

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
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STATE OF NEW JERSEY
220th LEGISLATURE

ADOPTED DECEMBER 11, 2023

Sponsored by:

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District 18 (Middlesex)

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

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District 14 (Mercer and Middlesex)

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District 11 (Monmouth)

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District 30 (Monmouth and Ocean)

Co-Sponsored by:

Assemblywoman Jimenez, Assemblyman DeAngelo, Assemblywomen Reynolds-Jackson, Murphy, Dunn, Assemblyman Verrelli, Assemblywomen Speight, Mosquera, Senators Bramnick and A.M.Bucco

SYNOPSIS

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

CURRENT VERSION OF TEXT

As reported by the Assembly Appropriations Committee on December 18, 2023, with amendments.

(Sponsorship Updated As Of: 1/8/2024)

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

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

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 are repealed.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

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

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

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

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

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

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

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

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

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

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.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AAP committee amendments adopted December 18, 2023.

1 those inefficiencies can harm patients, it is appropriate for the
2 Legislature to update now the uniform procedures and guidelines
3 for hospitals, physicians and health insurance carriers to follow in
4 communicating and following utilization management decisions and
5 determinations on patients' behalf.

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

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

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

22 "Carrier" means an insurance company, health service corporation,
23 hospital service corporation, medical service corporation, or health
24 maintenance organization authorized to issue health benefits plans in
25 this State ¹and shall include, but not be limited to, the State Health
26 Benefits Program and the School Employees' Health Benefits
27 Program¹.

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

33 "Commissioner" means the Commissioner of Banking and
34 Insurance.

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

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

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

1 regain maximum function, including of any bodily organ or part; or (2)
2 subject the covered person to severe pain that cannot be adequately
3 managed without the care or treatment that is the subject of the prior
4 authorization review. "Emergency service" shall include, but not be
5 limited to, mental health services and behavioral health services that
6 otherwise comply with this definition] "Emergency health care
7 services" means health care services that are provided in an emergency
8 facility after the sudden onset of a medical condition that manifests
9 itself by symptoms of sufficient severity, including severe pain, that
10 the absence of immediate medical attention could reasonably be
11 expected by a prudent layperson, who possesses an average knowledge
12 of health and medicine, to result in: (1) placing the health of the patient
13 in jeopardy; (2) serious impairment to bodily function; or (3) serious
14 dysfunction of any bodily organ or part¹.

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

21 "Health benefits plan" means a benefits plan which pays or
22 provides hospital and medical expense benefits for covered services,
23 and is delivered or issued for delivery in this State by or through a
24 carrier. For the purposes of sections 4 through 17 of
25 P.L. , c. (C.) (pending before the Legislature as this bill),
26 health benefits plan shall not include the following plans, policies, or
27 contracts: accident only; credit; disability; long-term care; Medicare
28 Supplement; ¹ **Medicare** **AMedicaid** Medicare Advantage;
29 Medicaid¹; Civilian Health and Medical Program for the Uniformed
30 Services; CHAMPUS supplement coverage; coverage arising out of a
31 workers' compensation or similar law; automobile medical payment
32 insurance; personal injury protection insurance issued pursuant to
33 P.L.1972, c.70 (C.39:6A-1 et seq.); or hospital confinement indemnity
34 coverage.

35 "Health care provider" means a physician and other health care
36 professionals licensed pursuant to Title 45 of the Revised Statutes, and
37 a hospital and other health care facilities licensed pursuant to Title 26
38 of the Revised Statutes.

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

46 "Hospital" means a general acute care facility licensed by the
47 Commissioner of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et

1 seq.), including rehabilitation, psychiatric, and long-term acute
2 facilities.

3 "Medical necessity" or "medically necessary" means or describes a
4 health care service that a health care provider, exercising ¹[his]¹
5 prudent clinical judgment, would provide to a covered person for the
6 purpose of evaluating, diagnosing, or treating an illness, injury,
7 disease, or its symptoms and that is: in accordance with the generally
8 accepted standards of medical practice; clinically appropriate, in terms
9 of type, frequency, extent, site, and duration, and considered effective
10 for the covered person's illness, injury, or disease; not primarily for the
11 convenience of the covered person or the health care provider; and not
12 more costly than an alternative service or sequence of services at least
13 as likely to produce equivalent therapeutic or diagnostic results as to
14 the diagnosis or treatment of that covered person's illness, injury, or
15 disease.

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

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

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

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

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

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

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

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

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

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

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

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

42 (4) the payer's policy or procedure for reducing the payment for a
43 duplicate or subsequent service provided by a health care provider on
44 the same date of service; ¹**[and]**¹

45 (5) ¹prescription drug formularies; and

46 (6)¹ any other information the commissioner deems necessary.

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

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

7 (1) provide ¹impacted¹ contracted in-network health care providers
8 with written notice of any new or ¹materially adverse¹ amended
9 requirement or restriction no less than 90 days before the requirement
10 or restriction is implemented;

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

14 (3) withhold implementation of any new ¹materially adverse¹
15 requirement or restriction until and unless 90 days have passed since
16 written notice was provided to ¹**[a]** an impacted¹ contracted in-
17 network health care provider.

18

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

24

25 7. (New section) a. A carrier shall respond to prior
26 authorization requests for medication coverage submitted using the
27 NCPDP SCRIPT Standard for ePA ¹(electronic prior authorization)¹
28 transactions, under the pharmacy benefit part of a health benefits
29 plan, within ¹24 hours for urgent requests and¹ 72 hours ¹for non-
30 urgent requests¹ after obtaining all necessary information to make
31 the approval or adverse determination.

32 b. Beginning January 1, 2027, a carrier shall only accept and
33 respond to prior authorization requests for medication coverage,
34 under the pharmacy benefit part of a health benefits plan submitted
35 through a secure electronic transmission using the ¹**[39]** NCPDP¹
36 SCRIPT Standard ¹for¹ ePA ¹**[**(electronic prior authorization)**]**¹
37 transactions.

38

39 8. (New section) ¹**[If]** Except where shorter time frames are
40 necessary to monitor patient safety or treatment effectiveness and with
41 notice to the treating provider, if¹ a payer requires prior authorization
42 for a health care service for the treatment of a chronic or long-term
43 care condition, the prior authorization shall remain valid for 180 days
44 and the payer shall not require the covered person to obtain a prior
45 authorization again for the health care service ¹within the 180-day
46 period¹.

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

5 a. ¹**[**be of the same specialty as the physician who typically
6 manages the medical condition or disease, or provides the health care
7 service involved in the request; and¹ make the adverse determination
8 under the clinical direction of a medical director of the payer who
9 shall:

10 (1) be licensed in this State; and

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

15 b. ¹**[**make the adverse determination under the clinical direction
16 of a medical director of the payer who is responsible for the provision
17 of health care services provided to covered persons of the State of New
18 Jersey¹ not be compensated by a payer based on the approval or denial
19 rate of the reviewing physician; and

20 c. not be provided preferential treatment by a payer in the
21 requests for prior authorization of the reviewing physician if that
22 physician is also a network provider for the payer¹.

23
24 10. (New section) ¹**[A]** Except where shorter time frames are
25 necessary to monitor patient safety or treatment effectiveness and with
26 notice to the treating provider,¹ prior authorization for a service which
27 includes a defined number of discrete services within a set
28 ¹**[**timeframe¹ time frame¹ shall be valid for purposes of authorizing
29 the health care provider to provide care for a period of ¹**[**one year¹
30 180 days¹ from the date the provider receives the prior authorization
31 and a payer shall not revoke, limit, condition or restrict a prior
32 authorization within that period if (1) the covered person continues to
33 be eligible for coverage; (2) the clinical information provided at the
34 time the prior authorization request was made has not been
35 misrepresented by the treating physician or covered person; and (3)
36 there has not been a material change in the clinical circumstances or
37 condition of the covered person.

38
39 11. (New section) a. On receipt of information documenting a
40 prior authorization from the covered person or the health care
41 provider of the covered person, a payer shall honor a prior
42 authorization granted to a covered person by a previous payer for at
43 least the initial 60 days of coverage under a new health plan of the
44 covered person, if that prior authorization was based on information
45 provided in good faith by a provider.

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

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

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

17

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

22 (1) in the case of a request for prior authorization for a covered
23 person who will be receiving inpatient hospital services, the payer
24 shall communicate the denial of the request or the limitation imposed
25 on the requested service to the hospital or health care provider within a
26 time frame appropriate to the medical exigencies of the case but no
27 later than 12 days if the request is submitted in paper, or ¹**[eight]**
28 nine¹ days if submitted ¹**[electronically]** through an electronic portal
29 provided by the payer¹, following the time the request was made;

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

37 (3) in the case of a request for prior authorization for a covered
38 person who will be receiving health care services in an outpatient or
39 other setting, including, but not limited to, a clinic, rehabilitation
40 facility or nursing home, the payer shall communicate the denial of the
41 request or the limitation imposed on the requested service to the
42 hospital or health care provider within a time frame appropriate to the
43 medical exigencies of the case but no later than ¹**[72 hours]** 12 days if
44 the request is submitted in paper, or nine days if submitted through an
45 electronic portal provided by the payer, following the time the request
46 was made¹; ¹**[and]**¹

1 (4) ¹in the case of a claim involving urgent care, the payer shall
2 notify the hospital or health care provider of the carrier's benefit
3 determination as soon as possible, taking into account the medical
4 exigencies, but not later than 72 hours after receipt of the claim by
5 the carrier, unless the hospital or health care provider fails to
6 provide sufficient information to determine whether, or to what
7 extent, benefits are covered or payable under the plan. In the case
8 of such a failure, the carrier shall notify the hospital or health care
9 provider as soon as possible, but not later than 24 hours after receipt
10 of the claim by the payer, of the specific information necessary to
11 complete the claim. The hospital or health care provider shall be
12 afforded a reasonable amount of time, taking into account the
13 circumstances, but not less than 48 hours, to provide the specified
14 information. The payer shall notify the hospital or health care
15 provider of the carrier's benefit determination as soon as possible,
16 but in no case later than 48 hours after the carrier's receipt of the
17 specified information; and

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

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

34 (1) in the case of a request for prior or concurrent authorization for
35 a covered person who will be receiving inpatient hospital services,
36 within a time frame appropriate to the medical exigencies of the case
37 but no later than ¹~~two~~ ¹12 calendar days beyond the time of receipt
38 by the payer from the hospital or health care provider of the additional
39 information that the payer has identified as needed to approve or made
40 an adverse determination with regard to the request for authorization¹.
41 For requests made through an electronic portal provided by the
42 payer, this time frame shall be within nine calendar days¹;

43 (2) in the case of a request for prior or concurrent authorization for
44 a covered person who is currently receiving inpatient hospital services
45 or care rendered in the emergency department of a hospital, no more
46 than 24 hours beyond the time of receipt by the payer from the hospital
47 or health care provider of the additional information that the payer has

1 identified as needed to approve or make an adverse determination with
2 regard to the request for prior or concurrent authorization; and

3 (3) in the case of a request for prior or concurrent authorization for
4 a covered person who will be receiving health care services in another
5 setting, within a time frame appropriate to the medical exigencies of
6 the case but no more than ¹~~two~~ 12¹ calendar days beyond the time
7 of receipt by the payer from the hospital or health care provider of the
8 additional information that the payer has identified as needed to
9 approve or make an adverse determination with regard to the request
10 for authorization. ¹For requests made through an electronic portal
11 provided by the payer, this time frame shall be within nine calendar
12 days.¹

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

17 d. If a payer fails to respond to an authorization request within the
18 time frames established pursuant to subsection a. ¹or b.¹ of this
19 section, the hospital or health care provider's claim for the service
20 shall not be denied on the basis of a failure to secure prior or
21 concurrent authorization for the service.

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

26

27 13. (New section) A payer shall ensure that ¹~~all appeals~~ any
28 adverse determinations of any appeal¹ are reviewed by a physician.
29 The physician shall:

30 a. ¹~~be currently in active practice in the same or similar~~
31 specialty as the physician who typically manages the medical
32 condition or disease for at least five consecutive years, or be
33 knowledgeable of, and have experience providing, the health care
34 services under review;

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

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

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

44 b. not be paid by a payer based on the reviewing physician's denial
45 or approval rate;

46 c. not have been directly involved in making an initial adverse
47 determination for the same claim;

1 d.¹ consider all known clinical aspects of the health care service
2 under review, including, but not limited to, a review of all pertinent
3 medical records provided to the payer by the health care provider of
4 the covered person, any relevant records provided to the payer by a
5 health care facility, and any medical literature provided to the payer by
6 the health care service provider of the covered person¹;

7 e. not be provided preferential treatment by the payer in the
8 reviewing physician's own requests for prior authorization if the
9 reviewing physician is also a network provider; and

10 f. when requested by the treating provider, engage in a telephonic
11 conversation with the treating provider to discuss the need for the
12 prescribed medication or service¹.

13

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

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

24 (2) requested authorization from the payer for the health care
25 services prior to rendering the services and the payer failed to
26 respond to the hospital or health care provider within the time
27 frames established pursuant to P.L. , c. (C.) (pending
28 before this Legislature as this bill); or

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

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

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

41

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

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

9 c. A payer shall approve coverage for emergency health care
10 services necessary to screen and stabilize a covered person ¹without
11 requiring any prior authorization¹. ¹**【If a health care provider certifies**
12 **in writing to a payer within 72 hours of a covered person's admission**
13 **that the covered person's condition requires emergency health care**
14 **services, that certification shall create a presumption that the**
15 **emergency health care services are medically necessary and that**
16 **presumption may be rebutted only if the payer establishes, with clear**
17 **and convincing evidence, that the emergency health care services**
18 **present identifiable evidence of fraud】** Admission on an in-patient
19 basis may be subject to concurrent review¹.

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

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

32
33 16. (New section) a. In addition to the protections afforded to a
34 health care provider or patient by the requirements of P.L. , c.
35 (C.) (pending before the Legislature as this bill), any failure by a
36 payer to comply with a deadline ¹**【or other requirement under the**
37 **provisions sections 5, 6, 9, 12, and 13 and subsection e. of section 15**
38 **of P.L. , c. (C.) (pending before the Legislature as this bill)】**¹
39 shall result in any health care services subject to review being
40 automatically deemed authorized.

41 b. Notwithstanding any health care services being automatically
42 deemed authorized pursuant to the terms of P.L. , c. (C.)
43 (pending before the Legislature as this bill), the Commissioner of
44 Banking and Insurance shall enforce the provisions of sections 3
45 through 15 of P.L. , c. (C.) (pending before the Legislature as
46 this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
47 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,

1 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.)
2 (pending before the Legislature as this bill). A payer found in
3 violation of those sections shall be liable for a civil penalty of not
4 more than \$10,000 for each day that the payer is in violation if
5 reasonable notice in writing is given of the intent to levy the penalty
6 and, at the discretion of the commissioner, the payer has 30 days, or
7 such additional time as the commissioner shall determine to be
8 reasonable, to remedy the condition which gave rise to the violation
9 and fails to do so within the time allowed. The penalty shall be
10 collected by the commissioner in the name of the State in a summary
11 proceeding in accordance with the "Penalty Enforcement Law of
12 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). The commissioner's
13 determination shall be a final agency decision subject to review by the
14 Appellate Division of the Superior Court.

15 c. If the Commissioner of Banking and Insurance has reason to
16 believe that a person is engaging in a practice or activity, for the
17 purpose of avoiding or circumventing the legislative intent of ¹sections
18 4 through 17 of P.L. , c. (C.) (pending before the Legislature
19 as this bill) and¹ sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
20 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,
21 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.)
22 (pending before the Legislature as this bill), the Commissioner of
23 Banking and Insurance is authorized to promulgate rules or regulations
24 necessary to prohibit that practice or activity and levy a civil penalty of
25 not more than \$10,000 for each day that person is in violation of that
26 rule or regulation.

27 d. For the purpose of administering the provisions of sections 3
28 through 15 of P.L. , c. (C.) (pending before the Legislature as
29 this bill) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154
30 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2,
31 26:2J-8.1 and 17:48F-13.1) as amended by P.L. , c. (C.)
32 (pending before the Legislature as this bill), 50 percent of the penalty
33 monies collected pursuant to subsections b. and c. of this section shall
34 be deposited into the General Fund. For the purpose of providing
35 payments to hospitals in accordance with the formula used for the
36 distribution of charity care subsidies that are provided pursuant to
37 P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50 percent of the penalty
38 monies collected pursuant to subsections b. and c. of this section shall
39 be deposited into the Health Care Subsidy Fund established pursuant
40 to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

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

45

46 17. (New section) A payer shall make statistics available
47 regarding prior authorization approvals and denials on its Internet

- 1 website in a readily accessible format¹, as determined by the
2 commissioner¹. Payers shall include categories for:
- 3 a. health care provider specialty;
 - 4 b. medication or diagnostic tests and procedures;
 - 5 c. indication offered;
 - 6 d. reason for denial;
 - 7 e. whether prior authorization determinations were:
 - 8 (1) appealed; or
 - 9 (2) approved or denied on appeal;
 - 10 f. the time between submission of prior authorization requests
11 and the determination;
 - 12 g. the average median time elapsed between a request for clinical
13 records from the requesting health care provider and receipt of
14 adequate clinical records to complete the prior authorization; and
 - 15 h. the number of appeals generated for cases denied in which
16 there was inadequate or no prior clinical information.

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

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

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

36 b. Within 12 months of 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 or a subsidiary that processes health care benefits claims as a
41 third party administrator shall use the standard health care
42 enrollment and claim forms in connection with all group and
43 individual contracts issued, delivered, executed or renewed in this
44 State.

45 c. Twelve months after the adoption of regulations establishing
46 standard health care enrollment and claim forms by the
47 Commissioner of Banking and Insurance pursuant to section 1 of
48 P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or its

1 agent shall require that health care providers file all claims for
2 payment for health care services. A covered person who receives
3 health care services shall not be required to submit a claim for
4 payment, but notwithstanding the provisions of this subsection to
5 the contrary, a covered person shall be permitted to submit a claim
6 on his own behalf, at the covered person's option. All claims shall
7 be filed using the standard health care claim form applicable to the
8 contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) In the event payment is withheld on all or a portion of a
22 claim by a payer pursuant to subparagraph (a) or (b) of this
23 paragraph, the claims payment shall be deemed to be overdue if not
24 remitted to the claimant or his agent by the payer on or before the
25 30th calendar day or the time limit established by the Medicare
26 program, whichever is earlier, following receipt by the payer of a
27 claim submitted by electronic means or on or before the 40th
28 calendar day following receipt of a claim submitted by other than
29 electronic means.

30 (9) An overdue payment shall bear simple interest at the rate of
31 12% per annum. The interest shall be paid to the health care
32 provider at the time the overdue payment is made. The amount of
33 interest paid to a health care provider for an overdue claim shall be
34 credited to any civil penalty for late payment of the claim levied by
35 the Department of Human Services against a payer that does not
36 reserve the right to change the premium.

37 (10) With the exception of claims that were submitted
38 fraudulently or submitted by health care providers that have a
39 pattern of inappropriate billing or claims that were subject to
40 coordination of benefits, no payer shall seek reimbursement for
41 overpayment of a claim previously paid pursuant to this section
42 later than 18 months after the date the first payment on the claim
43 was made. No payer shall seek more than one reimbursement for
44 overpayment of a particular claim. At the time the reimbursement
45 request is submitted to the health care provider, the payer shall
46 provide written documentation that identifies the error made by the
47 payer in the processing or payment of the claim that justifies the
48 reimbursement request. No payer shall base a reimbursement

1 request for a particular claim on extrapolation of other claims,
2 except under the following circumstances:

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

5 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

47 (12) No health care provider shall seek reimbursement from a
48 payer or covered person for underpayment of a claim submitted

1 pursuant to this section later than 18 months from the date the first
2 payment on the claim was made, except if the claim is the subject of
3 an appeal submitted pursuant to subsection e. of this section or the
4 claim is subject to continual claims submission. No health care
5 provider shall seek more than one reimbursement for underpayment
6 of a particular claim.

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

20 A health care provider may initiate an appeal on or before the
21 90th calendar day following receipt by the health care provider of
22 the payer's claims determination, which is the basis of the appeal,
23 on a form prescribed by the Commissioner of Banking and
24 Insurance which shall describe the type of substantiating
25 documentation that must be submitted with the form. The payer
26 shall conduct a review of the appeal and notify the health care
27 provider of its determination on or before the 30th calendar day
28 following the receipt of the appeal form. If the health care provider
29 is not notified of the payer's determination of the appeal within 30
30 days, the health care provider may refer the dispute to arbitration as
31 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

24 (a) signed by the arbitrator;

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

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

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

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

45 (6) If the arbitrator determines that a health care provider has
46 engaged in a pattern and practice of improper billing and a refund is
47 due to the payer, the arbitrator may award the payer a refund,
48 including interest accrued at the rate of 12% per annum. Interest

1 shall begin to accrue on the day the appeal was received by the
2 payer for resolution through the internal appeals process established
3 pursuant to paragraph (1) of this subsection.

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

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

12 g. Any person found in violation of this section with a pattern
13 and practice as determined by the Commissioner of Banking and
14 Insurance shall be liable to a civil penalty as set forth in section 17
15 of P.L.2005, c.352 (C.17B:30-55).
16 (cf: P.L.2005, c.352, s.10)

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

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

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

36 b. Within 12 months of 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 medical service corporation or its
40 agent or a subsidiary that processes health care benefits claims as a
41 third party administrator shall use the standard health care
42 enrollment and claim forms in connection with all group and
43 individual contracts issued, delivered, executed or renewed in this
44 State.

45 c. Twelve months after the adoption of regulations establishing
46 standard health care enrollment and claim forms by the
47 Commissioner of Banking and Insurance pursuant to section 1 of
48 P.L.1999, c.154 (C.17B:30-23), a medical service corporation or its

1 agent shall require that health care providers file all claims for
2 payment for health care services. A covered person who receives
3 health care services shall not be required to submit a claim for
4 payment, but notwithstanding the provisions of this subsection to
5 the contrary, a covered person shall be permitted to submit a claim
6 on his own behalf, at the covered person's option. All claims shall
7 be filed using the standard health care claim form applicable to the
8 contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) In the event payment is withheld on all or a portion of a
22 claim by a payer pursuant to subparagraph (a) or (b) of this
23 paragraph, the claims payment shall be deemed to be overdue if not
24 remitted to the claimant or his agent by the payer on or before the
25 30th calendar day or the time limit established by the Medicare
26 program, whichever is earlier, following receipt by the payer of a
27 claim submitted by electronic means or on or before the 40th
28 calendar day following receipt of a claim submitted by other than
29 electronic means.

30 (9) An overdue payment shall bear simple interest at the rate of
31 12% per annum. The interest shall be paid to the health care
32 provider at the time the overdue payment is made. The amount of
33 interest paid to a health care provider for an overdue claim shall be
34 credited to any civil penalty for late payment of the claim levied by
35 the Department of Human Services against a payer that does not
36 reserve the right to change the premium.

37 (10) With the exception of claims that were submitted
38 fraudulently or submitted by health care providers that have a
39 pattern of inappropriate billing or claims that were subject to
40 coordination of benefits, no payer shall seek reimbursement for
41 overpayment of a claim previously paid pursuant to this section
42 later than 18 months after the date the first payment on the claim
43 was made. No payer shall seek more than one reimbursement for
44 overpayment of a particular claim. At the time the reimbursement
45 request is submitted to the health care provider, the payer shall
46 provide written documentation that identifies the error made by the
47 payer in the processing or payment of the claim that justifies the
48 reimbursement request. No payer shall base a reimbursement

1 request for a particular claim on extrapolation of other claims,
2 except under the following circumstances:

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

5 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

47 (12) No health care provider shall seek reimbursement from a
48 payer or covered person for underpayment of a claim submitted

1 pursuant to this section later than 18 months from the date the first
2 payment on the claim was made, except if the claim is the subject of
3 an appeal submitted pursuant to subsection e. of this section or the
4 claim is subject to continual claims submission. No health care
5 provider shall seek more than one reimbursement for underpayment
6 of a particular claim.

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

20 A health care provider may initiate an appeal on or before the
21 90th calendar day following receipt by the health care provider of
22 the payer's claims determination, which is the basis of the appeal,
23 on a form prescribed by the Commissioner of Banking and
24 Insurance which shall describe the type of substantiating
25 documentation that must be submitted with the form. The payer
26 shall conduct a review of the appeal and notify the health care
27 provider of its determination on or before the 30th calendar day
28 following the receipt of the appeal form. If the health care provider
29 is not notified of the payer's determination of the appeal within 30
30 days, the health care provider may refer the dispute to arbitration as
31 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

24 (a) signed by the arbitrator;

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

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

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

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

45 (6) If the arbitrator determines that a health care provider has
46 engaged in a pattern and practice of improper billing and a refund is
47 due to the payer, the arbitrator may award the payer a refund,
48 including interest accrued at the rate of 12% per annum. Interest

1 shall begin to accrue on the day the appeal was received by the
2 payer for resolution through the internal appeals process established
3 pursuant to paragraph (1) of this subsection.

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

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

12 g. Any person found in violation of this section with a pattern
13 and practice as determined by the Commissioner of Banking and
14 Insurance shall be liable to a civil penalty as set forth in section 17
15 of P.L.2005, c.352 (C.17B:30-55).
16 (cf: P.L.2005, c.352, s.11)

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

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

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

36 b. Within 12 months of 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 health service corporation or its
40 agent or a subsidiary that processes health care benefits claims as a
41 third party administrator shall use the standard health care
42 enrollment and claim forms in connection with all group and
43 individual contracts issued, delivered, executed or renewed in this
44 State.

45 c. Twelve months after the adoption of regulations establishing
46 standard health care enrollment and claim forms by the
47 Commissioner of Banking and Insurance pursuant to section 1 of
48 P.L.1999, c.154 (C.17B:30-23), a health service corporation or its

1 agent shall require that health care providers file all claims for
2 payment for health care services. A covered person who receives
3 health care services shall not be required to submit a claim for
4 payment, but notwithstanding the provisions of this subsection to
5 the contrary, a covered person shall be permitted to submit a claim
6 on his own behalf, at the covered person's option. All claims shall
7 be filed using the standard health care claim form applicable to the
8 contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) In the event payment is withheld on all or a portion of a
22 claim by a payer pursuant to subparagraph (a) or (b) of this
23 paragraph, the claims payment shall be deemed to be overdue if not
24 remitted to the claimant or his agent by the payer on or before the
25 30th calendar day or the time limit established by the Medicare
26 program, whichever is earlier, following receipt by the payer of a
27 claim submitted by electronic means or on or before the 40th
28 calendar day following receipt of a claim submitted by other than
29 electronic means.

30 (9) An overdue payment shall bear simple interest at the rate of
31 12% per annum. The interest shall be paid to the health care
32 provider at the time the overdue payment is made. The amount of
33 interest paid to a health care provider for an overdue claim shall be
34 credited to any civil penalty for late payment of the claim levied by
35 the Department of Human Services against a payer that does not
36 reserve the right to change the premium.

37 (10) With the exception of claims that were submitted
38 fraudulently or submitted by health care providers that have a
39 pattern of inappropriate billing or claims that were subject to
40 coordination of benefits, no payer shall seek reimbursement for
41 overpayment of a claim previously paid pursuant to this section
42 later than 18 months after the date the first payment on the claim
43 was made. No payer shall seek more than one reimbursement for
44 overpayment of a particular claim. At the time the reimbursement
45 request is submitted to the health care provider, the payer shall
46 provide written documentation that identifies the error made by the
47 payer in the processing or payment of the claim that justifies the
48 reimbursement request. No payer shall base a reimbursement

1 request for a particular claim on extrapolation of other claims,
2 except under the following circumstances:

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

5 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

47 (12) No health care provider shall seek reimbursement from a
48 payer or covered person for underpayment of a claim submitted

1 pursuant to this section later than 18 months from the date the first
2 payment on the claim was made, except if the claim is the subject of
3 an appeal submitted pursuant to subsection e. of this section or the
4 claim is subject to continual claims submission. No health care
5 provider shall seek more than one reimbursement for underpayment
6 of a particular claim.

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

20 A health care provider may initiate an appeal on or before the
21 90th calendar day following receipt by the health care provider of
22 the payer's claims determination, which is the basis of the appeal,
23 on a form prescribed by the Commissioner of Banking and
24 Insurance which shall describe the type of substantiating
25 documentation that must be submitted with the form. The payer
26 shall conduct a review of the appeal and notify the health care
27 provider of its determination on or before the 30th calendar day
28 following the receipt of the appeal form. If the health care provider
29 is not notified of the payer's determination of the appeal within 30
30 days, the health care provider may refer the dispute to arbitration as
31 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

24 (a) signed by the arbitrator;

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

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

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

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

45 (6) If the arbitrator determines that a health care provider has
46 engaged in a pattern and practice of improper billing and a refund is
47 due to the payer, the arbitrator may award the payer a refund,
48 including interest accrued at the rate of 12% per annum. Interest

1 shall begin to accrue on the day the appeal was received by the
2 payer for resolution through the internal appeals process established
3 pursuant to paragraph (1) of this subsection.

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

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

12 g. Any person found in violation of this section with a pattern
13 and practice as determined by the Commissioner of Banking and
14 Insurance shall be liable to a civil penalty as set forth in section 17
15 of P.L.2005, c.352 (C.17B:30-55).
16 (cf: P.L.2005, c.352, s.12)

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

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

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

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

45 c. Twelve months after the adoption of regulations establishing
46 standard health care enrollment and claim forms by the
47 Commissioner of Banking and Insurance pursuant to section 1 of
48 P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service

1 organization or its agent shall require that health care providers file
2 all claims for payment for health care services. A covered person
3 who receives health care services shall not be required to submit a
4 claim for payment, but notwithstanding the provisions of this
5 subsection to the contrary, a covered person shall be permitted to
6 submit a claim on his own behalf, at the covered person's option.
7 All claims shall be filed using the standard health care claim form
8 applicable to the contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) In the event payment is withheld on all or a portion of a
22 claim by a payer pursuant to subparagraph (a) or (b) of this
23 paragraph, the claims payment shall be deemed to be overdue if not
24 remitted to the claimant or his agent by the payer on or before the
25 30th calendar day or the time limit established by the Medicare
26 program, whichever is earlier, following receipt by the payer of a
27 claim submitted by electronic means or on or before the 40th
28 calendar day following receipt of a claim submitted by other than
29 electronic means.

30 (9) An overdue payment shall bear simple interest at the rate of
31 12% per annum. The interest shall be paid to the health care
32 provider at the time the overdue payment is made. The amount of
33 interest paid to a health care provider for an overdue claim shall be
34 credited to any civil penalty for late payment of the claim levied by
35 the Department of Human Services against a payer that does not
36 reserve the right to change the premium.

37 (10) With the exception of claims that were submitted
38 fraudulently or submitted by health care providers that have a
39 pattern of inappropriate billing or claims that were subject to
40 coordination of benefits, no payer shall seek reimbursement for
41 overpayment of a claim previously paid pursuant to this section
42 later than 18 months after the date the first payment on the claim
43 was made. No payer shall seek more than one reimbursement for
44 overpayment of a particular claim. At the time the reimbursement
45 request is submitted to the health care provider, the payer shall
46 provide written documentation that identifies the error made by the
47 payer in the processing or payment of the claim that justifies the
48 reimbursement request. No payer shall base a reimbursement

1 request for a particular claim on extrapolation of other claims,
2 except under the following circumstances:

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

5 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

47 (12)No health care provider shall seek reimbursement from a
48 payer or covered person for underpayment of a claim submitted

1 pursuant to this section later than 18 months from the date the first
2 payment on the claim was made, except if the claim is the subject of
3 an appeal submitted pursuant to subsection e. of this section or the
4 claim is subject to continual claims submission. No health care
5 provider shall seek more than one reimbursement for underpayment
6 of a particular claim.

7 e. (1) A prepaid prescription service organization or its agent,
8 hereinafter the payer, shall establish an internal appeal mechanism
9 to resolve any dispute raised by a health care provider regardless of
10 whether the health care provider is under contract with the payer
11 regarding compliance with the requirements of this section or
12 compliance with the requirements of ~~sections 4 through 7 of~~ sections 5
13 through 15 of P.L. , c. (C.) (pending before the Legislature
14 as this bill). No dispute pertaining to medical necessity which is
15 eligible to be submitted to the Independent Health Care Appeals
16 Program established pursuant to section 11 of P.L.1997, c.192
17 (C.26:2S-11) shall be the subject of an appeal pursuant to this
18 subsection. The payer shall conduct the appeal at no cost to the
19 health care provider.
20

21 A health care provider may initiate an appeal on or before the
22 90th calendar day following receipt by the health care provider of
23 the payer's claims determination, which is the basis of the appeal,
24 on a form prescribed by the Commissioner of Banking and
25 Insurance which shall describe the type of substantiating
26 documentation that must be submitted with the form. The payer
27 shall conduct a review of the appeal and notify the health care
28 provider of its determination on or before the 30th calendar day
29 following the receipt of the appeal form. If the health care provider
30 is not notified of the payer's determination of the appeal within 30
31 days, the health care provider may refer the dispute to arbitration as
32 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

24 (a) signed by the arbitrator;

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

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

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

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

45 (6) If the arbitrator determines that a health care provider has
46 engaged in a pattern and practice of improper billing and a refund is
47 due to the payer, the arbitrator may award the payer a refund,
48 including interest accrued at the rate of 12% per annum. Interest

1 shall begin to accrue on the day the appeal was received by the
2 payer for resolution through the internal appeals process established
3 pursuant to paragraph (1) of this subsection.

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

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

12 g. Any person found in violation of this section with a pattern
13 and practice as determined by the Commissioner of Banking and
14 Insurance shall be liable to a civil penalty as set forth in section 17
15 of P.L.2005, c.352 (C.17B:30-55).
16 (cf: P.L.2005, c.352, s.16)

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

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

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

36 b. Within 12 months of 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 health insurer or its agent or a
40 subsidiary that processes health care benefits claims as a third party
41 administrator shall use the standard health care enrollment and
42 claim forms in connection with all individual policies issued,
43 delivered, executed or renewed in this State.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (c) In the event payment is withheld on all or a portion of a
22 claim by a payer pursuant to subparagraph (a) or (b) of this
23 paragraph, the claims payment shall be deemed to be overdue if not
24 remitted to the claimant or his agent by the payer on or before the
25 30th calendar day or the time limit established by the Medicare
26 program, whichever is earlier, following receipt by the payer of a
27 claim submitted by electronic means or on or before the 40th
28 calendar day following receipt of a claim submitted by other than
29 electronic means.

30 (9) An overdue payment shall bear simple interest at the rate of
31 12% per annum. The interest shall be paid to the health care
32 provider at the time the overdue payment is made. The amount of
33 interest paid to a health care provider for an overdue claim shall be
34 credited to any civil penalty for late payment of the claim levied by
35 the Department of Human Services against a payer that does not
36 reserve the right to change the premium.

37 (10) With the exception of claims that were submitted
38 fraudulently or submitted by health care providers that have a
39 pattern of inappropriate billing or claims that were subject to
40 coordination of benefits, no payer shall seek reimbursement for
41 overpayment of a claim previously paid pursuant to this section
42 later than 18 months after the date the first payment on the claim
43 was made. No payer shall seek more than one reimbursement for
44 overpayment of a particular claim. At the time the reimbursement
45 request is submitted to the health care provider, the payer shall
46 provide written documentation that identifies the error made by the
47 payer in the processing or payment of the claim that justifies the
48 reimbursement request. No payer shall base a reimbursement

1 request for a particular claim on extrapolation of other claims,
2 except under the following circumstances:

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

5 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

47 (12) No health care provider shall seek reimbursement from a
48 payer or covered person for underpayment of a claim submitted

1 pursuant to this section later than 18 months from the date the first
2 payment on the claim was made, except if the claim is the subject of
3 an appeal submitted pursuant to subsection e. of this section or the
4 claim is subject to continual claims submission. No health care
5 provider shall seek more than one reimbursement for underpayment
6 of a particular claim.

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

20 A health care provider may initiate an appeal on or before the
21 90th calendar day following receipt by the health care provider of
22 the payer's claims determination, which is the basis of the appeal,
23 on a form prescribed by the Commissioner of Banking and
24 Insurance which shall describe the type of substantiating
25 documentation that must be submitted with the form. The payer
26 shall conduct a review of the appeal and notify the health care
27 provider of its determination on or before the 30th calendar day
28 following the receipt of the appeal form. If the health care provider
29 is not notified of the payer's determination of the appeal within 30
30 days, the health care provider may refer the dispute to arbitration as
31 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

24 (a) signed by the arbitrator;

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

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

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

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

45 (6) If the arbitrator determines that a health care provider has
46 engaged in a pattern and practice of improper billing and a refund is
47 due to the payer, the arbitrator may award the payer a refund,
48 including interest accrued at the rate of 12% per annum. Interest

1 shall begin to accrue on the day the appeal was received by the
2 payer for resolution through the internal appeals process established
3 pursuant to paragraph (1) of this subsection.

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

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

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

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

16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 (i) the claim is incomplete with a statement as to what
47 substantiating documentation is required for adjudication of the
48 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

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.14)

13

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

16 7. 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 maintenance organization or its agent or a subsidiary
19 that processes health care benefits claims as a third party
20 administrator, shall demonstrate to the satisfaction of the
21 Commissioner of Banking and Insurance that it will adopt and
22 implement all of the standards to receive and transmit health care
23 transactions electronically, according to the corresponding
24 timetable, and otherwise comply with the provisions of this section,
25 as a condition of its continued authorization to do business in this
26 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 maintenance organization, or its agent,
32 its 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 maintenance organization
37 or its agent or a subsidiary that processes health care benefits claims
38 as a third party administrator shall use the standard health care
39 enrollment and claim forms in connection with all group and
40 individual health maintenance organization coverage for health care
41 services 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 health maintenance organization
46 or its 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 (i) the claim is incomplete with a statement as to what
47 substantiating documentation is required for adjudication of the
48 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

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 maintenance organization or its agent,
6 hereinafter the payer, shall establish an internal appeal mechanism
7 to resolve any dispute raised by a health care provider regardless of
8 whether the health care provider is under contract with the payer
9 regarding compliance with the requirements of this section or
10 compliance with the requirements of ~~sections 4 through 7 of~~ sections 5
11 through 15 of P.L. , c. (C.) (pending before the Legislature
12 as this bill). No dispute pertaining to medical necessity which is
13 eligible to be submitted to the Independent Health Care Appeals
14 Program established pursuant to section 11 of P.L.1997, c.192
15 (C.26:2S-11) shall be the subject of an appeal pursuant to this
16 subsection. The payer shall conduct the appeal at no cost to the
17 health care provider.
18

19 A health care provider may initiate an appeal on or before the
20 90th calendar day following receipt by the health care provider of
21 the payer's claims determination, which is the basis of the appeal,
22 on a form prescribed by the Commissioner of Banking and
23 Insurance which shall describe the type of substantiating
24 documentation that must be submitted with the form. The payer
25 shall conduct a review of the appeal and notify the health care
26 provider of its determination on or before the 30th calendar day
27 following the receipt of the appeal form. If the health care provider
28 is not notified of the payer's determination of the appeal within 30
29 days, the health care provider may refer the dispute to arbitration as
30 provided by paragraph (2) of this subsection.

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

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

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

47 (2) Any dispute regarding the determination of an internal
48 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

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

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

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

12 g. Any person found in violation of this section with a pattern
13 and practice as determined by the Commissioner of Banking and
14 Insurance shall be liable to a civil penalty as set forth in section 17
15 of P.L.2005, c.352 (C.17B:30-55).
16 (cf: P.L.2005, c.352, s.15)

17

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

20 10. a. If attempts to negotiate reimbursement for services
21 provided by an out-of-network health care provider, pursuant to
22 subsection c. of section 9 of **[this act]** P.L.2018, c.32 (C.26:2SS-9),
23 do not result in a resolution of the payment dispute, and the
24 difference between the carrier's and the provider's final offers is not
25 less than \$1,000, the carrier or out-of-network health care provider
26 may initiate binding arbitration to determine payment for the
27 services.

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

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

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

38 (3) The department shall contract, through the request for
39 proposal process, every three years, with one or more entities that
40 have experience in health care pricing arbitration. The department
41 may initially utilize the entity engaged under the **["Health Claims**
42 **Authorization, Processing, and Payment Act,"** P.L.2005, c.352
43 **(C.17B:30-48 et seq.)** "Ensuring Transparency in Prior
44 Authorization Act," P.L. , c. (C.) (pending before the
45 Legislature as this bill), for arbitration under **[this act]** P.L. , c.
46 (C.) (pending before the Legislature as this bill); however,
47 after a period of one year from the effective date of **[this act]**

1 P.L. , c. (C.) (pending before the Legislature as this bill),
2 the selection of the arbitration entity shall be through the Request
3 for Proposal process. Claims that are subject to arbitration pursuant
4 to the provisions of **【this act】** P.L. , c. (C.) (pending before
5 the Legislature as this bill), which previously would be subject to
6 arbitration pursuant to the "Health Claims Authorization,
7 Processing, and Payment Act," shall instead be subject to **【this act】**
8 P.L. , c. (C.) (pending before the Legislature as this bill);

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

16 (5) The arbitrator's decision shall be one of the two amounts
17 submitted by the parties as their final offers and shall be binding on
18 both parties. The decision of the arbitrator shall include detailed
19 written findings and shall be issued within 30 days after the request
20 is filed with the department. The detailed written findings shall be
21 an analysis of the decision including, but not limited to, information
22 concerning any databases, previous awards, or other documentation
23 or arguments that contributed to the arbitrator's decision. The
24 arbitrator's expenses and fees shall be split equally among the
25 parties except in situations in which the arbitrator determines that
26 the payment made by the carrier was not made in good faith, in
27 which case the carrier shall be responsible for all of the arbitrator's
28 expenses and fees. Each party shall be responsible for its own costs
29 and fees, including legal fees if any.

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

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

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

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

4 f. In the event an entity providing or administering a self-
5 funded health benefits plan elects to be subject to the provisions of
6 section 9 of **【this act】** P.L.2018, c.32 (C.26:2SS-9), as provided in
7 subsection d. of that section, the provisions of this section shall
8 apply to a self-funded plan in the same manner as the provisions of
9 this section apply to a carrier. If a self-funded plan does not elect to
10 be subject to the provision of section 9 of **【this act】** P.L.2018, c.32
11 (C.26:2SS-9), a member of that plan may initiate binding arbitration
12 as provided in section 11 of **【this act】** P.L.2018, c.32 (C.26:2SS-
13 11).

14 (cf: P.L.2022, c.74, s.2)**】**¹

15
16 ¹25.(New section) Following the effective date of P.L. , c.
17 (C.) (pending before the Legislature as this bill), a contract
18 entered into by the State Health Benefits Commission or the School
19 Employees' Health Benefits Commission with a vendor for claims
20 administration, network management, claims processing, or other
21 related services shall require that the vendor comply with the time
22 frames for providing information concerning utilization
23 management and the processing and payment of claims pursuant to
24 the provisions of section 5 of P.L. , c. (C.) (pending before
25 the Legislature as this bill) and the time frames governing prior and
26 concurrent authorization pursuant to sections 7, 8, 10, 11, 12, and
27 15 of P.L. , c. (C.) (pending before the Legislature as this
28 bill); provided, however, nothing in P.L. , c. (C.) (pending
29 before the Legislature as this bill) shall be construed to limit the
30 authority of, or process followed by, the third-party medical claims
31 reviewer of the commissions or the requirements imposed on
32 carriers with which the commissions' contract pursuant to the
33 provisions of P.L.2019, c.143 (C.52:14-17.30 et al.).¹

34
35 26. Section 20 of P.L.2005, c.352 (C.17B:30-56) is amended to
36 read as follows:

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

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

43
44 27. (New section) P.L. , c. (C.) (pending before the
45 Legislature as this bill) shall be liberally construed to effectuate the
46 legislative purposes thereof.

1 28. This act shall take effect on ¹**December 31, 2024** and shall
2 apply to health benefits plans delivered, issued, executed or
3 renewed in this State, or approved for renewal or issuance in this
4 State by the Commissioner of Banking and Insurance, on or after
5 the effective date of this act **January 1, 2025¹**.