

[First Reprint]
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:

6

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. ¹The decision of the arbitrator or
24 review organization, as appropriate, shall be binding on the provider
25 and hospital service corporation.¹

26 b. A hospital service corporation shall, within 120 days of the
27 adoption of regulations by the commissioner pursuant to this act, file
28 its internal dispute resolution procedure with the commissioner. The
29 procedure shall be deemed approved 90 days after filing if not
30 affirmatively approved or disapproved within that 90 days. During the
31 90-day review period, the commissioner may request such amendments

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted February 22, 1996.

1 to the procedure as he deems necessary. Any subsequent amendments
2 to a filed and approved procedure shall be deemed approved 90 days
3 after filing if not affirmatively approved or disapproved within 90 days
4 from the filing date.

5
6 2. a. A medical service corporation shall adopt and, after approval
7 by the Commissioner of Insurance pursuant to subsection b. of this
8 section, implement a procedure which shall be used to resolve billing
9 and payment disputes between health care providers and the
10 corporation resulting from lost or incomplete health care claim forms
11 or electronic submissions, or involving a request for additional
12 explanation as to services or treatment rendered by a health care
13 provider. The procedure shall provide for direct communication
14 between the provider and the medical service corporation and shall not
15 require any action by the covered individual after initial verification
16 that the covered individual received the services or treatment which
17 are the subject of the dispute.

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

23 ¹The decision of the arbitrator or review organization, as
24 appropriate, shall be binding on the provider and medical service
25 corporation.¹

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

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

1 that the covered individual received the services or treatment which
2 are the subject of the dispute.

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

8 ¹The decision of the arbitrator or review organization, as appropriate,
9 shall be binding on the provider and health service corporation.¹

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

20

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

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

38 ¹The decision of the arbitrator or review organization, as
39 appropriate, shall be binding on the provider and insurer.¹

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

1 filed and approved procedure shall be deemed approved 90 days after
2 filing if not affirmatively approved or disapproved within 90 days from
3 the filing date.

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

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

22 ¹The decision of the arbitrator or review organization, as
23 appropriate, shall be binding on the provider and insurer.¹

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

34
35 6. a. A health maintenance organization shall adopt and, after
36 approval by the Commissioner of Insurance pursuant to subsection b.
37 of this section, implement a procedure which shall be used to resolve
38 billing and payment disputes between health care providers and the
39 health maintenance organization resulting from lost or incomplete
40 health care claim forms or electronic submissions, or involving a
41 request for additional explanation as to services or treatment rendered
42 by a health care provider. The procedure shall require direct
43 communication between the provider and the health maintenance
44 organization and shall not require any action by the enrollee after
45 initial verification that the enrollee received the services or treatment
46 which are the subject of the dispute.

1 ¹The decision of the arbitrator or review organization, as
2 appropriate, shall be binding on the provider and health maintenance
3 organization.¹

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

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

19
20 ¹⁷. a. A dental service corporation shall adopt and, after approval
21 by the Commissioner of Insurance pursuant to subsection b. of this
22 section, implement a procedure which shall be used to resolve billing
23 and payment disputes between health care providers and the
24 corporation resulting from lost or incomplete health care claim forms
25 or electronic submissions, or involving a request for additional
26 explanation as to services or treatment rendered by a health care
27 provider. The procedure shall provide for direct communication
28 between the provider and the dental service corporation and shall not
29 require any action by the covered individual after initial verification
30 that the covered individual received the services or treatment which
31 are the subject of the dispute.

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

37 The decision of the arbitrator or review organization, as
38 appropriate, shall be binding on the provider and dental service
39 corporation.

40 b. A dental service corporation shall, within 120 days of the
41 adoption of regulations by the commissioner pursuant to this act, file
42 its internal dispute resolution procedure with the commissioner. The
43 procedure shall be deemed approved 90 days after filing if not
44 affirmatively approved or disapproved within that 90 days. During the
45 90-day review period, the commissioner may request such amendments
46 to the procedure as he deems necessary. Any subsequent amendments

1 to a filed and approved procedure shall be deemed approved 90 days
2 after filing if not affirmatively approved or disapproved within 90 days
3 from the filing date.¹

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

17 The procedure shall include an internal appeal process by which the
18 dental plan organization, the provider or the covered individual may
19 request an independent review of the initial resolution of the dispute
20 by an arbitrator or independent review organization agreed upon by
21 the parties to the appeal.

22 The decision of the arbitrator or review organization, as
23 appropriate, shall be binding on the provider and dental plan
24 organization.

25 b. A dental plan organization shall, within 120 days of the adoption
26 of 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.¹

35
36 ¹[7.] 9.¹ The Commissioner of Insurance shall promulgate rules
37 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
38 (C.52:14B-1 et seq.), to effectuate the purposes of this act. ¹The
39 regulations shall include procedures for the resolving of disputes
40 between carriers subject to the provisions of this act and covered
41 individuals.¹

42
43 ¹[8.] 10.¹ This act shall take effect on the 90th day following
44 enactment.

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