Sponsored by:
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Co-Sponsored by:
Assemblywoman Downey, Assemblymen Benson, Mejia, Assemblywomen Vainieri Huttle and Pinkin

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

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

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

(1) The Commissioner of Human Services shall [postpone all], unless there is a reasonable indication of willful fraud, abuse, or excessive or egregious billing practices, suspend, for a period of 90 days, and may subsequently suspend, in increments of 30 days, Medicaid audits of health care providers related to medical necessity, DRG coding, utilization management, or level of care. The Commissioner of Human Services shall apply for such State Medicaid plan amendments or Medicaid waivers as may be necessary to implement the provisions of this paragraph and to maintain federal financial participation for State Medicaid expenditures. This paragraph shall not apply to any audit that is required by the federal government in order to receive federal financial participation for State Medicaid expenditures unless the department receives federal approval to waive such a requirement.

(2) The Commissioner of Banking and Insurance shall [unlessthere is a reasonable indication of willful fraud, abuse, or excessive or egregious billing practices, suspend, for a period of 90 days, and may subsequently suspend, in increments of 30 days, the filing of any and all audits retrospective reviews of health care provider claims based on medical necessity, DRG coding, utilization management, or level of care, which audits would otherwise be required by the commissioner to be filed with the Department of Banking and Insurance by health insurance carriers for any purposes, including but not limited to medical necessity, DRG coding, utilization management, or level of care, which audits would otherwise be required by the commissioner to be filed with the Department of Banking and Insurance by health insurance carriers for any purposes, including but not limited to medical necessity, DRG coding, utilization management, or level of care.

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 emergency.

(3) A health insurance carrier shall:

(a) suspend [all] claims audit [related] activities, [including but not limited to] such as 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 for services obtained to diagnose coronavirus disease 2019 or obtained as a result of a coronavirus disease 2019 diagnosis;

(b) suspend [all administrative and technical denials of claims, including] 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, [services related to identifying and mitigating the spread of the disease,] DRG coding, utilization management, or level of care, unless there is [an] a reasonable indication of willful fraud [and] abuse, or excessive or egregious billing practices;

(d) suspend preauthorization, and concurrent review for outpatient services inpatient services related to coronavirus disease 2019;

(e) be prohibited from denying emergency department and inpatient hospital services related to coronavirus disease 2019 as not medically necessary on retrospective review, unless there is a reasonable indication of willful fraud, abuse, or excessive or egregious billing practices, 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 [to] 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 1\(^{45} 90\) 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 \(^{1}[\text{and State of Emergency}]\) 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 \([\text{or entity}]\), which, acting within the scope of its licensure or certification, provides health care services, \([\text{and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional}]\) and\(^{1}\) whose professional practice is regulated pursuant to Title 45 of the Revised Statutes \([\text{and}]\). “Health care provider” shall also mean\(^{1}\) a hospital or other health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) \(^{1}\).

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

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

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

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

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

(a) the health care provider is eligible at the date of service;
(b) the person who received the health care service was covered on the date of service;
(c) the claim is for a service or supply covered under the health benefits plan;
(d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51); and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

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

(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or
(iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

The payer may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section have been exhausted if the payer submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile each covered person's bill.
(b) If a payer has determined that the overpayment to the health care provider is a result of fraud committed by the health care provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care provider.

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:
(a) signed by the arbitrator;
(b) issued in writing, in a form prescribed by the Commissioner
of Banking and Insurance, including a statement of the issues in
dispute and the findings and conclusions on which the
determination is based; and
(c) issued on or before the 30th calendar day following the
receipt of the required documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) in administrative proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

If the payer issues a determination against the health care
provider, the payer shall notify the health care provider of its
findings on or before the 30th calendar day following the receipt of
the appeal form and shall include in the notification written
instructions for referring the dispute to arbitration as provided by
paragraph (2) of this subsection.
The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.

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

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

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

(4) An arbitrator's determination shall be:
   (a) signed by the arbitrator;
   (b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
   (c) issued on or before the 30th calendar day following the receipt of the required documentation.

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

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

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

f. As used in this section, "insured claim" or "claim" means a
claim by a covered person for payment of benefits under an insured
medical service corporation contract for which the financial
obligation for the payment of a claim under the contract rests upon
the medical service corporation.
g. Any person found in violation of this section with a pattern
and practice as determined by the Commissioner of Banking and
Insurance shall be liable to a civil penalty as set forth in section 17
of P.L.2005, c.352 (C.17B:30-55).1
(cf: P.L.2005, c.352, s.11.)

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

a. Within 180 days of the adoption of a timetable for
implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-
23), a health service corporation or its agent or a subsidiary that
processes health care benefits claims as a third party administrator,
shall demonstrate to the satisfaction of the Commissioner of
Banking and Insurance that it will adopt and implement all of the
standards to receive and transmit health care transactions
electronically, according to the corresponding timetable, and
otherwise comply with the provisions of this section, as a condition
of its continued authorization to do business in this State.
The Commissioner of Banking and Insurance may grant
extensions or waivers of the implementation requirement when it
has been demonstrated to the commissioner's satisfaction that
compliance with the timetable for implementation will result in an
undue hardship to a health service corporation, or its agent, its
subsidiary or its covered persons.
b. Within 12 months of the adoption of regulations establishing
standard health care enrollment and claim forms by the
Commissioner of Banking and Insurance pursuant to section 1 of
P.L.1999, c.154 (C.17B:30-23), a health service corporation or its
agent or a subsidiary that processes health care benefits claims as a
third party administrator shall use the standard health care
enrollment and claim forms in connection with all group and
individual contracts issued, delivered, executed or renewed in this
State.
c. Twelve months after the adoption of regulations establishing
standard health care enrollment and claim forms by the
Commissioner of Banking and Insurance pursuant to section 1 of
P.L.1999, c.154 (C.17B:30-23), a health service corporation or its agent shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

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

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

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

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

(a) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
(b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
(c) the payer disputes the amount claimed; or
(d) there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud,

the payer shall notify the health care provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and health care provider in writing within 40 days of receiving a claim submitted by other than electronic means, that:
(i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
(ii) the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;
(iii) the payer disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or
(iv) the payer finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

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

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

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

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

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

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

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

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

(10) With the exception of claims that were submitted
fraudulently or submitted by health care providers that have a
pattern of inappropriate billing or claims that were subject to
coordination of benefits, no payer shall seek reimbursement for
overpayment of a claim previously paid pursuant to this section
later than 18 months after the date the first payment on the claim
was made, except for claims subject to an audit that had been
suspended pursuant to the provisions of P.L. , c. (now
pending before the Legislature as this bill). No payer shall seek
more than one reimbursement for overpayment of a particular
claim. At the time the reimbursement request is submitted to the
health care provider, the payer shall provide written documentation
that identifies the error made by the payer in the processing or
payment of the claim that justifies the reimbursement request. No
payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:
(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:
(i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
(ii) the funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal set forth under paragraphs (1) and (2) of subsection e. of this section are exhausted; or
(iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:
   (a) signed by the arbitrator;
   (b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
   (c) issued on or before the 30th calendar day following the receipt of the required documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) No health care provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to subsection e. of this section or the claim is subject to continual claims submission. No health care provider shall seek more than one reimbursement for underpayment of a particular claim.
(1) A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care provider regardless of whether the health care provider is under contract with the payer regarding compliance with the requirements of this section or compliance with the requirements of sections 4 through 7 of P.L.2005, c.352 (C.17B:30-51 through C.17B:30-54). No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care provider.

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

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

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

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

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

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

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

(4) An arbitrator’s determination shall be:

(a) signed by the arbitrator;

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

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

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

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

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

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

f. As used in this section, “insured claim” or “claim” means a claim by a covered person for payment of benefits under an insured policy for which the financial obligation for the payment of a claim under the policy rests upon the health insurer.
g. Any person found in violation of this section with a pattern
and practice as determined by the Commissioner of Banking and
Insurance shall be liable to a civil penalty as set forth in section 17
of P.L.2005, c.352 (C.17B:30-55).1
(cf: P.L.2005, c.352, s.13)

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

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

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

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

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

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

(1) Effective 180 days after the effective date of P.L.1999,
c.154, a health insurer or its agent, hereinafter the payer, shall remit
payment for every insured claim submitted by a covered person or
health care provider, no later than the 30th calendar day following
receipt of the claim by the payer or no later than the time limit
established for the payment of claims in the Medicare program
pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the
claim is submitted by electronic means, and no later than the 40th
calendar day following receipt if the claim is submitted by other
than electronic means, if:
(a) the health care provider is eligible at the date of service;
(b) the person who received the health care service was covered
on the date of service;
(c) the claim is for a service or supply covered under the health
benefits plan;
(d) the claim is submitted with all the information requested by
the payer on the claim form or in other instructions that were
distributed in advance to the health care provider or covered person
in accordance with the provisions of section 4 of P.L.2005, c.352
(C.17:30-51) ; and
(e) the payer has no reason to believe that the claim has been
submitted fraudulently.
(2) If all or a portion of the claim is not paid within the time
frames provided in paragraph (1) of this subsection because:
(a) the claim submission is incomplete because the required
substantiating documentation has not been submitted to the payer;
(b) the diagnosis coding, procedure coding, or any other
required information to be submitted with the claim is incorrect;
(c) the payer disputes the amount claimed; or
(d) there is strong evidence of fraud by the provider and the
payer has initiated an investigation into the suspected fraud,
the payer shall notify the health care provider, by electronic
means and the covered person in writing within 30 days of
receiving an electronic claim, or notify the covered person and
health care provider in writing within 40 days of receiving a claim
submitted by other than electronic means, that:
(i) the claim is incomplete with a statement as to what
substantiating documentation is required for adjudication of the
claim;
(ii) the claim contains incorrect information with a statement as
to what information must be corrected for adjudication of the claim;
(iii) the payer disputes the amount claimed in whole or in part
with a statement as to the basis of that dispute; or
(iv) the payer finds there is strong evidence of fraud and has
initiated an investigation into the suspected fraud in accordance
with its fraud prevention plan established pursuant to section 1 of
P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
supporting documentation, to the Office of the Insurance Fraud
Prosecutor in the Department of Law and Public Safety established
(3) If all or a portion of an electronically submitted claim cannot
be adjudicated because the diagnosis coding, procedure coding or
any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.

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

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

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

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

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

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

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

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

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

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

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

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud
Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:
(a) signed by the arbitrator;
(b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
(c) issued on or before the 30th calendar day following the receipt of the required documentation.

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

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

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

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

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

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

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

\(^1\)7. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to read as follows:
7. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization or its agent or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

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

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

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

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

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

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

(2) If all or a portion of the claim is not paid within the time
frames provided in paragraph (1) of this subsection because:
(a) the claim submission is incomplete because the required
substantiating documentation has not been submitted to the payer;
(b) the diagnosis coding, procedure coding, or any other
required information to be submitted with the claim is incorrect;
(c) the payer disputes the amount claimed; or
(d) there is strong evidence of fraud by the provider and the
payer has initiated an investigation into the suspected fraud,
the payer shall notify the health care provider, by electronic
means and the covered person in writing within 30 days of
receiving an electronic claim, or notify the covered person and
health care provider in writing within 40 days of receiving a claim
submitted by other than electronic means, that:
(i) the claim is incomplete with a statement as to what
substantiating documentation is required for adjudication of the
claim;
(ii) the claim contains incorrect information with a statement as
to what information must be corrected for adjudication of the claim;
(iii) the payer disputes the amount claimed in whole or in part
with a statement as to the basis of that dispute; or
(iv) the payer finds there is strong evidence of fraud and has
initiated an investigation into the suspected fraud in accordance
with its fraud prevention plan established pursuant to section 1 of
P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with
supporting documentation, to the Office of the Insurance Fraud
Prosecutor in the Department of Law and Public Safety established

(3) If all or a portion of an electronically submitted claim cannot
be adjudicated because the diagnosis coding, procedure coding or
any other data required to be submitted with the claim was missing,
the payer shall electronically notify the health care provider or its
agent within seven days of that determination and request any
information required to complete adjudication of the claim.
Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

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

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

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

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

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

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.
(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

(10) With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made, except for claims subject to an audit that had been suspended pursuant to the provisions of P.L. 2005, c. 1 (C. 17:33A-15) (now pending before the Legislature as this bill). No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or
(d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An arbitrator's determination shall be:
   (a) signed by the arbitrator;
   (b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
   (c) issued on or before the 30th calendar day following the receipt of the required documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.
(4) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

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

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

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

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

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

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

(b) No payer shall deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists for the payer to believe that other insurance is available to the covered person. Good cause shall exist only if the payer's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered good cause.
(c) In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (a) or (b) of this paragraph, the claims payment shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means or on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

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

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

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

(b) in administrative proceedings;

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

(d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).
(11) (a) In seeking reimbursement for the overpayment from the health care provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect:

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

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

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

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

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

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

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

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

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

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

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

(2) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings. Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that a health care provider may aggregate his own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this subsection.
(3) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(4) An arbitrator's determination shall be:
   (a) signed by the arbitrator;
   (b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
   (c) issued on or before the 30th calendar day following the receipt of the required documentation.

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

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

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

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

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

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

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