CHAPTER 352

AN ACT concerning health claims and amending and supplementing various parts of the statutory law.

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

C.17B:30-48 Short title.

1. This act shall be known and may be cited as the "Health Claims Authorization, Processing and Payment Act."

C.17B:30-49 Findings, declarations relative to processing health claims.

2. The Legislature finds and declares that:

a. Health care services available under health benefits plans must be promptly provided to covered persons under all circumstances, along with timely reimbursement to hospitals and physicians for their services rendered;

b. However, confusion still exists among consumers, hospitals, physicians and carriers with respect to time frames for communication of determinations by carriers to deny, reduce or terminate benefits under the provisions of a health benefits plan based upon utilization management decisions;

c. Since it is the declared public policy of the State that hospital and related health care services be of the highest quality and demonstrated need and be efficiently provided and properly utilized at a reasonable cost, the hospital care and related health care services must be appropriate to the condition of the patient and payment must be for services that were rendered to the patient;

d. Because it is fair and reasonable for hospitals and physicians to receive reimbursement for health care services delivered to covered persons under their health benefits plans and inefficiencies in any area of the health care delivery system reflect poorly on all aspects of the health care delivery system, and because those inefficiencies can harm the consumers of health care, it is appropriate for the Legislature now to establish uniform procedures and guidelines for hospitals, physicians and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers.

C.17B:30-50 Definitions relative to processing health claims.

3. As used in sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54):

"Authorization" means a determination required under a health benefits plan, that based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity.

"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.

"Commissioner" means the Commissioner of Banking and Insurance.

"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 plan.

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

"Generally accepted standards of medical practice" means standards that are based on: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas; and any other relevant factor as determined by the commissioner by regulation.

"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 Medicare+Choice contracts to the extent not otherwise prohibited by federal law. For the purposes of sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54), health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Civilian Health and Medical Program for the Uniformed Services, 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.

"Hospital" means a general acute care facility licensed by the Commissioner of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and long-term acute facilities.

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

"Network provider" means a participating hospital or physician under contract or other agreement with a carrier to furnish health care services to covered persons.

"Payer" means a carrier which requires that utilization management be performed to authorize the approval of a health care service and includes an organized delivery system that is certified by the Commissioner of Health and Senior Services or licensed by the commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer's agent" or "agent" means an intermediary contracted or affiliated with the payer to provide authorization for service or perform administrative functions including, but not limited to, the payment of claims or the receipt, processing or transfer of claims or claim information.

"Physician" means a physician licensed pursuant to Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

C.17B:30-51 Information required from payer.

4. a. A payer shall provide the following information concerning utilization management and the processing and payment of claims in a clear and conspicuous manner through an Internet website no later than 30 calendar days before the information or policies or any changes in the information or policies take effect:

(1) a description of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of health care services;

(2) a list of the material, documents or other information required to be submitted to the payer with a claim for payment for health care services;

(3) a description of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description;

(4) the payer's policy or procedure for reducing the payment for a duplicate or subsequent service provided by a health care provider on the same date of service; and

(5) any other information the commissioner deems necessary.

b. Any changes in the information or policies required to be provided pursuant to subsection a. of this section shall be clearly noted on the Internet website.

C.17B:30-52 Response by payer to request for authorization of health care services.

5. a. A payer shall respond to a hospital or physician request for authorization of health care services by either approving or denying the request based on the covered person's health benefits

plan. Any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a physician under the clinical direction of the medical director who shall be licensed in this State and communicated to the hospital or physician by facsimile, E-mail or any other means of written communication agreed to by the payer and hospital or physician, as follows:

(1) in the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or physician within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made;

(2) in the case of a request for authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or physician within a time frame appropriate to the medical exigencies of the case but no later than 24 hours following the time the request was made;

(3) in the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or physician within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made; and

(4) if the payer requires additional information to approve or deny a request for authorization, the payer shall so notify the hospital or physician by facsimile, E-mail or any other means of written communication agreed to by the payer and hospital or physician within the applicable time frame set forth in paragraph (1), (2) or (3) of this subsection and shall identify the specific information needed to approve or deny the request for authorization.

If the payer is unable to approve or deny a request for authorization within the applicable time frame set forth in paragraph (1), (2) or (3) of this subsection because of the need for this additional information, the payer shall have an additional period within which to approve or deny the request, as follows:

(a) in the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services, within a time frame appropriate to the medical exigencies of the case but no later than 15 days beyond the time of receipt by the payer from the hospital or physician of the additional information that the payer has identified as needed to approve or deny the request for authorization;

(b) in the case of a request for authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, no more than 24 hours beyond the time of receipt by the payer from the hospital or physician of the additional information that the payer has identified as needed to approve or deny the request for authorization; and

(c) in the case of a request for authorization for a covered person who will be receiving health care services in another setting, within a time frame appropriate to the medical exigencies of the case but no more than 15 days beyond the time of receipt by the payer from the hospital or physician of the additional information that the payer has identified as needed to approve or deny the request for authorization.

b. Payers and hospitals shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the time frames established pursuant to subsection a. of this section.

c. If a payer fails to respond to an authorization request within the time frames established pursuant to subsection a. of this section, the hospital or physician's request shall be deemed approved and the payer shall be responsible to the hospital or physician for the payment of the covered services delivered pursuant to the hospital or physician's contract with the payer.

d. If a hospital or physician fails to respond to a payer's request for additional information necessary to render an authorization decision within 72 hours, the hospital or physician's request

for authorization shall be deemed withdrawn.

C.17B:30-53 Reimbursement for covered services, conditions.

6. a. When a hospital or physician complies with the provisions set forth in section 5 of P.L.2005, c.352 (C.17B:30-52), no payer, or payer's agent, shall deny reimbursement to a hospital or physician for covered services rendered to a covered person on grounds of medical necessity in the absence of fraud or misrepresentation if the hospital or physician:

(1) requested authorization from the payer and received approval for the health care services delivered prior to rendering the service;

(2) requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the hospital or physician within the time frames established pursuant to section 5 of P.L.2005, c.352 (C.17B:30-52); or

(3) received authorization for the covered service for a patient who is no longer eligible to receive coverage from that payer and it is determined that the patient is covered by another payer, in which case the subsequent payer, based on the subsequent payer's benefits plan, shall accept the authorization and reimburse the hospital or physician.

b. If the hospital is a network provider of the payer, health care services shall be reimbursed at the contracted rate for the services provided.

c. No payer, or payer's agent, shall amend a claim by changing the diagnostic code assigned to the services rendered by a hospital or physician without providing written justification.

C.17B:30-54 Reimbursement according to provider contract.

7. A payer, or payer's agent, shall reimburse a hospital or physician according to the provider contract for all medically necessary emergency and urgent care health care services that are covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury.

8. Section 11 of P.L.1997, c.192 (C.26:2S-11) is amended to read as follows:

C.26:2S-11 Independent Health Care Appeals Program.

11. There is established the Independent Health Care Appeals Program in the department.

The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person or any health care provider acting on behalf of the covered person but only with the covered person's consent. The appeal review shall not include any decisions regarding benefits not covered by the covered person's health benefits plan.

a. A covered person or health care provider may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit if the person or health care provider has already completed the carrier's appeals process, if any, and the person or health care provider contests the final decision by the carrier. The person or health care provider shall apply to the department within 60 days of the date the final decision was issued by the carrier, in a manner determined by the commissioner.

b. As part of the application, the covered person or health care provider shall provide the department with:

(1) The name and business address of the carrier;

(2) A brief description of the covered person's medical condition for which benefits were denied, reduced or terminated;

(3) A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and

(4) A written consent to obtain any necessary medical records from the carrier and, in the case of a carrier which offers a managed care plan, any other out-of-network physician the person may have consulted on the matter.

c. The covered person shall pay the department an application processing fee of $25, except that the commissioner may reduce or waive the fee in the case of financial hardship. The health care provider acting on the covered person's behalf shall bear all costs associated with the appeal

that are normally paid by the covered person.

d. Prior to receiving hospital services, a covered person or a person designated by the covered person may sign a consent form authorizing a health care provider acting on the covered person's behalf to appeal a determination by the carrier to deny, reduce or terminate benefits. The consent is valid for all stages of the carrier's informal and formal appeals process and the Independent Health Care Appeals Program established pursuant to this section. A covered person shall retain the right to revoke his consent at any time.

e. A health care provider shall provide notice to the covered person whenever the health care provider initiates an appeal of a carrier's determination to deny, reduce or terminate a benefit or deny payment for a health care service based on a medical necessity determination made by the carrier. The health care provider shall provide additional notice to the covered person each time the health care provider continues the appeal to the next stage of an appeals process, including any appeal to an independent utilization review organization pursuant to this section.

9. Section 12 of P.L.1997, c.192 (C.26:2S-12) shall be amended to read as follows:

C.26:2S-12 Contract to conduct appeal reviews; procedures.

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

b. The commissioner shall establish procedures for transmitting the completed application for an appeal review to the independent utilization review organization.

c. The independent utilization review organization shall promptly review the pertinent medical records of the covered person to determine the appropriate, medically necessary health care services the person should receive, based on applicable, generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards or associations and any applicable clinical protocols or practice guidelines developed by the carrier. The organization shall complete its review and make its determination within 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall convey to the covered person or the health care provider acting on behalf of the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive, which shall be binding on the carrier. If all or part of the organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services. If the covered person is not in agreement with the organization's decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. If the commissioner determines that a carrier has failed to comply with the decision of an independent utilization review organization or is otherwise in violation of patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care Appeals Program and the independent utilization review organization and the findings and

recommendations of the organization made pursuant to this act are confidential and shall be used only by the department, the organization and the affected carrier for the purposes of this act. The medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

g. The commissioner shall establish a reasonable, per case reimbursement schedule for the independent utilization review organization.

h. The cost of the appeal review shall be borne by the carrier pursuant to a schedule of fees established by the commissioner.

10. Section 2 of P.L.1999, c.154 (C.17:48-8.4) is amended to read as follows:

C.17:48-8.4 Hospital service corporation to receive, transmit transactions electronically; standards.

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. 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. 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).

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

C.17:48A-7.12 Medical service corporation to receive, transmit transactions electronically; standards.

3. 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. 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).

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

C.17:48E-10.1 Health service corporation to receive, transmit transactions electronically; standards.

4. 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. 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).

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

C.17B:26-9.1 Health insurer to receive, transmit transactions relative to individual policies electronically; standards.

5. 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. 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).

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

C.17B:27-44.2 Health insurer to receive, transmit transactions relative to group policies electronically; standards.

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.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. 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).

15. Section 7 of P.L.1999, c.154 (C.26:2J-8.1) is amended to read as follows:

C.26:2J-8.1 Health maintenance organization to receive, transmit transactions electronically; standards.

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 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. 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.26:2S-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 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).

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

C.17:48F-13.1 Prepaid prescription service organization to receive, transmit transactions electronically; standards.

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. 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.26:2S-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 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).

C.17B:30-55 Violations, penalties; rules, regulations.

17. a. The Commissioner of Banking and Insurance shall enforce the provisions of sections 2 through 7 of P.L.2005, c.352 (C17B:30-49 through C.17B:30-54) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L.2005, c.352 (C.17B:30-48 et al.). A payer found in violation of those sections shall be liable for a civil penalty of not more than $10,000 for each day that the payer is in violation if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty

Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). The commissioner's determination shall be a final agency decision subject to review by the Appellate Division of the Superior Court.

b. If the Commissioner of Banking and Insurance has reason to believe that a person is engaging in a practice or activity, for the purpose of avoiding or circumventing the legislative intent of sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L.2005, c.352 (C. 17B:30-48 et al.), the Commissioner of Banking and Insurance is authorized to promulgate rules or regulations necessary to prohibit that practice or activity and levy a civil penalty of not more than $10,000 for each day that person is in violation of that rule or regulation.

c. For the purpose of administering the provisions of sections 2 through 7 of P.L.2005, c.352 (C.17B:30-49 through C.17B:30-54) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L.1999, c.154 (C.17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L.2005, c.352 (C.17B:30-48 et al.), 50% of the penalty monies collected pursuant to subsections a. and b. of this section shall be deposited into the General Fund. For the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et seq.), 50% of the penalty monies collected pursuant to subsections a. and b. of this section shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

d. A penalty levied pursuant to this section against a payer that does not reserve the right to change the premium shall be credited towards a penalty levied against the payer by the Department of Human Services for the same violation.

18. Section 11 of P.L.1999, c.154 (C.26:1A-15.1) is amended to read as follows:

C.26:1A-15.1 Advisory board on electronic data interchange technology, electronic health records policy.

11. The Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, shall establish an advisory board to make recommendations to the commissioners on health information electronic data interchange technology policy , including a Statewide policy on electronic health records, and measures to protect the confidentiality of medical information. The members of the board shall include, at a minimum, representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, health care consumers and the commissioner of each department in the State that uses individuals' medical records or processes claims for health care services. The members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

19. Section 16 of P.L.1999, c.154 (C.17B:30-25) shall be amended to read as follows:

C.17B:30-25 Thomas A. Edison State College to study, monitor effectiveness of electronic data interchange technology, electronic health records.

16. Thomas A. Edison State College shall study and monitor the effectiveness of electronic data interchange technology and electronic health records in reducing administrative costs, identify means by which new electronic data interchange technology and electronic health records can be implemented to effect health care system cost savings, and determine the extent of electronic data interchange technology and electronic health records use in the State's health care system.

The Departments of Health and Senior Services and Banking and Insurance or any other department upon request shall cooperate with and provide assistance to the college in carrying out its study pursuant to this section.

The college shall report to the Legislature and the Governor from time to time on its findings and recommendations.

C.17B:30-56 Rules, regulations.

20. The Commissioner of Banking and Insurance shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

C.17B:30-57 Liberal construction.

21. This act shall be liberally construed to effectuate the legislative purposes of the act.

22. This act shall take effect on the 180th day after enactment, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act.

Approved January 12, 2006.