsection.

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

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

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

46 (2) Any dispute regarding the determination of an internal appeal
47 conducted pursuant to paragraph (1) of this subsection, may be
48 referred to arbitration as provided in this paragraph. The

1 Commissioner of Banking and Insurance shall contract with a
2 nationally recognized, independent organization that specializes in
3 arbitration to conduct the arbitration proceedings.

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

16 (3) An arbitrator may review any records in connection with the
17 dispute, including the claims file of the payer or of the health care
18 provider or the covered person, subject to confidentiality
19 requirements established by State or federal law.

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

21 (a) signed by the arbitrator;

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

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

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

29 (5) If the arbitrator determines that a payer has withheld or
30 denied payment in violation of the provisions of this section, the
31 arbitrator shall order the payer to make payment of the amount in
32 dispute, together with accrued interest, on or before the 10th
33 calendar day following the issuance of the determination. In
34 accordance with regulations adopted by the Commissioner of
35 Banking and Insurance, the cost of the arbitration proceedings,
36 including the payment of reasonable attorney's fees, shall be
37 awarded to the prevailing party.

38 (6) If the arbitrator issues a determination in favor of the payer,
39 the health care provider shall reimburse the payer any payment
40 made pursuant to paragraph (1) of this subsection on or before the
41 10th calendar day following the issuance of the determination.

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

45 f. As used in this subsection, "insured claim" or "claim" means a
46 claim by [an insured] covered person for payment of benefits under
47 an insured policy for which the financial obligation for the payment

1 of a claim under the policy rests upon the health insurer.

2 g. Any person found in violation of this section by the
3 Commissioner of Banking and Insurance shall be liable to a civil
4 penalty as set forth in section 12 of P.L. , c. (C.) (now
5 before the Legislature as this bill).
6 (cf: P.L.1999, c.154, s.6.)

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

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

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

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

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

46 d. (1) Effective 180 days after the effective date of P.L.1999,
47 c.154, a health maintenance organization or its agent, hereinafter
48 the payer, shall remit payment for every insured claim submitted by

1 [an enrollee or that enrollee's agent or assignee if the health
2 maintenance organization coverage for health care services provides
3 for assignment of benefits] a covered person or health care provider,
4 no later than the 30th calendar day following receipt of the claim by
5 the payer or no later than the time limit established for the payment
6 of claims in the Medicare program pursuant to
7 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is
8 submitted by electronic means, and no later than the 40th calendar
9 day following receipt if the claim is submitted by other than
10 electronic means, if:

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

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

18 (c) there is no dispute regarding the amount claimed;

19 (d) the payer has no reason to believe that the claim has been
20 submitted fraudulently; and

21 (e) the claim requires no special treatment that prevents timely
22 payments from being made on the claim under the terms of the
23 health maintenance organization coverage for health care services.

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

25 (a) the claim is an ineligible claim;

26 (b) the claim submission is incomplete because the required
27 substantiating documentation has not been submitted to the payer;

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

30 (d) the payer disputes the amount claimed; or

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

34 the payer shall notify the [enrollee, or that enrollee's agent or
35 assignee if the health maintenance organization coverage for health
36 care services provides for assignment of benefits] covered person or
37 health care provider, in writing or by electronic means, as
38 appropriate, within 30 days, of the following: if all or a portion of
39 the claim is denied, all the reasons for the denial; if the claim lacks
40 the required substantiating documentation, including incorrect
41 coding, a statement as to what substantiating documentation or
42 other information is required to complete adjudication of the claim;
43 if the amount of the claim is disputed, a statement that it is
44 disputed; and if the claim requires special treatment that prevents
45 timely payments from being made, a statement of the special
46 treatment to which the claim is subject.

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

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

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

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

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

34 (7) An overdue payment shall bear simple interest at the rate of
35 [10%] 25% per annum. The interest shall be paid at the time the
36 overdue payment is made.

37 (8) No payer shall seek reimbursement for overpayment of a
38 claim previously paid pursuant to this section later than the 180th
39 calendar day after the date the first payment on the claim was made.
40 At the time of submitting the reimbursement request to the health
41 care provider, the payer shall provide written documentation that
42 identifies the error made by the payer in the processing or payment
43 of the claim that justifies the reimbursement request. No payer
44 shall base a reimbursement request for a particular claim on
45 extrapolation of other claims, except under the following
46 circumstances:

47 (a) in judicial or quasi-judicial proceedings, including

1 arbitration;
2 (b) in administrative proceedings;
3 (c) in which relevant records required to be maintained by the
4 health care provider have been improperly altered or reconstructed,
5 or a material number of the relevant records are otherwise
6 unavailable; or
7 (d) in which there is clear evidence of fraud by the health care
8 provider.
9 (9) In seeking reimbursement for overpayment from the health
10 care provider, no payer shall collect or attempt to collect:
11 (a) the funds for reimbursement on or before the 45th calendar
12 day following the submission of the reimbursement request to the
13 health care provider;
14 (b) the funds for the reimbursement request if the health care
15 provider disputes the request and initiates an appeal on or before the
16 45th calendar day following the submission of the reimbursement
17 request to the health care provider and until the health care
18 provider's right to appeal set forth under paragraphs (1) and (2) of
19 subsection e. are exhausted;
20 (c) a monetary penalty against the reimbursement request,
21 including, but not limited to, an interest charge or late fee; or
22 (d) the funds for the reimbursement request by assessing them
23 against the payment of any future claim submitted by the health
24 care provider.
25 e. (1) A health maintenance organization or its agent, hereinafter
26 the payer, shall establish an internal appeal mechanism to resolve
27 any dispute regarding compliance with the requirements of this
28 section. The payer shall conduct the appeal at no cost to the health
29 care provider.
30 A health care provider shall initiate an appeal on a form
31 prescribed by the Commissioner of Banking and Insurance which
32 shall describe the type of substantiating documentation that shall be
33 submitted with the form. The payer shall conduct a review of the
34 appeal and notify the health care provider of its determination on or
35 before the 10th calendar day following the receipt of the appeal
36 form. If the health care provider is not notified of the payer's
37 determination of the appeal within 10 days, the payer shall remit
38 payment of the amount in dispute in full, together with accrued
39 interest at the rate of 25% per annum, on or before the 12th calendar
40 day following the receipt of the appeal form. If the payment is not
41 made in full within the time limit established in this paragraph, the
42 health care provider may refer the dispute to arbitration as provided
43 by paragraph (2) of this subsection.
44 If at the conclusion of the appeal the payer issues a
45 determination in favor of the health care provider, the payer shall
46 comply with the provisions of this section and pay in full the
47 amount of money in dispute, if applicable, with accrued interest at
48 the rate of 25% per annum, on or before the 30th calendar day

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

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

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

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

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

30 (3) An arbitrator may review any records in connection with the
31 dispute, including the claims file of the payer or of the health care
32 provider or the covered person, subject to confidentiality
33 requirements established by State or federal law.

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

35 (a) signed by the arbitrator;

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

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

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

43 (5) If the arbitrator determines that a payer has withheld or
44 denied payment in violation of the provisions of this section, the
45 arbitrator shall order the payer to make payment of the amount in
46 dispute, together with accrued interest, on or before the 10th
47 calendar day following the issuance of the determination. In
48 accordance with regulations adopted by the Commissioner of

1 Banking and Insurance, the cost of the arbitration proceedings,
2 including the payment of reasonable attorney's fees, shall be
3 awarded to the prevailing party.

4 (6) If the arbitrator issues a determination in favor of the payer,
5 the health care provider shall reimburse the payer any payment
6 made pursuant to paragraph (1) of this subsection on or before the
7 10th calendar day following the issuance of the determination.

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

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

17 g. Any person found in violation of this section by the
18 Commissioner of Banking and Insurance shall be liable to a civil
19 penalty as set forth in section 12 of P.L. , c. (C.) (now
20 before the Legislature as this bill).

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

22
23 7. Section 8 of P.L.1999, c.154 (C.17:48C-8.1) is amended to
24 read as follows:

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

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

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

1 issued, delivered, executed or renewed in this State.

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

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

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

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

31 (c) there is no dispute regarding the amount claimed;

32 (d) the payer has no reason to believe that the claim has been
33 submitted fraudulently; and

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

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

38 (a) the claim is an ineligible claim;

39 (b) the claim submission is incomplete because the required
40 substantiating documentation has not been submitted to the payer;

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

43 (d) the payer disputes the amount claimed; or

44 (e) the claim requires special treatment that prevents timely
45 payments from being made on the claim under the terms of the
46 contract, the payer shall notify the [subscriber, or that subscriber's
47 agent or assignee if the contract provides for assignment of

1 benefits] covered person or health care provider, in writing or by
2 electronic means, as appropriate, within 30 days, of the following:
3 if all or a portion of the claim is denied, all the reasons for the
4 denial; if the claim lacks the required substantiating documentation,
5 including incorrect coding, a statement as to what substantiating
6 documentation or other information is required to complete
7 adjudication of the claim; if the amount of the claim is disputed, a
8 statement that it is disputed; and if the claim requires special
9 treatment that prevents timely payments from being made, a
10 statement of the special treatment to which the claim is subject.

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

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

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

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

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

44 (7) An overdue payment shall bear simple interest at the rate of
45 [10%] 25% per annum. The interest shall be paid at the time the
46 overdue payment is made.

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

1 claim previously paid pursuant to this section later than the 180th
2 calendar day after the date the first payment on the claim was made.
3 At the time of submitting the reimbursement request to the health
4 care provider, the payer shall provide written documentation that
5 identifies the error made by the payer in the processing or payment
6 of the claim that justifies the reimbursement request. No payer
7 shall base a reimbursement request for a particular claim on
8 extrapolation of other claims, except under the following
9 circumstances:

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

12 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

40 A health care provider shall initiate an appeal on a form
41 prescribed by the Commissioner of Banking and Insurance which
42 shall describe the type of substantiating documentation that shall be
43 submitted with the form. The payer shall conduct a review of the
44 appeal and notify the health care provider of its determination on or
45 before the 10th calendar day following the receipt of the appeal
46 form. If the health care provider is not notified of the payer's
47 determination of the appeal within 10 days, the payer shall remit
48 payment of the amount in dispute in full, together with accrued

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

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

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

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

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

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

40 (3) An arbitrator may review any records in connection with the
41 dispute, including the claims file of the payer or of the health care
42 provider or the covered person, subject to confidentiality
43 requirements established by State or federal law.

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

45 (a) signed by the arbitrator;

46 (b) issued in writing, in a form prescribed by the Commissioner
47 of Banking and Insurance, including a statement of the issues in
48 dispute and the findings and conclusions on which the

1 determination is based; and

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

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

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

14 (6) If the arbitrator issues a determination in favor of the payer,
15 the health care provider shall reimburse the payer any payment
16 made pursuant to paragraph (1) of this subsection on or before the
17 10th calendar day following the issuance of the determination.

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

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

26 g. Any person found in violation of this section by the
27 Commissioner of Banking and Insurance shall be liable to a civil
28 penalty as set forth in section 12 of P.L. , c. (C.) (now
29 before the Legislature as this bill).

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

31

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

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

44 The Commissioner of Banking and Insurance may grant
45 extensions or waivers of the implementation requirement when it
46 has been demonstrated to the commissioner's satisfaction that
47 compliance with the timetable for implementation will result in an

- 1 undue hardship to a dental plan organization, its subsidiary or its
2 covered persons.
- 3 b. Within 12 months of the adoption of regulations establishing
4 standard health care enrollment and claim forms by the
5 Commissioner of Banking and Insurance pursuant to section 1 of
6 P.L.1999, c.154 (C.17B:30-23), a dental plan organization or a
7 subsidiary that processes health care benefits claims as a third party
8 administrator shall use the standard health care enrollment and
9 claim forms in connection with all group and individual contracts
10 issued, delivered, executed or renewed in this State.
- 11 c. Twelve months after the adoption of regulations establishing
12 standard health care enrollment and claim forms by the
13 Commissioner of Banking and Insurance pursuant to section 1 of
14 P.L.1999, c.154 (C.17B:30-23), a dental plan organization shall
15 require that health care providers file all claims for payment for
16 dental services. A covered person who receives dental services
17 shall not be required to submit a claim for payment, but
18 notwithstanding the provisions of this subsection to the contrary, a
19 covered person shall be permitted to submit a claim on his own
20 behalf, at the covered person's option. All claims shall be filed
21 using the standard health care claim form applicable to the contract.
- 22 d. (1) Effective 180 days after the effective date of P.L.1999,
23 c.154, a dental plan organization or its agent, hereinafter the payer,
24 shall remit payment for every insured claim submitted by a covered
25 person or that covered person's agent or assignee if the contract
26 provides for assignment of benefits, no later than the 30th calendar
27 day following receipt of the claim by the payer or no later than the
28 time limit established for the payment of claims in the Medicare
29 program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is
30 earlier, if the claim is submitted by electronic means, and no later
31 than the 40th calendar day following receipt if the claim is
32 submitted by other than electronic means, if:
- 33 (a) the claim is an eligible claim for a health care service
34 provided by an eligible health care provider to a covered person
35 under the contract;
- 36 (b) the claim has no material defect or impropriety, including,
37 but not limited to, any lack of required substantiating
38 documentation or incorrect coding;
- 39 (c) there is no dispute regarding the amount claimed;
- 40 (d) the payer has no reason to believe that the claim has been
41 submitted fraudulently; and
- 42 (e) the claim requires no special treatment that prevents timely
43 payments from being made on the claim under the terms of the
44 contract.
- 45 (2) If all or a portion of the claim is denied by the payer because:
- 46 (a) the claim is an ineligible claim;
- 47 (b) the claim submission is incomplete because the required
48 substantiating documentation has not been submitted to the payer;

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

3 (d) the payer disputes the amount claimed; or

4 (e) the claim requires special treatment that prevents timely
5 payments from being made on the claim under the terms of the
6 contract, the payer shall notify the covered person, or that covered
7 person's agent or assignee if the contract provides for assignment of
8 benefits, in writing or by electronic means, as appropriate, within
9 30 days, of the following: if all or a portion of the claim is denied,
10 all the reasons for the denial; if the claim lacks the required
11 substantiating documentation, including incorrect coding, a
12 statement as to what substantiating documentation or other
13 information is required to complete adjudication of the claim; if the
14 amount of the claim is disputed, a statement that it is disputed; and
15 if the claim requires special treatment that prevents timely
16 payments from being made, a statement of the special treatment to
17 which the claim is subject.

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

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

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

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

42 In the event payment is withheld on all or a portion of a claim by
43 a payer pursuant to subparagraph (b) of paragraph (2) of this
44 subsection, the claims payment shall be overdue if not remitted to
45 the claimant or his agent by the payer on or before the 30th calendar
46 day or the time limit established by the Medicare program,
47 whichever is earlier, for claims submitted by electronic means and
48 the 40th calendar day for claims submitted by other than electronic

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

3 (7) An overdue payment shall bear simple interest at the rate of
4 [10%] 25% per annum. The interest shall be paid at the time the
5 overdue payment is made.

6 (8) No payer shall seek reimbursement for overpayment of a
7 claim previously paid pursuant to this section later than the 180th
8 calendar day after the date the first payment on the claim was made.
9 At the time of submitting the reimbursement request to the health
10 care provider, the payer shall provide written documentation that
11 identifies the error made by the payer in the processing or payment
12 of the claim that justifies the reimbursement request. No payer
13 shall base a reimbursement request for a particular claim on
14 extrapolation of other claims, except under the following
15 circumstances:

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

18 (b) in administrative proceedings;

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

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

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

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

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

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

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

41 e. (1) A dental plan organization or its agent, hereinafter the
42 payer, shall establish an internal appeal mechanism to resolve any
43 dispute regarding compliance with the requirements of this section.
44 The payer shall conduct the appeal at no cost to the health care
45 provider.

46 A health care provider shall initiate an appeal on a form
47 prescribed by the Commissioner of Banking and Insurance which

1 shall describe the type of substantiating documentation that shall be
2 submitted with the form. The payer shall conduct a review of the
3 appeal and notify the health care provider of its determination on or
4 before the 10th calendar day following the receipt of the appeal
5 form. If the health care provider is not notified of the payer's
6 determination of the appeal within 10 days, the payer shall remit
7 payment of the amount in dispute in full, together with accrued
8 interest at the rate of 25% per annum, on or before the 12th calendar
9 day following the receipt of the appeal form. If the payment is not
10 made in full within the time limit established this paragraph, the
11 health care provider may refer the dispute to arbitration as provided
12 by paragraph (2) of this subsection.

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

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

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

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

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

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

1 provider or the covered person, subject to confidentiality
2 requirements established by State or federal law.

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

4 (a) signed by the arbitrator;

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

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

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

12 (5) If the arbitrator determines that a payer has withheld or
13 denied payment in violation of the provisions of this section, the
14 arbitrator shall order the payer to make payment of the amount in
15 dispute, together with accrued interest, on or before the 10th
16 calendar day following the issuance of the determination. In
17 accordance with regulations adopted by the Commissioner of
18 Banking and Insurance, the cost of the arbitration proceedings,
19 including the payment of reasonable attorney's fees, shall be
20 awarded to the prevailing party.

21 (6) If the arbitrator issues a determination in favor of the payer,
22 the health care provider shall reimburse the payer any payment
23 made pursuant to paragraph (1) of this subsection on or before the
24 10th calendar day following the issuance of the determination.

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

28 f. As used in this subsection, "insured claim" or "claim" means a
29 claim by [an enrollee] a covered person for payment of benefits
30 under an insured dental plan organization contract for which the
31 financial obligation for the payment of a claim under the contract
32 rests upon the dental plan organization.

33 g. Any person found in violation of this section by the
34 Commissioner of Banking and Insurance shall be liable to a civil
35 penalty as set forth in section 12 of P.L. , c. (C.) (now
36 before the Legislature as this bill).

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

38

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

41 10. a. Within 180 days of the adoption of a timetable for
42 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
43 23), a prepaid prescription service organization, or a subsidiary that
44 processes health care benefits claims as a third party administrator,
45 shall demonstrate to the satisfaction of the Commissioner of
46 Banking and Insurance that it will adopt and implement all of the
47 standards to receive and transmit health care transactions

1 electronically, according to the corresponding timetable, and
2 otherwise comply with the provisions of this section, as a condition
3 of its continued authorization to do business in this State.

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

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

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

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

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

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

- 1 (c) there is no dispute regarding the amount claimed;
- 2 (d) the payer has no reason to believe that the claim has been
3 submitted fraudulently; and
- 4 (e) the claim requires no special treatment that prevents timely
5 payments from being made on the claim under the terms of the
6 contract.
- 7 (2) If all or a portion of the claim is denied by the payer because:
- 8 (a) the claim is an ineligible claim;
- 9 (b) the claim submission is incomplete because the required
10 substantiating documentation has not been submitted to the payer;
- 11 (c) the diagnosis coding, procedure coding, or any other required
12 information to be submitted with the claim is incorrect;
- 13 (d) the payer disputes the amount claimed; or
- 14 (e) the claim requires special treatment that prevents timely
15 payments from being made on the claim under the terms of the
16 contract, the payer shall notify the [enrollee, or that enrollee's agent
17 or assignee if the contract provides for assignment of benefits]
18 covered person or health care provider, in writing or by electronic
19 means, as appropriate, within 30 days, of the following: if all or a
20 portion of the claim is denied, all the reasons for the denial; if the
21 claim lacks the required substantiating documentation, including
22 incorrect coding, a statement as to what substantiating
23 documentation or other information is required to complete
24 adjudication of the claim; if the amount of the claim is disputed, a
25 statement that it is disputed; and if the claim requires special
26 treatment that prevents timely payments from being made, a
27 statement of the special treatment to which the claim is subject.
- 28 (3) Any portion of a claim that meets the criteria established in
29 paragraph (1) of this subsection shall be paid in full by the payer in
30 accordance with the time limit established in paragraph (1) of this
31 subsection.
- 32 (4) A payer shall acknowledge receipt of a claim submitted by
33 electronic means from a health care provider or [enrollee] covered
34 person, no later than two working days following receipt of the
35 transmission of the claim.
- 36 (5) If a payer subject to the provisions of P.L.1983, c.320
37 (C.17:33A-1 et seq.) has reason to believe that a claim has been
38 submitted fraudulently, it shall investigate the claim in accordance
39 with its fraud prevention plan established pursuant to section 1 of
40 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
41 supporting documentation, to the Office of the Insurance Fraud
42 Prosecutor in the Department of Law and Public Safety established
43 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 44 (6) Payment of an eligible claim pursuant to paragraphs (1) and
45 (3) of this subsection shall be deemed to be overdue if not remitted
46 to the claimant or his agent by the payer on or before the 30th
47 calendar day or the time limit established by the Medicare program,

1 whichever is earlier, following receipt by the payer of a claim
2 submitted by electronic means and on or before the 40th calendar
3 day following receipt of a claim submitted by other than electronic
4 means.

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

14 (7) An overdue payment shall bear simple interest at the rate of
15 ~~[10%]~~ 25% per annum. The interest shall be paid at the time the
16 overdue payment is made.

17 (8) No payer shall seek reimbursement for overpayment of a
18 claim previously paid pursuant to this section later than the 180th
19 calendar day after the date the first payment on the claim was made.
20 At the time of submitting the reimbursement request to the health
21 care provider, the payer shall provide written documentation that
22 identifies the error made by the payer in the processing or payment
23 of the claim that justifies the reimbursement request. No payer
24 shall base a reimbursement request for a particular claim on
25 extrapolation of other claims, except under the following
26 circumstances:

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

29 (b) in administrative proceedings;

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

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

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

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

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

47 (c) a monetary penalty against the reimbursement request,

1 including, but not limited to, an interest charge or late fee; or
2 (d) the funds for the reimbursement request by assessing them
3 against the payment of any future claim submitted by the health
4 care provider.
5 e. (1) A prepaid prescription service organization or its agent,
6 hereinafter the payer, shall establish an internal appeal mechanism
7 to resolve any dispute regarding compliance with the requirements
8 of this section. The payer shall conduct the appeal at no cost to the
9 health care provider.
10 A health care provider shall initiate an appeal on a form
11 prescribed by the Commissioner of Banking and Insurance which
12 shall describe the type of substantiating documentation that shall be
13 submitted with the form. The payer shall conduct a review of the
14 appeal and notify the health care provider of its determination on or
15 before the 10th calendar day following the receipt of the appeal
16 form. If the health care provider is not notified of the payer's
17 determination of the appeal within 10 days, the payer shall remit
18 payment of the amount in dispute in full, together with accrued
19 interest at the rate of 25% per annum, on or before the 12th calendar
20 day following the receipt of the appeal form. If the payment is not
21 made in full within the time limit established in this paragraph, the
22 health care provider may refer the dispute to arbitration as provided
23 by paragraph (2) of this subsection.
24 If at the conclusion of the appeal the payer issues a
25 determination in favor of the health care provider, the payer shall
26 comply with the provisions of this section and pay in full the
27 amount of money in dispute, if applicable, with accrued interest at
28 the rate of 25% per annum, on or before the 30th calendar day
29 following the notification of the payer's determination on the
30 appeal.
31 If at the conclusion of the appeal the payer issues a
32 determination in favor of the payer, the payer shall notify the health
33 care provider of its findings on or before the 10th calendar day
34 following the receipt of the appeal form and shall include in the
35 notification written instructions for referring the dispute to
36 arbitration as provided by paragraph (2) of this subsection.
37 The payer shall report annually to the Commissioner of Banking
38 and Insurance the number of appeals it has received and the
39 resolution of each appeal.
40 (2) Any dispute regarding the determination of an internal appeal
41 conducted pursuant to paragraph (1) of this subsection, may be
42 referred to arbitration as provided in this paragraph. The
43 Commissioner of Banking and Insurance shall contract with a
44 nationally recognized, independent organization that specializes in
45 arbitration to conduct the arbitration proceedings.
46 Any party may initiate an arbitration proceeding on or before the
47 90th calendar day following the receipt of the determination which
48 is the basis of the arbitration, on a form prescribed by the

1 Commissioner of Banking and Insurance. No dispute shall be
2 accepted for arbitration unless the payment amount in dispute is
3 \$1,000 or more, except that disputed amounts may be aggregated
4 for the purposes of meeting the threshold requirements of this
5 paragraph. No dispute pertaining to medical necessity which is
6 eligible to be submitted to the Independent Health Care Appeals
7 Program established pursuant to section 11 of P.L.1997, c.192
8 (C.26:2S-11) shall be the subject of arbitration pursuant to this
9 paragraph.

10 (3) An arbitrator may review any records in connection with the
11 dispute, including the claims file of the payer or of the health care
12 provider or the covered person, subject to confidentiality
13 requirements established by State or federal law.

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

15 (a) signed by the arbitrator;

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

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

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

23 (5) If the arbitrator determines that a payer has withheld or
24 denied payment in violation of the provisions of this section, the
25 arbitrator shall order the payer to make payment of the amount in
26 dispute, together with accrued interest, on or before the 10th
27 calendar day following the issuance of the determination. In
28 accordance with regulations adopted by the Commissioner of
29 Banking and Insurance, the cost of the arbitration proceedings,
30 including the payment of reasonable attorney's fees, shall be
31 awarded to the prevailing party.

32 (6) If the arbitrator issues a determination in favor of the payer,
33 the health care provider shall reimburse the payer any payment
34 made pursuant to paragraph (1) of this subsection on or before the
35 10th calendar day following the issuance of the determination.

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

39 f. As used in this subsection, "insured claim" or "claim" means a
40 claim by [an enrollee] a covered person for payment of benefits
41 under an insured prepaid prescription service organization contract
42 for which the financial obligation for the payment of a claim under
43 the contract rests upon the prepaid prescription service
44 organization.

45 g. Any person found in violation of this section by the
46 Commissioner of Banking and Insurance shall be liable to a civil
47 penalty as set forth in section 12 of P.L. , c. (C.) (now

1 before the Legislature as this bill).

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

3

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

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

11 (1) that are submitted to the payer;

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

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

16 [(2)] (4) that are [rejected] denied at their initial submission
17 because of a lack of substantiating documentation;

18 [(3)] (5) that are [rejected] denied at their initial submission
19 because of incorrect coding or incorrect enrollment information;

20 [(4)] (6) that are [rejected] denied at their initial submission
21 because of a dispute in the amount claimed;

22 [(5)] (7) that are not paid in accordance with the time limit
23 established by law because the payer deems the claim to require
24 special treatment that prevents timely payments from being made;

25 [(6)] (8) that are not paid in accordance with the time limits for
26 payment established by law even though the claims meet the criteria
27 established by law;

28 [(7)] (9) upon which the [10%] interest penalty established by
29 law has been paid, and the aggregate amount of interest paid for the
30 period covered by the report;

31 [(8)] (10) that are denied or referred to the payer's fraud
32 investigation unit, if applicable, or to the Office of the Insurance
33 Fraud Prosecutor in the Department of Law and Public Safety
34 established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16)
35 because the payer has reason to believe that the claim has been
36 submitted fraudulently; and

37 [(9)] (11) any other information the commissioner requires.

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

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

6 c. If, following the examination, the commissioner determines
7 that a payer has not complied with the provisions sections 2 through
8 10 of P.L.1999, c.154 (C.17:48-8.4 et al.), the commissioner shall
9 within 180 days of the determination: require the implementation of
10 a plan of remedial action by the payer; require that the payer's
11 claims processing procedures be monitored by a private auditing
12 firm for a time period he deems appropriate; or both.

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

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

21 (2) a payer has failed to pay interest as required pursuant to law,
22 the commissioner shall impose a civil penalty of not more than
23 \$10,000 upon the payer, to be collected pursuant to "the penalty
24 enforcement law," N.J.S.2A:58-1 et seq.

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

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

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

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

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

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

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

3

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

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

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

1 12. (New section) The Commissioner of Banking and Insurance
2 shall enforce the provisions of sections 2 through 10 of P.L.1999,
3 c.154 (C.17:48-8.4 et al.) and P.L.1999, c.155 (C.17B:30-26 et
4 seq.). Except as otherwise provided in subsection c. of section 5 of
5 P.L.1999, c.155 (C.17B:30-30), any person found in violation of the
6 provisions of those sections shall be liable to a civil penalty of not
7 less than \$250 and not greater than \$10,000 for each day that the
8 person is in violation if reasonable notice in writing is given of the
9 intent to levy the penalty and, at the discretion of the Commissioner
10 of Banking and Insurance, the person has 30 days, or such
11 additional time as the Commissioner of Banking and Insurance shall
12 determine to be reasonable, to remedy the condition which gave rise
13 to the violation, and fails to do so within the time allowed. The
14 penalty shall be collected by the Commissioner of Banking and
15 Insurance in the name of the State in a summary proceeding in
16 accordance with the "Penalty Enforcement Law of 1999," P.L.1999,
17 c.274 (C.2A:58-10 et seq.).

18
19 13. (New section) The Commissioner of Banking and Insurance
20 shall promulgate rules and regulations pursuant to the
21 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
22 seq.) necessary to effectuate the purposes of P.L. , c. (C.)
23 (now pending before the Legislature as this bill).

24
25 14. (New section) This act shall take effect on the 120th day
26 after enactment, but the Commissioner of Banking and Insurance
27 may take such anticipatory administrative action in advance as shall
28 be necessary for the implementation of this act.

29
30

31 STATEMENT

32

33 This bill is intended to ensure that health care providers, or
34 simply "providers," including, but not limited to physicians, dentists
35 and other licensed health care professionals, hospitals and other
36 health care facilities, receive timely and equitable payment of health
37 and dental claims from insurance carriers and have a process for
38 resolving disputes with insurance carriers over claims processing or
39 payment. The provisions of this bill apply to hospital, medical, and
40 health service corporations, commercial individual and group
41 insurers, health maintenance organizations, dental service
42 corporations, dental plan organizations, and prepaid prescription
43 service organizations, which are generally referred to in the bill as
44 "payers."

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

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

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

25 Following an internal appeal, either party can refer the dispute to
26 arbitration conducted by an organization that is under contract with
27 the Department of Banking and Insurance. The arbitrator's
28 determinations shall be binding to all parties in the dispute. If the
29 arbitrator rules in favor of the provider, the payer shall remit
30 payment, including accrued interest, within 10 days. If the
31 arbitrator rules in favor of the payer, the provider shall repay within
32 10 days any payment that was made to the provider.

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

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