SENATE, No. 47

STATE OF NEW JERSEY

INTRODUCED JANUARY 18, 1996

By Senators LaROSSA and LITTELL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

subject of the dispute.

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

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

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

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

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

7. The Commissioner of Insurance shall promulgate rules pursuant

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

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

STATEMENT

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

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

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