INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

**Health Benefit Plans Prompt Payment of Claims** 

Proposed Amendments: N.J.A.C. 11:22-1.1, 1.2 and 1.4 through 1.10

Proposed New Rules: N.J.A.C. 11:22-1.8, 1.9 and 1.12

Proposed Repeals and New Rules: N.J.A.C. 11:22-1 Appendices A, B

and B-1

Proposed Repeal: N.J.A.C. 11:22-1 Appendix A-1

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15(e), P.L. 1999, c. 154, N.J.S.A. 17B:30-30 and 31 and P.L. 2005, c. 352.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2007-214

Submit comments by August 31, 2007 to:

Robert Melillo, Chief Legislative & Regulatory Affairs 20 West State Street PO Box 325 Trenton, NJ 08625-0325

FAX: 609-292-0896

Email: LegsRegs@dobi.state.nj.us

The agency proposal follows:

#### **Summary**

The Health Claims Authorization, Processing and Payment Act (HCAPPA or Act), P.L. 2005, c. 352, enacted on January 12, 2006 and effective July 11, 2006, established uniform procedures and guidelines for health insurance carriers and medical providers

to administer utilization management and claim payment processes. HCAPPA applies to all health insurance carriers except dental service corporations and dental plan organizations. Among other things, HCAPPA amends the Health Information Electronic Interchange Technology law (P.L. 1999, c. 154) with respect to both claims payment and the establishment of an independent claims arbitration program. HCAPPA maintains the current statutory timeframes for a carrier's payment of claims that meet the standards set forth in HCAPPA (that is, payment within 30 calendar days for claims submitted electronically, and 40 calendar days for claims submitted by other than electronic means), but imposes certain notice requirements on carriers denying payment and raises the interest rate for overdue payments from 10 percent to 12 percent per annum. Except for 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, HCAPPA limits the timeframe within which a carrier may seek reimbursement of overpaid claims to 18 months after the date the first payment on the claim was made. Likewise, providers may only seek reimbursement of underpaid claims within 18 months from the date the first payment was made. HCAPPA requires carriers to establish an internal appeal mechanism for resolution of claims payment disputes. If a provider remains dissatisfied after having pursued an appeal(s) through this internal appeal mechanism, HCAPPA permits the provider to request nonappealable and binding arbitration through an independent claims arbitration program administered by the Department of Banking and Insurance (Department). HCAPPA requires a claim dispute submitted for arbitration to be in an amount no less

than \$1,000, but claims may be aggregated by a provider to meet that minimum.

Since HCAPPA's effective date, the Department has issued two bulletins (Bulletin Nos. 06-16 and 06-17), several forms (for example, consent and notice forms regarding appeals of utilization management determinations and consent, notice and application forms regarding prompt payment of claims), and FAQs to provide guidance to carriers, health care providers and other interested parties concerning their rights and responsibilities pursuant to HCAPPA prior to the Department's adoption of rules implementing HCAPPA. All of this data appears on the Department's website at <a href="https://www.njdobi.org">www.njdobi.org</a>. This proposal implements those provisions of HCAPPA relating to claims payment and the establishment of the independent claims arbitration program, and includes amendments to the Department's current prompt payment of claims rules at N.J.A.C. 11:22-1 and new rules within that subchapter.

Specifically, these proposed amendments and new rules implementing both HCAPPA and P.L. 2005, c. 286 include the following:

N.J.A.C. 11:22-1.1, Purpose and scope, is being amended to include prepaid prescription service organizations within the scope of the rules.

Several definitions are being amended or added at N.J.A.C. 11:22-1.2. The current definition of "agent" is being replaced with a new definition that more accurately describes the functions of an agent and those entities considered to be agents. The definition of "carrier" is being amended to include prepaid prescription service organizations. The definition of "claim" is being amended to include a request from a provider, as well as a covered person, for payment of benefits under a policy or

contract issued by a carrier for which the financial obligation for the payment of a claim under the policy or contract rests in whole or in part with the carrier. The definition of "clean claim" is being revised to include an additional element (that is, that the health care provider providing the service or supply is eligible at the date of service), and to delete an existing element (that is, that the claim does not require "special treatment"). The definition of "health benefits plan" is being amended to include Medicare Advantage contracts within the definition, and to exclude Medicare risk contracts and the Civilian Health and Medical Program for Uniformed Services.

The proposed amendments add new definitions for "alternate dispute resolution," "arbitration," "arbitration organization," "arbitrator," "medical necessity" or "medically necessary," "network provider," "payment dispute," "prepaid prescription service organization" and "substantiating documentation."

N.J.A.C. 11:22-1.4, Claim submission requirements, is amended to replace the current requirement that carriers provide covered persons, at their request and annually, with data and forms used by the carrier for the manual and electronic submission of claims with the requirement that carriers provide certain claims processing and payment information through an internet website only. Another proposed amendment to that section would also include a new subsection, codified as new subsection (b), permitting carriers to impose certain claim submission deadlines that are consistent with timeframes set forth at N.J.S.A. 45:1-10.1 for licensed health care professionals and N.J.S.A. 26:2H-12.12 for licensed health care facilities. In cases where the carrier is other than the primary payer, the starting date in determining these

deadlines would commence from the date of payment, denial or notice from the primary payer, and not from the date of service.

N.J.A.C. 11:22-1.5, Prompt payment of claims, currently requires carriers to pay previously disputed or denied claims upon receipt of requested missing information or documentation. This proposal requires carriers to pay previously disputed or denied claims upon receipt of requested missing information or "substantiating documentation," which includes any information specific to the particular health care service or supply provided to a covered person. N.J.A.C. 11:22-1.5 is further being amended to add a new subsection prohibiting carriers from denying, delaying or pending payment of a claim while seeking coordination of benefits information except for good cause. Additionally, the section is being revised to state that payment of a claim is considered to have been made on the date it is placed in the United States mail in a postpaid envelope containing the most recent address filed with the carrier by the provider, thereby placing the burden on providers to ensure that a current address is maintained by carriers. The current timeframe within which "clean claims" are to be paid (that is, 30 calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. §1395u(c)2(b), whichever is earlier; or 40 calendar days after receipt of the claim where the claim is submitted by other than electronic means) remains. The provision regarding the rate of interest to be paid on overdue claims currently appearing at N.J.A.C. 11:22-1.6 is being relocated as subsection (e) to this section, and is being revised to increase the interest rate payable by a carrier or its agent from 10 percent to

12 percent per year on all late-paid claims payments made on or after July 11, 2006 regardless of whether the services or supplies relating to the claim were provided prior to July 11, 2006. Interest begins to accrue 30 or 40 days, as applicable, from the date the carrier receives all information and documentation required to process the claim even if that date is prior to July 11, 2006. However, the current 10 percent rate will continue to apply to dental provider organizations and dental service corporations.

N.J.A.C. 11:22-1.6, Denied and disputed claims, requires carriers to either deny or dispute a claim that was not paid pursuant to N.J.A.C. 11:22-1.5. Carriers are required to either deny or dispute a pending claim within the timeframes set forth in this section. This section is being amended to set forth specific grounds on which a carrier may deny or dispute a claim, and to establish requirements with respect to the notice carriers must give to the provider and/or the covered person related to each of those reasons. If a carrier fails to comply with the notice requirements, the claim is deemed to be overdue. The current subsection (f) addressing carrier adjustments to previously-paid claims is being removed from this section, and a new section addressing that issue is being included at N.J.A.C. 11:22-1.8.

N.J.A.C. 11:22-1.7, Prompt payment of capitation payments, is being amended to reflect the increased interest amount to be paid by carriers or their agents, other than dental provider organizations and dental service corporations, on overdue capitation payments.

A new section is being added at N.J.A.C. 11:22-1.8, Reimbursement of overpaid claims. This new section sets forth the circumstances under which a carrier or its agent

may base a request for reimbursement of a paid claim on extrapolation of other claims. The section also reflects the HCAPPA requirement that carrier requests for reimbursement of overpaid claims shall be made within 18 months of the date on which the first payment on the claim was made. The rule applies to all reimbursement requests made after the effective date of HCAPPA (that is, July 11, 2006) and regardless of whether the claim was for services provided before or after that date. The rule sets forth the conditions under which carriers may offset overpayments, allows for providers to contest a notice of overpayment, and contains the procedural requirements for a carrier to request reimbursement of an overpaid claim.

A new section is being added at N.J.A.C. 11:22-1.9, Reimbursement of underpaid claims. Like carrier requests for reimbursement of overpaid claims, this new section establishes that provider requests for reimbursement of underpaid claims must be made within 18 months from the date the first payment on the claim was made unless the claim is the subject of an internal appeal or is subject to continual claims submission, and applies to all requests made after the effective date of HCAPPA (that is, July 11, 2006) regardless of when services were provided. The rule also contains the procedural requirements for a provider to request reimbursement of an underpaid claim.

Subsection (a) of N.J.A.C. 11:22-1.8, Internal appeals, recodified as N.J.A.C. 11:22-1.10 and amended, replaces the current rules addressing both internal and external appeals. This amended section applies only to internal appeals of payment disputes, and not to appeals related to medical necessity. The rule sets forth all requirements related to the appeal process for both providers and carriers, including the

provider's request for, and carrier's acknowledgment of, an appeal; the carrier's review and determination of an appeal; and the carrier's obligations depending on whether a determination is adverse or favorable to a provider.

N.J.A.C. 11:22-1.8, (b), (c) and (d) are recodified and amended as proposed new section N.J.A.C. 11:22-1.11, External appeals – alternate payment dispute resolution, which limits to dental provider organizations and dental service corporations the applicability of the current rules regarding an independent, external alternate payment dispute resolution (ADR) mechanism available to providers. This rule applies to providers requesting review of an adverse decision rendered through a dental provider organization's or dental service corporation's internal appeal process.

N.J.A.C. 11:22-1.12 is a new section implementing HCAPPA's provisions addressing nonappealable, binding independent arbitration of claims payment disputes. This section sets forth standards and procedures for the arbitration process, including arbitrable disputes, and arbitration application and proceeding requirements. The independent arbitration mechanism is available for claims payment disputes arising from a decision of an internal appeal conducted pursuant to a carrier's internal appeal mechanism described in this subchapter. It is not available for medical necessity disputes, which are addressed by the Health Care Quality Act (at N.J.S.A. 26:2S-11) and rules promulgated thereunder, or for claims payment disputes between a provider and either a dental provider organization or dental service corporation, which are addressed by an alternate payment dispute resolution process pursuant to proposed N.J.A.C. 11:22-1.11. Claims eligible for arbitration must have a disputed amount of at least

\$1,000, which may be aggregated by a health care provider, and an arbitration proceeding must be requested within 90 calendar days of the provider's receipt of the determination that is the basis of the appeal. Providers may not use the independent arbitration mechanism if a disputed claim amount is less than \$1,000 and cannot be aggregated with other disputed claim amounts in a timely manner to meet the \$1,000 arbitration threshold. The arbitration organization is required to conduct a proceeding within 30 days of receipt of a complete request for arbitration application, and to issue a complete written determination concerning the dispute that is consistent with the standards for such determinations set forth in subsection (n) of the new section. If a determination results in a carrier's paying a claim, the payment with interest is to be made within 10 business days following the issuance of the determination. If a determination is made that a provider has engaged in a pattern and practice of improper billing and a refund is due the carrier or its agent, the refund with interest may be awarded. The arbitrator may not award legal fees or costs.

N.J.A.C. 11:22-1.13 is the recodification with amendment of the Department's current reporting requirements rule at N.J.A.C. 11:22-1.9. The amended section eliminates the requirement for submission of separate quarterly reports on the timeliness of claims payments and quarterly and annual reports on the reasons for denial and late payment of claims; consequently, the format and instructions for those reports currently at subchapter Appendices A, A-1, B and B-1 are proposed for repeal. The current requirements are being replaced with combined quarterly and annual reports on the timeliness of claims payments and reasons for denial and late payment

of claims. The Department will determine a format for this report and notify carriers by way of bulletin and/or the Department's website; however, the new report should be comparable in format and content to the Appendix B report being repealed. The current requirements for exemption from having the annual report examined by an auditing firm are being changed to allow an exemption if a carrier has \$5 million or less of annual premium on its own, rather than on a consolidated basis. The amendments also reduce the documentation the Department requires to establish that annual premium is less than \$5 million. The new section requires all quarterly reports to be submitted in hard copy only, and all annual reports to be submitted both in hard copy and electronically. The changes also include updating certain mailing address and other information for submission of reports.

In addition to some minor "housekeeping" amendments, N.J.A.C. 11:22-1.10, Remediation/penalty, recodified as N.J.A.C. 11:22-1.14, is being amended to expand its application. Currently, N.J.A.C. 11:22-1.14(a) and (b) permit the Commissioner to impose certain remediation requirements and/or penalties for noncompliance with the reporting requirements at proposed N.J.A.C. 11:22-1.13 on either carriers alone, carriers and ODSs, or carriers and ODSs and their agents. This proposed amendment permits the Commissioner to impose all these remediation requirements and penalties on carriers and their agents. Also, a new subsection (c) is being added that allows the Commissioner to impose certain penalties on any person for violations of this subchapter under certain conditions.

As a 60-day comment period is provided for this notice of proposal pursuant to

N.J.A.C. 1:30-3.3(a)5, this notice is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

# **Social Impact**

Generally, the proposed amendments and new rules will have a favorable impact on carriers, providers and covered persons in that they establish standards and procedures concerning the prompt payment of health claims and a two-step process for resolving claims payment disputes. Nevertheless, some of the proposed amendments and/or new rules will impose certain requirements and result in outcomes that may impact some affected parties unfavorably and others more favorably. The amendments and new rules will have no direct impact on covered persons because the system by which claims are paid, and the disputes arising as a result of unresolved and unpaid claims, involve carriers and the providers who provided health care services to covered persons. Carriers may be somewhat unfavorably impacted by the requirement that they maintain websites containing detailed information concerning the manual and electronic submission of claims. On the other hand, they may be favorably impacted by being permitted to impose claim submission deadlines. Providers will benefit from the information contained on the carriers' websites, but may experience a slightly unfavorable impact in having to comply with the carriers' claim submission deadlines. Providers should not be unfavorably affected by the requirement that they notify carriers of their current address to ensure that claims are paid promptly.

Carriers may be unfavorably impacted if they deny or dispute a claim because

they will be required to notify the provider, as well as the covered person in certain cases, of the specific reason(s) for non-payment and the steps the provider must take to correct the claims information provided to the carrier. Providers will benefit from such notice because it will assist them in completing the claims submission process and securing payment of their claim(s).

The new rule requiring both carriers and providers to request reimbursement of overpaid and underpaid claims, respectively, within 18 months may unfavorably impact both parties because it limits the timeframe within which such requests may be made. However, carriers who are being requested to reimburse underpaid claims, as well as providers being requested to repay overpaid claims, will be favorably impacted in that they will know they can only receive such a request within a limited timeframe. Additionally, carriers may be unfavorably impacted by the new rules limiting the circumstances under which they may base a reimbursement request on extrapolation of other claims and offset overpayments. Providers will be favorably impacted by those same rules, and by their ability to contest a carrier's request for reimbursement of an overpayment. Providers should not be unfavorably impacted by the procedural requirements for requesting reimbursement of an underpaid claim.

The two-step claims dispute resolution process (that is, a carrier's internal appeal mechanism and nonappealable, binding independent arbitration) set up by these rules will also impact carriers and providers both favorably and unfavorably. Generally speaking, this system should be favorable to both parties in that it will allow claims disputes to be thoroughly and fairly reviewed and adjudicated. Nevertheless, both

appeal mechanisms place certain procedural requirements on both parties that may be somewhat burdensome. For the internal appeal phase, providers will be required to complete applications with all substantiating documentation and carriers are required to acknowledge such applications, conduct a review, provide notice of the outcome, and make payment if appropriate within strict timeframes. Providers will benefit from a review of their claim(s) by an independent arbitrator, but will also be required to comply with the application process, including meeting the \$1,000 minimum disputed amount, within the allotted timeframe for doing so. As stated above in the Summary, providers may not use the independent arbitration mechanism if a disputed claim amount is less than \$1,000 and cannot be aggregated with other disputed claim amounts in a timely manner to meet the \$1,000 arbitration threshold. Carriers may be unfavorably impacted in that their determinations adverse to providers will be reviewed and possibly reversed.

Carriers will be favorably impacted by the changes being made to the reporting requirements. Most carriers will experience a decrease in the amount of reporting, and more carriers will be able to request an exemption from the audited report requirement.

# **Economic Impact**

These proposed amendments and new rules may have an unfavorable economic impact on both carriers and providers. Carriers will be required to bear the expense related to posting claims processing and payment information on their websites. Except

for good cause, the new rules prohibit carriers from denying, delaying or pending payment of a claim while seeking coordination of benefits information, thereby requiring carriers to make payment sooner than they may have otherwise. The rules also increase the rate of interest on overdue claims and capitation payments from 10 percent to 12 percent per year. Moreover, if a carrier does not properly deny or dispute a claim(s), the claim(s) is deemed overdue, thereby compelling the carrier to pay the claim(s) at the increased interest rate. Carriers will be unfavorably impacted if they are required to reimburse providers who have successfully requested reimbursement of underpaid claims. The internal claims dispute appeal mechanism may have an unfavorable impact on carriers in that they will bear the costs related to the appeal process and, in some instances, pay previously denied claims. If a claim dispute is referred to arbitration, carriers will also be responsible for their share of the arbitration and review fees, in addition to any claim(s) payment plus interest. Providers may also be unfavorably impacted by these amendments and new rules if they are unsuccessful in their request for reimbursement of an underpaid claim(s) or in their appeal of an unpaid claim(s), or if they are required to re-pay a carrier for an overpaid claim(s). Providers will also be responsible for payment of their share of the fees related to the arbitration process.

Both carriers and providers may also be favorably impacted by these proposed amendments and new rules. Carriers would benefit from any successful attempts to request reimbursement of overpaid claims, and from any internal appeal or arbitration determination in their favor. Likewise, providers would be favorably impacted by any

successful attempts to request reimbursement of underpaid claims, and from any internal appeal or arbitration determination in their favor.

The proposed amendments to the reporting requirements at N.J.A.C. 11:22-1.13 on timeliness and reason for denial of claims will generally reduce carriers' compliance costs.

The proposed amendments and new rules will not have any direct economic impact on covered persons because, as stated above in the Social Impact, the system by which claims are paid, and the disputes arising as a result of unresolved and unpaid claims, involve carriers and the providers who provided health care services to covered persons.

# **Federal Standards Statement**

A Federal standards analysis is not required because the Department's proposed amendments and new rules are not subject to any Federal standards or requirements.

## Jobs Impact

The Department does not anticipate that these proposed amendments and new rules will result in the generation or loss of jobs.

# **Agriculture Industry Impact**

The proposed amendments and new rules will have no agriculture industry impact.

# **Regulatory Flexibility Analysis**

These proposed amendments and new rules, as described in the Summary above, may apply to some "small business" carriers, their agents, providers or arbitration organizations as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments and new rules would require carriers to maintain current claims submission requirements and other information on their websites for use by providers; to provide certain notices to providers regarding denied or disputed claims; to provide specific information to providers when requesting reimbursement of overpaid claims; to establish an internal appeals mechanism for the resolution of claim payment disputes; to file certain quarterly and annual claims payment reports with the Department; and to provide, upon request, certain fee schedules to providers who are compensated under a health benefits plan on a per-procedure basis.

The amendments and new rules would also require small business providers intending to request payment of underpaid claims to do so by filing specific information with carriers, and to initiate claims payment appeals and arbitration of claims payment disputes by filing detailed applications and other forms. The amendments and new rules also impose certain administrative requirements on the arbitration organization that will be conducting the claims payment dispute proceedings, such as issuing written determinations containing specific information.

While these requirements impose certain administrative, reporting and/or recordkeeping responsibilities on carriers and providers, it is unlikely that the

requirements would necessitate any additional professional services. The costs of compliance with the proposed amendments and new rules are discussed in the Economic Impact statement above. The proposed amendments and new rules do not establish differing compliance or reporting requirements or timetables applicable to small business carriers or providers, or exempt them from any of the requirements. As stated in the Summary above, HCAPPA was enacted specifically to put in place uniform procedures and guidelines for the administration of utilization management and claim payment processes in an effort to address existing confusion among carriers and providers concerning those issues. The Department believes that these proposed amendments and new rules should be applied uniformly because the legislative intent would be undermined if this proposal implementing HCAPPA applied different compliance requirements based on business size.

## **Smart Growth Impact**

The proposed amendments and new rules will have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

<u>Full text</u> of the proposal follows (additions indicated in boldface <u>thus</u>; deletions indicated in brackets [thus]):

#### **SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS**

## 11:22-1.1 Purpose and scope

- (a) (No change.)
- (b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, **prepaid prescription service organization**, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State; any organized delivery system; and to any agent, employee or other representative of such entity that processes claims for such entity.

#### 11:22-1.2 **Definitions**

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise[.] :

"ADR" [means] or <u>"</u>alternate dispute resolution<u>" means any procedure, other</u> than litigation, used in the conciliatory resolution of a dispute, including, but not limited to, mediation and arbitration, but shall not include claims payment disputes arbitration pursuant to P.L. 2006, c. 352.

["Agent" means any entity, including a subsidiary of a carrier, [or] an organized delivery system as defined by N.J.S.A. 17:48H-1 with which a carrier has contracted to perform claims processing or claims payment services.]

"Agent" means an intermediary contracted by or affiliated with a carrier to perform administrative functions including, but not limited to, the payment of claims or the receipt, processing or transfer of claims or claim information, such as an organized delivery system (ODS) as defined at

N.J.S.A. 17:48H-1 et seq. or a third party administrator as defined at N.J.S.A. 17B:27B-1 et seq.

"Arbitration" means the process of determining a payment dispute pursuant to P.L. 2005, c. 352 between a carrier and a provider by one or more impartial persons for a final and binding determination.

"Arbitration organization" means the nationally recognized, independent organization with which the Department of Banking and Insurance has contracted for the purpose of conducting arbitration proceedings and making a determination in accordance with the requirements of this subchapter.

"Arbitrator" means an individual employed by, or under contract with, the arbitration organization who is responsible for conducting an arbitration proceeding and making a determination in accordance with the requirements of this subchapter.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State, [and] a dental service corporation or dental plan organization authorized to issue dental plans in this State, or a prepaid prescription service organization.

"Claim" means a request by a covered person <u>or a provider</u> [, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person,] for payment [relating to health care

services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier] of benefits under a policy or contract issued by a carrier for which the financial obligation for the payment of a claim under the policy or contract rests in whole or in part with the carrier.

"Clean claim" means:

1. - 3. (\*No change.)

# 4. The health care provider providing the service or supply is eligible at the date of service; and

- [4.] <u>5.</u> The carrier does not reasonably believe that the claim has been submitted fraudulently. [; and
- 5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file]

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage [and risk contracts] **and Medicare Advantage contracts** to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, 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] [(]N.J.S.A. 39:6A-1 et seq.[)] or hospital confinement indemnity coverage.

[(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.]

"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. Depending upon the facts and circumstances of a particular case, medical necessity may include a service or supply that is cosmetic, dental, experimental or investigational. Medical necessity does not include claims payment issues.

"Network provider" means a health care provider who has entered into a contract with a carrier to provide health care services or supplies to covered persons for a predetermined fee or set of fees.

"Payment dispute" means a claim that remains unresolved between a carrier and provider following an internal appeal conducted pursuant to the carrier's internal appeal mechanism created pursuant to P.L. 2005, c. 352. A payment dispute shall not include a dispute pertaining to medical necessity that is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11.

"Prepaid prescription service organization" means any prepaid prescription service organization issued a certificate of authority pursuant to N.J.S.A. 17:48F-1 et seq.

"Substantiating documentation" means any information specific to the particular health care service or supply provided to a covered person.

# 11:22-1.4 Claim submission requirements

(a) [A carrier or its agent shall notify its participating health care providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims.] A carrier or its agent shall provide in a clear and conspicuous manner through an Internet website

including but not limited to (a)1 through 6 below. Carriers or their agents may change the required information and documentation as long as [participating] health care providers are given at least 30 days prior notice of the change in the requirements. Carriers or their agents shall also supply participating health care providers with a street address where claim submissions can be delivered by hand or registered/certified mail.

- 1. A list of the material, documents or other information required to be submitted to the carrier or its agent with a claim for payment for health care services or supplies;
- 2. A description of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description, and an explanation of the additional information required;
- 3. The policy or procedure for reducing the payment for a duplicate or subsequent service or supply provided by a health care provider on the same date;
  - 4. The procedure for payment to assistant surgeons;
- 5. The policy for reimbursement for administration of immunization and injectable medications; and
- 6. The policy regarding recognition of Current Procedural

  Terminology CPT modifiers.
  - (b) A carrier or its agent may impose a claim submission deadline

provided it is consistent with the timeframes set forth at N.J.S.A. 45:1-10.1 and 26:2H-12.12, as applicable. Where a carrier is not the primary payer under coordination of benefits, it may impose a deadline for submission of supplemental or coordination of benefit claims provided the timeframe for doing so is consistent with N.J.S.A. 45:1-10.1 and 26:2H-12.12, and the starting date in determining the deadline commences from the date of payment, denial or notice from the primary payer and not from the date of service.

## 11:22-1.5 Prompt payment of claims

- (a) A carrier [and] **or** its agent shall remit payment of clean claims pursuant to the following time frames:
  - 1. 2. (No change.)
- (b) [Carriers and their] **A carrier or its** agent[s] shall pay claims that are disputed or denied because of missing information or **substantiating** documentation within 30 or 40 calendar days of receipt of the missing information or **substantiating** documentation, as applicable, pursuant to (a) above.
- (c) No carrier or its agent shall deny, delay or pend payment of a claim in whole or in part while seeking coordination of benefits information unless good cause exists for the carrier or its agent to believe that other insurance is available to the covered person. Good cause shall exist only if the carrier's or agent's records indicate that other coverage exists. Routine requests to determine whether coordination of benefits exists shall not be considered

#### good cause.

- [(c)] **(d)** Payment of a claim shall be considered to have been made:
- On the date a draft or other valid instrument equivalent to payment
  was placed in the United States mail in a [properly addressed,] postpaid envelope
  containing the most recent address filed by the provider with the carrier or
  its agent; or
- 2. If not paid pursuant to [(c)] **(d)**1 above, on the date of delivery **to the payee** of a draft or other valid instrument equivalent to payment.
- (e) If a dental provider organization or a dental service corporation fails to pay a clean claim within the time limits set forth in this section, the dental provider organization or dental service corporation shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. For claims paid on or after July 11, 2006 by a carrier or its agent other than a dental provider organization or a dental service corporation, if the carrier or its agent fails to pay a clean claim within the time limits set forth in this section, the overdue payment shall include simple interest on the claim amount at the rate of 12 percent per year and shall include the interest amount with the claim amount at the time the overdue claim is paid. For all carriers, interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is

received by the carrier even if that date is prior to July 11, 2006. The carrier may aggregate interest amounts up to \$25.00, with the consent of the provider.

[(d)] (No change in text.)

# 11:22-1.6 Denied and disputed claims

- (a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5. A carrier's or its agent's characterization of a claim as pending shall not release the carrier of its obligation to either deny or dispute a claim in accordance with this section. [The pending of a claim does not constitute a dispute or denial.] The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify [both] the covered person, when he or she will have increased responsibility for payment, and the provider of the basis for its decision to deny or dispute, including:
- The identification and explanation of all reasons why the claim was denied or disputed;
- [i. If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

- ii. Examples of reasons why a claim cannot be entered into the claims system include: group not covered on date of service; employee/dependent not covered on date of service; non-payment of premium; missing data fields; missing or incorrect data (for example, CPT code, date of service, provider name); and ineligible provider.
- iii. If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, the carrier's first review after the claim is entered shall identify all applicable reasons for any denial or disputed claim.
- iv. A carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.
- 2. Where missing information or documentation is a reason for denying or disputing a claim, the notice shall identify with specificity the additional information or documentation that is required and the carrier shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the provider;
- 3. If the amount of the claim is disputed, an explanation of the reason for the dispute, including any change of coding performed by the carrier and the reasons for such change of coding; and]

# 2. If the claim is incomplete, the notice shall include a statement

specifically identifying the substantiating documentation or other information that is required for adjudication of the claim. The carrier shall engage in a good faith effort to expeditiously obtain such substantiating documentation or other information by, among other things, telephoning the provider;

- 3. If the diagnosis coding, procedure coding, or any other required information required to be submitted with the claim is incorrect, the notice shall include a statement specifically identifying the information that must be corrected for adjudication of the claim;
- 4. If the carrier or its agent disputes the amount of the claim in whole or in part, the notice shall include a statement of the basis for that dispute, including any change of coding performed by the carrier and the reasons for such change of coding;
- 5. 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 carrier or its agent shall electronically notify the health care provider or its agent, within seven days of receipt of the claim, of that determination and request any information required to complete adjudication of the claim. If the missing information is subsequently submitted, the carrier's or its agent's first review after the claim is entered into the claim system shall identify all applicable reasons for any denied, delayed or disputed claim;

- 6. If the carrier or its agent finds there is strong evidence of fraud, the notice shall state that it has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to N.J.S.A. 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 N.J.S.A. 17:33A-16; and
- [4] <u>7.</u> The <u>notice shall include the</u> toll free telephone number [for] <u>through which</u> the carrier or its agent [who] can be contacted by the provider or covered person to discuss the claim.
- (b) [A] <u>If a carrier or its agent [that does not]</u> <u>denies or disputes a claim in</u> <u>whole or in part and fails to provide the notice required by (a) above, the claim shall be deemed to be overdue [shall waive its right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with the carrier's Fraud Prevention and Detection Plan].</u>
- [(c) If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to \$25.00, with

the consent of the provider.]

- [(d)] **(c)** If a carrier **or its agent** subject to the provisions of N.J.S.A. 17:33A-1 et seq. has reason to believe that the claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 or, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.
  - [(e)] (d) (No change in text.)
- [(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable error(s) in the submission, processing or payment of a particular claim(s), and shall not be based on extrapolation, with the following exceptions:
  - 1. Where the extrapolation, including the method, is non-binding;
  - 2. In judicial or quasi-judicial proceedings, including arbitration;
  - 3. In governmental administrative proceedings;
- 4. Where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or
  - 5. Where there is clear evidence of claim fraud or abuse by the provider.]

# 11:22-1.7 Prompt payment of capitation payments

(a) Payment of a capitation payment to a health care provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due

date of the payment in the contract if:

- 1. (No change.)
- 2. The health care provider has supplied such information to the [insurer] **carrier or its agent** as may be required under the contract before payment is to be made.
- (b) An overdue payment <u>from a dental provider organization or a dental service corporation to a provider</u> shall [include] <u>bear</u> simple interest on the amount of the payment at the rate of 10 percent per year and [shall add] the interest amount [to] <u>shall be included in</u> the payment [when it] <u>at the time the overdue payment</u> is made. <u>An overdue payment from all other carriers or their agents on all claims paid on or after July 11, 2006, shall bear simple interest on the amount of the payment at the rate of 12 percent per year and the interest <u>amount shall be included in the payment at the time the overdue payment is made.</u></u>

#### 11:22-1.8 Reimbursement of overpaid claims

- (a) No carrier or its agent shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:
  - 1. In judicial or quasi-judicial proceedings, including arbitration;
  - 2. In governmental administrative proceedings;
  - 3. Where relevant records required to be maintained by the

provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or

- 4. Where there is clear evidence of claim fraud or abuse by the provider and the carrier has investigated the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 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 N.J.S.A. 17:33A-16.
- (b) A carrier or its agent may request reimbursement for the overpayment of a claim only if the carrier or agent submits a written reimbursement request to the provider within 18 months of the date on which the first payment on the overpaid claim was made. This requirement shall apply to all reimbursement requests made after July 11, 2006, and regardless of whether the claim was for services provided before or after that date.
- 1. The written reimbursement request shall be a separate notice to the provider and shall include:
  - i. A clear identification of the claim;
  - ii. The name of the patient and the date of the service;
- iii. An explanation of the basis upon which the carrier or its agent believes the amount paid on the claim was in excess of the amount due, and

- iv. Notice to the provider of his or her right to contest the reimbursement request.
- 2. No carrier or its agent may seek more than one reimbursement for overpayment of a particular claim.
- 3. No carrier or its agent in seeking reimbursement for overpayment of a claim 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 reimbursement request and initiates an appeal pursuant to N.J.A.C. 11:22-1.10 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 pursuant to N.J.A.C. 11:22-1.10 and 1.12, (or in the case of dental service corporations and dental plan organizations, pursuant to N.J.A.C. 11:22-1.10 and 1.11) have been exhausted; or
- <u>iii. A monetary penalty against the reimbursement</u>
  request, including but not limited to, an interest charge or a late fee.
- 4. A carrier or its agent may offset against a provider's future claims an overpayment to a provider on which a carrier or its agent issued a reimbursement request pursuant to this subsection only if:

- i. The offset action applies to claims submitted by the health care provider after the 45th calendar day following the submission of a reimbursement request to the provider, or after the provider has exhausted his or her rights to appeal pursuant to N.J.A.C. 11:22-1.10 and 1.12 (or in the case of dental service corporations and dental plan organizations, pursuant to N.J.A.C. 11:22-1.10 and 1.11);
- ii. The carrier or its agent submits to the provider in writing a detailed offset notice so that the provider is able to reconcile each covered person's bill that is the subject of the offset action;
  - iii. The provider does not contest the offset action; and
- iv. The provider was given 30 days after receipt of the offset notice to reimburse the carrier or its agent for the overpayment and did not reimburse the carrier or its agent.
- 5. A provider may contest a reimbursement request through the internal and external appeal processes set forth at N.J.A.C. 11:22-1.10 and 1.12, except that dental service corporations and dental plan organizations may appeal pursuant to N.J.A.C. 11:22-1.10 and 1.11.
  - 6. The limitations of this subsection shall not apply:
- i. Where an overpayment is the result of provider fraud that has been reported to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to N.J.S.A. 17:33A-16;

ii. Where a provider has demonstrated a pattern of inappropriate billing; or

iii. Where a claim(s) is subject to coordination of benefits (COB).

# 11:22-1.9 Reimbursement of underpaid claims

- (a) No health care provider shall request reimbursement from a carrier or its agent or from a covered person later than 18 months from the date the first payment on the claim was made unless the claim is the subject of an internal appeal pursuant to N.J.A.C. 11:22-1.10 or is subject to continual claims submission. This requirement shall apply to all reimbursement requests made after July 11, 2006 and regardless of whether the claim was for services provided before or after that date.
- 1. The written reimbursement request shall be a separate notice to the carrier or its agent or the covered person and shall include:
  - i. A clear identification of the claim;
- <u>ii. The name of the provider's patient and the date of service; and</u>
- <u>iii. An explanation of the basis upon which the provider</u> believes the amount paid on the claim was less than the amount due.
- 2. No health care provider shall seek more than one reimbursement for underpayment of any particular claim.

3. A claim(s) for which a provider requests reimbursement pursuant to this section shall not be eligible for appeal pursuant to the carrier's or its agent's internal appeal mechanism or the arbitration mechanism unless the claim(s) is submitted within the internal appeal timeframes set forth at N.J.A.C. 11:22-1.10.

# 11:22-[1.8] 1.10 Internal [and external] appeals

(a) Every carrier <u>or its agent</u> shall establish an internal appeals mechanism to resolve <u>payment</u> disputes between carriers or their agents and [participating] health care providers [relating to payment of claims], but not including appeals <u>related to medical necessity</u> made pursuant to N.J.A.C. [8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7] <u>11:24-8.5 through 8.7 and 11:24A-3.6 and 3.7</u>. [The internal appeals mechanism shall be described in the participating provider contract].

# 1. A health care provider may initiate an appeal of a carrier's or its agent's claim determination:

i. Within 90 calendar days of receipt of the carrier's or agent's determination that is the basis of the appeal. For out-of-network providers, the 90-day timeframe commences from the earlier of when the provider actually receives notice of the determination from the carrier or its agent or from the provider's patient; or

## ii. Within 90 calendar days of a carrier's or its agent's

missed due date for the claim determination, including at the provider's option, a claim that has been pended.

- 2. A provider shall initiate an appeal by submitting to the carrier or its agent a complete Health Care Provider Application to Appeal a Claims Determination form, which shall include all substantiating documentation required by the carrier or its agent. The carrier or its agent shall not reject an appeal based on the provider's failure to notify his or her patient of the appeal. The Application form and instructions are incorporated by reference into this subchapter as Appendix A and are also available for download on the Department's website at <a href="https://www.njdobi.org">www.njdobi.org</a>. A carrier or its agent may make available the Application form and instructions on its website to allow for electronic submission of Applications.
- 3. The carrier or its agent shall acknowledge receipt of an Application within five business days in the same manner in which the Application was received (that is, in writing or electronically). The acknowledgment shall state the following:
  - (i.) Whether the Application is complete or incomplete;
- (ii.) If incomplete, whether the Application is being accepted for review or rejected;
- (iii.) If rejected, the reason(s) for rejection, and any procedure for correcting the deficiencies within the 90-day timeframe set forth in this section. If a provider fails to correct any deficiencies in its

Application within the 90-day timeframe, the provider may proceed to arbitration in accordance with N.J.A.C. 11:22-1.12(b).

- 4. If an Application is accepted for review, the carrier or its agent shall conduct a review of the appeal and notify the health care provider of its determination within 30 calendar days of receipt of the complete application.
- [1.] The internal review shall be conducted by employees of the carrier <u>or its agent</u> who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider. <u>If the carrier or its agent fails to notify the provider of its determination within 30 calendar days of receipt of the complete application, the provider may initiate an arbitration proceeding in accordance with N.J.A.C. 11:22-1.12(c).</u>
- [2. The internal review shall be conducted and its results communicated] **5. The carrier or its agent shall communicate the results of the internal review** in a written decision to the provider [within 10 business days of the receipt of the appeal. The written decision], **which** shall include:
  - i. (No change.)
  - ii. A statement of the [participating] provider's grievance;
- iii. The decision of the [reviewers] along] reviewer(s), together with a detailed explanation of the [contractual and/or medical] basis for such decision;
  - iv. A description of the [evidence or] substantiating

documentation which supports the decision, including any relevant fee schedule(s), relevant formula(e) for payment of the claim(s) and controlling contract provision(s); and

v. If the payment decision is adverse to the health care provider in any respect, a description of the method to obtain an external review of the decision by arbitration pursuant to N.J.A.C. 11:22-1.12, except for payment decisions issued by dental service corporations and dental provider organizations, which shall provide a description of the alternate payment dispute resolution mechanism available pursuant to N.J.A.C. 11:22-1.11.

vi. If the decision favors the health care provider in any respect, the carrier or its agent shall be required to pay within 30 calendar days of the date of issuance of the carrier's or its agent's determination of the appeal, the amount due as determined by the internal appeal, if applicable, with accrued interest at the rate of 12 percent per year calculated from the date of receipt of the internal appeal by the carrier or its agent at its designated address. Dental provider organizations and dental service corporations shall pay the amount due as determined by the internal appeal with accrued interest at the rate of 10 percent per year calculated from the date of receipt of the internal appeal by the dental provider organization or dental service corporation.

11:22-1.11 External appeals - alternate payment dispute resolution

[(b)] (a) Every [carrier] dental service corporation and dental provider

<u>resolution</u> shall offer an independent, external <u>alternate payment dispute</u>

<u>resolution</u> (ADR) mechanism to [participating] health care providers to review adverse decisions of its internal appeals process.

- 1.(No change.)
- 2. The ADR mechanism, including the method to submit a claim through such mechanism, shall be described [in the participating provider contract and] in the final internal decision denying or disputing the [participating] health care provider's claim, in full or in part.
  - 3. (No change.).
- [(c) Carriers] **(b) Dental service corporations and dental provider organizations** shall annually notify [participating] providers in writing of the internal appeals process and the ADR mechanism and how they can be utilized.
- [(d) Carriers] (c) Dental service corporations and dental provider organizations shall annually report, in a format prescribed by the Department, [which includes] the number of internal and external provider appeals received and how they were resolved.

## <u>11:22-1.12</u> <u>External appeals - arbitration</u>

(a) Any dispute regarding the determination of an internal appeal conducted pursuant to a carrier's or its agent's internal appeal mechanism established pursuant to P.L. 2005, c. 352 and described at N.J.A.C. 11:22-1.10 may be referred to arbitration, except for disputes between a provider

and a dental service corporation or dental provider organization which may be referred to the ADR mechanism described at N.J.A.C. 11:22-1.11, and except for the following disputes that are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11:

- 1. Disputes involving whether a treatment or service is medically necessary;
- 2. Disputes involving whether a treatment or service is experimental or investigational;
- 3. Disputes involving whether a treatment or service is cosmetic; and
- 4. Disputes involving whether a treatment or service is medical or dental.
- (b) Any provider involved in a payment dispute for which any determination, including a determination of incompleteness, was made by a carrier's or its agent's internal appeal mechanism created pursuant to P.L. 2005, c. 352 and described at N.J.A.C. 11:22-1.10 may initiate an arbitration proceeding within 90 calendar days of the receipt of the determination that is the basis of the appeal.
- (c) A provider who has not been notified by a carrier or its agent within 30 calendar days of the carrier's or its agent's receipt of the appeal to be conducted pursuant to the internal appeal mechanism created by P.L.

- 2005, c. 352 and described at N.J.A.C. 11:22-1.10 may initiate an arbitration proceeding within 90 calendar days of the carrier's or its agent's missed due date for the determination on the internal appeal.
- (d) A provider shall initiate an arbitration proceeding by submitting a complete Request for Arbitration Application directly to the arbitration organization with which the Department has contracted pursuant to P.L. 2005, c. 352. Applications may be submitted electronically or by mail pursuant to the instructions accompanying the application form.
- (e) Upon receipt of a Request for Arbitration Application, the arbitration organization, or the Department at its option, shall review the application and make a determination regarding the eligibility of the claim(s) and completeness of the Application. The arbitration organization shall accept for processing a complete Application that meets the following criteria:
- 1. The covered person's health benefits plan under which the payment dispute has arisen was delivered or issued for delivery in New Jersey, and is not an out-of-State plan, a self-funded plan, or a Federal plan, except for Managed Medicaid;
- 2. The disputed claim amount shall be \$1,000 or more. The disputed claim amount may be aggregated by a provider for purposes of meeting the \$1,000 threshold requirement only by carrier and CPT code or by carrier and covered person. An Application with claims having an

aggregated payment dispute amount greater than \$2,000 shall be considered multiple Applications for purposes of arbitration fee calculations and may be adjudicated as separate arbitration proceedings. A non-aggregated claim equal to or greater than \$1,000 shall be considered a single Application and proceeding for purposes of arbitration fee calculations;

- 3. The provider initiating the arbitration request shall have rendered a covered service to a covered person under the health benefits plan at the time of the action on which the arbitration is based;
- 4. The service that is the subject of the arbitration request reasonably appears to be a covered service under the health benefits plan that covers the covered person, and the covered person was enrolled with the carrier at the time the service was rendered;
- 5. The Application includes, or the covered person has previously submitted, a fully-executed 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 signed by the covered person in the event that the covered person's confidential information accompanies the arbitration request, which is incorporated by reference into this subchapter as Appendix B and available for download on the Department's website at www.njdobi.org;
- 6. One-half of the arbitration organization's review fee and onehalf of the arbitration fee as set forth in the Request for Arbitration

Application shall accompany the application. If not included, the request for arbitration shall be deemed incomplete; and

- 7. The provider initiating the arbitration request has submitted to the arbitration organization all information requested by the arbitration organization as necessary to conduct the arbitration proceeding in addition to the Request for Arbitration Application.
- (f) The arbitration organization shall reject a Request for Arbitration Application received in excess of 90 calendar days after the provider's receipt of the carrier's or its agent's written determination on the internal appeal conducted pursuant to the internal appeal mechanism created by P.L. 2005, c. 352 and described at N.J.A.C. 11:22-1.10, or in excess of 90 calendar days after a carrier's or its agent's missed due date for the written determination of the provider's internal appeal conducted pursuant to the internal appeal mechanism created by P.L. 2005, c. 352 and described at N.J.A.C. 11:22-1.10.
- (g) Within five business days of receipt of the Request for Arbitration

  Application, the arbitration organization shall acknowledge receipt of the

  Application to the carrier or its agent and the provider and provide notice of

  any deficiencies in the Application or accompanying documents and of the

  procedure for correcting the deficiencies.
- (h) If a provider fails to correct any deficiencies within 15 business days of receipt of notice, the arbitration request application shall be deemed withdrawn.

- (i) If an arbitration request is rejected in whole or in part based on information submitted with the provider's Request for Arbitration Application, the arbitration organization shall retain the provider's review fee and refund the arbitration fee. If the request for arbitration is initially accepted, but later rejected as ineligible for arbitration based on information in whole or in part submitted by the carrier or its agent, the arbitration organization shall retain the review fees of both the provider and the carrier or its agent and refund the arbitration fees.
- (j) Within 30 days of receipt of a complete Request for Arbitration

  Application and accompanying documents as set forth in (e) above, the

  arbitrator shall conduct an arbitration proceeding to determine whether the

  provider requesting the arbitration was properly or improperly reimbursed

  for the claim(s) by the carrier or its agent and issue a written determination

  regarding the payment dispute.
- (k) The arbitration proceeding shall be conducted pursuant to the rules of the arbitration organization deemed acceptable by the Commissioner, including rules of discovery subject to confidentiality requirements established by State or Federal law.
- (I) The arbitration proceeding shall be limited to only the issue(s) in dispute for which the Request for Arbitration Application was made and accepted by the arbitration organization.
  - (m) The only evidence admissible in an arbitration proceeding or on

which the arbitrator's determination may be made are the documents submitted to, requested by, and accepted by, the arbitration organization by either the provider or the carrier or its agent involved in the payment dispute. In-person or telephonic testimony shall not be permitted.

- 1. Absent court order, the arbitration organization shall not provide any person, other than the Department, with copies of documentation received by or on behalf of a party(ies) to an arbitration proceeding, and as may be deemed necessary by incorporation or reference in its written arbitration determination. The arbitration organization shall provide prompt notice to the Department and the affected party(ies) to an arbitration proceeding of any subpoena or court order demanding information or documentation received from a party(ies) to an arbitration, or testimony related to an arbitration. If, as a result of a court order or subpoena, the arbitration organization is ultimately required to produce information or testify, it shall, to the extent practicable, provide advance notice to the Department and the affected party(ies); however, if not practicable, the arbitration organization shall provide notice to the Department and the affected party(ies) at the time it produces such information or testifies, or immediately thereafter.
- (n) The arbitrator shall issue a signed, written determination of the payment dispute, which shall explain each and every basis of the determination, and shall include, but not be limited to, a full and complete

## statement of the following:

- 1. The issue(s) in dispute;
- 2. Findings of fact;
- 3. Conclusions on which the determination was based, including all evidence relied on in support thereof; and
- 4. The amount of the award, if any, including interest, with the amount of the interest specified.
- (o) The Department shall determine the appropriateness of publication of an arbitration proceeding determination and shall consider, among other things, the general significance of the facts, issues and outcome of the particular determination to other claims disputes. No confidential and/or proprietary information concerning a particular arbitration proceeding shall be made public, and all such information shall be redacted from the determination prior to its publication.
- (p) The arbitrator's determination shall be nonappealable and binding on all parties to the payment dispute. The arbitrator's determination and/or award may be vacated or modified only in accordance with N.J.S.A. 2A:24-1 et seq.
- (q) If the arbitrator determines that a carrier or its agent has erroneously withheld or denied payment of a claim, the arbitrator shall order the carrier or its agent to make payment of the claim on or before the tenth business day following the issuance of the determination, together with

interest at the rate of 12 percent per annum accruing from the date the appeal was received by the carrier or its agent for resolution through the internal appeal process or, if that date is unknown, from 45 days prior to the date of filing the Request for Arbitration Application. If the arbitrator determines that a carrier or its agent has withheld or denied payment on the basis that information requested by the carrier or its agent was not submitted by the provider when the claim was initially processed by the carrier or its agent pursuant to its internal appeal process, the carrier or its agent shall not be required to pay any accrued interest.

- (r) If the arbitrator determines that a provider has engaged in a pattern and practice of improper billing and a refund is due to the carrier or its agent, the arbitrator may award the carrier or its agent a refund, including interest accrued at the rate of 12 percent per annum. Interest shall begin to accrue on the date the appeal was received by the carrier or its agent for resolution through the internal appeal process described at N.J.A.C. 11:22-1.10.
  - (s) The arbitrator shall not award legal fees or costs.

## 11:22-[1.9]**1.13 Reporting requirements**

(a) A carrier [or ODS] shall report to the Department on a quarterly and annual basis on the timeliness of claims payments [in the format set forth in Appendix A to this subchapter, incorporated herein by reference, on a quarterly basis,] and on

the reasons for denial and late payment of claims in [the] <u>a</u> format <u>to be determined</u> <u>by the Commissioner and distributed by bulletin or similar means and/or on the Department's website.</u> [set forth in Appendix B to this subchapter, incorporated herein by reference, on an annual and quarterly basis. Instructions for these documents are provided in subchapter Appendix A-1 and Appendix B-1, respectively, incorporated herein by reference.] Due dates for the reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and March 31 for the [fourth quarter in Appendix A and the] annual report [for Appendix B].

- (b) The annual report on **the timeliness of claims payments and** on the reasons for denial and late payment of claims shall be audited by a private auditing firm at the expense of the carrier [or ODS]. The annual report shall be accompanied by the report of the auditing firm that reviewed the report. In addition to the Department, copies of the audited annual report shall be sent to the Governor and the majority and minority offices of the Legislature.
  - (c) The report shall be submitted [to the Department] by the due date to:

New Jersey Department of Banking and Insurance

Life & Health Actuarial, 11th Floor

**Prompt Payment Reports** 

20 West State Street (for private Express Delivery)

PO Box [329] **325 (for regular US mail)** 

Trenton, New Jersey 08625-[0329] **0325** 

- (d) [Reports] All quarterly reports shall be submitted by the due date in hard copy only. All annual reports shall be submitted by the due date in both hard copy and electronically using an Excel spreadsheet by either e-mail, CD-ROM or Diskette. The Department shall provide a blank Excel template for use in filing this report. [and as an Excel spreadsheet by one of the following media:
  - 1. CD-ROM;
  - 2. Zip diskette; or
  - 3. Floppy diskette.]
- (e) A carrier [or ODS] may request an exemption from the requirements to have the annual report [required by (b) above] audited and to submit a report of the auditing firm. This exemption must be obtained on an annual basis. Such an exemption may be granted if the carrier [or ODS] meets the following conditions:
- 1. The carrier [or ODS] must file the annual [Appendix B] report [required by (a) above] in a timely manner. The report shall be accompanied by a request for exemption from the requirements that the report be audited and that a report of the auditing firm be submitted; **and**
- [2. The carrier or ODS shall have filed the four quarterly Appendix A reports required by (a) above in a timely manner, unless the carrier or ODS was exempted from such filing pursuant to (g) below; and]
- [3] <u>2</u>. The annual premiums earned by the carrier [or ODS] in New Jersey for all health benefits plans as defined in N.J.A.C. 11:22-1.2 were less than \$5 million in the year covered by the annual report for which the exemption is requested. The

carrier [or ODS] shall provide, in its request for exemption, [a reconciliation of these premiums to the net earned premiums for "health benefit plans" as defined at N.J.A.C. 11:4-23A.2 and as reported to the Commissioner pursuant to N.J.A.C. 11:4-23A.8(a)1. The \$5 million limit shall be applied on a consolidated basis for companies under common control.] a copy of the report of net earned premiums submitted to the Commissioner pursuant to N.J.A.C. 11:4-23A.8(a)1 or, alternatively, other evidence acceptable to the Commissioner that premiums are less than \$5 million.

- (f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:
  - 1. (No change.)
- 2. The carrier [or ODS] has not filed a report, made a refund, or paid an assessment required by law applicable to a carrier [or ODS]; or
- 3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of N.J.A.C. 11:22-[1.9] **1.13** and N.J.S.A. 17B:30-12 et seq.
- (g) A carrier [or ODS] which has obtained an exemption from filing an audited annual report under (e) and (f) above shall also be exempt from filing quarterly [Appendix A and B] reports for the year following the year for which the exemption was

obtained. If the carrier [or ODS] seeks an exemption from filing an audited annual report for the year following the year for which such an exemption was previously obtained, a separate request for an exemption shall be required for the audited annual report for that ensuing year.

## 11:22-[1.10] **1.14** Remediation/penalty

- (a) Upon review of the reports required by N.J.A.C. 11:22-[1.9] **1.13**, the Commissioner may require that the carrier or [ODS] **its agent**, at its own expense:
  - 1. Implement a plan of remedial action; and/or
- 2. [Have] **Require** the claims processing procedures of the carrier or its agent **to** be monitored by a private auditing firm for a period to be determined by the Commissioner.
- (b) The Commissioner may impose a civil penalty of not more than \$10,000 upon the carrier **or its agent**, to be collected pursuant to ["] the [penalty enforcement law] **"Penalty Enforcement Law**, N.J.S.A. 2A:58-1 et seq., if, following the remediation measures in (a) above, the Commissioner determines that:
  - 1. (No change.)
- 2. A carrier[, ODS or the agent of a carrier or ODS] **or its agent** has failed to pay interest as required pursuant to N.J.A.C. 11:22-1.7.
- (c) In addition to any other penalties provided by law, the

  Commissioner may impose a civil penalty as set forth at N.J.S.A. 17B:30-55

  against any person found in violation of this subchapter based upon their

having engaged in a pattern or practice of conduct as determined by the Commissioner.

inoregs/bbPromptPay(c. 352)