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**BULLETIN 07-14**

**TO: PROVIDERS, CARRIERS AND PAYERS SUBJECT TO P.L. 2005, C.352, AND OTHER INTERESTED PARTIES**

**FROM: STEVEN M. GOLDMAN, COMMISSIONER**

**RE: P.L. 2005, C.352 – HEALTH CLAIMS AUTHORIZATION, PROCESSING AND PAYMENT ACT (HCAPPA) – ARBITRATION PROGRAM**

The purpose of this bulletin is to advise providers, carriers, payers and other interested parties of actions taken by the Department of Banking and Insurance (Department) in furtherance of implementation of the Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c.352. The Department issued Bulletin No. 06-16 on July 10, 2006 (available at <http://www.state.nj.us/dobi/bulletin06.html>) providing guidance concerning certain HCAPPA issues prior to that law becoming fully implemented. Bulletin 06-16 advised carriers and other interested parties of their rights and responsibilities under HCAPPA, and addressed issues such as the carrier's internal claims appeal mechanism, the independent claims arbitration program and the Department's involvement in a state bidding process to award a contract to a qualified vendor to operate the Program for Independent Claims Payment Arbitration (PICPA). At this time, the Department is announcing the award of the independent arbitration organization (AO) contract to MAXIMUS, Inc., and that MAXIMUS and the Department are working towards making the PICPA operational. The Department expects that the PICPA will begin accepting applications on or about July 2, 2007. Should there be any change in this start date due to technical difficulties, our website will be updated.

**Background**

The HCAPPA, enacted on January 12, 2006, became effective on July 11, 2006. Among other things, the HCAPPA amended the Health Information Electronic Interchange Technology law (P.L. 1999, c. 154), with respect to claims payment and the establishment of an independent claims arbitration program to be administered through the Department. The HCAPPA requires carriers to establish an internal claims appeal mechanism and permits health care providers to request binding arbitration if the provider is dissatisfied with the outcome of a claim(s) appealed through the carrier's internal claims appeal mechanism. Carriers have had to comply with the HCAPPA-required internal claims appeal process since July 11, 2006, but the PICPA has yet to become operational due to the state bidding process for awarding the AO contract.

The State issued Request for Proposal #07-x-38874 on October 3, 2006, and bids were accepted until November 14, 2006. The contract awarded to MAXIMUS became final on March 15, 2007. The Notice of Award, T-2471, is available for review on the Department of Treasury's website at <http://www.state.nj.us/treasury/purchase/noa/contracts/t2471.shtml>. The

Department and MAXIMUS have been developing web-based tools and protocols for the submission of data to the PICPA. This process is nearing completion.

### **Submission of Claims to the PICPA**

On or about July 2, 2007, parties with claims eligible for arbitration may complete an application accessible online at [www.njpicpa.maximus.com](http://www.njpicpa.maximus.com), and submit the application, together with required review and arbitration fees, to the PICPA. Initially, applications can only be submitted online. Providers wishing to submit applications by mail should contact MAXIMUS using the contact information on their website at [www.njpicpa.maximus.com](http://www.njpicpa.maximus.com). The completed online applications can also be printed and/or saved for the applicant's own records. Supporting documentation may be submitted online, FAX'd or mailed using the case number generated through the online submission process. Fees must be submitted by mail at this time and must also include the case number. An application for arbitration will not be considered until the required application fees are received.

### **Claim eligibility**

A claim is eligible for arbitration if:

1. The claim was submitted to an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization, prepaid prescription service organization, or its agent, including an organized delivery system (ODS) or a third party administrator (TPA), for payment under a health benefits plan issued in this State. Claim disputes submitted to a self-funded entity, the State Health Benefits Program, a dental service corporation, or a dental plan organization (DPO) are not eligible for resolution through the PICPA;
2. The claim arises from health care services rendered on or after July 11, 2006;
3. The health care provider appealed the denied claim to the carrier by submitting the *Health Care Provider Application to Appeal a Claims Determination* available online at <http://www.state.nj.us/dobi/formlist.htm#352> to access the carrier's internal claims appeal process;
4. The carrier's internal claims appeal process was completed, **or** the carrier failed to comply with the processing and review timeframes with respect to the claim and the health care provider has documentation supporting that contention;
5. When aggregating claims (for the purpose of reaching the minimum \$1,000 dispute threshold), a health care provider aggregates claims by carrier and covered person **or** by carrier and CPT code; and
6. The health care provider timely submits the application for arbitration and the appropriate fees.

### **Timeliness of the Application for the PICPA**

HCAPPA permits an application for arbitration of a disputed claim to be submitted to the PICPA within 90 days<sup>1</sup> of the date that the carrier's final determination on the internal claim

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<sup>1</sup> Except as otherwise specified, "days" refers to calendar days.

appeal was due. HCAPPA requires the AO to render a decision on the case within 30 days following receipt of all required documentation and fees.

In Bulletin 06-16, the Department stated that claims eligible for arbitration would be considered timely if filed within 90-days following the receipt of a determination on the internal claims appeal, **or** within 60-days following the start-date of the PICPA, whichever occurred later. The Department intended the 60-day time period to address those claims appeals completed prior to the start-date of the PICPA. However, because of the time that it has taken to establish the PICPA, and the potential number of pending eligible claims, the Department believes it is appropriate to phase-in the deadlines for submission of applications for arbitration, and provide an extension of the deadline by which the AO must render a determination on an accepted case. Accordingly, the Department is setting forth the following deadlines:

**1. If the claims appeal was completed, or should have been completed, by the payer on or before July 31, 2007,** then the application for arbitration must be submitted no later than November 30, 2007, and the AO shall render a decision within 60 days following receipt of the required documentation **and** fees.

**2. If the claims appeal is completed, or should be completed, by the payer on or after August 1, 2007,** then the application for arbitration must be submitted within 90 days following the date that the claims appeal is (or should have been) completed by the payer. The AO shall render a decision on such accepted requests within 30 days following the date of receipt of the required documentation **and** fees.

### **Required Fees**

Both parties to an arbitration are required to pay a review fee **and** an arbitration fee. The party seeking to initiate arbitration must submit its fees with its arbitration application. If the application initially meets the criteria for acceptance, the AO will notify the responding party of the action and of the fee requirement. If, based on information from the responding party, the AO ultimately determines that the case does not meet the criteria for arbitration, the AO will return the arbitration fees to both parties, but will retain the review fees. The fees are as follows:

For arbitration of a **single** claim in which the amount in dispute is at least \$1,000, the AO requires **each party** to pay a \$50 review fee **and** a \$130 arbitration fee by submitting **two separate** checks or money orders (one for the review fee, and one for the arbitration fee) annotated by the application's case number.

For arbitration of **aggregated** claims in which the disputed amount **for each** individual claim is **less than \$1,000**, an additional \$50 review fee and \$130 arbitration fee will be assessed for every \$1,000 worth of disputed claim amounts. For example, five aggregated claims in which the disputed amount for each individual claim is \$900, for a total of \$4,500, would be assessed on the basis of four review and four arbitration fees.

For arbitration of **aggregated** claims in which the disputed amount **for each** individual claim **exceeds \$1,000**, fees will be assessed based on the number of individual claims rather than their dollar amount. For example, five aggregated claims in which the disputed amount for each individual claim is \$5,000 would be assessed on the basis of five review and five arbitration fees.

Further information regarding fees can be obtained from the AO.

## Reviews

The AO reviews the case based solely on the documented record. The AO will take phone calls to discuss the arbitration process and administrative issues only. Reviews will be performed by independent and impartial health claims professionals with at least five years of health claims processing experience. If the AO requires any information in addition to that already submitted by either party, the AO will make a request in writing, and the information must be supplied in writing within 10 days.

## Health Insurance Portability and Accountability Act (HIPAA)

The Department believes that release of personal health information (PHI) by a carrier and health care provider to the AO is permitted under HIPAA with a consent to disclosure for treatment, payment and health care operations (45 C.F.R. 164.506), and that no authorization is required for release of PHI in furtherance of the arbitration process (45 C.F.R. 164.512). Nevertheless, the Department prepared the *Consent to Representation In Appeals Of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals And Independent Arbitration of Claims* form, available online at <http://www.state.nj.us/dobi/chap352/352consentform.doc>, for health care providers to use in their discretion for arbitration. The AO may release PHI as required for the arbitration process, including communications with Department personnel. The AO or Department may produce reports for public consumption using aggregated and/or de-identified data only.

The Department requests that carriers and other payers provide the Department with information on how they and their claims-paying agents, if any, should be contacted for the arbitration process. The Department intends to provide this information to the AO to expedite communication between the AO and carriers/payers. At a minimum, contact information must include an individual employee's name and title, e-mail address, telephone number, phone and FAX numbers, and a postal address. The information should be sent by e-mail to: [PICPA@dobi.state.nj.us](mailto:PICPA@dobi.state.nj.us).

For questions regarding this Bulletin, contact [PICPA@dobi.state.nj.us](mailto:PICPA@dobi.state.nj.us). After the PICPA becomes operational, the Department will be promulgating regulations for the internal claims appeal process and the arbitration mechanism. The Department anticipates adding PICPA-related questions and answers to its website at <http://www.state.nj.us/dobi/chap352/352implementnotice.html> with other information about compliance with the HCAPPA.

6/29/07 \_\_\_\_\_  
Date

/s/ Steven M. Goldman \_\_\_\_\_  
Steven M. Goldman, Commissioner

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