SENATE SUBSTITUTE FOR

SENATE, No. 1794

STATE OF NEW JERSEY

220th LEGISLATURE

ADOPTED DECEMBER 21, 2023

Sponsored by:
Senator VIN GOPAL
District 11 (Monmouth)
Senator ROBERT W. SINGER
District 30 (Monmouth and Ocean)

Co-Sponsored by:
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SYNOPSIS

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

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate.

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

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

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 are repealed.

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

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

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

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

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

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

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

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

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

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

Matter underlined 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.
24 "Clinical criteria" means the written policies; written screening
25 procedures; determination rules; determination abstracts; clinical
26 protocols; practice guidelines; medical protocols; and any other
27 criteria or rationale used for the purposes of utilization management
28 to determine the necessity and appropriateness of covered services.
29 "Commissioner" means the Commissioner of Banking and
30 Insurance.
31 "Covered person" means a person on whose behalf a carrier
32 offering the plan is obligated to pay benefits or provide services
33 pursuant to the health benefits plan.
34 "Covered service" means a health care service provided to a
35 covered person under a health benefits plan for which the carrier is
36 obligated to pay benefits or provide services, including, but not
37 limited to, health care procedures, treatments, or services and the
38 provision of pharmaceutical products or services or durable medical
39 equipment.
40 "Emergency health care services" means health care services that
41 are provided in an emergency facility after the sudden onset of a
42 medical condition that manifests itself by symptoms of sufficient
43 severity, including severe pain, that the absence of immediate medical
44 attention could reasonably be expected by a prudent layperson, who
45 possesses an average knowledge of health and medicine, to result in:
46 (1) placing the health of the patient in jeopardy; (2) serious impairment
47 to bodily function; or (3) serious dysfunction of any bodily organ or
48 part.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a

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

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

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

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

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

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

(5) prescription drug formularies; and

(6) any other information the commissioner deems necessary.

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

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

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

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

(3) withhold implementation of any new materially adverse requirement or restriction until and unless 90 days have passed

since written notice was provided to an impacted contracted in-network health care provider.

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

7. (New section) a. A carrier shall respond to prior authorization requests for medication coverage submitted using the NCPDP SCRIPT Standard for ePA (electronic prior authorization) transactions, under the pharmacy benefit part of a health benefits plan, within 24 hours for urgent requests and 72 hours for non-urgent requests after obtaining all necessary information to make the approval or adverse determination.

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

8. (New section) Except where shorter time frames are necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, if a payer requires prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for 180 days and the payer shall not require the covered person to obtain a prior authorization again for the health care service within the 180-day period.

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

a. make the adverse determination under the clinical direction of a medical director of the payer who shall:

(1) be licensed in this State; and

(2) strictly follow a medical policy that has been developed and made available in accordance with P.L.   , c.   (C.   ) (pending before the Legislature as this bill) and the "New Jersey Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.);

b. not be compensated by a payer based on the approval or denial rate of the reviewing physician; and

c. not be provided preferential treatment by a payer in the requests for prior authorization of the reviewing physician if that physician is also a network provider for the payer.

1 10. (New section) Except where shorter time frames are necessary
2 to monitor patient safety or treatment effectiveness and with notice to
3 the treating provider, prior authorization for a service which includes a
4 defined number of discrete services within a set time frame shall be
5 valid for purposes of authorizing the health care provider to provide
6 care for a period of 180 days from the date the provider receives the
7 prior authorization and a payer shall not revoke, limit, condition or
8 restrict a prior authorization within that period if (1) the covered
9 person continues to be eligible for coverage; (2) the clinical
10 information provided at the time the prior authorization request was
11 made has not been misrepresented by the treating physician or covered
12 person; and (3) there has not been a material change in the clinical
13 circumstances or condition of the covered person.
14
15 11. (New section) a. On receipt of information documenting a
16 prior authorization from the covered person or the health care
17 provider of the covered person, a payer shall honor a prior
18 authorization granted to a covered person by a previous payer for at
19 least the initial 60 days of coverage under a new health plan of the
20 covered person, if that prior authorization was based on information
21 provided in good faith by a provider.
22 b. During the initial 60 days described in subsection a. of this
23 section, a payer may perform its own review to grant a prior
24 authorization.
25 c. If there is a change in coverage or approval criteria for a
26 previously prior authorized covered service by the health benefits
27 plan issuing the change, the change in coverage or approval criteria
28 shall not affect a covered person who received prior authorization
29 before the effective date of the change for the remainder of the plan
30 year of the covered person, unless the prior authorization previously
31 issued for a covered service was issued based on materially
32 inaccurate medical information or fraudulent information.
33 d. A payer shall continue to honor a prior authorization it has
34 granted to a covered person when the covered person changes
35 products under the same payer, provided the service for which prior
36 authorization was issued remains a covered benefit under the terms
37 and conditions of the replacement health benefits plan.
38
39 12. (New section) a. A denial of prior authorization shall be
40 communicated to the hospital or health care provider by facsimile, e-
41 mail or any other means of written communication agreed to by the
42 payer and hospital or health care provider, as follows:
43 (1) in the case of a request for prior authorization for a covered
44 person who will be receiving inpatient hospital services, the payer
45 shall communicate the denial of the request or the limitation imposed
46 on the requested service to the hospital or health care provider within a
47 time frame appropriate to the medical exigencies of the case but no
48 later than 12 days if the request is submitted in paper, or nine days if

submitted through an electronic portal provided by the payer, following the time the request was made;

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

(3) in the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than 12 days if the request is submitted in paper, or nine days if submitted through an electronic portal provided by the payer, following the time the request was made;

(4) in the case of a claim involving urgent care, the payer shall notify the hospital or health care provider of the carrier's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the carrier, unless the hospital or health care provider fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the carrier shall notify the hospital or health care provider as soon as possible, but not later than 24 hours after receipt of the claim by the payer, of the specific information necessary to complete the claim. The hospital or health care provider shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The payer shall notify the hospital or health care provider of the carrier's benefit determination as soon as possible, but in no case later than 48 hours after the carrier's receipt of the specified information; and

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

b. If the payer is unable to approve or make an adverse determination with regard to a request for authorization within the applicable time frame set forth in paragraph (1), (2), (3), or (4) of this subsection because of the need for this additional information, the

payer shall have an additional period within which to approve or make an adverse determination with regard to the request, as follows:

(1) in the case of a request for prior or concurrent authorization for a covered person who will be receiving inpatient hospital services, within a time frame appropriate to the medical exigencies of the case but no later than 12 calendar days beyond the time of receipt by the payer from the hospital or health care provider of the additional information that the payer has identified as needed to approve or made an adverse determination with regard to the request for authorization. For requests made through an electronic portal provided by the payer, this time frame shall be within nine calendar days;

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

(3) in the case of a request for prior or concurrent authorization for a covered person who will be receiving health care services in another setting, within a time frame appropriate to the medical exigencies of the case but no more than 12 calendar days beyond the time of receipt by the payer from the hospital or health care provider of the additional information that the payer has identified as needed to approve or make an adverse determination with regard to the request for authorization. For requests made through an electronic portal provided by the payer, this time frame shall be within nine calendar days.

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

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

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

13. (New section) a. A payer shall ensure that any adverse determinations of any appeal are reviewed by a physician. The physician shall:

a. be board certified in a same or similar specialty that has experience treating the condition or service under review or has experience treating the condition within the last five years;

1 b. not be paid by a payer based on the reviewing physician's denial
2 or approval rate;
3 c. not have been directly involved in making an initial adverse
4 determination for the same claim;
5 d. consider all known clinical aspects of the health care service
6 under review, including, but not limited to, a review of all pertinent
7 medical records provided to the payer by the health care provider of
8 the covered person, any relevant records provided to the payer by a
9 health care facility, and any medical literature provided to the payer by
10 the health care service provider of the covered person;
11 e. not be provided preferential treatment by the payer in the
12 reviewing physician's own requests for prior authorization if the
13 reviewing physician is also a network provider; and
14 f. when requested by the treating provider, engage in a telephonic
15 conversation with the treating provider to discuss the need for the
16 prescribed medication or service.
17
18 14. (New section) a. When a hospital or health care provider
19 complies with the provisions set forth in P.L. , c. (C.)
20 (pending before the Legislature as this bill), no payer shall deny
21 reimbursement to a hospital or health care provider for covered
22 services rendered to a covered person on grounds of failure to
23 secure prior or concurrent authorization in the absence of fraud or
24 misrepresentation if the hospital or health care provider:
25 (1) requested authorization from the payer and received
26 approval for the health care services delivered prior to rendering the
27 service;
28 (2) requested authorization from the payer for the health care
29 services prior to rendering the services and the payer failed to
30 respond to the hospital or health care provider within the time
31 frames established pursuant to P.L. , c. (C.) (pending
32 before this Legislature as this bill); or
33 (3) received authorization for the covered service for a patient
34 who is no longer eligible to receive coverage from that payer and it
35 is determined that the patient is covered by another payer, in which
36 case the subsequent payer, based on the subsequent payer's benefits
37 plan, shall accept the authorization and reimburse the hospital or
38 health care provider.
39 b. If the hospital is a network provider of the payer, health care
40 services shall be reimbursed at the contracted rate for the services
41 provided.
42 c. No payer shall amend a claim by changing the diagnostic
43 code assigned to the services rendered by a hospital or health care
44 provider without providing written justification.
45
46 15. (New section) a. A payer shall reimburse a hospital or health
47 care provider according to the provider contract for all medically
48 necessary emergency and urgent care health care services that are

covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury; pre-hospital transportation; or the provision of emergency health care services.

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

c. A payer shall approve coverage for emergency health care services necessary to screen and stabilize a covered person without requiring any prior authorization. Admission on an in-patient basis may be subject to concurrent review.

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

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

16. (New section) a. In addition to the protections afforded to a health care provider or patient by the requirements of P.L. , c. (C.) (pending before the Legislature as this bill), any failure by a payer to comply with a deadline shall result in any health care services subject to review being automatically deemed authorized.

b. Notwithstanding any health care services being automatically deemed authorized pursuant to the terms of P.L. , c. (C.) (pending before the Legislature as this bill), the Commissioner of Banking and Insurance shall enforce the provisions of sections 3 through 15 of P.L. , c. (C.) (pending before the Legislature as this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.) (pending before the Legislature as this bill). A payer found in violation of those sections shall be liable for a civil penalty of not more than $10,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation

1 and fails to do so within the time allowed. The penalty shall be
2 collected by the commissioner in the name of the State in a summary
3 proceeding in accordance with the "Penalty Enforcement Law of
4 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). The commissioner's
5 determination shall be a final agency decision subject to review by the
6 Appellate Division of the Superior Court.
7 c. If the Commissioner of Banking and Insurance has reason to
8 believe that a person is engaging in a practice or activity, for the
9 purpose of avoiding or circumventing the legislative intent of sections
10 4 through 17 of P.L. , c. (C.) (pending before the Legislature
11 as this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
12 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,
13 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.)
14 (pending before the Legislature as this bill), the Commissioner of
15 Banking and Insurance is authorized to promulgate rules or regulations
16 necessary to prohibit that practice or activity and levy a civil penalty of
17 not more than $10,000 for each day that person is in violation of that
18 rule or regulation.
19 d. For the purpose of administering the provisions of sections 3
20 through 15 of P.L. , c. (C.) (pending before the Legislature as
21 this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
22 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,
23 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.)
24 (pending before the Legislature as this bill), 50 percent of the penalty
25 monies collected pursuant to subsections b. and c. of this section shall
26 be deposited into the General Fund. For the purpose of providing
27 payments to hospitals in accordance with the formula used for the
28 distribution of charity care subsidies that are provided pursuant to
29 P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50 percent of the penalty
30 monies collected pursuant to subsections b. and c. of this section shall
31 be deposited into the Health Care Subsidy Fund established pursuant
32 to section 8 of P.L.1992, c.160 (C.26:2H-18.58).
33 e. A penalty levied pursuant to this section against a payer that
34 does not reserve the right to change the premium shall be credited
35 towards a penalty levied against the payer by the Department of
36 Human Services for the same violation.
37
38 17. (New section) A payer shall make statistics available
39 regarding prior authorization approvals and denials on its Internet
40 website in a readily accessible format, as determined by the
41 commissioner. Payers shall include categories for:
42 a. health care provider specialty;
43 b. medication or diagnostic tests and procedures;
44 c. indication offered;
45 d. reason for denial;
46 e. whether prior authorization determinations were:
47 (1) appealed; or
48 (2) approved or denied on appeal;

1 f. the time between submission of prior authorization requests
2 and the determination;
3 g. the average median time elapsed between a request for clinical
4 records from the requesting health care provider and receipt of
5 adequate clinical records to complete the prior authorization; and
6 h. the number of appeals generated for cases denied in which
7 there was inadequate or no prior clinical information.
8
9 18. Section 4 of P.L.1999, c.154 (C.17:48-8.4) is amended to
10 read as follows:
11 4. a. Within 180 days of the adoption of a timetable for
12 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
13 23), a hospital service corporation or its agent or a subsidiary that
14 processes health care benefits claims as a third party administrator,
15 shall demonstrate to the satisfaction of the Commissioner of
16 Banking and Insurance that it will adopt and implement all of the
17 standards to receive and transmit health care transactions
18 electronically, according to the corresponding timetable, and
19 otherwise comply with the provisions of this section, as a condition
20 of its continued authorization to do business in this State.
21 The Commissioner of Banking and Insurance may grant
22 extensions or waivers of the implementation requirement when it
23 has been demonstrated to the commissioner's satisfaction that
24 compliance with the timetable for implementation will result in an
25 undue hardship to a hospital service corporation, or its agent, its
26 subsidiary or its covered persons.
27 b. Within 12 months of the adoption of regulations establishing
28 standard health care enrollment and claim forms by the
29 Commissioner of Banking and Insurance pursuant to section 1 of
30 P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or its
31 agent or a subsidiary that processes health care benefits claims as a
32 third party administrator shall use the standard health care
33 enrollment and claim forms in connection with all group and
34 individual contracts issued, delivered, executed or renewed in this
35 State.
36 c. Twelve months after the adoption of regulations establishing
37 standard health care enrollment and claim forms by the
38 Commissioner of Banking and Insurance pursuant to section 1 of
39 P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or its
40 agent shall require that health care providers file all claims for
41 payment for health care services. A covered person who receives
42 health care services shall not be required to submit a claim for
43 payment, but notwithstanding the provisions of this subsection to
44 the contrary, a covered person shall be permitted to submit a claim
45 on his own behalf, at the covered person's option. All claims shall
46 be filed using the standard health care claim form applicable to the
47 contract.

1 d. For the purposes of this subsection, "substantiating
2 documentation" means any information specific to the particular
3 health care service provided to a covered person.
4 (1) Effective 180 days after the effective date of P.L.1999,
5 c.154, a hospital service corporation or its agent, hereinafter the
6 payer, shall remit payment for every insured claim submitted by a
7 covered person or health care provider, no later than the 30th
8 calendar day following receipt of the claim by the payer or no later
9 than the time limit established for the payment of claims in the
10 Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B),
11 whichever is earlier, if the claim is submitted by electronic means,
12 and no later than the 40th calendar day following receipt if the
13 claim is submitted by other than electronic means, if:
14 (a) the health care provider is eligible at the date of service;
15 (b) the person who received the health care service was covered
16 on the date of service;
17 (c) the claim is for a service or supply covered under the health
18 benefits plan;
19 (d) the claim is submitted with all the information requested by
20 the payer on the claim form or in other instructions that were
21 distributed in advance to the health care provider or covered person
22 in accordance with the provisions of [section 4 of P.L.2005, c.352
23 (C.17B:30-51)] section 5 of P.L. , c. (C.) (pending before
24 the Legislature as this bill); and
25 (e) the payer has no reason to believe that the claim has been
26 submitted fraudulently.
27 (2) If all or a portion of the claim is not paid within the time
28 frames provided in paragraph (1) of this subsection because:
29 (a) the claim submission is incomplete because the required
30 substantiating documentation has not been submitted to the payer;
31 (b) the diagnosis coding, procedure coding, or any other
32 required information to be submitted with the claim is incorrect;
33 (c) the payer disputes the amount claimed; or
34 (d) there is strong evidence of fraud by the provider and the
35 payer has initiated an investigation into the suspected fraud,
36 the payer shall notify the health care provider, by electronic
37 means and the covered person in writing within 30 days of
38 receiving an electronic claim, or notify the covered person and
39 health care provider in writing within 40 days of receiving a claim
40 submitted by other than electronic means, that:
41 (i) the claim is incomplete with a statement as to what
42 substantiating documentation is required for adjudication of the
43 claim;
44 (ii) the claim contains incorrect information with a statement as
45 to what information must be corrected for adjudication of the claim;
46 (iii) the payer disputes the amount claimed in whole or in part
47 with a statement as to the basis of that dispute; or

1 (iv) the payer finds there is strong evidence of fraud and has
2 initiated an investigation into the suspected fraud in accordance
3 with its fraud prevention plan established pursuant to section 1 of
4 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
5 supporting documentation, to the Office of the Insurance Fraud
6 Prosecutor in the Department of Law and Public Safety established
7 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
8 (3) If all or a portion of an electronically submitted claim cannot
9 be adjudicated because the diagnosis coding, procedure coding or
10 any other data required to be submitted with the claim was missing,
11 the payer shall electronically notify the health care provider or its
12 agent within seven days of that determination and request any
13 information required to complete adjudication of the claim.
14 (4) Any portion of a claim that meets the criteria established in
15 paragraph (1) of this subsection shall be paid by the payer in
16 accordance with the time limit established in paragraph (1) of this
17 subsection.
18 (5) A payer shall acknowledge receipt of a claim submitted by
19 electronic means from a health care provider, no later than two
20 working days following receipt of the transmission of the claim.
21 (6) If a payer subject to the provisions of P.L.1983, c.320
22 (C.17:33A-1 et seq.) has reason to believe that a claim has been
23 submitted fraudulently, it shall investigate the claim in accordance
24 with its fraud prevention plan established pursuant to section 1 of
25 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
26 supporting documentation, to the Office of the Insurance Fraud
27 Prosecutor in the Department of Law and Public Safety established
28 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
29 (7) Payment of an eligible claim pursuant to paragraphs (1) and
30 (4) of this subsection shall be deemed to be overdue if not remitted
31 to the claimant or his agent by the payer on or before the 30th
32 calendar day or the time limit established by the Medicare program,
33 whichever is earlier, following receipt by the payer of a claim
34 submitted by electronic means and on or before the 40th calendar
35 day following receipt of a claim submitted by other than electronic
36 means.
37 If payment is withheld on all or a portion of a claim by a payer
38 pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph
39 (3) of this subsection, the claims payment shall be overdue if not
40 remitted to the claimant or his agent by the payer on or before the
41 30th calendar day or the time limit established by the Medicare
42 program, whichever is earlier, for claims submitted by electronic
43 means and the 40th calendar day for claims submitted by other than
44 electronic means, following receipt by the payer of the required
45 documentation or information or modification of an initial
46 submission.
47 If payment is withheld on all or a portion of a claim by a payer
48 pursuant to paragraph (2) or (3) of this subsection and the provider

1 is not notified within the time frames provided for in those
2 paragraphs, the claim shall be deemed to be overdue.
3 (8) (a) No payer that has reserved the right to change the
4 premium shall deny payment on all or a portion of a claim because
5 the payer requests documentation or information that is not specific
6 to the health care service provided to the covered person.
7 (b) No payer shall deny payment on all or a portion of a claim
8 while seeking coordination of benefits information unless good
9 cause exists for the payer to believe that other insurance is available
10 to the covered person. Good cause shall exist only if the payer's
11 records indicate that other coverage exists. Routine requests to
12 determine whether coordination of benefits exists shall not be
13 considered good cause.
14 (c) In the event payment is withheld on all or a portion of a
15 claim by a payer pursuant to subparagraph (a) or (b) of this
16 paragraph, the claims payment shall be deemed to be overdue if not
17 remitted to the claimant or his agent by the payer on or before the
18 30th calendar day or the time limit established by the Medicare
19 program, whichever is earlier, following receipt by the payer of a
20 claim submitted by electronic means or on or before the 40th
21 calendar day following receipt of a claim submitted by other than
22 electronic means.
23 (9) An overdue payment shall bear simple interest at the rate of
24 12% per annum. The interest shall be paid to the health care
25 provider at the time the overdue payment is made. The amount of
26 interest paid to a health care provider for an overdue claim shall be
27 credited to any civil penalty for late payment of the claim levied by
28 the Department of Human Services against a payer that does not
29 reserve the right to change the premium.
30 (10) With the exception of claims that were submitted
31 fraudulently or submitted by health care providers that have a
32 pattern of inappropriate billing or claims that were subject to
33 coordination of benefits, no payer shall seek reimbursement for
34 overpayment of a claim previously paid pursuant to this section
35 later than 18 months after the date the first payment on the claim
36 was made. No payer shall seek more than one reimbursement for
37 overpayment of a particular claim. At the time the reimbursement
38 request is submitted to the health care provider, the payer shall
39 provide written documentation that identifies the error made by the
40 payer in the processing or payment of the claim that justifies the
41 reimbursement request. No payer shall base a reimbursement
42 request for a particular claim on extrapolation of other claims,
43 except under the following circumstances:
44 (a) in judicial or quasi-judicial proceedings, including
45 arbitration;
46 (b) in administrative proceedings;
47 (c) in which relevant records required to be maintained by the
48 health care provider have been improperly altered or reconstructed,

1 or a material number of the relevant records are otherwise
2 unavailable; or
3 (d) in which there is clear evidence of fraud by the health care
4 provider and the payer has investigated the claim in accordance
5 with its fraud prevention plan established pursuant to section 1 of
6 P.L.1993, c.362 (C.17:33A-15), and referred the claim, together
7 with supporting documentation, to the Office of the Insurance Fraud
8 Prosecutor in the Department of Law and Public Safety established
9 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
10 (11) (a) In seeking reimbursement for the overpayment from the
11 health care provider, except as provided for in subparagraph (b) of
12 this paragraph, no payer shall collect or attempt to collect:
13 (i) the funds for the reimbursement on or before the 45th
14 calendar day following the submission of the reimbursement request
15 to the health care provider;
16 (ii) the funds for the reimbursement if the health care provider
17 disputes the request and initiates an appeal on or before the 45th
18 calendar day following the submission of the reimbursement request
19 to the health care provider and until the health care provider's rights
20 to appeal set forth under paragraphs (1) and (2) of subsection e. of
21 this section are exhausted; or
22 (iii) a monetary penalty against the reimbursement request,
23 including but not limited to, an interest charge or a late fee.
24 The payer may collect the funds for the reimbursement request
25 by assessing them against payment of any future claims submitted
26 by the health care provider after the 45th calendar day following the
27 submission of the reimbursement request to the health care provider
28 or after the health care provider's rights to appeal set forth under
29 paragraphs (1) and (2) of subsection e. of this section have been
30 exhausted if the payer submits an explanation in writing to the
31 provider in sufficient detail so that the provider can reconcile each
32 covered person's bill.
33 (b) If a payer has determined that the overpayment to the health
34 care provider is a result of fraud committed by the health care
35 provider and the payer has conducted its investigation and reported
36 the fraud to the Office of the Insurance Fraud Prosecutor as
37 required by law, the payer may collect an overpayment by assessing
38 it against payment of any future claim submitted by the health care
39 provider.
40 (12) No health care provider shall seek reimbursement from a
41 payer or covered person for underpayment of a claim submitted
42 pursuant to this section later than 18 months from the date the first
43 payment on the claim was made, except if the claim is the subject of
44 an appeal submitted pursuant to subsection e. of this section or the
45 claim is subject to continual claims submission. No health care
46 provider shall seek more than one reimbursement for underpayment
47 of a particular claim.

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

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

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

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

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

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

1 Any party may initiate an arbitration proceeding on or before the
2 90th calendar day following the receipt of the determination which
3 is the basis of the appeal, on a form prescribed by the
4 Commissioner of Banking and Insurance. No dispute shall be
5 accepted for arbitration unless the payment amount in dispute is
6 $1,000 or more, except that a health care provider may aggregate
7 his own disputed claim amounts for the purposes of meeting the
8 threshold requirements of this subsection. No dispute pertaining to
9 medical necessity which is eligible to be submitted to the
10 Independent Health Care Appeals Program established pursuant to
11 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
12 arbitration pursuant to this subsection.
13 (3) The arbitrator shall conduct the arbitration proceedings
14 pursuant to the rules of the arbitration entity, including rules of
15 discovery subject to confidentiality requirements established by
16 State or federal law.
17 (4) An arbitrator's determination shall be:
18 (a) signed by the arbitrator;
19 (b) issued in writing, in a form prescribed by the Commissioner
20 of Banking and Insurance, including a statement of the issues in
21 dispute and the findings and conclusions on which the
22 determination is based; and
23 (c) issued on or before the 30th calendar day following the
24 receipt of the required documentation.
25 The arbitration shall be nonappealable and binding on all parties
26 to the dispute.
27 (5) If the arbitrator determines that a payer has withheld or
28 denied payment in violation of the provisions of this section, the
29 arbitrator shall order the payer to make payment of the claim,
30 together with accrued interest, on or before the 10th business day
31 following the issuance of the determination. If the arbitrator
32 determines that a payer has withheld or denied payment on the basis
33 of information submitted by the health care provider and the payer
34 requested, but did not receive, this information from the health care
35 provider when the claim was initially processed pursuant to
36 subsection d. of this section or reviewed under internal appeal
37 pursuant to paragraph (1) of this subsection, the payer shall not be
38 required to pay any accrued interest.
39 (6) If the arbitrator determines that a health care provider has
40 engaged in a pattern and practice of improper billing and a refund is
41 due to the payer, the arbitrator may award the payer a refund,
42 including interest accrued at the rate of 12% per annum. Interest
43 shall begin to accrue on the day the appeal was received by the
44 payer for resolution through the internal appeals process established
45 pursuant to paragraph (1) of this subsection.
46 (7) The arbitrator shall file a copy of each determination with
47 and in the form prescribed by the Commissioner of Banking and
48 Insurance.

1 f. As used in this section, "insured claim" or "claim" means a
2 claim by a covered person for payment of benefits under an insured
3 hospital service corporation contract for which the financial
4 obligation for the payment of a claim under the contract rests upon
5 the hospital service corporation.
6 g. Any person found in violation of this section with a pattern
7 and practice as determined by the Commissioner of Banking and
8 Insurance shall be liable to a civil penalty as set forth in section 17
9 of P.L.2005, c.352 (C.17B:30-55).
10 (cf: P.L.2005, c.352, s.10)
11
12 19. Section 3 of P.L.1999, c.154 (C.17:48A-7.12) is amended to
13 read as follows:
14 3. a. Within 180 days of the adoption of a timetable for
15 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
16 23), a medical service corporation or its agent or a subsidiary that
17 processes health care benefits claims as a third party administrator,
18 shall demonstrate to the satisfaction of the Commissioner of
19 Banking and Insurance that it will adopt and implement all of the
20 standards to receive and transmit health care transactions
21 electronically, according to the corresponding timetable, and
22 otherwise comply with the provisions of this section, as a condition
23 of its continued authorization to do business in this State.
24 The Commissioner of Banking and Insurance may grant
25 extensions or waivers of the implementation requirement when it
26 has been demonstrated to the commissioner's satisfaction that
27 compliance with the timetable for implementation will result in an
28 undue hardship to a medical service corporation, or its agent, its
29 subsidiary or its covered persons.
30 b. Within 12 months of the adoption of regulations establishing
31 standard health care enrollment and claim forms by the
32 Commissioner of Banking and Insurance pursuant to section 1 of
33 P.L.1999, c.154 (C.17B:30-23), a medical service corporation or its
34 agent or a subsidiary that processes health care benefits claims as a
35 third party administrator shall use the standard health care
36 enrollment and claim forms in connection with all group and
37 individual contracts issued, delivered, executed or renewed in this
38 State.
39 c. Twelve months after the adoption of regulations establishing
40 standard health care enrollment and claim forms by the
41 Commissioner of Banking and Insurance pursuant to section 1 of
42 P.L.1999, c.154 (C.17B:30-23), a medical service corporation or its
43 agent shall require that health care providers file all claims for
44 payment for health care services. A covered person who receives
45 health care services shall not be required to submit a claim for
46 payment, but notwithstanding the provisions of this subsection to
47 the contrary, a covered person shall be permitted to submit a claim
48 on his own behalf, at the covered person's option. All claims shall

be filed using the standard health care claim form applicable to the contract.

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

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

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

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

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

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

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

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

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

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

(c) the payer disputes the amount claimed; or

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

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

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

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

1 (iii) the payer disputes the amount claimed in whole or in part
2 with a statement as to the basis of that dispute; or
3 (iv) the payer finds there is strong evidence of fraud and has
4 initiated an investigation into the suspected fraud in accordance
5 with its fraud prevention plan established pursuant to section 1 of
6 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
7 supporting documentation, to the Office of the Insurance Fraud
8 Prosecutor in the Department of Law and Public Safety established
9 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
10 (3) If all or a portion of an electronically submitted claim cannot
11 be adjudicated because the diagnosis coding, procedure coding or
12 any other data required to be submitted with the claim was missing,
13 the payer shall electronically notify the health care provider or its
14 agent within seven days of that determination and request any
15 information required to complete adjudication of the claim.
16 (4) Any portion of a claim that meets the criteria established in
17 paragraph (1) of this subsection shall be paid by the payer in
18 accordance with the time limit established in paragraph (1) of this
19 subsection.
20 (5) A payer shall acknowledge receipt of a claim submitted by
21 electronic means from a health care provider, no later than two
22 working days following receipt of the transmission of the claim.
23 (6) If a payer subject to the provisions of P.L.1983, c.320
24 (C.17:33A-1 et seq.) has reason to believe that a claim has been
25 submitted fraudulently, it shall investigate the claim in accordance
26 with its fraud prevention plan established pursuant to section 1 of
27 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
28 supporting documentation, to the Office of the Insurance Fraud
29 Prosecutor in the Department of Law and Public Safety established
30 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
31 (7) Payment of an eligible claim pursuant to paragraphs (1) and
32 (4) of this subsection shall be deemed to be overdue if not remitted
33 to the claimant or his agent by the payer on or before the 30th
34 calendar day or the time limit established by the Medicare program,
35 whichever is earlier, following receipt by the payer of a claim
36 submitted by electronic means and on or before the 40th calendar
37 day following receipt of a claim submitted by other than electronic
38 means.
39 If payment is withheld on all or a portion of a claim by a payer
40 pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph
41 (3) of this subsection, the claims payment shall be overdue if not
42 remitted to the claimant or his agent by the payer on or before the
43 30th calendar day or the time limit established by the Medicare
44 program, whichever is earlier, for claims submitted by electronic
45 means and the 40th calendar day for claims submitted by other than
46 electronic means, following receipt by the payer of the required
47 documentation or information or modification of an initial
48 submission.

1 If payment is withheld on all or a portion of a claim by a payer
2 pursuant to paragraph (2) or (3) of this subsection and the provider
3 is not notified within the time frames provided for in those
4 paragraphs, the claim shall be deemed to be overdue.
5 (8) (a) No payer that has reserved the right to change the
6 premium shall deny payment on all or a portion of a claim because
7 the payer requests documentation or information that is not specific
8 to the health care service provided to the covered person.
9 (b) No payer shall deny payment on all or a portion of a claim
10 while seeking coordination of benefits information unless good
11 cause exists for the payer to believe that other insurance is available
12 to the covered person. Good cause shall exist only if the payer's
13 records indicate that other coverage exists. Routine requests to
14 determine whether coordination of benefits exists shall not be
15 considered good cause.
16 (c) In the event payment is withheld on all or a portion of a
17 claim by a payer pursuant to subparagraph (a) or (b) of this
18 paragraph, the claims payment shall be deemed to be overdue if not
19 remitted to the claimant or his agent by the payer on or before the
20 30th calendar day or the time limit established by the Medicare
21 program, whichever is earlier, following receipt by the payer of a
22 claim submitted by electronic means or on or before the 40th
23 calendar day following receipt of a claim submitted by other than
24 electronic means.
25 (9) An overdue payment shall bear simple interest at the rate of
26 12% per annum. The interest shall be paid to the health care
27 provider at the time the overdue payment is made. The amount of
28 interest paid to a health care provider for an overdue claim shall be
29 credited to any civil penalty for late payment of the claim levied by
30 the Department of Human Services against a payer that does not
31 reserve the right to change the premium.
32 (10) With the exception of claims that were submitted
33 fraudulently or submitted by health care providers that have a
34 pattern of inappropriate billing or claims that were subject to
35 coordination of benefits, no payer shall seek reimbursement for
36 overpayment of a claim previously paid pursuant to this section
37 later than 18 months after the date the first payment on the claim
38 was made. No payer shall seek more than one reimbursement for
39 overpayment of a particular claim. At the time the reimbursement
40 request is submitted to the health care provider, the payer shall
41 provide written documentation that identifies the error made by the
42 payer in the processing or payment of the claim that justifies the
43 reimbursement request. No payer shall base a reimbursement
44 request for a particular claim on extrapolation of other claims,
45 except under the following circumstances:
46 (a) in judicial or quasi-judicial proceedings, including
47 arbitration;
48 (b) in administrative proceedings;

1 (c) in which relevant records required to be maintained by the
2 health care provider have been improperly altered or reconstructed,
3 or a material number of the relevant records are otherwise
4 unavailable; or
5 (d) in which there is clear evidence of fraud by the health care
6 provider and the payer has investigated 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), and referred the claim, together
9 with 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 (11) (a) In seeking reimbursement for the overpayment from the
13 health care provider, except as provided for in subparagraph (b) of
14 this paragraph, no payer shall collect or attempt to collect:
15 (i) the funds for the reimbursement on or before the 45th
16 calendar day following the submission of the reimbursement request
17 to the health care provider;
18 (ii) the funds for the reimbursement if the health care provider
19 disputes the request and initiates an appeal on or before the 45th
20 calendar day following the submission of the reimbursement request
21 to the health care provider and until the health care provider's rights
22 to appeal set forth under paragraphs (1) and (2) of subsection e. of
23 this section are exhausted; or
24 (iii) a monetary penalty against the reimbursement request,
25 including but not limited to, an interest charge or a late fee.
26 The payer may collect the funds for the reimbursement request
27 by assessing them against payment of any future claims submitted
28 by the health care provider after the 45th calendar day following the
29 submission of the reimbursement request to the health care provider
30 or after the health care provider's rights to appeal set forth under
31 paragraphs (1) and (2) of subsection e. of this section have been
32 exhausted if the payer submits an explanation in writing to the
33 provider in sufficient detail so that the provider can reconcile each
34 covered person's bill.
35 (b) If a payer has determined that the overpayment to the health
36 care provider is a result of fraud committed by the health care
37 provider and the payer has conducted its investigation and reported
38 the fraud to the Office of the Insurance Fraud Prosecutor as
39 required by law, the payer may collect an overpayment by assessing
40 it against payment of any future claim submitted by the health care
41 provider.
42 (12) No health care provider shall seek reimbursement from a
43 payer or covered person for underpayment of a claim submitted
44 pursuant to this section later than 18 months from the date the first
45 payment on the claim was made, except if the claim is the subject of
46 an appeal submitted pursuant to subsection e. of this section or the
47 claim is subject to continual claims submission. No health care

1 provider shall seek more than one reimbursement for underpayment
2 of a particular claim.
3 e. (1) A medical service corporation or its agent, hereinafter
4 the payer, shall establish an internal appeal mechanism to resolve
5 any dispute raised by a health care provider regardless of whether
6 the health care provider is under contract with the payer regarding
7 compliance with the requirements of this section or compliance
8 with the requirements of [sections 4 through 7 of P.L.2005, c.352
9 (C.17B:30-51 through C.17B:30-54)] <u>sections 5 through 15 of</u>
10 <u>P.L. , c. (C.) (pending before the Legislature as this bill)</u>.
11 No dispute pertaining to medical necessity which is eligible to be
12 submitted to the Independent Health Care Appeals Program
13 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
14 shall be the subject of an appeal pursuant to this subsection. The
15 payer shall conduct the appeal at no cost to the health care provider.
16 A health care provider may initiate an appeal on or before the
17 90th calendar day following receipt by the health care provider of
18 the payer's claims determination, which is the basis of the appeal,
19 on a form prescribed by the Commissioner of Banking and
20 Insurance which shall describe the type of substantiating
21 documentation that must be submitted with the form. The payer
22 shall conduct a review of the appeal and notify the health care
23 provider of its determination on or before the 30th calendar day
24 following the receipt of the appeal form. If the health care provider
25 is not notified of the payer's determination of the appeal within 30
26 days, the health care provider may refer the dispute to arbitration as
27 provided by paragraph (2) of this subsection.
28 If the payer issues a determination in favor of the health care
29 provider, the payer shall comply with the provisions of this section
30 and pay the amount of money in dispute, if applicable, with accrued
31 interest at the rate of 12% per annum, on or before the 30th calendar
32 day following the notification of the payer's determination on the
33 appeal. Interest shall begin to accrue on the day the appeal was
34 received by the payer.
35 If the payer issues a determination against the health care
36 provider, the payer shall notify the health care provider of its
37 findings on or before the 30th calendar day following the receipt of
38 the appeal form and shall include in the notification written
39 instructions for referring the dispute to arbitration as provided by
40 paragraph (2) of this subsection.
41 The payer shall report annually to the Commissioner of Banking
42 and Insurance the number of appeals it has received and the
43 resolution of each appeal.
44 (2) Any dispute regarding the determination of an internal
45 appeal conducted pursuant to paragraph (1) of this subsection may
46 be referred to arbitration as provided in this paragraph. The
47 Commissioner of Banking and Insurance shall contract with a

1 nationally recognized, independent organization that specializes in
2 arbitration to conduct the arbitration proceedings.
3 Any party may initiate an arbitration proceeding on or before the
4 90th calendar day following the receipt of the determination which
5 is the basis of the appeal, on a form prescribed by the
6 Commissioner of Banking and Insurance. No dispute shall be
7 accepted for arbitration unless the payment amount in dispute is
8 $1,000 or more, except that a health care provider may aggregate
9 his own disputed claim amounts for the purposes of meeting the
10 threshold requirements of this subsection. No dispute pertaining to
11 medical necessity which is eligible to be submitted to the
12 Independent Health Care Appeals Program established pursuant to
13 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
14 arbitration pursuant to this subsection.
15 (3) The arbitrator shall conduct the arbitration proceedings
16 pursuant to the rules of the arbitration entity, including rules of
17 discovery subject to confidentiality requirements established by
18 State or federal law.
19 (4) An arbitrator's determination shall be:
20 (a) signed by the arbitrator;
21 (b) issued in writing, in a form prescribed by the Commissioner
22 of Banking and Insurance, including a statement of the issues in
23 dispute and the findings and conclusions on which the
24 determination is based; and
25 (c) issued on or before the 30th calendar day following the
26 receipt of the required documentation.
27 The arbitration shall be nonappealable and binding on all parties
28 to the dispute.
29 (5) If the arbitrator determines that a payer has withheld or
30 denied payment in violation of the provisions of this section, the
31 arbitrator shall order the payer to make payment of the claim,
32 together with accrued interest, on or before the 10th business day
33 following the issuance of the determination. If the arbitrator
34 determines that a payer has withheld or denied payment on the basis
35 of information submitted by the health care provider and the payer
36 requested, but did not receive, this information from the health care
37 provider when the claim was initially processed pursuant to
38 subsection d. of this section or reviewed under internal appeal
39 pursuant to paragraph (1) of this subsection, the payer shall not be
40 required to pay any accrued interest.
41 (6) If the arbitrator determines that a health care provider has
42 engaged in a pattern and practice of improper billing and a refund is
43 due to the payer, the arbitrator may award the payer a refund,
44 including interest accrued at the rate of 12% per annum. Interest
45 shall begin to accrue on the day the appeal was received by the
46 payer for resolution through the internal appeals process established
47 pursuant to paragraph (1) of this subsection.

1 (7) The arbitrator shall file a copy of each determination with
2 and in the form prescribed by the Commissioner of Banking and
3 Insurance.
4 f. As used in this section, "insured claim" or "claim" means a
5 claim by a covered person for payment of benefits under an insured
6 medical service corporation contract for which the financial
7 obligation for the payment of a claim under the contract rests upon
8 the medical service corporation.
9 g. Any person found in violation of this section with a pattern
10 and practice as determined by the Commissioner of Banking and
11 Insurance shall be liable to a civil penalty as set forth in section 17
12 of P.L.2005, c.352 (C.17B:30-55).
13 (cf: P.L.2005, c.352, s.11)
14
15 20. Section 4 of P.L.1999, c.154 (C.17:48E-10.1) is amended to
16 read as follows:
17 4. a. Within 180 days of the adoption of a timetable for
18 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
19 23), a health service corporation or its agent or a subsidiary that
20 processes health care benefits claims as a third party administrator,
21 shall demonstrate to the satisfaction of the Commissioner of
22 Banking and Insurance that it will adopt and implement all of the
23 standards to receive and transmit health care transactions
24 electronically, according to the corresponding timetable, and
25 otherwise comply with the provisions of this section, as a condition
26 of its continued authorization to do business in this State.
27 The Commissioner of Banking and Insurance may grant
28 extensions or waivers of the implementation requirement when it
29 has been demonstrated to the commissioner's satisfaction that
30 compliance with the timetable for implementation will result in an
31 undue hardship to a health service corporation, or its agent, its
32 subsidiary or its covered persons.
33 b. Within 12 months of the adoption of regulations establishing
34 standard health care enrollment and claim forms by the
35 Commissioner of Banking and Insurance pursuant to section 1 of
36 P.L.1999, c.154 (C.17B:30-23), a health service corporation or its
37 agent or a subsidiary that processes health care benefits claims as a
38 third party administrator shall use the standard health care
39 enrollment and claim forms in connection with all group and
40 individual contracts issued, delivered, executed or renewed in this
41 State.
42 c. Twelve months after the adoption of regulations establishing
43 standard health care enrollment and claim forms by the
44 Commissioner of Banking and Insurance pursuant to section 1 of
45 P.L.1999, c.154 (C.17B:30-23), a health service corporation or its
46 agent shall require that health care providers file all claims for
47 payment for health care services. A covered person who receives
48 health care services shall not be required to submit a claim for

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

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

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

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

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

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

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

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

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

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

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

(c) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

1 documentation or information or modification of an initial
2 submission.
3 If payment is withheld on all or a portion of a claim by a payer
4 pursuant to paragraph (2) or (3) of this subsection and the provider
5 is not notified within the time frames provided for in those
6 paragraphs, the claim shall be deemed to be overdue.
7 (8) (a) No payer that has reserved the right to change the
8 premium shall deny payment on all or a portion of a claim because
9 the payer requests documentation or information that is not specific
10 to the health care service provided to the covered person.
11 (b) No payer shall deny payment on all or a portion of a claim
12 while seeking coordination of benefits information unless good
13 cause exists for the payer to believe that other insurance is available
14 to the covered person. Good cause shall exist only if the payer's
15 records indicate that other coverage exists. Routine requests to
16 determine whether coordination of benefits exists shall not be
17 considered good cause.
18 (c) In the event payment is withheld on all or a portion of a
19 claim by a payer pursuant to subparagraph (a) or (b) of this
20 paragraph, the claims payment shall be deemed to be overdue if not
21 remitted to the claimant or his agent by the payer on or before the
22 30th calendar day or the time limit established by the Medicare
23 program, whichever is earlier, following receipt by the payer of a
24 claim submitted by electronic means or on or before the 40th
25 calendar day following receipt of a claim submitted by other than
26 electronic means.
27 (9) An overdue payment shall bear simple interest at the rate of
28 12% per annum. The interest shall be paid to the health care
29 provider at the time the overdue payment is made. The amount of
30 interest paid to a health care provider for an overdue claim shall be
31 credited to any civil penalty for late payment of the claim levied by
32 the Department of Human Services against a payer that does not
33 reserve the right to change the premium.
34 (10) With the exception of claims that were submitted
35 fraudulently or submitted by health care providers that have a
36 pattern of inappropriate billing or claims that were subject to
37 coordination of benefits, no payer shall seek reimbursement for
38 overpayment of a claim previously paid pursuant to this section
39 later than 18 months after the date the first payment on the claim
40 was made. No payer shall seek more than one reimbursement for
41 overpayment of a particular claim. At the time the reimbursement
42 request is submitted to the health care provider, the payer shall
43 provide written documentation that identifies the error made by the
44 payer in the processing or payment of the claim that justifies the
45 reimbursement request. No payer shall base a reimbursement
46 request for a particular claim on extrapolation of other claims,
47 except under the following circumstances:

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

(b) in administrative proceedings;

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

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

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

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

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

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

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

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

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of

1 an appeal submitted pursuant to subsection e. of this section or the
2 claim is subject to continual claims submission. No health care
3 provider shall seek more than one reimbursement for underpayment
4 of a particular claim.
5 e. (1) A health service corporation or its agent, hereinafter the
6 payer, shall establish an internal appeal mechanism to resolve any
7 dispute raised by a health care provider regardless of whether the
8 health care provider is under contract with the payer regarding
9 compliance with the requirements of this section or compliance
10 with the requirements of [sections 4 through 7 of P.L.2005, c.352
11 (C.17B:30-51 through C.17B:30-54)] sections 5 through 15 of
12 P.L. , c. (C.) (pending before the Legislature as this bill).
13 No dispute pertaining to medical necessity which is eligible to be
14 submitted to the Independent Health Care Appeals Program
15 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
16 shall be the subject of an appeal pursuant to this subsection. The
17 payer shall conduct the appeal at no cost to the health care provider.
18 A health care provider may initiate an appeal on or before the
19 90th calendar day following receipt by the health care provider of
20 the payer's claims determination, which is the basis of the appeal,
21 on a form prescribed by the Commissioner of Banking and
22 Insurance which shall describe the type of substantiating
23 documentation that must be submitted with the form. The payer
24 shall conduct a review of the appeal and notify the health care
25 provider of its determination on or before the 30th calendar day
26 following the receipt of the appeal form. If the health care provider
27 is not notified of the payer's determination of the appeal within 30
28 days, the health care provider may refer the dispute to arbitration as
29 provided by paragraph (2) of this subsection.
30 If the payer issues a determination in favor of the health care
31 provider, the payer shall comply with the provisions of this section
32 and pay the amount of money in dispute, if applicable, with accrued
33 interest at the rate of 12% per annum, on or before the 30th calendar
34 day following the notification of the payer's determination on the
35 appeal. Interest shall begin to accrue on the day the appeal was
36 received by the payer.
37 If the payer issues a determination against the health care
38 provider, the payer shall notify the health care provider of its
39 findings on or before the 30th calendar day following the receipt of
40 the appeal form and shall include in the notification written
41 instructions for referring the dispute to arbitration as provided by
42 paragraph (2) of this subsection.
43 The payer shall report annually to the Commissioner of Banking
44 and Insurance the number of appeals it has received and the
45 resolution of each appeal.
46 (2) Any dispute regarding the determination of an internal
47 appeal conducted pursuant to paragraph (1) of this subsection may
48 be referred to arbitration as provided in this paragraph. The

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

1 (7) The arbitrator shall file a copy of each determination with
2 and in the form prescribed by the Commissioner of Banking and
3 Insurance.
4 f. As used in this section, "insured claim" or "claim" means a
5 claim by a covered person for payment of benefits under an insured
6 health service corporation contract for which the financial
7 obligation for the payment of a claim under the contract rests upon
8 the health service corporation.
9 g. Any person found in violation of this section with a pattern
10 and practice as determined by the Commissioner of Banking and
11 Insurance shall be liable to a civil penalty as set forth in section 17
12 of P.L.2005, c.352 (C.17B:30-55).
13 (cf: P.L.2005, c.352, s.12)
14
15 21. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to
16 read as follows:
17 10. a. Within 180 days of the adoption of a timetable for
18 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
19 23), a prepaid prescription service organization or its agent or a
20 subsidiary that processes health care benefits claims as a third party
21 administrator, shall demonstrate to the satisfaction of the
22 Commissioner of Banking and Insurance that it will adopt and
23 implement all of the standards to receive and transmit health care
24 transactions electronically, according to the corresponding
25 timetable, and otherwise comply with the provisions of this section,
26 as a condition of its continued authorization to do business in this
27 State.
28 The Commissioner of Banking and Insurance may grant
29 extensions or waivers of the implementation requirement when it
30 has been demonstrated to the commissioner's satisfaction that
31 compliance with the timetable for implementation will result in an
32 undue hardship to a prepaid prescription service organization, or its
33 agent, its subsidiary or its covered enrollees.
34 b. Within 12 months of the adoption of regulations establishing
35 standard health care enrollment and claim forms by the
36 Commissioner of Banking and Insurance pursuant to section 1 of
37 P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service
38 organization or its agent or a subsidiary that processes health care
39 benefits claims as a third party administrator shall use the standard
40 health care enrollment and claim forms in connection with all
41 contracts issued, delivered, executed or renewed in this State.
42 c. Twelve months after the adoption of regulations establishing
43 standard health care enrollment and claim forms by the
44 Commissioner of Banking and Insurance pursuant to section 1 of
45 P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service
46 organization or its agent shall require that health care providers file
47 all claims for payment for health care services. A covered person
48 who receives health care services shall not be required to submit a

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

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

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

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

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

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

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

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

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

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

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

(c) the payer disputes the amount claimed; or

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

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

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

1 (ii) the claim contains incorrect information with a statement as
2 to what information must be corrected for adjudication of the claim;
3 (iii) the payer disputes the amount claimed in whole or in part
4 with a statement as to the basis of that dispute; or
5 (iv) the payer finds there is strong evidence of fraud and has
6 initiated an investigation into the suspected fraud 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 referred 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 (3) If all or a portion of an electronically submitted claim cannot
13 be adjudicated because the diagnosis coding, procedure coding or
14 any other data required to be submitted with the claim was missing,
15 the payer shall electronically notify the health care provider or its
16 agent within seven days of that determination and request any
17 information required to complete adjudication of the claim.
18 (4) Any portion of a claim that meets the criteria established in
19 paragraph (1) of this subsection shall be paid by the payer in
20 accordance with the time limit established in paragraph (1) of this
21 subsection.
22 (5) A payer shall acknowledge receipt of a claim submitted by
23 electronic means from a health care provider, no later than two
24 working days following receipt of the transmission of the claim.
25 (6) If a payer subject to the provisions of P.L.1983, c.320
26 (C.17:33A-1 et seq.) has reason to believe that a claim has been
27 submitted fraudulently, it shall investigate the claim in accordance
28 with its fraud prevention plan established pursuant to section 1 of
29 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
30 supporting documentation, to the Office of the Insurance Fraud
31 Prosecutor in the Department of Law and Public Safety established
32 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
33 (7) Payment of an eligible claim pursuant to paragraphs (1) and
34 (4) of this subsection shall be deemed to be overdue if not remitted
35 to the claimant or his agent by the payer on or before the 30th
36 calendar day or the time limit established by the Medicare program,
37 whichever is earlier, following receipt by the payer of a claim
38 submitted by electronic means and on or before the 40th calendar
39 day following receipt of a claim submitted by other than electronic
40 means.
41 If payment is withheld on all or a portion of a claim by a payer
42 pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph
43 (3) of this subsection, the claims payment shall be overdue if not
44 remitted to the claimant or his agent by the payer on or before the
45 30th calendar day or the time limit established by the Medicare
46 program, whichever is earlier, for claims submitted by electronic
47 means and the 40th calendar day for claims submitted by other than
48 electronic means, following receipt by the payer of the required

1 documentation or information or modification of an initial
2 submission.
3 If payment is withheld on all or a portion of a claim by a payer
4 pursuant to paragraph (2) or (3) of this subsection and the provider
5 is not notified within the time frames provided for in those
6 paragraphs, the claim shall be deemed to be overdue.
7 (8) (a) No payer that has reserved the right to change the
8 premium shall deny payment on all or a portion of a claim because
9 the payer requests documentation or information that is not specific
10 to the health care service provided to the covered person.
11 (b) No payer shall deny payment on all or a portion of a claim
12 while seeking coordination of benefits information unless good
13 cause exists for the payer to believe that other insurance is available
14 to the covered person. Good cause shall exist only if the payer's
15 records indicate that other coverage exists. Routine requests to
16 determine whether coordination of benefits exists shall not be
17 considered good cause.
18 (c) In the event payment is withheld on all or a portion of a
19 claim by a payer pursuant to subparagraph (a) or (b) of this
20 paragraph, the claims payment shall be deemed to be overdue if not
21 remitted to the claimant or his agent by the payer on or before the
22 30th calendar day or the time limit established by the Medicare
23 program, whichever is earlier, following receipt by the payer of a
24 claim submitted by electronic means or on or before the 40th
25 calendar day following receipt of a claim submitted by other than
26 electronic means.
27 (9) An overdue payment shall bear simple interest at the rate of
28 12% per annum. The interest shall be paid to the health care
29 provider at the time the overdue payment is made. The amount of
30 interest paid to a health care provider for an overdue claim shall be
31 credited to any civil penalty for late payment of the claim levied by
32 the Department of Human Services against a payer that does not
33 reserve the right to change the premium.
34 (10)With the exception of claims that were submitted
35 fraudulently or submitted by health care providers that have a
36 pattern of inappropriate billing or claims that were subject to
37 coordination of benefits, no payer shall seek reimbursement for
38 overpayment of a claim previously paid pursuant to this section
39 later than 18 months after the date the first payment on the claim
40 was made. No payer shall seek more than one reimbursement for
41 overpayment of a particular claim. At the time the reimbursement
42 request is submitted to the health care provider, the payer shall
43 provide written documentation that identifies the error made by the
44 payer in the processing or payment of the claim that justifies the
45 reimbursement request. No payer shall base a reimbursement
46 request for a particular claim on extrapolation of other claims,
47 except under the following circumstances:

1 (a) in judicial or quasi-judicial proceedings, including
2 arbitration;
3 (b) in administrative proceedings;
4 (c) in which relevant records required to be maintained by the
5 health care provider have been improperly altered or reconstructed,
6 or a material number of the relevant records are otherwise
7 unavailable; or
8 (d) in which there is clear evidence of fraud by the health care
9 provider and the payer has investigated the claim in accordance
10 with its fraud prevention plan established pursuant to section 1 of
11 P.L.1993, c.362 (C.17:33A-15), and referred the claim, together
12 with supporting documentation, to the Office of the Insurance Fraud
13 Prosecutor in the Department of Law and Public Safety established
14 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
15 (11) (a) In seeking reimbursement for the overpayment from the
16 health care provider, except as provided for in subparagraph (b) of
17 this paragraph, no payer shall collect or attempt to collect:
18 (i) the funds for the reimbursement on or before the 45th
19 calendar day following the submission of the reimbursement request
20 to the health care provider;
21 (ii) the funds for the reimbursement if the health care provider
22 disputes the request and initiates an appeal on or before the 45th
23 calendar day following the submission of the reimbursement request
24 to the health care provider and until the health care provider's rights
25 to appeal set forth under paragraphs (1) and (2) of subsection e. of
26 this section are exhausted; or
27 (iii) a monetary penalty against the reimbursement request,
28 including but not limited to, an interest charge or a late fee.
29 The payer may collect the funds for the reimbursement request
30 by assessing them against payment of any future claims submitted
31 by the health care provider after the 45th calendar day following the
32 submission of the reimbursement request to the health care provider
33 or after the health care provider's rights to appeal set forth under
34 paragraphs (1) and (2) of subsection e. of this section have been
35 exhausted if the payer submits an explanation in writing to the
36 provider in sufficient detail so that the provider can reconcile each
37 covered person's bill.
38 (b) If a payer has determined that the overpayment to the health
39 care provider is a result of fraud committed by the health care
40 provider and the payer has conducted its investigation and reported
41 the fraud to the Office of the Insurance Fraud Prosecutor as
42 required by law, the payer may collect an overpayment by assessing
43 it against payment of any future claim submitted by the health care
44 provider.
45 (12) No health care provider shall seek reimbursement from a
46 payer or covered person for underpayment of a claim submitted
47 pursuant to this section later than 18 months from the date the first
48 payment on the claim was made, except if the claim is the subject of

an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission. No health care provider shall seek more than one reimbursement for underpayment of a particular claim.

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

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

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

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

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

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may

1 be referred to arbitration as provided in this paragraph. The
2 Commissioner of Banking and Insurance shall contract with a
3 nationally recognized, independent organization that specializes in
4 arbitration to conduct the arbitration proceedings.
5 Any party may initiate an arbitration proceeding on or before the
6 90th calendar day following the receipt of the determination which
7 is the basis of the appeal, on a form prescribed by the
8 Commissioner of Banking and Insurance. No dispute shall be
9 accepted for arbitration unless the payment amount in dispute is
10 $1,000 or more, except that a health care provider may aggregate
11 his own disputed claim amounts for the purposes of meeting the
12 threshold requirements of this subsection. No dispute pertaining to
13 medical necessity which is eligible to be submitted to the
14 Independent Health Care Appeals Program established pursuant to
15 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
16 arbitration pursuant to this subsection.
17 (3) The arbitrator shall conduct the arbitration proceedings
18 pursuant to the rules of the arbitration entity, including rules of
19 discovery subject to confidentiality requirements established by
20 State or federal law.
21 (4) An arbitrator's determination shall be:
22 (a) signed by the arbitrator;
23 (b) issued in writing, in a form prescribed by the Commissioner
24 of Banking and Insurance, including a statement of the issues in
25 dispute and the findings and conclusions on which the
26 determination is based; and
27 (c) issued on or before the 30th calendar day following the
28 receipt of the required documentation.
29 The arbitration shall be nonappealable and binding on all parties
30 to the dispute.
31 (5) If the arbitrator determines that a payer has withheld or
32 denied payment in violation of the provisions of this section, the
33 arbitrator shall order the payer to make payment of the claim,
34 together with accrued interest, on or before the 10th business day
35 following the issuance of the determination. If the arbitrator
36 determines that a payer has withheld or denied payment on the basis
37 of information submitted by the health care provider and the payer
38 requested, but did not receive, this information from the health care
39 provider when the claim was initially processed pursuant to
40 subsection d. of this section or reviewed under internal appeal
41 pursuant to paragraph (1) of this subsection, the payer shall not be
42 required to pay any accrued interest.
43 (6) If the arbitrator determines that a health care provider has
44 engaged in a pattern and practice of improper billing and a refund is
45 due to the payer, the arbitrator may award the payer a refund,
46 including interest accrued at the rate of 12% per annum. Interest
47 shall begin to accrue on the day the appeal was received by the

payer for resolution through the internal appeals process established pursuant to paragraph (1) of this subsection.

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

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

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

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

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

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

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

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

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or its agent shall require that health care providers file all claims for payment for health care services. A covered person who receives health care

services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the policy.

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

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

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

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

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

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

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

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

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

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

(c) the payer disputes the amount claimed; or

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

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

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

1 (ii) the claim contains incorrect information with a statement as
2 to what information must be corrected for adjudication of the claim;
3 (iii) the payer disputes the amount claimed in whole or in part
4 with a statement as to the basis of that dispute; or
5 (iv) the payer finds there is strong evidence of fraud and has
6 initiated an investigation into the suspected fraud 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 referred 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 (3) If all or a portion of an electronically submitted claim cannot
13 be adjudicated because the diagnosis coding, procedure coding or
14 any other data required to be submitted with the claim was missing,
15 the payer shall electronically notify the health care provider or its
16 agent within seven days of that determination and request any
17 information required to complete adjudication of the claim.
18 (4) Any portion of a claim that meets the criteria established in
19 paragraph (1) of this subsection shall be paid by the payer in
20 accordance with the time limit established in paragraph (1) of this
21 subsection.
22 (5) A payer shall acknowledge receipt of a claim submitted by
23 electronic means from a health care provider, no later than two
24 working days following receipt of the transmission of the claim.
25 (6) If a payer subject to the provisions of P.L.1983, c.320
26 (C.17:33A-1 et seq.) has reason to believe that a claim has been
27 submitted fraudulently, it shall investigate the claim in accordance
28 with its fraud prevention plan established pursuant to section 1 of
29 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
30 supporting documentation, to the Office of the Insurance Fraud
31 Prosecutor in the Department of Law and Public Safety established
32 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
33 (7) Payment of an eligible claim pursuant to paragraphs (1) and
34 (4) of this subsection shall be deemed to be overdue if not remitted
35 to the claimant or his agent by the payer on or before the 30th
36 calendar day or the time limit established by the Medicare program,
37 whichever is earlier, following receipt by the payer of a claim
38 submitted by electronic means and on or before the 40th calendar
39 day following receipt of a claim submitted by other than electronic
40 means.
41 If payment is withheld on all or a portion of a claim by a payer
42 pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph
43 (3) of this subsection, the claims payment shall be overdue if not
44 remitted to the claimant or his agent by the payer on or before the
45 30th calendar day or the time limit established by the Medicare
46 program, whichever is earlier, for claims submitted by electronic
47 means and the 40th calendar day for claims submitted by other than
48 electronic means, following receipt by the payer of the required

documentation or information or modification of an initial submission.

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

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

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

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

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

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

1 (a) in judicial or quasi-judicial proceedings, including
2 arbitration;
3 (b) in administrative proceedings;
4 (c) in which relevant records required to be maintained by the
5 health care provider have been improperly altered or reconstructed,
6 or a material number of the relevant records are otherwise
7 unavailable; or
8 (d) in which there is clear evidence of fraud by the health care
9 provider and the payer has investigated the claim in accordance
10 with its fraud prevention plan established pursuant to section 1 of
11 P.L.1993, c.362 (C.17:33A-15), and referred the claim, together
12 with supporting documentation, to the Office of the Insurance Fraud
13 Prosecutor in the Department of Law and Public Safety established
14 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
15 (11) (a) In seeking reimbursement for the overpayment from the
16 health care provider, except as provided for in subparagraph (b) of
17 this paragraph, no payer shall collect or attempt to collect:
18 (i) the funds for the reimbursement on or before the 45th
19 calendar day following the submission of the reimbursement request
20 to the health care provider;
21 (ii) the funds for the reimbursement if the health care provider
22 disputes the request and initiates an appeal on or before the 45th
23 calendar day following the submission of the reimbursement request
24 to the health care provider and until the health care provider's rights
25 to appeal set forth under paragraphs (1) and (2) of subsection e. of
26 this section are exhausted; or
27 (iii) a monetary penalty against the reimbursement request,
28 including but not limited to, an interest charge or a late fee.
29 The payer may collect the funds for the reimbursement request
30 by assessing them against payment of any future claims submitted
31 by the health care provider after the 45th calendar day following the
32 submission of the reimbursement request to the health care provider
33 or after the health care provider's rights to appeal set forth under
34 paragraphs (1) and (2) of subsection e. of this section have been
35 exhausted if the payer submits an explanation in writing to the
36 provider in sufficient detail so that the provider can reconcile each
37 covered person's bill.
38 (b) If a payer has determined that the overpayment to the health
39 care provider is a result of fraud committed by the health care
40 provider and the payer has conducted its investigation and reported
41 the fraud to the Office of the Insurance Fraud Prosecutor as
42 required by law, the payer may collect an overpayment by assessing
43 it against payment of any future claim submitted by the health care
44 provider.
45 (12) No health care provider shall seek reimbursement from a
46 payer or covered person for underpayment of a claim submitted
47 pursuant to this section later than 18 months from the date the first
48 payment on the claim was made, except if the claim is the subject of

1 an appeal submitted pursuant to subsection e. of this section or the
2 claim is subject to continual claims submission. No health care
3 provider shall seek more than one reimbursement for underpayment
4 of a particular claim.
5 e. (1) A health insurer or its agent, hereinafter the payer, shall
6 establish an internal appeal mechanism to resolve any dispute raised
7 by a health care provider regardless of whether the health care
8 provider is under contract with the payer regarding compliance with
9 the requirements of this section or compliance with the
10 requirements of [sections 4 through 7 of P.L.2005, c.352
11 (C.17B:30-51 through C.17B:30-54)] sections 5 through 15 of
12 P.L. , c. (C.) (pending before the Legislature as this bill).
13 No dispute pertaining to medical necessity which is eligible to be
14 submitted to the Independent Health Care Appeals Program
15 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
16 shall be the subject of an appeal pursuant to this subsection. The
17 payer shall conduct the appeal at no cost to the health care provider.
18 A health care provider may initiate an appeal on or before the
19 90th calendar day following receipt by the health care provider of
20 the payer's claims determination, which is the basis of the appeal,
21 on a form prescribed by the Commissioner of Banking and
22 Insurance which shall describe the type of substantiating
23 documentation that must be submitted with the form. The payer
24 shall conduct a review of the appeal and notify the health care
25 provider of its determination on or before the 30th calendar day
26 following the receipt of the appeal form. If the health care provider
27 is not notified of the payer's determination of the appeal within 30
28 days, the health care provider may refer the dispute to arbitration as
29 provided by paragraph (2) of this subsection.
30 If the payer issues a determination in favor of the health care
31 provider, the payer shall comply with the provisions of this section
32 and pay the amount of money in dispute, if applicable, with accrued
33 interest at the rate of 12% per annum, on or before the 30th calendar
34 day following the notification of the payer's determination on the
35 appeal. Interest shall begin to accrue on the day the appeal was
36 received by the payer.
37 If the payer issues a determination against the health care
38 provider, the payer shall notify the health care provider of its
39 findings on or before the 30th calendar day following the receipt of
40 the appeal form and shall include in the notification written
41 instructions for referring the dispute to arbitration as provided by
42 paragraph (2) of this subsection.
43 The payer shall report annually to the Commissioner of Banking
44 and Insurance the number of appeals it has received and the
45 resolution of each appeal.
46 (2) Any dispute regarding the determination of an internal
47 appeal conducted pursuant to paragraph (1) of this subsection may
48 be referred to arbitration as provided in this paragraph. The

1 Commissioner of Banking and Insurance shall contract with a
2 nationally recognized, independent organization that specializes in
3 arbitration to conduct the arbitration proceedings.
4 Any party may initiate an arbitration proceeding on or before the
5 90th calendar day following the receipt of the determination which
6 is the basis of the appeal, on a form prescribed by the
7 Commissioner of Banking and Insurance. No dispute shall be
8 accepted for arbitration unless the payment amount in dispute is
9 $1,000 or more, except that a health care provider may aggregate
10 his own disputed claim amounts for the purposes of meeting the
11 threshold requirements of this subsection. No dispute pertaining to
12 medical necessity which is eligible to be submitted to the
13 Independent Health Care Appeals Program established pursuant to
14 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
15 arbitration pursuant to this subsection.
16 (3) The arbitrator shall conduct the arbitration proceedings
17 pursuant to the rules of the arbitration entity, including rules of
18 discovery subject to confidentiality requirements established by
19 State or federal law.
20 (4) An arbitrator's determination shall be:
21 (a) signed by the arbitrator;
22 (b) issued in writing, in a form prescribed by the Commissioner
23 of Banking and Insurance, including a statement of the issues in
24 dispute and the findings and conclusions on which the
25 determination is based; and
26 (c) issued on or before the 30th calendar day following the
27 receipt of the required documentation.
28 The arbitration shall be nonappealable and binding on all parties
29 to the dispute.
30 (5) If the arbitrator determines that a payer has withheld or
31 denied payment in violation of the provisions of this section, the
32 arbitrator shall order the payer to make payment of the claim,
33 together with accrued interest, on or before the 10th business day
34 following the issuance of the determination. If the arbitrator
35 determines that a payer has withheld or denied payment on the basis
36 of information submitted by the health care provider and the payer
37 requested, but did not receive, this information from the health care
38 provider when the claim was initially processed pursuant to
39 subsection d. of this section or reviewed under internal appeal
40 pursuant to paragraph (1) of this subsection, the payer shall not be
41 required to pay any accrued interest.
42 (6) If the arbitrator determines that a health care provider has
43 engaged in a pattern and practice of improper billing and a refund is
44 due to the payer, the arbitrator may award the payer a refund,
45 including interest accrued at the rate of 12% per annum. Interest
46 shall begin to accrue on the day the appeal was received by the
47 payer for resolution through the internal appeals process established
48 pursuant to paragraph (1) of this subsection.

1 (7) The arbitrator shall file a copy of each determination with
2 and in the form prescribed by the Commissioner of Banking and
3 Insurance.
4 f. As used in this section, "insured claim" or "claim" means a
5 claim by a covered person for payment of benefits under an insured
6 policy for which the financial obligation for the payment of a claim
7 under the policy rests upon the health insurer.
8 g. Any person found in violation of this section with a pattern
9 and practice as determined by the Commissioner of Banking and
10 Insurance shall be liable to a civil penalty as set forth in section 17
11 of P.L.2005, c.352 (C.17B:30-55).
12 (cf: P.L.2005, c.352, s.13)
13
14 23. Section 6 of P.L.1999, c.154 (C.17B:27-44.2) is amended to
15 read as follows:
16 6. a. Within 180 days of the adoption of a timetable for
17 implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
18 23), a health insurer or its agent or a subsidiary that processes
19 health care benefits claims as a third party administrator, shall
20 demonstrate to the satisfaction of the Commissioner of Banking and
21 Insurance that it will adopt and implement all of the standards to
22 receive and transmit health care transactions electronically,
23 according to the corresponding timetable, and otherwise comply
24 with the provisions of this section, as a condition of its continued
25 authorization to do business in this State.
26 The Commissioner of Banking and Insurance may grant
27 extensions or waivers of the implementation requirement when it
28 has been demonstrated to the commissioner's satisfaction that
29 compliance with the timetable for implementation will result in an
30 undue hardship to a health insurer, or its agent, its subsidiary or its
31 covered persons.
32 b. Within 12 months of the adoption of regulations establishing
33 standard health care enrollment and claim forms by the
34 Commissioner of Banking and Insurance pursuant to section 1 of
35 P.L.1999, c.154 (C.17B:30-23), a health insurer or its agent or a
36 subsidiary that processes health care benefits claims as a third party
37 administrator shall use the standard health care enrollment and
38 claim forms in connection with all group policies issued, delivered,
39 executed or renewed in this State.
40 c. Twelve months after the adoption of regulations establishing
41 standard health care enrollment and claim forms by the
42 Commissioner of Banking and Insurance pursuant to section 1 of
43 P.L.1999, c.154 (C.17B:30-23), a health insurer or its agent shall
44 require that health care providers file all claims for payment for
45 health care services. A covered person who receives health care
46 services shall not be required to submit a claim for payment, but
47 notwithstanding the provisions of this subsection to the contrary, a
48 covered person shall be permitted to submit a claim on his own

1 behalf, at the covered person's option. All claims shall be filed
2 using the standard health care claim form applicable to the policy.
3 d. For the purposes of this subsection, "substantiating
4 documentation" means any information specific to the particular
5 health care service provided to a covered person.
6 (1) Effective 180 days after the effective date of P.L.1999,
7 c.154, a health insurer or its agent, hereinafter the payer, shall remit
8 payment for every insured claim submitted by a covered person or
9 health care provider, no later than the 30th calendar day following
10 receipt of the claim by the payer or no later than the time limit
11 established for the payment of claims in the Medicare program
12 pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the
13 claim is submitted by electronic means, and no later than the 40th
14 calendar day following receipt if the claim is submitted by other
15 than electronic means, if:
16 (a) the health care provider is eligible at the date of service;
17 (b) the person who received the health care service was covered
18 on the date of service;
19 (c) the claim is for a service or supply covered under the health
20 benefits plan;
21 (d) the claim is submitted with all the information requested by
22 the payer on the claim form or in other instructions that were
23 distributed in advance to the health care provider or covered person
24 in accordance with the provisions of [section 4 of P.L.2005, c.352
25 (C.17B:30-51)] section 5 of P.L. , c. (C.) (pending before
26 the Legislature as this bill); and
27 (e) the payer has no reason to believe that the claim has been
28 submitted fraudulently.
29 (2) If all or a portion of the claim is not paid within the time
30 frames provided in paragraph (1) of this subsection because:
31 (a) the claim submission is incomplete because the required
32 substantiating documentation has not been submitted to the payer;
33 (b) the diagnosis coding, procedure coding, or any other
34 required information to be submitted with the claim is incorrect;
35 (c) the payer disputes the amount claimed; or
36 (d) there is strong evidence of fraud by the provider and the
37 payer has initiated an investigation into the suspected fraud,
38 the payer shall notify the health care provider, by electronic
39 means and the covered person in writing within 30 days of
40 receiving an electronic claim, or notify the covered person and
41 health care provider in writing within 40 days of receiving a claim
42 submitted by other than electronic means, that:
43 (i) the claim is incomplete with a statement as to what
44 substantiating documentation is required for adjudication of the
45 claim;
46 (ii) the claim contains incorrect information with a statement as
47 to what information must be corrected for adjudication of the claim;

1 (iii) the payer disputes the amount claimed in whole or in part
2 with a statement as to the basis of that dispute; or
3 (iv) the payer finds there is strong evidence of fraud and has
4 initiated an investigation into the suspected fraud in accordance
5 with its fraud prevention plan established pursuant to section 1 of
6 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
7 supporting documentation, to the Office of the Insurance Fraud
8 Prosecutor in the Department of Law and Public Safety established
9 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
10 (3) If all or a portion of an electronically submitted claim cannot
11 be adjudicated because the diagnosis coding, procedure coding or
12 any other data required to be submitted with the claim was missing,
13 the payer shall electronically notify the health care provider or its
14 agent within seven days of that determination and request any
15 information required to complete adjudication of the claim.
16 (4) Any portion of a claim that meets the criteria established in
17 paragraph (1) of this subsection shall be paid by the payer in
18 accordance with the time limit established in paragraph (1) of this
19 subsection.
20 (5) A payer shall acknowledge receipt of a claim submitted by
21 electronic means from a health care provider, no later than two
22 working days following receipt of the transmission of the claim.
23 (6) If a payer subject to the provisions of P.L.1983, c.320
24 (C.17:33A-1 et seq.) has reason to believe that a claim has been
25 submitted fraudulently, it shall investigate the claim in accordance
26 with its fraud prevention plan established pursuant to section 1 of
27 P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with
28 supporting documentation, to the Office of the Insurance Fraud
29 Prosecutor in the Department of Law and Public Safety established
30 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
31 (7) Payment of an eligible claim pursuant to paragraphs (1) and
32 (4) of this subsection shall be deemed to be overdue if not remitted
33 to the claimant or his agent by the payer on or before the 30th
34 calendar day or the time limit established by the Medicare program,
35 whichever is earlier, following receipt by the payer of a claim
36 submitted by electronic means and on or before the 40th calendar
37 day following receipt of a claim submitted by other than electronic
38 means.
39 If payment is withheld on all or a portion of a claim by a payer
40 pursuant to subparagraph (a) or (b) of paragraph (2) or paragraph
41 (3) of this subsection, the claims payment shall be overdue if not
42 remitted to the claimant or his agent by the payer on or before the
43 30th calendar day or the time limit established by the Medicare
44 program, whichever is earlier, for claims submitted by electronic
45 means and the 40th calendar day for claims submitted by other than
46 electronic means, following receipt by the payer of the required
47 documentation or information or modification of an initial
48 submission.

1 If payment is withheld on all or a portion of a claim by a payer
2 pursuant to paragraph (2) or (3) of this subsection and the provider
3 is not notified within the time frames provided for in those
4 paragraphs, the claim shall be deemed to be overdue.
5 (8) (a) No payer that has reserved the right to change the
6 premium shall deny payment on all or a portion of a claim because
7 the payer requests documentation or information that is not specific
8 to the health care service provided to the covered person.
9 (b) No payer shall deny payment on all or a portion of a claim
10 while seeking coordination of benefits information unless good
11 cause exists for the payer to believe that other insurance is available
12 to the covered person. Good cause shall exist only if the payer's
13 records indicate that other coverage exists. Routine requests to
14 determine whether coordination of benefits exists shall not be
15 considered good cause.
16 (c) In the event payment is withheld on all or a portion of a
17 claim by a payer pursuant to subparagraph (a) or (b) of this
18 paragraph, the claims payment shall be deemed to be overdue if not
19 remitted to the claimant or his agent by the payer on or before the
20 30th calendar day or the time limit established by the Medicare
21 program, whichever is earlier, following receipt by the payer of a
22 claim submitted by electronic means or on or before the 40th
23 calendar day following receipt of a claim submitted by other than
24 electronic means.
25 (9) An overdue payment shall bear simple interest at the rate of
26 12% per annum. The interest shall be paid to the health care
27 provider at the time the overdue payment is made. The amount of
28 interest paid to a health care provider for an overdue claim shall be
29 credited to any civil penalty for late payment of the claim levied by
30 the Department of Human Services against a payer that does not
31 reserve the right to change the premium.
32 (10) With the exception of claims that were submitted
33 fraudulently or submitted by health care providers that have a
34 pattern of inappropriate billing or claims that were subject to
35 coordination of benefits, no payer shall seek reimbursement for
36 overpayment of a claim previously paid pursuant to this section
37 later than 18 months after the date the first payment on the claim
38 was made. No payer shall seek more than one reimbursement for
39 overpayment of a particular claim. At the time the reimbursement
40 request is submitted to the health care provider, the payer shall
41 provide written documentation that identifies the error made by the
42 payer in the processing or payment of the claim that justifies the
43 reimbursement request. No payer shall base a reimbursement
44 request for a particular claim on extrapolation of other claims,
45 except under the following circumstances:
46 (a) in judicial or quasi-judicial proceedings, including
47 arbitration;
48 (b) in administrative proceedings;

1 (c) in which relevant records required to be maintained by the
2 health care provider have been improperly altered or reconstructed,
3 or a material number of the relevant records are otherwise
4 unavailable; or
5 (d) in which there is clear evidence of fraud by the health care
6 provider and the payer has investigated 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), and referred the claim, together
9 with 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 (11) (a) In seeking reimbursement for the overpayment from the
13 health care provider, except as provided for in subparagraph (b) of
14 this paragraph, no payer shall collect or attempt to collect:
15 (i) the funds for the reimbursement on or before the 45th
16 calendar day following the submission of the reimbursement request
17 to the health care provider;
18 (ii) the funds for the reimbursement if the health care provider
19 disputes the request and initiates an appeal on or before the 45th
20 calendar day following the submission of the reimbursement request
21 to the health care provider and until the health care provider's rights
22 to appeal set forth under paragraphs (1) and (2) of subsection e. of
23 this section are exhausted; or
24 (iii) a monetary penalty against the reimbursement request,
25 including but not limited to, an interest charge or a late fee.
26 The payer may collect the funds for the reimbursement request
27 by assessing them against payment of any future claims submitted
28 by the health care provider after the 45th calendar day following the
29 submission of the reimbursement request to the health care provider
30 or after the health care provider's rights to appeal set forth under
31 paragraphs (1) and (2) of subsection e. of this section have been
32 exhausted if the payer submits an explanation in writing to the
33 provider in sufficient detail so that the provider can reconcile each
34 covered person's bill.
35 (b) If a payer has determined that the overpayment to the health
36 care provider is a result of fraud committed by the health care
37 provider and the payer has conducted its investigation and reported
38 the fraud to the Office of the Insurance Fraud Prosecutor as
39 required by law, the payer may collect an overpayment by assessing
40 it against payment of any future claim submitted by the health care
41 provider.
42 (12) No health care provider shall seek reimbursement from a
43 payer or covered person for underpayment of a claim submitted
44 pursuant to this section later than 18 months from the date the first
45 payment on the claim was made, except if the claim is the subject of
46 an appeal submitted pursuant to subsection e. of this section or the
47 claim is subject to continual claims submission. No health care

1 provider shall seek more than one reimbursement for underpayment
2 of a particular claim.
3 e. (1) A health insurer or its agent, hereinafter the payer, shall
4 establish an internal appeal mechanism to resolve any dispute raised
5 by a health care provider regardless of whether the health care
6 provider is under contract with the payer regarding compliance with
7 the requirements of this section or compliance with the
8 requirements of [sections 4 through 7 of P.L.2005, c.352
9 (C.17B:30-51 through C.17B:30-54)] sections 5 through 15
10 of P.L. , c. (C.) (pending before the Legislature as this
11 bill). No dispute pertaining to medical necessity which is eligible
12 to be submitted to the Independent Health Care Appeals Program
13 established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)
14 shall be the subject of an appeal pursuant to this subsection. The
15 payer shall conduct the appeal at no cost to the health care provider.
16 A health care provider may initiate an appeal on or before the
17 90th calendar day following receipt by the health care provider of
18 the payer's claims determination, which is the basis of the appeal,
19 on a form prescribed by the Commissioner of Banking and
20 Insurance which shall describe the type of substantiating
21 documentation that must be submitted with the form. The payer
22 shall conduct a review of the appeal and notify the health care
23 provider of its determination on or before the 30th calendar day
24 following the receipt of the appeal form. If the health care provider
25 is not notified of the payer's determination of the appeal within 30
26 days, the health care provider may refer the dispute to arbitration as
27 provided by paragraph (2) of this subsection.
28 If the payer issues a determination in favor of the health care
29 provider, the payer shall comply with the provisions of this section
30 and pay the amount of money in dispute, if applicable, with accrued
31 interest at the rate of 12% per annum, on or before the 30th calendar
32 day following the notification of the payer's determination on the
33 appeal. Interest shall begin to accrue on the day the appeal was
34 received by the payer.
35 If the payer issues a determination against the health care
36 provider, the payer shall notify the health care provider of its
37 findings on or before the 30th calendar day following the receipt of
38 the appeal form and shall include in the notification written
39 instructions for referring the dispute to arbitration as provided by
40 paragraph (2) of this subsection.
41 The payer shall report annually to the Commissioner of Banking
42 and Insurance the number of appeals it has received and the
43 resolution of each appeal.
44 (2) Any dispute regarding the determination of an internal
45 appeal conducted pursuant to paragraph (1) of this subsection may
46 be referred to arbitration as provided in this paragraph. The
47 Commissioner of Banking and Insurance shall contract with a

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

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) the payer disputes the amount claimed; or

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

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

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

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

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

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

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

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

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

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

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

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

documentation or information or modification of an initial submission.

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

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

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

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

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

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

1 (a) in judicial or quasi-judicial proceedings, including
2 arbitration;
3 (b) in administrative proceedings;
4 (c) in which relevant records required to be maintained by the
5 health care provider have been improperly altered or reconstructed,
6 or a material number of the relevant records are otherwise
7 unavailable; or
8 (d) in which there is clear evidence of fraud by the health care
9 provider and the payer has investigated the claim in accordance
10 with its fraud prevention plan established pursuant to section 1 of
11 P.L.1993, c.362 (C.17:33A-15), and referred the claim, together
12 with supporting documentation, to the Office of the Insurance Fraud
13 Prosecutor in the Department of Law and Public Safety established
14 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
15 (11)(a) In seeking reimbursement for the overpayment from the
16 health care provider, except as provided for in subparagraph (b) of
17 this paragraph, no payer shall collect or attempt to collect:
18 (i) the funds for the reimbursement on or before the 45th
19 calendar day following the submission of the reimbursement request
20 to the health care provider;
21 (ii) the funds for the reimbursement if the health care provider
22 disputes the request and initiates an appeal on or before the 45th
23 calendar day following the submission of the reimbursement request
24 to the health care provider and until the health care provider's rights
25 to appeal set forth under paragraphs (1) and (2) of subsection e. of
26 this section are exhausted; or
27 (iii) a monetary penalty against the reimbursement request,
28 including but not limited to, an interest charge or a late fee.
29 The payer may collect the funds for the reimbursement request
30 by assessing them against payment of any future claims submitted
31 by the health care provider after the 45th calendar day following the
32 submission of the reimbursement request to the health care provider
33 or after the health care provider's rights to appeal set forth under
34 paragraphs (1) and (2) of subsection e. of this section have been
35 exhausted if the payer submits an explanation in writing to the
36 provider in sufficient detail so that the provider can reconcile each
37 covered person's bill.
38 (b) If a payer has determined that the overpayment to the health
39 care provider is a result of fraud committed by the health care
40 provider and the payer has conducted its investigation and reported
41 the fraud to the Office of the Insurance Fraud Prosecutor as
42 required by law, the payer may collect an overpayment by assessing
43 it against payment of any future claim submitted by the health care
44 provider.
45 (12) No health care provider shall seek reimbursement from a
46 payer or covered person for underpayment of a claim submitted
47 pursuant to this section later than 18 months from the date the first
48 payment on the claim was made, except if the claim is the subject of

an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission. No health care provider shall seek more than one reimbursement for underpayment of a particular claim.

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

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

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

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

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

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may

be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

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

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

(4) An arbitrator's determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

payer for resolution through the internal appeals process established pursuant to paragraph (1) of this subsection.

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

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

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

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

25. (New section) Following the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), a contract entered into by the State Health Benefits Commission or the School Employees' Health Benefits Commission with a vendor for claims administration, network management, claims processing, or other related services shall require that the vendor comply with the time frames for providing information concerning utilization management and the processing and payment of claims pursuant to the provisions of section 5 of P.L. , c. (C.) (pending before the Legislature as this bill) and the time frames governing prior and concurrent authorization pursuant to sections 7, 8, 10, 11, 12, and 15 of P.L. , c. (C.) (pending before the Legislature as this bill); provided, however, nothing in P.L. , c. (C.) (pending before the Legislature as this bill) shall be construed to limit the authority of, or process followed by, the third-party medical claims reviewer of the commissions or the requirements imposed on carriers with which the commissions' contract pursuant to the provisions of P.L.2019, c.143 (C.52:14-17.30 et al.).

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

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

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

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

28. This act shall take effect on January 1, 2025.

STATEMENT

The substitute bill repeals the "Health Claims Authorization, Processing and Payment Act" and replaces it with the "Ensuring Transparency in Prior Authorization Act." Prior authorization is the process by which a payer determines the medical necessity of an otherwise covered service prior to its rendering and subsequent level of reimbursement for claims submitted. Payer is the term used in the bill to capture health insurance companies and other types of health insurers and benefits plans who require utilization management to be performed to authorize the approval of a health care service.

Under the bill, a payer is required to provide, in a clear and conspicuous manner, information on an Internet website regarding its use of utilization management and the processing and payment of claims in detail, including prescription drug formularies, using easily understandable language, for review by health care providers, individuals covered by a health insurer or benefits plan, and the general public. The information is to be posted no later than 30 calendar days before any provisions take effect. Changes made to this information are to be clearly noted on the website. For health care services, excluding the provision of pharmaceutical products, a payer is to provide contracted impacted in-network health care providers with written notice with any new or materially adverse amended requirements or restriction no less than 90 days before the item is implemented and is restricted from implementing certain changes until the changes have been posted on its website and included in a notification to the in-network providers.

The bill provides several parameters within which the prior authorization process is to operate, including the following: (1) a payer is to respond to a hospital or health care provider request for prior authorization upon submission of all necessary information; (2) a carrier is to respond to prior authorization requests for medication coverage submitted using the NCPDP SCRIPT Standard for ePA transactions, under the pharmacy benefit part of a health benefits plan, within 24 hours for urgent requests and 72 hours for non-urgent requests after obtaining all necessary information; (3) except where a shorter time frame is necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, prior authorization for treatment of a long term care or chronic condition or for when a service includes a defined number of discrete services in a set time frame is to remain valid for 180 days; and (4) denial or limitation of a prior authorization request is to be made by a physician who, among other requirements, is of the

1 same specialty as the physician who typically manages the medical
2 condition or disease.
3 If prior authorization granted by a previous payer for treatment
4 of a covered person was based on information provided in good
5 faith by a health care provider, a new payer is to honor the prior
6 authorization for at least the initial 60 days of coverage under a new
7 health plan. A denial of a prior authorization is to be
8 communicated (1) no later than 12 days if the request is submitted
9 in paper, or nine days if submitted electronically, following the time
10 the request was made, for a covered person who will receive
11 inpatient or outpatient hospital services; (2) 24 hours for a covered
12 person currently receiving inpatient hospital services; and (3) no
13 later than 72 hours for a claim involving urgent care, unless
14 information received by a hospital or health care provider fails to
15 provide sufficient information. These same time frames are
16 applicable if a payer requests additional information from a
17 provider or hospital. If a payer fails to respond to an authorization
18 request within these time frames, a claim for services provided that
19 is submitted by a hospital or health care provider to the payer
20 cannot be denied on the basis of a failure to secure prior
21 authorization for the service.
22 The bill also establishes requirements of a physician who is to
23 approve or make an adverse determination of a prior authorization
24 request and of a physician who is to review an appeal of an adverse
25 determination decision. Moreover, the bill establishes the
26 conditions in which a payer cannot deny a request for prior
27 authorization.
28 With regards to medically necessary emergency health care
29 services, a payer is to approve coverage for screening and
30 stabilizing a covered person without prior authorization. Admission
31 on an in-patient basis may be subject to concurrent review.
32 Included are penalties applicable to payers for noncompliance
33 with a deadline delineated in the bill. The Department of Banking
34 and Insurance is authorized as the enforcing agency of the bill's
35 provisions.
36 The bill requires payers to make available, in readily accessible
37 format as determined by the department, statistics on prior
38 authorization approvals and denials on the Internet website of the
39 payer. Part of the statistics to be made available include the time
40 between submission of prior authorization requests and
41 determinations; the average median time that elapsed between a
42 request for clinical records by a payer to a health care provider and
43 receipt of adequate records by the payer; and the number of appeals
44 generated for cases denied in which there was inadequate or no
45 prior clinical information.
46 The health benefits programs of the State Health Benefits
47 Commission and the School Employees' Health Benefits
48 Commission are to comply with specific provisions of the bill,

1 provided that nothing in the bill is to limit the authority of, or
2 process followed by, the third-party medical claims reviewer of the
3 commissions or the requirements imposed on carriers with which
4 the commissions' contract pursuant to current law.
5 Lastly, the bill makes technical updates to current law.