

[First Reprint]

ASSEMBLY, No. 4005

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED MAY 4, 2020

Sponsored by:

Assemblywoman ANGELICA M. JIMENEZ

District 32 (Bergen and Hudson)

Assemblyman RALPH R. CAPUTO

District 28 (Essex)

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

Co-Sponsored by:

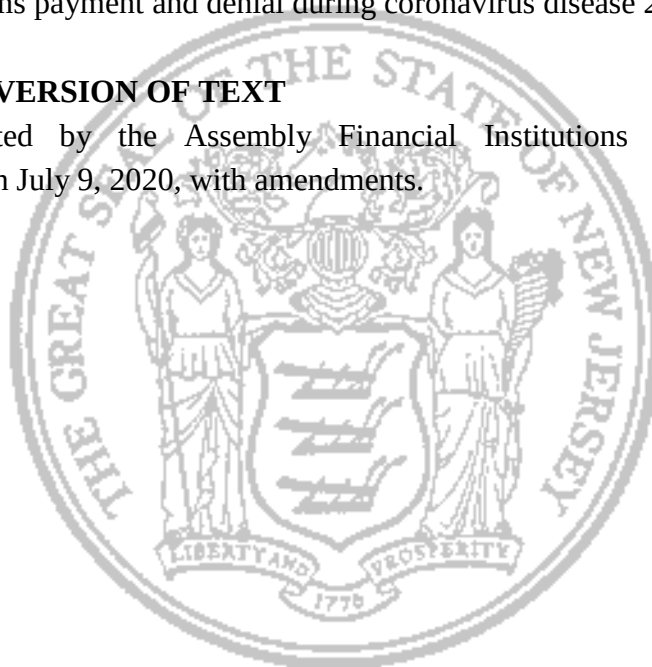
**Assemblywoman Downey, Assemblymen Benson, Mejia and
Assemblywoman Vainieri Huttie**

SYNOPSIS

Concerns certain Medicaid and health insurance audits and health care provider claims payment and denial during coronavirus disease 2019 pandemic.

CURRENT VERSION OF TEXT

As reported by the Assembly Financial Institutions and Insurance Committee on July 9, 2020, with amendments.



(Sponsorship Updated As Of: 5/28/2020)

1 AN ACT concerning certain audits and claims of healthcare
 2 providers related to the coronavirus disease 2019 health
 3 emergency ¹, amending P.L.1999, c.154 (C.17B:30-23 et al.) and
 4 supplementing Title 17B of the New Jersey Statutes¹ .
 5

6 **BE IT ENACTED** by the Senate and General Assembly of the State
 7 of New Jersey:
 8

9 1. ¹(New section)¹ a. Notwithstanding the provisions of any
 10 law, rule, or regulation to the contrary, beginning upon March 9,
 11 2020, the date of the Public Health Emergency and State of
 12 Emergency declared by the Governor in Executive Order 103 of
 13 2020 concerning the coronavirus disease 2019 pandemic, for the
 14 duration of the ¹**state of emergency or the**¹ public health
 15 emergency ¹**],** whichever period of declared emergency is longer, ¹**]**¹
 16 and for a period of 90 days thereafter:

17 (1) The Commissioner of Human Services shall ¹**postpone all**,
 18 unless there is a reasonable indication of willful fraud, abuse, or
 19 excessive or egregious billing practices, suspend, for a period of 90
 20 days, and may subsequently suspend, in increments of 30 days,¹
 21 Medicaid audits of health care providers ¹related to medical
 22 necessity, DRG coding, utilization management, or level of care¹.
 23

24 The Commissioner of Human Services shall apply for such State
 25 Medicaid plan amendments or Medicaid waivers as may be
 26 necessary to implement the provisions of this paragraph and to
 27 maintain federal financial participation for State Medicaid
 28 expenditures. This paragraph shall not apply to any audit that is
 29 required by the federal government in order to receive federal
 30 financial participation for State Medicaid expenditures unless the
 31 department receives federal approval to waive such a requirement.
 32 ¹The calculation of the time limits for overpayment recoupment
 33 pursuant to the requirements of the “Health Claims Authorization,
 34 Processing and Payment Act” P.L.2005, c.352 (C.17B:30-48 et
 35 seq.) shall not include any days commencing on March 9, 2020 and
 36 falling within the duration of the public health emergency.¹

37 (2) The Commissioner of Banking and Insurance shall ¹unless
 38 there is a reasonable indication of willful fraud, abuse, or excessive
 39 or egregious billing practices,¹ suspend ¹, for a period of 90 days,
 40 and may subsequently suspend, in increments of 30 days,¹ the filing
 41 of ¹**any and all audits** retrospective reviews¹ of health care
 42 ¹**providers** provider claims based on medical necessity, DRG
 43 coding, utilization management, or level of care¹ , which audits
 44 would otherwise be required by the commissioner to be filed with
 45 the Department of Banking and Insurance by health insurance
 carriers for any purposes ¹**],** including but not limited to medical

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 AFI committee amendments adopted July 9, 2020.

necessity, DRG coding, utilization management, and level of care].
The calculation of the time limits for overpayment recoupment
pursuant to the requirements of the “Health Claims Authorization,
Processing and Payment Act” P.L.2005, c.352 (C.17B:30-48 et
seq.) shall not include any days commencing on March 9, 2020 and
falling within the duration of the public health emergency¹.

(3) A health insurance carrier shall:

(a) suspend ¹[all] claims¹ audit ¹[related]¹ activities,
¹[including but not limited to] such as¹ medical necessity, DRG
coding, utilization management, level of care, and any other audits
as prescribed by the Commissioner of Banking and Insurance
pursuant to paragraph (2) of this subsection ¹for services obtained
to diagnose coronavirus disease 2019 or obtained as a result of a
coronavirus disease 2019 diagnosis¹ ;

(b) suspend ¹[all administrative and technical denials of claims,
including]¹ denials based on health care provider credentialing
requirements. Any credentialing determination shall be issued
within 45 days after receipt by the health insurance carrier of a
Universal Physician Application Credentialing Application or a
complete New Jersey Physician Recredentialing Application;

(c) not retrospectively deny claims related to coronavirus
disease 2019 care and services for medical necessity, ¹[services
related to identifying and mitigating the spread of the disease,]
DRG coding, utilization management,¹ or level of care, unless there
is ¹[an] a reasonable¹ indication of willful fraud ¹[and],¹ abuse ¹,
or excessive or egregious billing practices¹;

(d) suspend preauthorization, and concurrent review for
¹[outpatient services] inpatient services related to coronavirus
disease 2019¹;

(e) be prohibited from denying emergency department and
inpatient hospital services ¹related to coronavirus disease 2019¹ as
not medically necessary on retrospective review ¹, unless there is a
reasonable indication of willful fraud, abuse, or excessive or
egregious billing practices,¹ if the services were rendered by a
hospital during the Public Health Emergency declared by Executive
Order No. 103 regarding the coronavirus disease 2019;

(f) ensure that documentation requirements for retrospective
review are reasonable, and ¹[to]¹ take into consideration the
extraordinary circumstances that existed at the time healthcare
services were provided during the Public Health Emergency
declared by Executive Order No. 103 regarding the coronavirus
disease 2019; and

(g) process for payment all undisputed outstanding claims for
services rendered prior to March 9, 2020, and all claims for services
rendered on or after March 9, 2020 until after the public health
crisis.

(4) A health care provider shall have a period of no less than ¹45 ¹90 days after receipt of notice of an adverse determination to file an internal appeal with a health insurance carrier for the duration of the Public Health Emergency ¹and State of Emergency¹ declared by Executive Order No. 103 regarding the coronavirus disease 2019, and extended by any subsequent orders.

b. As used in this section;

“Credentialing” means the process of assessing and validating the qualifications of a health care provider including, but not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgement.

“Health insurance carrier” means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

“Health care provider” means an individual ¹or entity¹, which, acting within the scope of its licensure or certification, provides health care services, ¹and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional¹ and¹ whose professional practice is regulated pursuant to Title 45 of the Revised Statutes ¹; and¹ . “Health care provider” shall also mean¹ a hospital or other health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) ¹.¹

“Medicaid” means the program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

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

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

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

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or its

1 agent or a subsidiary that processes health care benefits claims as a
2 third party administrator shall use the standard health care
3 enrollment and claim forms in connection with all group and
4 individual contracts issued, delivered, executed or renewed in this
5 State.

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

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

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

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

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

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

36 (d) the claim is submitted with all the information requested by
37 the payer on the claim form or in other instructions that were
38 distributed in advance to the health care provider or covered person
39 in accordance with the provisions of section 4 of P.L.2005, c.352
40 (C.17B:30-51); and

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

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

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

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

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

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

1 day following receipt of a claim submitted by other than electronic
2 means.

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

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

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

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

28 (c) In the event payment is withheld on all or a portion of a
29 claim by a payer pursuant to subparagraph (a) or (b) of this
30 paragraph, the claims payment shall be deemed to be overdue if not
31 remitted to the claimant or his agent by the payer on or before the
32 30th calendar day or the time limit established by the Medicare
33 program, whichever is earlier, following receipt by the payer of a
34 claim submitted by electronic means or on or before the 40th
35 calendar day following receipt of a claim submitted by other than
36 electronic means.

37 (9) An overdue payment shall bear simple interest at the rate of
38 12% per annum. The interest shall be paid to the health care
39 provider at the time the overdue payment is made. The amount of
40 interest paid to a health care provider for an overdue claim shall be
41 credited to any civil penalty for late payment of the claim levied by
42 the Department of Human Services against a payer that does not
43 reserve the right to change the premium.

44 (10) With the exception of claims that were submitted
45 fraudulently or submitted by health care providers that have a
46 pattern of inappropriate billing or claims that were subject to
47 coordination of benefits, no payer shall seek reimbursement for
48 overpayment of a claim previously paid pursuant to this section
49 later than 18 months after the date the first payment on the claim

1 was made , except for claims subject to an audit that had been
2 suspended pursuant to the provisions of P.L. , c. (C.) (now
3 pending before the Legislature as this bill). No payer shall seek
4 more than one reimbursement for overpayment of a particular
5 claim. At the time the reimbursement request is submitted to the
6 health care provider, the payer shall provide written documentation
7 that identifies the error made by the payer in the processing or
8 payment of the claim that justifies the reimbursement request. No
9 payer shall base a reimbursement request for a particular claim on
10 extrapolation of other claims, except under the following
11 circumstances:

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

14 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

47 If the payer issues a determination against the health care
48 provider, the payer shall notify the health care provider of its
49 findings on or before the 30th calendar day following the receipt of

1 the appeal form and shall include in the notification written
2 instructions for referring the dispute to arbitration as provided by
3 paragraph (2) of this subsection.

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

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

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

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

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

30 (a) signed by the arbitrator;

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

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

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

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

1 pursuant to paragraph (1) of this subsection, the payer shall not be
2 required to pay any accrued interest.

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

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

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

18 g. Any person found in violation of this section with a pattern
19 and practice as determined by the Commissioner of Banking and
20 Insurance shall be liable to a civil penalty as set forth in section 17
21 of P.L.2005, c.352 (C.17B:30-55).¹
22 (cf: P.L.2005, c.352, s.10)

23
24 ¹3. Section 3 of P.L.1999, c.154 (C.17:48A-7.12) is amended to
25 read as follows:

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

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

42 b. Within 12 months of 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 medical service corporation or its
46 agent or a subsidiary that processes health care benefits claims as a
47 third party administrator shall use the standard health care
48 enrollment and claim forms in connection with all group and

1 individual contracts issued, delivered, executed or renewed in this
2 State.

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

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

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

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

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

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

33 (d) the claim is submitted with all the information requested by
34 the payer on the claim form or in other instructions that were
35 distributed in advance to the health care provider or covered person
36 in accordance with the provisions of section 4 of P.L.2005, c.352
37 (C.17B:30-51) ; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (10) With the exception of claims that were submitted
43 fraudulently or submitted by health care providers that have a
44 pattern of inappropriate billing or claims that were subject to
45 coordination of benefits, no payer shall seek reimbursement for
46 overpayment of a claim previously paid pursuant to this section
47 later than 18 months after the date the first payment on the claim
48 was made , except for claims subject to an audit that had been
49 suspended pursuant to the provisions of P.L. , c. (C.) (now

1 pending before the Legislature as this bill). No payer shall seek
2 more than one reimbursement for overpayment of a particular
3 claim. At the time the reimbursement request is submitted to the
4 health care provider, the payer shall provide written documentation
5 that identifies the error made by the payer in the processing or
6 payment of the claim that justifies the reimbursement request. No
7 payer shall base a reimbursement request for a particular claim on
8 extrapolation of other claims, except under the following
9 circumstances:

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

12 (b) in administrative proceedings;

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

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

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

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

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

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

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

47 (b) If a payer has determined that the overpayment to the health
48 care provider is a result of fraud committed by the health care
49 provider and the payer has conducted its investigation and reported

1 the fraud to the Office of the Insurance Fraud Prosecutor as
2 required by law, the payer may collect an overpayment by assessing
3 it against payment of any future claim submitted by the health care
4 provider.

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

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

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

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

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

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

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

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

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

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

27 (a) signed by the arbitrator;

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

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

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

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

48 (6) If the arbitrator determines that a health care provider has
49 engaged in a pattern and practice of improper billing and a refund is

1 due to the payer, the arbitrator may award the payer a refund,
2 including interest accrued at the rate of 12% per annum. Interest
3 shall begin to accrue on the day the appeal was received by the
4 payer for resolution through the internal appeals process established
5 pursuant to paragraph (1) of this subsection.

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

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

14 g. Any person found in violation of this section with a pattern
15 and practice as determined by the Commissioner of Banking and
16 Insurance shall be liable to a civil penalty as set forth in section 17
17 of P.L.2005, c.352 (C.17B:30-55).¹

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

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

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

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

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

47 c. Twelve months after the adoption of regulations establishing
48 standard health care enrollment and claim forms by the
49 Commissioner of Banking and Insurance pursuant to section 1 of

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

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

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

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

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

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

28 (d) the claim is submitted with all the information requested by
29 the payer on the claim form or in other instructions that were
30 distributed in advance to the health care provider or covered person
31 in accordance with the provisions of section 4 of P.L.2005, c.352
32 (C.17B:30-51) ; 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
49 program, whichever is earlier, for claims submitted by electronic

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

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

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

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

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

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

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

1 payer shall base a reimbursement request for a particular claim on
2 extrapolation of other claims, except under the following
3 circumstances:

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

6 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

48 (12) No health care provider shall seek reimbursement from a
49 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). No dispute pertaining to
14 medical necessity which is eligible to be submitted to the
15 Independent Health Care Appeals Program established pursuant to
16 section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of
17 an appeal pursuant to this subsection. The payer shall conduct the
18 appeal at no cost to the health care provider.

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
49 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 health service corporation contract for which the financial
7 obligation for the payment of a claim under the contract rests upon
8 the health service corporation.

9 g. Any person found in violation of this section with a pattern
10 and practice as determined by the Commissioner of Banking and
11 Insurance shall be liable to a civil penalty as set forth in section 17
12 of P.L.2005, c.352 (C.17B:30-55).¹
13 (cf: P.L.2005, c.352, s.12)

14
15 ¹5. Section 5 of P.L.1999, c.154 (C.17B:26-9.1) is amended to
16 read as follows:

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

27 The Commissioner of Banking and Insurance may grant
28 extensions or waivers of the implementation requirement when it
29 has been demonstrated to the commissioner's satisfaction that
30 compliance with the timetable for implementation will result in an
31 undue hardship to a health insurer, or its agent, its subsidiary or its
32 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 insurer or its agent or a
37 subsidiary that processes health care benefits claims as a third party
38 administrator shall use the standard health care enrollment and
39 claim forms in connection with all individual policies issued,
40 delivered, executed or renewed in this State.

41 c. Twelve months after the adoption of regulations establishing
42 standard health care enrollment and claim forms by the
43 Commissioner of Banking and Insurance pursuant to section 1 of
44 P.L.1999, c.154 (C.17B:30-23), a health insurer or its agent shall
45 require that health care providers file all claims for payment for
46 health care services. A covered person who receives health care
47 services shall not be required to submit a claim for payment, but
48 notwithstanding the provisions of this subsection to the contrary, a
49 covered person shall be permitted to submit a claim on his own

1 behalf, at the covered person's option. All claims shall be filed
2 using the standard health care claim form applicable to the policy.

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

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

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

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

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

21 (d) the claim is submitted with all the information requested by
22 the payer on the claim form or in other instructions that were
23 distributed in advance to the health care provider or covered person
24 in accordance with the provisions of section 4 of P.L.2005, c.352
25 (C.17B:30-51); and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 If payment is withheld on all or a portion of a claim by a payer
48 pursuant to paragraph (2) or (3) of this subsection and the provider

1 is not notified within the time frames provided for in those
2 paragraphs, the claim shall be deemed to be overdue.

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

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

14 (c) In the event payment is withheld on all or a portion of a
15 claim by a payer pursuant to subparagraph (a) or (b) of this
16 paragraph, the claims payment shall be deemed to be overdue if not
17 remitted to the claimant or his agent by the payer on or before the
18 30th calendar day or the time limit established by the Medicare
19 program, whichever is earlier, following receipt by the payer of a
20 claim submitted by electronic means or on or before the 40th
21 calendar day following receipt of a claim submitted by other than
22 electronic means.

23 (9) An overdue payment shall bear simple interest at the rate of
24 12% per annum. The interest shall be paid to the health care
25 provider at the time the overdue payment is made. The amount of
26 interest paid to a health care provider for an overdue claim shall be
27 credited to any civil penalty for late payment of the claim levied by
28 the Department of Human Services against a payer that does not
29 reserve the right to change the premium.

30 (10) With the exception of claims that were submitted
31 fraudulently or submitted by health care providers that have a
32 pattern of inappropriate billing or claims that were subject to
33 coordination of benefits, no payer shall seek reimbursement for
34 overpayment of a claim previously paid pursuant to this section
35 later than 18 months after the date the first payment on the claim
36 was made , except for claims subject to an audit that had been
37 suspended pursuant to the provisions of P.L. , c. (C.) (now
38 pending before the Legislature as this bill). No payer shall seek
39 more than one reimbursement for overpayment of a particular
40 claim. At the time the reimbursement request is submitted to the
41 health care provider, the payer shall provide written documentation
42 that identifies the error made by the payer in the processing or
43 payment of the claim that justifies the reimbursement request. No
44 payer shall base a reimbursement request for a particular claim on
45 extrapolation of other claims, except under the following
46 circumstances:

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

49 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

13 A health care provider may initiate an appeal on or before the
14 90th calendar day following receipt by the health care provider of
15 the payer's claims determination, which is the basis of the appeal,
16 on a form prescribed by the Commissioner of Banking and
17 Insurance which shall describe the type of substantiating
18 documentation that must be submitted with the form. The payer
19 shall conduct a review of the appeal and notify the health care
20 provider of its determination on or before the 30th calendar day
21 following the receipt of the appeal form. If the health care provider
22 is not notified of the payer's determination of the appeal within 30
23 days, the health care provider may refer the dispute to arbitration as
24 provided by paragraph (2) of this subsection.

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

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

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

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

47 Any party may initiate an arbitration proceeding on or before the
48 90th calendar day following the receipt of the determination which
49 is the basis of the appeal, on a form prescribed by the

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

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

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

15 (a) signed by the arbitrator;

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

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

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

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

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

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

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

1 g. Any person found in violation of this section with a pattern
2 and practice as determined by the Commissioner of Banking and
3 Insurance shall be liable to a civil penalty as set forth in section 17
4 of P.L.2005, c.352 (C.17B:30-55).¹
5 (cf: P.L.2005, c.352, s.13)
6

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

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

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

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

33 c. Twelve months after 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 insurer or its agent shall
37 require that health care providers file all claims for payment for
38 health care services. A covered person who receives health care
39 services shall not be required to submit a claim for payment, but
40 notwithstanding the provisions of this subsection to the contrary, a
41 covered person shall be permitted to submit a claim on his own
42 behalf, at the covered person's option. All claims shall be filed
43 using the standard health care claim form applicable to the policy.

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

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

- 1 health care provider, no later than the 30th calendar day following
2 receipt of the claim by the payer or no later than the time limit
3 established for the payment of claims in the Medicare program
4 pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the
5 claim is submitted by electronic means, and no later than the 40th
6 calendar day following receipt if the claim is submitted by other
7 than electronic means, if:
- 8 (a) the health care provider is eligible at the date of service;
 - 9 (b) the person who received the health care service was covered
10 on the date of service;
 - 11 (c) the claim is for a service or supply covered under the health
12 benefits plan;
 - 13 (d) the claim is submitted with all the information requested by
14 the payer on the claim form or in other instructions that were
15 distributed in advance to the health care provider or covered person
16 in accordance with the provisions of section 4 of P.L.2005, c.352
17 (C.17B:30-51) ; and
 - 18 (e) the payer has no reason to believe that the claim has been
19 submitted fraudulently.
- 20 (2) If all or a portion of the claim is not paid within the time
21 frames provided in paragraph (1) of this subsection because:
- 22 (a) the claim submission is incomplete because the required
23 substantiating documentation has not been submitted to the payer;
 - 24 (b) the diagnosis coding, procedure coding, or any other
25 required information to be submitted with the claim is incorrect;
 - 26 (c) the payer disputes the amount claimed; or
 - 27 (d) there is strong evidence of fraud by the provider and the
28 payer has initiated an investigation into the suspected fraud,
29 the payer shall notify the health care provider, by electronic
30 means and the covered person in writing within 30 days of
31 receiving an electronic claim, or notify the covered person and
32 health care provider in writing within 40 days of receiving a claim
33 submitted by other than electronic means, that:
- 34 (i) the claim is incomplete with a statement as to what
35 substantiating documentation is required for adjudication of the
36 claim;
 - 37 (ii) the claim contains incorrect information with a statement as
38 to what information must be corrected for adjudication of the claim;
 - 39 (iii) the payer disputes the amount claimed in whole or in part
40 with a statement as to the basis of that dispute; or
 - 41 (iv) the payer finds there is strong evidence of fraud and has
42 initiated an investigation into the suspected fraud in accordance
43 with its fraud prevention plan established pursuant to section 1 of
44 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
45 supporting documentation, to the Office of the Insurance Fraud
46 Prosecutor in the Department of Law and Public Safety established
47 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
- 48 (3) If all or a portion of an electronically submitted claim cannot
49 be adjudicated because the diagnosis coding, procedure coding or

1 any other data required to be submitted with the claim was missing,
2 the payer shall electronically notify the health care provider or its
3 agent within seven days of that determination and request any
4 information required to complete adjudication of the claim.

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

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

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

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

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

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

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

46 (b) No payer shall deny payment on all or a portion of a claim
47 while seeking coordination of benefits information unless good
48 cause exists for the payer to believe that other insurance is available
49 to the covered person. Good cause shall exist only if the payer's

1 records indicate that other coverage exists. Routine requests to
2 determine whether coordination of benefits exists shall not be
3 considered good cause.

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

13 (9) An overdue payment shall bear simple interest at the rate of
14 12% per annum. The interest shall be paid to the health care
15 provider at the time the overdue payment is made. The amount of
16 interest paid to a health care provider for an overdue claim shall be
17 credited to any civil penalty for late payment of the claim levied by
18 the Department of Human Services against a payer that does not
19 reserve the right to change the premium.

20 (10) With the exception of claims that were submitted
21 fraudulently or submitted by health care providers that have a
22 pattern of inappropriate billing or claims that were subject to
23 coordination of benefits, no payer shall seek reimbursement for
24 overpayment of a claim previously paid pursuant to this section
25 later than 18 months after the date the first payment on the claim
26 was made , except for claims subject to an audit that had been
27 suspended pursuant to the provisions of P.L. , c. (C.) (now
28 pending before the Legislature as this bill). No payer shall seek
29 more than one reimbursement for overpayment of a particular
30 claim. At the time the reimbursement request is submitted to the
31 health care provider, the payer shall provide written documentation
32 that identifies the error made by the payer in the processing or
33 payment of the claim that justifies the reimbursement request. No
34 payer shall base a reimbursement request for a particular claim on
35 extrapolation of other claims, except under the following
36 circumstances:

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

39 (b) in administrative proceedings;

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

44 (d) in which there is clear evidence of fraud by the health care
45 provider and the payer has investigated the claim in accordance
46 with its fraud prevention plan established pursuant to section 1 of
47 P.L.1993, c.362 (C.17:33A-15), and referred the claim, together
48 with supporting documentation, to the Office of the Insurance Fraud

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

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

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

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

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

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

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

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

41 e. (1) A health insurer or its agent, hereinafter the payer, shall
42 establish an internal appeal mechanism to resolve any dispute raised
43 by a health care provider regardless of whether the health care
44 provider is under contract with the payer regarding compliance with
45 the requirements of this section or compliance with the
46 requirements of sections 4 through 7 of P.L.2005, c.352 (C.17B:30-
47 51 through C.17B:30-54). No dispute pertaining to medical
48 necessity which is eligible to be submitted to the Independent
49 Health Care Appeals Program established pursuant to section 11 of

1 P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal
2 pursuant to this subsection. The payer shall conduct the appeal at
3 no cost to the health care provider.

4 A health care provider may initiate an appeal on or before the
5 90th calendar day following receipt by the health care provider of
6 the payer's claims determination, which is the basis of the appeal,
7 on a form prescribed by the Commissioner of Banking and
8 Insurance which shall describe the type of substantiating
9 documentation that must be submitted with the form. The payer
10 shall conduct a review of the appeal and notify the health care
11 provider of its determination on or before the 30th calendar day
12 following the receipt of the appeal form. If the health care provider
13 is not notified of the payer's determination of the appeal within 30
14 days, the health care provider may refer the dispute to arbitration as
15 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

6 (a) signed by the arbitrator;

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

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

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

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

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

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

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

41 g. Any person found in violation of this section with a pattern
42 and practice as determined by the Commissioner of Banking and
43 Insurance shall be liable to a civil penalty as set forth in section 17
44 of P.L.2005, c.352 (C.17B:30-55).¹

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

46

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

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

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

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

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

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

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

1 and no later than the 40th calendar day following receipt if the
2 claim is submitted by other than electronic means, if:

- 3 (a) the health care provider is eligible at the date of service;
4 (b) the person who received the health care service was covered
5 on the date of service;
6 (c) the claim is for a service or supply covered under the health
7 benefits plan;
8 (d) the claim is submitted with all the information requested by
9 the payer on the claim form or in other instructions that were
10 distributed in advance to the health care provider or covered person
11 in accordance with the provisions of section 4 of P.L.2005, c.352
12 (C.17B:30-51); and
13 (e) the payer has no reason to believe that the claim has been
14 submitted fraudulently.

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

- 17 (a) the claim submission is incomplete because the required
18 substantiating documentation has not been submitted to the payer;
19 (b) the diagnosis coding, procedure coding, or any other
20 required information to be submitted with the claim is incorrect;
21 (c) the payer disputes the amount claimed; or

22 (d) there is strong evidence of fraud by the provider and the
23 payer has initiated an investigation into the suspected fraud,
24 the payer shall notify the health care provider, by electronic
25 means and the covered person in writing within 30 days of
26 receiving an electronic claim, or notify the covered person and
27 health care provider in writing within 40 days of receiving a claim
28 submitted by other than electronic means, that:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (c) In the event payment is withheld on all or a portion of a
2 claim by a payer pursuant to subparagraph (a) or (b) of this
3 paragraph, the claims payment shall be deemed to be overdue if not
4 remitted to the claimant or his agent by the payer on or before the
5 30th calendar day or the time limit established by the Medicare
6 program, whichever is earlier, following receipt by the payer of a
7 claim submitted by electronic means or on or before the 40th
8 calendar day following receipt of a claim submitted by other than
9 electronic means.

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

17 (10) With the exception of claims that were submitted
18 fraudulently or submitted by health care providers that have a
19 pattern of inappropriate billing or claims that were subject to
20 coordination of benefits, no payer shall seek reimbursement for
21 overpayment of a claim previously paid pursuant to this section
22 later than 18 months after the date the first payment on the claim
23 was made , except for claims subject to an audit that had been
24 suspended pursuant to the provisions of P.L. , c. (C.) (now
25 pending before the Legislature as this bill). No payer shall seek
26 more than one reimbursement for overpayment of a particular
27 claim. At the time the reimbursement request is submitted to the
28 health care provider, the payer shall provide written documentation
29 that identifies the error made by the payer in the processing or
30 payment of the claim that justifies the reimbursement request. No
31 payer shall base a reimbursement request for a particular claim on
32 extrapolation of other claims, except under the following
33 circumstances:

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

36 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

39 e. (1) A health maintenance organization or its agent,
40 hereinafter the payer, shall establish an internal appeal mechanism
41 to resolve any dispute raised by a health care provider regardless of
42 whether the health care provider is under contract with the payer
43 regarding compliance with the requirements of this section or
44 compliance with the requirements of sections 4 through 7 of
45 P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54). No dispute
46 pertaining to medical necessity which is eligible to be submitted to
47 the Independent Health Care Appeals Program established pursuant
48 to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of

1 an appeal pursuant to this subsection. The payer shall conduct the
2 appeal at no cost to the health care provider.

3 A health care provider may initiate an appeal on or before the
4 90th calendar day following receipt by the health care provider of
5 the payer's claims determination, which is the basis of the appeal,
6 on a form prescribed by the Commissioner of Banking and
7 Insurance which shall describe the type of substantiating
8 documentation that must be submitted with the form. The payer
9 shall conduct a review of the appeal and notify the health care
10 provider of its determination on or before the 30th calendar day
11 following the receipt of the appeal form. If the health care provider
12 is not notified of the payer's determination of the appeal within 30
13 days, the health care provider may refer the dispute to arbitration as
14 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

6 (a) signed by the arbitrator;

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

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

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

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

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

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

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

43 g. Any person found in violation of this section with a pattern
44 and practice as determined by the Commissioner of Banking and
45 Insurance shall be liable to a civil penalty as set forth in section 17
46 of P.L.2005, c.352 (C.17B:30-55).¹

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

48

49 ¹8. Section 10 of P.L.1999, c.154 (C.17:48F-13.1) is amended to

1 read as follows:

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

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

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

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

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

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

1 and no later than the 40th calendar day following receipt if the
2 claim is submitted by other than electronic means, if:

3 (a) the health care provider is eligible at the date of service;
4 (b) the person who received the health care service was covered
5 on the date of service;
6 (c) the claim is for a service or supply covered under the health
7 benefits plan;
8 (d) the claim is submitted with all the information requested by
9 the payer on the claim form or in other instructions that were
10 distributed in advance to the health care provider or covered person
11 in accordance with the provisions of section 4 of P.L.2005, c.352
12 (C.17B:30-51); and
13 (e) the payer has no reason to believe that the claim has been
14 submitted fraudulently.

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

17 (a) the claim submission is incomplete because the required
18 substantiating documentation has not been submitted to the payer;
19 (b) the diagnosis coding, procedure coding, or any other
20 required information to be submitted with the claim is incorrect;
21 (c) the payer disputes the amount claimed; or
22 (d) there is strong evidence of fraud by the provider and the
23 payer has initiated an investigation into the suspected fraud,
24 the payer shall notify the health care provider, by electronic
25 means and the covered person in writing within 30 days of
26 receiving an electronic claim, or notify the covered person and
27 health care provider in writing within 40 days of receiving a claim
28 submitted by other than electronic means, that:

29 (i) the claim is incomplete with a statement as to what
30 substantiating documentation is required for adjudication of the
31 claim;
32 (ii) the claim contains incorrect information with a statement as
33 to what information must be corrected for adjudication of the claim;
34 (iii) the payer disputes the amount claimed in whole or in part
35 with a statement as to the basis of that dispute; or
36 (iv) the payer finds there is strong evidence of fraud and has
37 initiated an investigation into the suspected fraud in accordance
38 with its fraud prevention plan established pursuant to section 1 of
39 P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
40 supporting documentation, to the Office of the Insurance Fraud
41 Prosecutor in the Department of Law and Public Safety established
42 pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

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

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

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

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

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

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

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

1 (c) In the event payment is withheld on all or a portion of a
2 claim by a payer pursuant to subparagraph (a) or (b) of this
3 paragraph, the claims payment shall be deemed to be overdue if not
4 remitted to the claimant or his agent by the payer on or before the
5 30th calendar day or the time limit established by the Medicare
6 program, whichever is earlier, following receipt by the payer of a
7 claim submitted by electronic means or on or before the 40th
8 calendar day following receipt of a claim submitted by other than
9 electronic means.

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

17 (10) With the exception of claims that were submitted
18 fraudulently or submitted by health care providers that have a
19 pattern of inappropriate billing or claims that were subject to
20 coordination of benefits, no payer shall seek reimbursement for
21 overpayment of a claim previously paid pursuant to this section
22 later than 18 months after the date the first payment on the claim
23 was made , except for claims subject to an audit that had been
24 suspended pursuant to the provisions of P.L. , c. (C.) (now
25 pending before the Legislature as this bill). No payer shall seek
26 more than one reimbursement for overpayment of a particular
27 claim. At the time the reimbursement request is submitted to the
28 health care provider, the payer shall provide written documentation
29 that identifies the error made by the payer in the processing or
30 payment of the claim that justifies the reimbursement request. No
31 payer shall base a reimbursement request for a particular claim on
32 extrapolation of other claims, except under the following
33 circumstances:

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

36 (b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

39 e. (1) A prepaid prescription service organization or its agent,
40 hereinafter the payer, shall establish an internal appeal mechanism
41 to resolve any dispute raised by a health care provider regardless of
42 whether the health care provider is under contract with the payer
43 regarding compliance with the requirements of this section or
44 compliance with the requirements of sections 4 through 7 of
45 P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54). No dispute
46 pertaining to medical necessity which is eligible to be submitted to
47 the Independent Health Care Appeals Program established pursuant
48 to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of

1 an appeal pursuant to this subsection. The payer shall conduct the
2 appeal at no cost to the health care provider.

3 A health care provider may initiate an appeal on or before the
4 90th calendar day following receipt by the health care provider of
5 the payer's claims determination, which is the basis of the appeal,
6 on a form prescribed by the Commissioner of Banking and
7 Insurance which shall describe the type of substantiating
8 documentation that must be submitted with the form. The payer
9 shall conduct a review of the appeal and notify the health care
10 provider of its determination on or before the 30th calendar day
11 following the receipt of the appeal form. If the health care provider
12 is not notified of the payer's determination of the appeal within 30
13 days, the health care provider may refer the dispute to arbitration as
14 provided by paragraph (2) of this subsection.

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

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

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

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

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

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

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

6 (a) signed by the arbitrator;

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

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

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

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

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

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

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

42 g. Any person found in violation of this section with a pattern
43 and practice as determined by the Commissioner of Banking and
44 Insurance shall be liable to a civil penalty as set forth in section 17
45 of P.L.2005, c.352 (C.17B:30-55).¹
46 (cf: P.L.2005, c.352, s.16)

47
48 ¹**[2.] 9.**¹ This act shall take effect immediately and shall be
49 retroactive to March 9, 2020.