CHAPTER 67

AN ACT concerning organized delivery systems, supplementing P.L.1999, c.409 (C.17:48H-1 et seq.) and amending P.L.1999, c.155.

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

C.17:48H-33.1 Adoption, implementation of standards by organized delivery system for electronic transactions.

1. 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), an organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.), or a subsidiary thereof 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 an organized delivery system, 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), an organized delivery system 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 health benefits plans for which the organized delivery system has contracted with a carrier to provide health care services.

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), an organized delivery system 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 health benefits plan contract or policy.

d. (1) An organized delivery system or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a covered person or that covered person's agent or assignee if the health benefits plan contract or policy provides for assignment of benefits, 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 claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health benefits plan contract or policy;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

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

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

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on

the claim under the terms of the health benefits plan contract or policy, the payer shall notify the covered person, or that covered person's agent or assignee if the health benefits plan contract or policy provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) 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.

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

(5) 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).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent or assignee 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.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent or a assignee 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 modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits plan contract or policy for which the financial obligation for the payment of a claim under the health benefits plan contract or policy rests upon the organized delivery system.

C.17:48H-33.2 Organized delivery system subject to regulations under C.17B:30-26 et seq.

2. An organized delivery system which is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.) shall be subject to the provisions of P.L.1999, c.155 (C.17B:30-26 et seq.) and the regulations promulgated thereunder.

3. Section 1 of P.L.1999, c.155 (C.17B:30-26) is amended to read as follows:

C.17B:30-26 Definitions relative to payment of health and dental insurance plans.

1. As used in this act:

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a payer, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"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 and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Contract holder" means an employer or organization that purchases a contract for services.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.

"Covered service" means a health care service provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Eligible claim" or "claim for eligible services" means a claim for a covered service under a health benefits or dental plan, subject to any conditions imposed by the health benefits or dental plan.

"Eligible health care provider" means a health care provider whose services are reimbursable under a health benefits or dental plan.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Insured claim" or "claim" means a claim by a covered person for payment of benefits under an insured health benefits or dental plan.

"Insured health benefits or dental plan" means a health benefits or dental plan providing benefits for covered services to covered persons for which the contract holder pays a premium, which may include a deductible amount payable to a health care provider, and for which the financial obligation for the payment of claims under the plan rests upon the payer.

"Organized delivery system" means an organized delivery system that is either certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer" means a carrier or any agent thereof or an organized delivery system or any agent thereof who is doing business in the State and is under a contractual obligation to pay insured claims.

4. This act shall take effect immediately.

Approved April 19, 2001.