ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 1255

STATE OF NEW JERSEY

220th LEGISLATURE

ADOPTED DECEMBER 11, 2023

Sponsored by:
Assemblyman STERLEY S. STANLEY
District 18 (Middlesex)
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)

Co-Sponsored by:
Assemblywoman Jimenez, Assemblyman DeAngelo, Assemblywomen Reynolds-Jackson, Murphy, Dunn, Assemblyman Verrelli and Assemblywoman Speight

SYNOPSIS

Updates requirements and standards for authorization and prior authorization of health care services.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Financial Institutions and Insurance Committee.

AN ACT concerning prior authorization of services covered by health benefits plans and supplementing and revising various parts of the statutory law.

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

1. Sections 1 through 7 of P.L.2005, c.352 (C.17B:30-48 et seq.) are repealed.

2. (New section) This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

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

a. Prior authorization is a type of utilization management technique used by health plans and carriers to ensure safety and appropriateness of medical and pharmacy services, reduce low-value care, and control costs;

b. Providers and patients have raised concerns that the current process of prior authorization is burdensome and leads to care being delayed or abandoned;

c. In 2005, New Jersey enacted the "Health Claims Authorization, Processing and Payment Act," ("HCAPPA"), a groundbreaking law which established uniform procedures and guidelines for hospitals, physicians and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of patients;

d. In the nearly two decades since HCAPPA was signed into law, the process has continued to be a source of abrasion and concern for providers and patients;

e. The Centers for Medicare and Medicaid Services have recently implemented additional controls on the prior authorization, process such as accelerated turnaround times for prior authorization requests from providers, and are currently considering, among other items, ways to improve efficiency in prior authorization, including the use of electronic submission of prior authorization requests;

f. When it is used, prior authorization should utilize an automated process to minimize the burden placed upon both physicians and health plans; and

g. Therefore, because it is fair and reasonable for hospitals and physicians to receive reimbursement for health care services delivered to covered persons under their health benefits plans and inefficiencies in any area of the health care delivery system reflect poorly on all aspects of the health care delivery system, and because those inefficiencies can harm patients, it is appropriate for the Legislature to update now the uniform procedures and guidelines

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

Matter underlined <u>thus</u> is new matter.

for hospitals, physicians and health insurance carriers to follow in communicating and following utilization management decisions and determinations on patients' behalf.

4. (New section) As used in sections 4 through 17 of P.L. , c. (C.) (pending before the Legislature as this bill):

"Adverse determination" means a decision by a payer that the health care services furnished or proposed to be furnished to a covered person are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate services which are not covered for reasons other than their medical necessity or experimental or investigational nature is not an "adverse determination" for the purposes of P.L. , c. (C.) (pending before the Legislature as this bill).

"Authorization" means a determination required under a health benefits plan, that based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity, and includes, but is not limited to, prior authorization.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State and shall include, but not be limited to, the State Health Benefits Program and the School Employees' Health Benefits Program.

"Clinical criteria" means the written policies; written screening procedures; determination rules; determination abstracts; clinical protocols; practice guidelines; medical protocols; and any other criteria or rationale used for the purposes of utilization management to determine the necessity and appropriateness of covered services.

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services, including, but not limited to, health care procedures, treatments, or services and the provision of pharmaceutical products or services or durable medical equipment.

"Emergency service" means a health care service with respect to which the application of the time periods for making a nonexpedited prior authorization, in the opinion of a health care provider with knowledge of the covered person's medical conditions and exercising reasonable medical judgement could: (1) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, including of any

bodily organ or part; or (2) subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization review. “Emergency service” shall include, but not be limited to, mental health services and behavioral health services that otherwise comply with this definition.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; physician and specialty society recommendations; and the views of physicians practicing in relevant clinical areas.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of sections 4 through 17 of P.L. , c. (C.) (pending before the Legislature as this bill), health benefits plan shall not include the following plans, policies, or contracts: accident only; credit; disability; long-term care; Medicare Supplement; Medicare AMedicaid; Civilian Health and Medical Program for the Uniformed Services; CHAMPUS supplement coverage; coverage arising out of a workers' compensation or similar law; automobile medical payment insurance; personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.); or hospital confinement indemnity coverage.

“Health care provider” means a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

“Health care service” means health care procedures, treatments or services provided by: (1) a health care facility licensed in New Jersey; or (2) a doctor of medicine, a doctor of osteopathy, or a health care provider performing within the scope of practice of the profession in which the provider is licensed in New Jersey. “Health care service” also includes the provision of pharmaceutical products or services or durable medical equipment.

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

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration,

and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

"NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version 2017071, or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions of the NCPDP SCRIPT Standard may be used.

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

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

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

"Prior authorization" means the process by which a payer determines the medical necessity of an otherwise covered service prior to the rendering of the service including, but not limited to, preadmission review, pretreatment review, utilization review, and case management. "Prior authorization" also includes a payer's requirement that a covered person or health care provider notify the carrier or payer prior to providing a health care service.

"Submission" means transmission of information by a health care provider or the authorized representative of a health care provider to a payer by any means (1) to which a network provider and health benefits plan have agreed to consider acceptable, or (2) by a readily accessible secure communications mechanism identified by a payer or its agent on its public website.

"Urgent care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination may seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or, in the opinion of a physician with knowledge of the medical condition of the covered person, subjects the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In determining if a claim involves urgent care, a payer shall apply the judgement of a prudent layperson who possesses an

average knowledge of health and medicine. However, if a physician with knowledge of the medical condition of the covered person determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

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

5. (New section) a. A payer shall provide the following information concerning utilization management and the processing and payment of claims in a clear and conspicuous manner, described in detail but also in easily understandable language, to covered persons, health care providers, and the general public, through an Internet website no later than 30 calendar days before the information or policies or any changes in the information or policies take effect:

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

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

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

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

(5) any other information the commissioner deems necessary.

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

c. A payer shall, for health care services as defined pursuant to section 4 of P.L. , c. (C.) (pending before the Legislature as this bill) but excluding the provision of pharmaceutical products:

(1) provide contracted in-network health care providers with written notice of any new or amended requirement or restriction no less than 90 days before the requirement or restriction is implemented;

(2) ensure that any new or amended requirement is not implemented unless the payer's Internet website has been updated to reflect the new or amended requirement or restriction; and

(3) withhold implementation of any new requirement or restriction until and unless 90 days have passed since written notice was provided to a contracted in-network health care provider.

6. (New section) A payer shall respond to a hospital or health care provider request for prior authorization of health care services by either approving or denying the request based on the covered person's health benefits plan upon submission of all necessary information.

7. (New section) a. A carrier shall respond to prior authorization requests for medication coverage submitted using the NCPDP SCRIPT Standard for ePA transactions, under the pharmacy benefit part of a health benefits plan, within 72 hours after obtaining all necessary information to make the approval or adverse determination.

b. Beginning January 1, 2027, a carrier shall only accept and respond to prior authorization requests for medication coverage, under the pharmacy benefit part of a health benefits plan submitted through a secure electronic transmission using the 39 SCRIPT Standard ePA (electronic prior authorization) transactions.

8. (New section) If a payer requires prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for 180 days and the payer shall not require the covered person to obtain a prior authorization again for the health care service.

9. (New section) Any denial of a request for prior authorization or limitation imposed by a payer on a requested service on the basis of utilization management determination shall be made by a physician who shall:

a. be of the same specialty as the physician who typically manages the medical condition or disease, or provides the health care service involved in the request; and

b. make the adverse determination under the clinical direction of a medical director of the payer who is responsible for the provision of health care services provided to covered persons of the State of New Jersey.

10. (New section) A prior authorization for a service which includes a defined number of discrete services within a set timeframe shall be valid for purposes of authorizing the health care provider to provide care for a period of one year from the date the provider receives the prior authorization and a payer shall not

revoke, limit, condition or restrict a prior authorization within that period if (1) the covered person continues to be eligible for coverage; (2) the clinical information provided at the time the prior authorization request was made has not been misrepresented by the treating physician or covered person; and (3) there has not been a material change in the clinical circumstances or condition of the covered person.

11. (New section) a. On receipt of information documenting a prior authorization from the covered person or the health care provider of the covered person, a payer shall honor a prior authorization granted to a covered person by a previous payer for at least the initial 60 days of coverage under a new health plan of the covered person, if that prior authorization was based on information provided in good faith by a provider.

b. During the initial 60 days described in subsection a. of this section, a payer may perform its own review to grant a prior authorization.

c. If there is a change in coverage or approval criteria for a previously prior authorized covered service by the health benefits plan issuing the change, the change in coverage or approval criteria shall not affect a covered person who received prior authorization before the effective date of the change for the remainder of the plan year of the covered person, unless the prior authorization previously issued for a covered service was issued based on materially inaccurate medical information or fraudulent information.

d. A payer shall continue to honor a prior authorization it has granted to a covered person when the covered person changes products under the same payer, provided the service for which prior authorization was issued remains a covered benefit under the terms and conditions of the replacement health benefits plan.

12. (New section) a. A denial of prior authorization shall be communicated to the hospital or health care provider by facsimile, e-mail or any other means of written communication agreed to by the payer and hospital or health care provider, as follows:

(1) in the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than 12 days if the request is submitted in paper, or eight days if submitted electronically, following the time the request was made;

(2) in the case of a request for prior authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, the payer shall communicate the denial of the request or the limitation imposed on

the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than 24 hours;

(3) in the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than 72 hours; and

(4) if the payer requires additional information to approve or make an adverse determination with regard to a request for prior authorization, the payer shall so notify the hospital or health care provider by facsimile, e-mail or any other means of written communication agreed to by the payer and hospital or health care provider within the applicable time frame set forth in paragraph (1), (2) or (3) of this subsection and shall identify the specific information needed to approve or make the adverse determination with regard to the request for authorization.

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

(1) in the case of a request for prior or concurrent authorization for a covered person who will be receiving inpatient hospital services, within a time frame appropriate to the medical exigencies of the case but no later than two calendar days beyond the time of receipt by the payer from the hospital or health care provider of the additional information that the payer has identified as needed to approve or made an adverse determination with regard to the request for authorization;

(2) in the case of a request for prior or concurrent authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, no more than 24 hours beyond the time of receipt by the payer from the hospital or health care provider of the additional information that the payer has identified as needed to approve or make an adverse determination with regard to the request for prior or concurrent authorization; and

(3) in the case of a request for prior or concurrent authorization for a covered person who will be receiving health care services in another setting, within a time frame appropriate to the medical exigencies of the case but no more than two calendar days beyond the time of receipt by the payer from the hospital or health care provider of the additional information that the payer has identified

as needed to approve or make an adverse determination with regard to the request for authorization.

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

d. If a payer fails to respond to an authorization request within the time frames established pursuant to subsection a. of this section, the hospital or health care provider's claim for the service shall not be denied on the basis of a failure to secure prior or concurrent authorization for the service.

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

13. (New section) A payer shall ensure that all appeals are reviewed by a physician. The physician shall:

a. be currently in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least five consecutive years, or be knowledgeable of, and have experience providing, the health care services under review;

b. not be employed by or under contract with a payer other than to participate in one or more of the payer's health care provider networks or to perform reviews on appeal, or otherwise have any financial interest in the outcome of the appeal;

c. not have been directly involved in making adverse determinations; and

d. consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the payer by the health care provider of the covered person, any relevant records provided to the payer by a health care facility, and any medical literature provided to the payer by the health care service provider of the covered person.

14. (New section) a. When a hospital or health care provider complies with the provisions set forth in P.L. , c. (C.) (pending before the Legislature as this bill), no payer shall deny reimbursement to a hospital or health care provider for covered services rendered to a covered person on grounds of failure to secure prior or concurrent authorization in the absence of fraud or misrepresentation if the hospital or health care provider:

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

(2) requested authorization from the payer for the health care services prior to rendering the services and the payer failed to

respond to the hospital or health care provider within the time frames established pursuant to P.L. , c. (C.) (pending before this Legislature as this bill); or

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

b. If the hospital is a network provider of the payer, health care services shall be reimbursed at the contracted rate for the services provided.

c. No payer shall amend a claim by changing the diagnostic code assigned to the services rendered by a hospital or health care provider without providing written justification.

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

b. A payer shall allow a covered person and the covered person’s health care provider a minimum of 24 hours following an emergency admission or provision of emergency health care services for the covered person or health care provider to notify the payer of the admission or provision of covered services. If the admission or covered service occurs on a holiday or weekend, a payer shall not require notification until the next business day after the admission or provision of the covered service.

c. A payer shall approve coverage for emergency health care services necessary to screen and stabilize a covered person. If a health care provider certifies in writing to a payer within 72 hours of a covered person’s admission that the covered person’s condition requires emergency health care services, that certification shall create a presumption that the emergency health care services are medically necessary and that presumption may be rebutted only if the payer establishes, with clear and convincing evidence, that the emergency health care services present identifiable evidence of fraud.

d. A payer shall not determine medical necessity or appropriateness of emergency health care services based on whether or not those services are provided by participating or nonparticipating providers. A payer shall ensure that restrictions on coverage of emergency health care services provided by nonparticipating providers shall not be greater than restrictions that apply when those services are provided by participating providers.

e. If a covered person receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a payer shall make an authorization determination within 150 minutes of receiving a request. If the authorization determination is not made within 150 minutes, those services shall be deemed approved.

16. (New section) a. In addition to the protections afforded to a health care provider or patient by the requirements of P.L. , c. (C.) (pending before the Legislature as this bill), any failure by a payer to comply with a deadline or other requirement under the provisions sections 5, 6, 9, 12, and 13 and subsection e. of section 15 of P.L. , c. (C.) (pending before the Legislature as this bill) shall result in any health care services subject to review being automatically deemed authorized.

b. Notwithstanding any health care services being automatically deemed authorized pursuant to the terms of P.L. , c. (C.) (pending before the Legislature as this bill), the Commissioner of Banking and Insurance shall enforce the provisions of sections 3 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.) (pending before the Legislature as this bill). A payer found in violation of those sections shall be liable for a civil penalty of not more than $10,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). The commissioner's determination shall be a final agency decision subject to review by the Appellate Division of the Superior Court.

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

d. For the purpose of administering the provisions of sections 3 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.) (pending before the Legislature as this bill), 50 percent of the penalty monies collected pursuant to subsections b. and c. of this section shall be deposited into the General Fund. For the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50 percent of the penalty monies collected pursuant to subsections b. and c. of this section shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

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

17. (New section) A payer shall make statistics available regarding prior authorization approvals and denials on its Internet website in a readily accessible format. Payers shall include categories for:

a. health care provider specialty;

b. medication or diagnostic tests and procedures;

c. indication offered;

d. reason for denial;

e. whether prior authorization determinations were:

(1) appealed; or

(2) approved or denied on appeal;

f. the time between submission of prior authorization requests and the determination;

g. the average median time elapsed between a request for clinical records from the requesting health care provider and receipt of adequate clinical records to complete the prior authorization; and

h. the number of appeals generated for cases denied in which there was inadequate or no prior clinical information.

18. Section 4 of P.L.1999, c.154 (C.17:48-8.4) is amended to read as follows:

4. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A hospital service corporation or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.10)

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

3. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a medical service corporation or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A medical service corporation or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.11)

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

4. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A health service corporation or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.12)

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

10. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A prepaid prescription service organization or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

f. As used in this section, "insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured prepaid prescription service organization contract for which the financial obligation for the payment of a claim under the contract rests upon the prepaid prescription service organization.

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.16)

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

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

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.13)

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

6. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to

receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill);and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.14)

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

7. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and

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

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

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

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

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

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

(a) the health care provider is eligible at the date of service;

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

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

(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of **[**section 4 of P.L.2005, c.352 (C.17B:30-51) **]** section 5 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(e) the payer has no reason to believe that the claim has been submitted fraudulently.

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

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

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

(c) the payer disputes the amount claimed; or

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

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the

30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

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

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

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

(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th

calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or

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

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

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

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

e. (1) A health maintenance organization or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of **[**sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54)**]** sections 5 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

A health care provider may initiate an appeal on or before the 90th calendar day following receipt by the health care provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

g. Any person found in violation of this section with a pattern and practice as determined by the Commissioner of Banking and Insurance shall be liable to a civil penalty as set forth in section 17 of P.L.2005, c.352 (C.17B:30-55).

(cf: P.L.2005, c.352, s.15)

25. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to read as follows:

10. a. If attempts to negotiate reimbursement for services provided by an out-of-network health care provider, pursuant to subsection c. of section 9 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-9), do not result in a resolution of the payment dispute, and the

difference between the carrier's and the provider's final offers is not less than $1,000, the carrier or out-of-network health care provider may initiate binding arbitration to determine payment for the services.

b. The binding arbitration shall adhere to the following requirements:

(1) The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer before arbitration, which in the case of the carrier shall be the amount paid pursuant to subsection c. of section 9 of P.L.2018, c.32 (C.26:2SS-9). In response to this notice, the out-of-network provider shall inform the carrier of its final offer before the arbitration occurs;

(2) Arbitration shall be initiated by filing a request with the department;

(3) The department shall contract, through the request for proposal process, every three years, with one or more entities that have experience in health care pricing arbitration. The department may initially utilize the entity engaged under the **[**"Health Claims Authorization, Processing, and Payment Act," P.L.2005, c.352 (C.17B:30-48 et seq.)**]** "Ensuring Transparency in Prior Authorization Act," P.L. , c. (C.) (pending before the Legislature as this bill), for arbitration under **[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill); however, after a period of one year from the effective date of **[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill), the selection of the arbitration entity shall be through the Request for Proposal process. Claims that are subject to arbitration pursuant to the provisions of **[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill), which previously would be subject to arbitration pursuant to the "Health Claims Authorization, Processing, and Payment Act," shall instead be subject to **[**this act**]** P.L. , c. (C.) (pending before the Legislature as this bill);

(4) The arbitration shall consist of a review of the written submissions by both parties, which shall include the final offer for the payment by the carrier for the out-of-network health care provider's fee made pursuant to subsection c. of section 9 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-9) and the final offer by the out-of-network provider for the fee the provider will accept as payment from the carrier; and

(5) The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties. The decision of the arbitrator shall include detailed written findings and shall be issued within 30 days after the request is filed with the department. The detailed written findings shall be an analysis of the decision including, but not limited to, information concerning any databases, previous awards, or other documentation or arguments that contributed to the arbitrator's decision. The

arbitrator's expenses and fees shall be split equally among the parties except in situations in which the arbitrator determines that the payment made by the carrier was not made in good faith, in which case the carrier shall be responsible for all of the arbitrator's expenses and fees. Each party shall be responsible for its own costs and fees, including legal fees if any.

c. (1) The amount awarded by the arbitrator that is in excess of any payment already made pursuant to subsection c. of section 9 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-9) shall be paid within 20 days of the arbitrator's decision as provided in subsection b. of this section.

(2) The interest charges for overdue payments, pursuant to P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the pendency of a decision under subsection b. of this section and any interest required to be paid a provider pursuant to P.L.1999, c.154 (C.17B:30-23 et al.) shall not accrue until after 20 days following an arbitrator's decision as provided in subsection b. of this section, but in no circumstances longer than 150 days from the date that the out-of-network provider billed the carrier for services rendered, unless both parties agree to a longer period of time.

d. This section shall apply only if the covered person complies with any applicable preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity to access in-network inpatient or outpatient benefits.

e. This section shall not apply to a covered person who knowingly, voluntarily, and specifically selected an out-of-network provider for health care services.

f. In the event an entity providing or administering a self-funded health benefits plan elects to be subject to the provisions of section 9 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-9), as provided in subsection d. of that section, the provisions of this section shall apply to a self-funded plan in the same manner as the provisions of this section apply to a carrier. If a self-funded plan does not elect to be subject to the provision of section 9 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-9), a member of that plan may initiate binding arbitration as provided in section 11 of **[**this act**]** P.L.2018, c.32 (C.26:2SS-11).

(cf: P.L.2022, c.74, s.2)

26. Section 20 of P.L.2005, c.352 (C.17B:30-56) is amended to read as follows:

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

(cf: P.L.2005,c.352,s.20)

27. (New section) P.L. , c. (C.) (pending before the Legislature as this bill) shall be liberally construed to effectuate the legislative purposes thereof.

28. This act shall take effect on December 31, 2024 and shall apply to health benefits plans delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act.