

SENATE, No. 47

STATE OF NEW JERSEY

INTRODUCED JANUARY 18, 1996

By Senators LaROSSA and LITTELL

1 AN ACT concerning the resolution of certain health care claim  
2 payment disputes.

3

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

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7 1. a. A hospital service corporation shall adopt and, after approval  
8 by the Commissioner of Insurance pursuant to subsection b. of this  
9 section, implement a procedure which shall be used to resolve billing  
10 and payment disputes between health care providers and the  
11 corporation resulting from lost or incomplete health care claim forms  
12 or electronic submissions, or involving a request for additional  
13 explanation as to services or treatment rendered by a health care  
14 provider. The procedure shall provide for direct communication  
15 between the provider and the hospital service corporation and shall not  
16 require any action by the covered individual after initial verification  
17 that the covered individual received the services or treatment which  
18 are the subject of the dispute.

19 The procedure shall include an internal appeal process by which the  
20 hospital service corporation, the provider or the covered individual  
21 may request an independent review of the initial resolution of the  
22 dispute by an arbitrator or independent review organization agreed  
23 upon by the parties to the appeal.

24 b. A hospital service corporation shall, within 120 days of the  
25 adoption of regulations by the commissioner pursuant to this act, file  
26 its internal dispute resolution procedure with the commissioner. The  
27 procedure shall be deemed approved 90 days after filing if not  
28 affirmatively approved or disapproved within that 90 days. During the  
29 90-day review period, the commissioner may request such amendments  
30 to the procedure as he deems necessary. Any subsequent amendments  
31 to a filed and approved procedure shall be deemed approved 90 days  
32 after filing if not affirmatively approved or disapproved within 90 days  
33 from the filing date.

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35 2. a. A medical service corporation shall adopt and, after approval  
36 by the Commissioner of Insurance pursuant to subsection b. of this  
37 section, implement a procedure which shall be used to resolve billing

1 and payment disputes between health care providers and the  
2 corporation resulting from lost or incomplete health care claim forms  
3 or electronic submissions, or involving a request for additional  
4 explanation as to services or treatment rendered by a health care  
5 provider. The procedure shall provide for direct communication  
6 between the provider and the medical service corporation and shall not  
7 require any action by the covered individual after initial verification  
8 that the covered individual received the services or treatment which  
9 are the subject of the dispute.

10 The procedure shall include an internal appeal process by which the  
11 medical service corporation, the provider or the covered individual  
12 may request an independent review of the initial resolution of the  
13 dispute by an arbitrator or independent review organization agreed  
14 upon by the parties to the appeal.

15 b. A medical service corporation shall, within 120 days of the  
16 adoption of regulations by the commissioner pursuant to this act, file  
17 its internal dispute resolution procedure with the commissioner. The  
18 procedure shall be deemed approved 90 days after filing if not  
19 affirmatively approved or disapproved within that 90 days. During the  
20 90-day review period, the commissioner may request such amendments  
21 to the procedure as he deems necessary. Any subsequent amendments  
22 to a filed and approved procedure shall be deemed approved 90 days  
23 after filing if not affirmatively approved or disapproved within 90 days  
24 from the filing date.

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26 3. a. A health service corporation shall adopt and, after approval  
27 by the Commissioner of Insurance pursuant to subsection b. of this  
28 section, implement a procedure which shall be used to resolve billing  
29 and payment disputes between health care providers and the  
30 corporation resulting from lost or incomplete health care claim forms  
31 or electronic submissions, or involving a request for additional  
32 explanation as to services or treatment rendered by a health care  
33 provider. The procedure shall provide for direct communication  
34 between the provider and the health service corporation and shall not  
35 require any action by the covered individual after initial verification  
36 that the covered individual received the services or treatment which  
37 are the subject of the dispute.

38 The procedure shall include an internal appeal process by which the  
39 health service corporation, the provider or the covered individual may  
40 request an independent review of the initial resolution of the dispute  
41 by an arbitrator or independent review organization agreed upon by  
42 the parties to the appeal.

43 b. A health service corporation shall, within 120 days of the  
44 adoption of regulations by the commissioner pursuant to this act, file  
45 its internal dispute resolution procedure with the commissioner. The  
46 procedure shall be deemed approved 90 days after filing if not

1 affirmatively approved or disapproved within that 90 days. During the  
2 90-day review period, the commissioner may request such amendments  
3 to the procedure as he deems necessary. Any subsequent amendments  
4 to a filed and approved procedure shall be deemed approved 90 days  
5 after filing if not affirmatively approved or disapproved within 90 days  
6 from the filing date.

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8 4. a. An insurer issuing individual health insurance policies shall  
9 adopt and, after approval by the Commissioner of Insurance pursuant  
10 to subsection b. of this section, implement a procedure which shall be  
11 used to resolve billing and payment disputes between health care  
12 providers and the insurer resulting from lost or incomplete health care  
13 claim forms or electronic submissions, or involving a request for  
14 additional explanation as to services or treatment rendered by a health  
15 care provider. The procedure shall require direct communication  
16 between the provider and the health insurer and shall not require any  
17 action by the covered individual after initial verification that the  
18 covered individual received the services or treatment which are the  
19 subject of the dispute.

20 The procedure shall include an internal appeal process by which the  
21 insurer, the provider or the covered individual may request an  
22 independent review of the initial resolution of the dispute by an  
23 arbitrator or independent review organization agreed upon by the  
24 parties to the appeal.

25 b. A health insurer shall, within 120 days of the adoption of  
26 regulations by the commissioner pursuant to this act, file its internal  
27 dispute resolution procedure with the commissioner. The procedure  
28 shall be deemed approved 90 days after filing if not affirmatively  
29 approved or disapproved within that 90 days. During the 90-day  
30 review period, the commissioner may request such amendments to the  
31 procedure as he deems necessary. Any subsequent amendments to a  
32 filed and approved procedure shall be deemed approved 90 days after  
33 filing if not affirmatively approved or disapproved within 90 days from  
34 the filing date.

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36 5. a. An insurer issuing group health insurance policies shall adopt  
37 and, after approval by the Commissioner of Insurance pursuant to  
38 subsection b. of this section, implement a procedure which shall be  
39 used to resolve billing and payment disputes between health care  
40 providers and the insurer resulting from lost or incomplete health care  
41 claim forms or electronic submissions, or involving a request for  
42 additional explanation as to services or treatment rendered by a health  
43 care provider. The procedure shall require direct communication  
44 between the provider and the health insurer and shall not require any  
45 action by the covered individual after initial verification that the  
46 covered individual received the services or treatment which are the

1 subject of the dispute.

2 The procedure shall include an internal appeal process by which the  
3 insurer, the provider or the covered individual may request an  
4 independent review of the initial resolution of the dispute by an  
5 arbitrator or independent review organization agreed upon by the  
6 parties to the appeal.

7 b. A health insurer shall, within 120 days of the adoption of  
8 regulations by the commissioner pursuant to this act, file its internal  
9 dispute resolution procedure with the commissioner. The procedure  
10 shall be deemed approved 90 days after filing if not affirmatively  
11 approved or disapproved within that 90 days. During the 90-day  
12 review period, the commissioner may request such amendments to the  
13 procedure as he deems necessary. Any subsequent amendments to a  
14 filed and approved procedure shall be deemed approved 90 days after  
15 filing if not affirmatively approved or disapproved within 90 days from  
16 the filing date.

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18 6. a. A health maintenance organization shall adopt and, after  
19 approval by the Commissioner of Insurance pursuant to subsection b.  
20 of this section, implement a procedure which shall be used to resolve  
21 billing and payment disputes between health care providers and the  
22 health maintenance organization resulting from lost or incomplete  
23 health care claim forms or electronic submissions, or involving a  
24 request for additional explanation as to services or treatment rendered  
25 by a health care provider. The procedure shall require direct  
26 communication between the provider and the health maintenance  
27 organization and shall not require any action by the enrollee after  
28 initial verification that the enrollee received the services or treatment  
29 which are the subject of the dispute.

30 The procedure shall include an internal appeal process by which the  
31 health maintenance organization, the provider or the enrollee may  
32 request an independent review of the initial resolution of the dispute  
33 by an arbitrator or independent review organization agreed upon by  
34 the parties to the appeal.

35 b. A health maintenance organization shall, within 120 days of the  
36 adoption of regulations by the commissioner pursuant to this act, file  
37 its internal dispute resolution procedure with the commissioner. The  
38 procedure shall be deemed approved 90 days after filing if not  
39 affirmatively approved or disapproved within that 90 days. During the  
40 90-day review period, the commissioner may request such amendments  
41 to the procedure as he deems necessary. Any subsequent amendments  
42 to a filed and approved procedure shall be deemed approved 90 days  
43 after filing if not affirmatively approved or disapproved within 90 days  
44 from the filing date.

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46 7. The Commissioner of Insurance shall promulgate rules pursuant

1 to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1  
2 et seq.), to effectuate the purposes of this act.

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4 8. This act shall take effect on the 90th day following enactment.

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7 STATEMENT

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9 This bill provides for the resolution of routine billing disputes  
10 between insurers and health care providers without unnecessarily  
11 involving the insured. It requires hospital service, medical service and  
12 health service corporations, commercial health insurers and health  
13 maintenance organizations (HMO's) to adopt and implement, after  
14 approval by the Commissioner of Insurance, a procedure which shall  
15 be used to resolve billing and payment disputes between the provider  
16 and the payer which result from lost or incomplete health care claim  
17 forms or electronic submissions, or involve a request for additional  
18 explanation as to services or treatment rendered by a health care  
19 provider. The bill requires direct communication between the provider  
20 and the insurer and also provides that the covered individual shall not  
21 be required to take any action to rectify the problem, other than verify  
22 that the services or treatment were, in fact, received. The bill also  
23 requires that the procedure include an appeal process whereby the  
24 insurer, the provider or the covered individual may request an  
25 independent review of the initial resolution of the dispute by an  
26 arbitrator or independent review organization, agreed upon by the  
27 parties to the appeal.

28 This bill is part of a legislative package designed to effectuate the  
29 recommendations of the Healthcare Information Networks and  
30 Technologies (HINT) report to the Legislature under the joint auspices  
31 of Thomas Edison State College and the New Jersey Institute of  
32 Technology.

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37 Provides for resolution of certain billing disputes between insurer and  
38 health care provider without involving insured.