

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:**

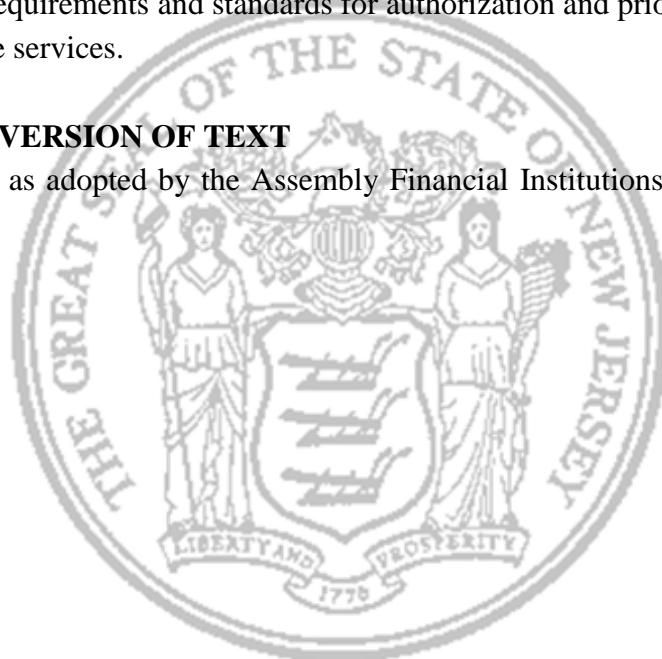
**Assemblywoman Jimenez, Assemblyman DeAngelo, Assemblywomen Reynolds-Jackson, Murphy, Dunn, Assemblyman Verrelli and Assemblywoman Speight**

**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.



1 **AN ACT** concerning prior authorization of services covered by  
2 health benefits plans and supplementing and revising various  
3 parts of the statutory law.  
4

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

7  
8 1. Sections 1 through 7 of P.L.2005, c.352 (C.17B:30-48 et  
9 seq.) are repealed.  
10

11 2. (New section) This act shall be known and may be cited as  
12 the “Ensuring Transparency in Prior Authorization Act.”  
13

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

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

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

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

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

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

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

40 g. Therefore, because it is fair and reasonable for hospitals and  
41 physicians to receive reimbursement for health care services  
42 delivered to covered persons under their health benefits plans and  
43 inefficiencies in any area of the health care delivery system reflect  
44 poorly on all aspects of the health care delivery system, and because  
45 those inefficiencies can harm patients, it is appropriate for the  
46 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 thus is new matter.

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

4

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

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

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

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

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

31 "Commissioner" means the Commissioner of Banking and  
32 Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16

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

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

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

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

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

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

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

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

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

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

4 (3) withhold implementation of any new requirement or  
5 restriction until and unless 90 days have passed since written notice  
6 was provided to a contracted in-network health care provider.  
7

8 6. (New section) A payer shall respond to a hospital or health  
9 care provider request for prior authorization of health care services  
10 by either approving or denying the request based on the covered  
11 person's health benefits plan upon submission of all necessary  
12 information.  
13

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

20 b. Beginning January 1, 2027, a carrier shall only accept and  
21 respond to prior authorization requests for medication coverage,  
22 under the pharmacy benefit part of a health benefits plan submitted  
23 through a secure electronic transmission using the 39 SCRIPT  
24 Standard ePA (electronic prior authorization) transactions.  
25

26 8. (New section) If a payer requires prior authorization for a  
27 health care service for the treatment of a chronic or long-term care  
28 condition, the prior authorization shall remain valid for 180 days  
29 and the payer shall not require the covered person to obtain a prior  
30 authorization again for the health care service.  
31

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

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

39 b. make the adverse determination under the clinical direction  
40 of a medical director of the payer who is responsible for the  
41 provision of health care services provided to covered persons of the  
42 State of New Jersey.  
43

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

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

8

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

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

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

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

32

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

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

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



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

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

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

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

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

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

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

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

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

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

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

16

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

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

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

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

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

36

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

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

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

- 1 respond to the hospital or health care provider within the time  
2 frames established pursuant to P.L. , c. (C. ) (pending  
3 before this Legislature as this bill); or
- 4 (3) received authorization for the covered service for a patient  
5 who is no longer eligible to receive coverage from that payer and it  
6 is determined that the patient is covered by another payer, in which  
7 case the subsequent payer, based on the subsequent payer's benefits  
8 plan, shall accept the authorization and reimburse the hospital or  
9 health care provider.
- 10 b. If the hospital is a network provider of the payer, health care  
11 services shall be reimbursed at the contracted rate for the services  
12 provided.
- 13 c. No payer shall amend a claim by changing the diagnostic  
14 code assigned to the services rendered by a hospital or health care  
15 provider without providing written justification.  
16
- 17 15. (New section) a. A payer shall reimburse a hospital or health  
18 care provider according to the provider contract for all medically  
19 necessary emergency and urgent care health care services that are  
20 covered under the health benefits plan, including all tests necessary  
21 to determine the nature of an illness or injury; pre-hospital  
22 transportation; or the provision of emergency health care services.
- 23 b. A payer shall allow a covered person and the covered  
24 person's health care provider a minimum of 24 hours following an  
25 emergency admission or provision of emergency health care  
26 services for the covered person or health care provider to notify the  
27 payer of the admission or provision of covered services. If the  
28 admission or covered service occurs on a holiday or weekend, a  
29 payer shall not require notification until the next business day after  
30 the admission or provision of the covered service.
- 31 c. A payer shall approve coverage for emergency health care  
32 services necessary to screen and stabilize a covered person. If a  
33 health care provider certifies in writing to a payer within 72 hours  
34 of a covered person's admission that the covered person's condition  
35 requires emergency health care services, that certification shall  
36 create a presumption that the emergency health care services are  
37 medically necessary and that presumption may be rebutted only if  
38 the payer establishes, with clear and convincing evidence, that the  
39 emergency health care services present identifiable evidence of  
40 fraud.
- 41 d. A payer shall not determine medical necessity or  
42 appropriateness of emergency health care services based on whether  
43 or not those services are provided by participating or  
44 nonparticipating providers. A payer shall ensure that restrictions on  
45 coverage of emergency health care services provided by  
46 nonparticipating providers shall not be greater than restrictions that  
47 apply when those services are provided by participating providers.

1 e. If a covered person receives an emergency health care  
2 service that requires immediate post-evaluation or post-stabilization  
3 services, a payer shall make an authorization determination within  
4 150 minutes of receiving a request. If the authorization  
5 determination is not made within 150 minutes, those services shall  
6 be deemed approved.

7  
8 16. (New section) a. In addition to the protections afforded to a  
9 health care provider or patient by the requirements of P.L. , c.  
10 (C. ) (pending before the Legislature as this bill), any failure by  
11 a payer to comply with a deadline or other requirement under the  
12 provisions sections 5, 6, 9, 12, and 13 and subsection e. of section  
13 15 of P.L. , c. (C. ) (pending before the Legislature as this  
14 bill) shall result in any health care services subject to review being  
15 automatically deemed authorized.

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

38 c. If the Commissioner of Banking and Insurance has reason to  
39 believe that a person is engaging in a practice or activity, for the  
40 purpose of avoiding or circumventing the legislative intent of  
41 sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4,  
42 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and  
43 17:48F-13.1) as amended by P.L. , c. (C. ) (pending before  
44 the Legislature as this bill), the Commissioner of Banking and  
45 Insurance is authorized to promulgate rules or regulations necessary  
46 to prohibit that practice or activity and levy a civil penalty of not  
47 more than \$10,000 for each day that person is in violation of that  
48 rule or regulation.

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

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

20

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

- 25 a. health care provider specialty;
- 26 b. medication or diagnostic tests and procedures;
- 27 c. indication offered;
- 28 d. reason for denial;
- 29 e. whether prior authorization determinations were:
  - 30 (1) appealed; or
  - 31 (2) approved or denied on appeal;
- 32 f. the time between submission of prior authorization requests  
33 and the determination;
- 34 g. the average median time elapsed between a request for  
35 clinical records from the requesting health care provider and receipt  
36 of adequate clinical records to complete the prior authorization; and
- 37 h. the number of appeals generated for cases denied in which  
38 there was inadequate or no prior clinical information.

39

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (c) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

41  
42 19. Section 3 of P.L.1999, c.154 (C.17:48A-7.12) is amended to  
43 read as follows:

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

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

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

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

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

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

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

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

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

- 1 (c) the claim is for a service or supply covered under the health  
2 benefits plan;
- 3 (d) the claim is submitted with all the information requested by  
4 the payer on the claim form or in other instructions that were  
5 distributed in advance to the health care provider or covered person  
6 in accordance with the provisions of **section 4** of P.L.2005, c.352  
7 (C.17B:30-51) **section 5** of P.L. , c. (C. ) (pending before  
8 the Legislature as this bill); and
- 9 (e) the payer has no reason to believe that the claim has been  
10 submitted fraudulently.
- 11 (2) If all or a portion of the claim is not paid within the time  
12 frames provided in paragraph (1) of this subsection because:
- 13 (a) the claim submission is incomplete because the required  
14 substantiating documentation has not been submitted to the payer;
- 15 (b) the diagnosis coding, procedure coding, or any other  
16 required information to be submitted with the claim is incorrect;
- 17 (c) the payer disputes the amount claimed; or
- 18 (d) there is strong evidence of fraud by the provider and the  
19 payer has initiated an investigation into the suspected fraud,  
20 the payer shall notify the health care provider, by electronic  
21 means and the covered person in writing within 30 days of  
22 receiving an electronic claim, or notify the covered person and  
23 health care provider in writing within 40 days of receiving a claim  
24 submitted by other than electronic means, that:
- 25 (i) the claim is incomplete with a statement as to what  
26 substantiating documentation is required for adjudication of the  
27 claim;
- 28 (ii) the claim contains incorrect information with a statement as  
29 to what information must be corrected for adjudication of the claim;
- 30 (iii) the payer disputes the amount claimed in whole or in part  
31 with a statement as to the basis of that dispute; or
- 32 (iv) the payer finds there is strong evidence of fraud and has  
33 initiated an investigation into the suspected fraud in accordance  
34 with its fraud prevention plan established pursuant to section 1 of  
35 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with  
36 supporting documentation, to the Office of the Insurance Fraud  
37 Prosecutor in the Department of Law and Public Safety established  
38 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 39 (3) If all or a portion of an electronically submitted claim cannot  
40 be adjudicated because the diagnosis coding, procedure coding or  
41 any other data required to be submitted with the claim was missing,  
42 the payer shall electronically notify the health care provider or its  
43 agent within seven days of that determination and request any  
44 information required to complete adjudication of the claim.
- 45 (4) Any portion of a claim that meets the criteria established in  
46 paragraph (1) of this subsection shall be paid by the payer in  
47 accordance with the time limit established in paragraph (1) of this  
48 subsection.

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

41  
42 20. Section 4 of P.L.1999, c.154 (C.17:48E-10.1) is amended to  
43 read as follows:

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

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

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

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

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

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

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

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

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

- 1 (c) the claim is for a service or supply covered under the health  
2 benefits plan;
- 3 (d) the claim is submitted with all the information requested by  
4 the payer on the claim form or in other instructions that were  
5 distributed in advance to the health care provider or covered person  
6 in accordance with the provisions of **section 4** of P.L.2005, c.352  
7 (C.17B:30-51) **section 5** of P.L. , c. (C. ) (pending before  
8 the Legislature as this bill); and
- 9 (e) the payer has no reason to believe that the claim has been  
10 submitted fraudulently.
- 11 (2) If all or a portion of the claim is not paid within the time  
12 frames provided in paragraph (1) of this subsection because:
- 13 (a) the claim submission is incomplete because the required  
14 substantiating documentation has not been submitted to the payer;
- 15 (b) the diagnosis coding, procedure coding, or any other  
16 required information to be submitted with the claim is incorrect;
- 17 (c) the payer disputes the amount claimed; or
- 18 (d) there is strong evidence of fraud by the provider and the  
19 payer has initiated an investigation into the suspected fraud,  
20 the payer shall notify the health care provider, by electronic  
21 means and the covered person in writing within 30 days of  
22 receiving an electronic claim, or notify the covered person and  
23 health care provider in writing within 40 days of receiving a claim  
24 submitted by other than electronic means, that:
- 25 (i) the claim is incomplete with a statement as to what  
26 substantiating documentation is required for adjudication of the  
27 claim;
- 28 (ii) the claim contains incorrect information with a statement as  
29 to what information must be corrected for adjudication of the claim;
- 30 (iii) the payer disputes the amount claimed in whole or in part  
31 with a statement as to the basis of that dispute; or
- 32 (iv) the payer finds there is strong evidence of fraud and has  
33 initiated an investigation into the suspected fraud in accordance  
34 with its fraud prevention plan established pursuant to section 1 of  
35 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with  
36 supporting documentation, to the Office of the Insurance Fraud  
37 Prosecutor in the Department of Law and Public Safety established  
38 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 39 (3) If all or a portion of an electronically submitted claim cannot  
40 be adjudicated because the diagnosis coding, procedure coding or  
41 any other data required to be submitted with the claim was missing,  
42 the payer shall electronically notify the health care provider or its  
43 agent within seven days of that determination and request any  
44 information required to complete adjudication of the claim.
- 45 (4) Any portion of a claim that meets the criteria established in  
46 paragraph (1) of this subsection shall be paid by the payer in  
47 accordance with the time limit established in paragraph (1) of this  
48 subsection.

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

47 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

41  
42 21. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to  
43 read as follows:

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

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

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

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

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

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

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

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

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

- 1 (c) the claim is for a service or supply covered under the health  
 2 benefits plan;
- 3 (d) the claim is submitted with all the information requested by  
 4 the payer on the claim form or in other instructions that were  
 5 distributed in advance to the health care provider or covered person  
 6 in accordance with the provisions of **section 4** of P.L.2005, c.352  
 7 (C.17B:30-51) **section 5** of P.L. , c. (C. ) (pending before  
 8 the Legislature as this bill); and
- 9 (e) the payer has no reason to believe that the claim has been  
 10 submitted fraudulently.
- 11 (2) If all or a portion of the claim is not paid within the time  
 12 frames provided in paragraph (1) of this subsection because:
- 13 (a) the claim submission is incomplete because the required  
 14 substantiating documentation has not been submitted to the payer;
- 15 (b) the diagnosis coding, procedure coding, or any other  
 16 required information to be submitted with the claim is incorrect;
- 17 (c) the payer disputes the amount claimed; or
- 18 (d) there is strong evidence of fraud by the provider and the  
 19 payer has initiated an investigation into the suspected fraud,  
 20 the payer shall notify the health care provider, by electronic  
 21 means and the covered person in writing within 30 days of  
 22 receiving an electronic claim, or notify the covered person and  
 23 health care provider in writing within 40 days of receiving a claim  
 24 submitted by other than electronic means, that:
- 25 (i) the claim is incomplete with a statement as to what  
 26 substantiating documentation is required for adjudication of the  
 27 claim;
- 28 (ii) the claim contains incorrect information with a statement as  
 29 to what information must be corrected for adjudication of the claim;
- 30 (iii) the payer disputes the amount claimed in whole or in part  
 31 with a statement as to the basis of that dispute; or
- 32 (iv) the payer finds there is strong evidence of fraud and has  
 33 initiated an investigation into the suspected fraud in accordance  
 34 with its fraud prevention plan established pursuant to section 1 of  
 35 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with  
 36 supporting documentation, to the Office of the Insurance Fraud  
 37 Prosecutor in the Department of Law and Public Safety established  
 38 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 39 (3) If all or a portion of an electronically submitted claim cannot  
 40 be adjudicated because the diagnosis coding, procedure coding or  
 41 any other data required to be submitted with the claim was missing,  
 42 the payer shall electronically notify the health care provider or its  
 43 agent within seven days of that determination and request any  
 44 information required to complete adjudication of the claim.
- 45 (4) Any portion of a claim that meets the criteria established in  
 46 paragraph (1) of this subsection shall be paid by the payer in  
 47 accordance with the time limit established in paragraph (1) of this  
 48 subsection.

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

45 A health care provider may initiate an appeal on or before the  
46 90th calendar day following receipt by the health care provider of  
47 the payer's claims determination, which is the basis of the appeal,  
48 on a form prescribed by the Commissioner of Banking and

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

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

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

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

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

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

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

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

48 (a) signed by the arbitrator;



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (c) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

40  
41 23. Section 6 of P.L.1999, c.154 (C.17B:27-44.2) is amended to  
42 read as follows:

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (c) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

40  
41 24. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to  
42 read as follows:

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

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

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

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

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

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

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

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

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



- 1 (c) the claim is for a service or supply covered under the health  
2 benefits plan;
- 3 (d) the claim is submitted with all the information requested by  
4 the payer on the claim form or in other instructions that were  
5 distributed in advance to the health care provider or covered person  
6 in accordance with the provisions of **section 4** of P.L.2005, c.352  
7 (C.17B:30-51) **section 5** of P.L. , c. (C. ) (pending before  
8 the Legislature as this bill); and
- 9 (e) the payer has no reason to believe that the claim has been  
10 submitted fraudulently.
- 11 (2) If all or a portion of the claim is not paid within the time  
12 frames provided in paragraph (1) of this subsection because:
- 13 (a) the claim submission is incomplete because the required  
14 substantiating documentation has not been submitted to the payer;
- 15 (b) the diagnosis coding, procedure coding, or any other  
16 required information to be submitted with the claim is incorrect;
- 17 (c) the payer disputes the amount claimed; or
- 18 (d) there is strong evidence of fraud by the provider and the  
19 payer has initiated an investigation into the suspected fraud,  
20 the payer shall notify the health care provider, by electronic  
21 means and the covered person in writing within 30 days of  
22 receiving an electronic claim, or notify the covered person and  
23 health care provider in writing within 40 days of receiving a claim  
24 submitted by other than electronic means, that:
- 25 (i) the claim is incomplete with a statement as to what  
26 substantiating documentation is required for adjudication of the  
27 claim;
- 28 (ii) the claim contains incorrect information with a statement as  
29 to what information must be corrected for adjudication of the claim;
- 30 (iii) the payer disputes the amount claimed in whole or in part  
31 with a statement as to the basis of that dispute; or
- 32 (iv) the payer finds there is strong evidence of fraud and has  
33 initiated an investigation into the suspected fraud in accordance  
34 with its fraud prevention plan established pursuant to section 1 of  
35 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with  
36 supporting documentation, to the Office of the Insurance Fraud  
37 Prosecutor in the Department of Law and Public Safety established  
38 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 39 (3) If all or a portion of an electronically submitted claim cannot  
40 be adjudicated because the diagnosis coding, procedure coding or  
41 any other data required to be submitted with the claim was missing,  
42 the payer shall electronically notify the health care provider or its  
43 agent within seven days of that determination and request any  
44 information required to complete adjudication of the claim.
- 45 (4) Any portion of a claim that meets the criteria established in  
46 paragraph (1) of this subsection shall be paid by the payer in  
47 accordance with the time limit established in paragraph (1) of this  
48 subsection.

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

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

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

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

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

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

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

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

1 30th calendar day or the time limit established by the Medicare  
2 program, whichever is earlier, following receipt by the payer of a  
3 claim submitted by electronic means or on or before the 40th  
4 calendar day following receipt of a claim submitted by other than  
5 electronic means.

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

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

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

29 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

45 A health care provider may initiate an appeal on or before the  
46 90th calendar day following receipt by the health care provider of  
47 the payer's claims determination, which is the basis of the appeal,  
48 on a form prescribed by the Commissioner of Banking and

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

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

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

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

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

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

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

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

48 (a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

42  
43 25. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to  
44 read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

28 f. In the event an entity providing or administering a self-  
29 funded health benefits plan elects to be subject to the provisions of  
30 section 9 of **【this act】 P.L.2018, c.32 (C.26:2SS-9)**, as provided in  
31 subsection d. of that section, the provisions of this section shall  
32 apply to a self-funded plan in the same manner as the provisions of  
33 this section apply to a carrier. If a self-funded plan does not elect to  
34 be subject to the provision of section 9 of **【this act】 P.L.2018, c.32**  
35 **(C.26:2SS-9)**, a member of that plan may initiate binding arbitration  
36 as provided in section 11 of **【this act】 P.L.2018, c.32 (C.26:2SS-**  
37 **11)**.

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

39

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

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

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



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

4

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