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INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Health Benefit Plans

Proposed Amendments: N.J.A.C. 11:22-1.1, 1.2, 1.5, 1.6, 1.8, 1.9, and 1.10

Proposed Repeal and New Rule: N.J.A.C. 11:22-1.4

Proposed New Rules: N.J.A.C. 11:22-1.8, 1.9, and 1.11 through 1.15

Proposed Repeals: N.J.A.C. 11:22-1 Appendix A, A-1, B, and B-1

Authorized By: Richard J. Badolato, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17B:30-30, 31, and 33; and P.L. 1999, c. 154, and P.L. 2005, c. 352.

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

Proposal Number: PRN 2017-207.

Submit comments by October 20, 2017, to:

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The agency proposal follows:

Summary

The Health Claims Authorization, Processing and Payment Act ("HCAPPA" or "Act"), P.L. 2005, c. 352 (N.J.S.A. 17B:30-48 et seq.), enacted on January 12, 2006, and effective July 11, 2006, established uniform procedures and guidelines for health carriers and medical providers to administer utilization management and claim payment processes. HCAPPA applies to all health carriers, but its definition of "carrier" does not include dental service corporations and dental plan organizations. Among other things, HCAPPA amends certain sections of the Health Information Electronic Interchange Technology (HINT) law, P.L. 1999, c. 154 (N.J.S.A. 17B:23 et seq.), with respect to both claims payment and the establishment of an independent claims payment arbitration program. HCAPPA maintains the current statutory timeframes for a carrier's payment of claims (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 most 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 health 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 also provides additional guidelines for health carriers to follow in providing the internal and external appeals for resolution of claims payment disputes. If a provider remains dissatisfied after having pursued an appeal(s) through an 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 payment 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 the effective date of HCAPPA, the Department has issued four bulletins (Bulletin Nos. 06-16, 06-17, 07-14, and 10-32); 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 and other information 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 information appears on the Department's website at www.dobi.nj.gov.

In July 2007, the Department proposed rules implementing those provisions of HCAPPA related to claims payment and the establishment of the independent claims arbitration program, which included 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. That notice of proposal appeared in the July 2, 2007 New Jersey Register (39 N.J.R. 2455(a)). The Department received numerous comments to that notice of proposal, and final rules were never adopted. The original proposal expired on July 2, 2008. The Department is again proposing rules to implement these provisions of HCAPPA. Specifically, this new rulemaking includes the following:

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

Several definitions are amended or added at N.J.A.C. 11:22-1.2. The definition of “carrier” is amended to include prepaid prescription service organizations. The definition of “claim” is deleted and replaced to include a request from a provider without regard to whether payment is pursuant to an assignment of benefits. The definition of “clean claim” is revised to clarify that a clean claim is one that is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person in accordance with N.J.A.C. 11:22-1.4, to include an additional element (that is, that the health care provider providing the service or supply is eligible at the date of service, as defined in the HCAPPA), and to delete an existing element (that is, that the claim does not require “special treatment”). The definition of “health benefits plan” is amended to exclude a reference to Medicare risk contracts, to include Medicare Advantage, and to exclude from the definition dental plans and Tri-Care to be consistent with the definition in the statute at N.J.S.A. 17B:30-50.

The Department proposes new definitions for “agent” (which is deleted and replaced), “arbitration,” “arbitration organization,” “arbitrator,” “dental carrier," "dental plan," "health carrier," "‘medical necessity’ or ‘medically necessary,’” “‘network provider’ or ‘participating provider,’” “payment dispute,” “prepaid prescription service organization,” “prescription drug plan,” and “substantiating documentation.” This amendments also change the term “alternate” in “alternate dispute resolution” to “alternative” as a matter of form and adds a new definition for “alternative dispute resolution.”

N.J.A.C. 11:22-1.4, Claim submission requirements, is proposed for repeal and

replacement to require health carriers to provide certain claims processing and payment information that is contained in the proposed new rule through a publicly-accessible internet website.

N.J.A.C. 11:22-1.5, Prompt payment of claims, is amended to include in subsection (b), the term "substantiating documentation" and to add a new subsection (c) 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 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," rather than "properly addressed." 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 relocated as proposed new subsection (e). The new subsection distinguishes between the 10 percent interest rate to be paid by dental plan organizations and dental service corporations, and the 12 percent interest rate to be paid by health carriers, on all late-paid claims payments. For all carriers, 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.

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. New language is added at subsection (a) stating that 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. This section revises the specific grounds on which a carrier may deny or dispute a claim, and establishes requirements with respect to the notice carriers must give to the provider and/or the covered person related to each of those reasons. Subsection (c) is deleted since aggregation of interest is no longer permitted pursuant to the HCAPPA and the timelines and interest requirements are described in other parts of the rule, as discussed above. Subsection (f), the current provision addressing carrier adjustments to previously-paid claims, is deleted from this section, and a new section addressing carrier reimbursement of overpaid claims is proposed at N.J.A.C. 11:22-1.8.

Proposed new N.J.A.C. 11:22-1.8, Reimbursement of overpaid claims, sets forth the circumstances under which a health carrier or its agent may base a request for reimbursement of a paid claim on extrapolation of other claims (that is, determining the total reimbursement due from a provider based on errors detected from a sample of that provider's claims). Subsection (b) reflects the HCAPPA requirement that health carriers' 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. This subsection also sets forth the conditions under which health carriers may offset overpayments of insured claims, allows for providers to contest a notice of overpayment, and contains the procedural requirements for a health carrier to request reimbursement of an overpaid claim. For requests made beyond the 18-month period, this subsection additionally requires the carrier to include the legal basis relied on in making the request and information about the appeal process related to the request.

Proposed new N.J.A.C. 11:22-1.9, Reimbursement of underpaid claims, like carrier requests for reimbursement of overpaid claims, 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. The rule also contains the procedural requirements for a provider to request reimbursement of an underpaid claim. Also, no provider is permitted to seek more than one reimbursement for underpayment of any particular claim.

Existing N.J.A.C. 11:22-1.8, Internal appeals – health carriers, addresses both internal and external appeals. This recodified section, as amended, applies only to internal appeals of payment disputes between health carriers or their agents and health care providers with respect to services or supplies covered by a health benefits or prescription drug plan, and not to appeals related to medical necessity. The rule sets forth all requirements related to the appeal process for both providers and health carriers, including the provider's request for an appeal; the carrier's review and determination of an appeal; and the health carrier's obligations depending on whether a determination is adverse or favorable to a provider.

Proposed new N.J.A.C. 11:22-1.11, Internal appeals – dental plan organizations and dental service corporations, addresses dental plan organization and dental service corporation internal appeals mechanisms to resolve disputes between dental carriers or their agents and participating health care providers relating to payment of claims for services or supplies covered by a dental plan. The rule requires that the internal appeal mechanism be described in the participating provider contract, and sets forth all requirements related to the appeal process.

Existing N.J.A.C. 11:22-1.8(b), (c), and (d) are amended and recodified as N.J.A.C. 11:22-1.12, External appeals -- alternative payment dispute resolution – dental plan organizations and dental service corporations. This section requires every dental plan organization and dental service corporation to offer an independent, external alternative payment dispute resolution mechanism (ADR) to participating health care providers to review adverse

decisions of its internal appeals process. The rule includes all requirements related to the ADR mechanism.

Proposed new N.J.A.C. 11:22-1.13, External appeals – health carriers - arbitration, implements HCAPPA's provisions addressing nonappealable, binding independent arbitration of claim 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 claim payment disputes following an internal appeal conducted pursuant to a health carrier's internal appeal mechanism described in this subchapter. It is not available for disputes regarding medical necessity. Claims eligible for arbitration must have a disputed amount of at least $1,000, and an arbitration proceeding must be requested within 90 calendar days of the provider's receipt of the internal appeal decision (90 days to request an internal appeal after claim decision; 90 days to request arbitration after the internal appeal decision). The arbitration organization is required to issue a decision within 30 days of receipt of a completed arbitration request application that is consistent with the standards for such determinations set forth in subsection (n). If a determination results in a carrier 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.

Recodified N.J.A.C. 11:22-1.14 amends the Department's current reporting requirements rules to eliminate 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. The amendments also deletes the format and instructions for those reports currently at

N.J.A.C. 11:22 Appendix A, A-1, B, and B-1. The current requirements are being formally replaced with combined quarterly and annual reports on the timeliness of claims payments and reasons for denial and late payment of claims. Prior to this rulemaking, the Department issued Bulletin 08-09, which suspended N.J.A.C. 11:22 Appendix A- New Jersey Claims Payment Exhibit – through which a carrier or ODS filed a quarterly report on the timeliness of claim payment. Bulletin 08-09 also requires that carriers that are not otherwise exempt submit 1st, 2nd, and 3rd quarter reports on reasons for denial and late payment of claims in the form of N.J.A.C. 11:22 Appendix B via hard copy only; electronic format is not required. However, for the annual report, Bulletin 08-09 requires the report to be submitted in both hard copy and electronic format including diskette, CD-ROM, and e-mail. Bulletin 08-09 can be accessed on the Department's website at http://www.state.nj.us/dobi/bulletins/blt08_09.pdf and these referenced reports can be accessed through the Department's website at http://www.state.nj.us/dobi/division_insurance/lhactuar.htm. However, proposed changes at N.J.A.C. 11:22-1.14 eliminate the requirement that all reports be submitted by hard copy and by either CD-ROM, Zip Diskette and or floppy diskette. The amended section requires all quarterly reports to be submitted electronically via SERFF, and all annual reports to be submitted both in hard copy and electronically. 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 amended section also reduces the documentation the Department requires to establish that annual premium is less than $5 million. The changes also include updating certain mailing address and other information for submission of reports.

At N.J.A.C. 11:22-1.15, minor housekeeping amendments are proposed to the rule

addressing remediation following the Commissioner's review of the reports required to be submitted pursuant to N.J.A.C. 11:22-1.14. A new subsection is proposed, allowing the Commissioner to impose certain penalties 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 excepted from the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

This rulemaking implements the HCAPPA, which has been in effect since 2006. Generally, this rulemaking favorably impacts carriers, providers, and covered persons in that it clarifies some points of ambiguity that have existed in interpretations of the HCAPPA. While some of the amendments and/or new rules included in this rulemaking impose certain requirements and result in outcomes that impact some affected parties unfavorably and others more favorably, all parties have been complying with these requirements since the HCAPPA's effective date and this rulemaking imposes no requirements beyond those set forth in the HCAPPA. Some of the specific requirements include the following:

The rulemaking establishes standards and procedures concerning the prompt payment of health claims and a two-step process for resolving claims payment disputes. The rulemaking has 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 have been somewhat unfavorably impacted by the statutory requirement now being codified in the rules that they maintain websites containing detailed information concerning the manual and electronic

submission of claims, but providers benefit from that information. 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 have been unfavorably impacted by the statutory requirement -- now being codified -- that if they deny or dispute a claim, they are 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 benefit from such notice because it assists them in completing the claims submission process and securing payment of their claim(s).

The newly codified statutory requirement that both health carriers and providers request reimbursement of overpaid and underpaid claims, respectively, within 18 months may have unfavorably impacted both parties because it limits the timeframe within which such requests may be made. However, both parties are favorably impacted in that they know they can only receive such a request within a limited timeframe. Additionally, carriers may have been unfavorably impacted by the statutory provision being codified in the new rules that limits the circumstances under which they may base a reimbursement request on extrapolation of other claims and offset overpayments. Providers are favorably impacted by these limitations, and by their ability to contest a carrier's request for reimbursement of an overpayment.

The two-step claims payment dispute resolution process established by the HCAPPA and being codified in these rules (that is, a health carrier's internal appeal mechanism and nonappealable, binding independent arbitration, or a dental plan organization's and dental service corporation's internal appeal mechanism and external alternative payment dispute resolution mechanism) has impacted carriers and providers both favorably and unfavorably. Generally

speaking, this system is favorable to both parties in that it allows claims disputes to be thoroughly and fairly reviewed and adjudicated. Nevertheless, both appeal mechanisms place certain procedural requirements on both parties that may be considered somewhat burdensome. Carriers may have been, and may continue to be, unfavorably impacted in that their determinations made at the internal appeal stage that are adverse to providers may be ultimately be reversed.

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

Economic Impact

As stated above in the Social Impact statement, the HCAPPA has been in effect since 2006, and carriers and providers have been complying with its requirements since its effective date. Accordingly, no new expenses are imposed by this rulemaking on carriers and providers, as the cost of complying with its provisions has been borne by both parties since the HCAPPA's effective date. Specifically, carriers are required to bear the expense related to posting claims processing and payment information on their websites. Except for good cause, the HCAPPA and new rules prohibit carriers from denying, delaying, or pending payment of a claim while seeking information as to whether a covered person has other health coverage that may be primary, thereby requiring carriers to make payment sooner than they may have otherwise. The HCAPPA and the amended rules also increase the rate of interest on most overdue claims payments from 10 percent to 12 percent per year for health carriers and their agents. 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. The rate of interest for dental plan organizations and dental service corporations remains at 10 percent. Health carriers are 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 unfavorably impacted health carriers and may continue to do so in that health carriers bear the costs related to the appeal process and, in some instances, pay previously denied claims. If a claim dispute is referred to arbitration, health carriers are also responsible for their share of the arbitration and review fees, in addition to any claim(s) payment plus interest. Providers may have also been unfavorably impacted and may continue to be so impacted if they are unsuccessful in their request for reimbursement of any underpaid claim(s) or in their appeal of any unpaid or underpaid claim(s), or if they are required to re-pay a carrier for any overpaid claim(s). Providers are also responsible for payment of their share of the fees related to the arbitration process.

Both health carriers and providers may have been favorably impacted and may continue to be so impacted by the provisions of the Act and by this rulemaking . Health carriers benefit from any successful attempts to request reimbursement of overpaid claims, and from any internal appeal or arbitration determination in their favor. Likewise, providers are 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 changes in reporting requirements at recodified N.J.A.C. 11:22-1.14 on timeliness and reason for denial of claims will generally reduce carriers' compliance costs.

While some of the requirements contained in the HCAPPA and this rulemaking have increased health carrier costs to a certain extent as described above, those costs are outweighed

by the benefits gained by health carriers, providers, and consumers of health care. The uniform procedures and guidelines established by the HCAPPA and implemented in the proposed rules enable health carriers and providers to more effectively and efficiently provide health care consumers with the services available under their health benefits and prescription drug plans and ensure timely reimbursement to providers for delivery of those services.

Federal Standards Statement

A Federal standards analysis is not required because the Department's rulemaking is not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that this rulemaking will result in the generation or loss of jobs.

Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedures Act, the Department does not expect any impact on the agriculture industry from this rulemaking.

Regulatory Flexibility Analysis

This rulemaking , 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. This rulemaking requires health 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; and to establish an internal appeals mechanism for the resolution of claim payment disputes. The rulemaking also requires health and dental carriers to file certain quarterly and annual claims payment reports with the Department.

This rulemaking also requires providers that are small businesses and that intend to request payment of unpaid and 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 rulemaking also sets forth certain requirements for the claims payment dispute proceedings, such as the issuance by the arbitration organization of written determinations containing specific information.

While these requirements impose certain administrative, reporting, and/or recordkeeping responsibilities on health and dental 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 rulemaking, implementing HCAPPA, applied different compliance requirements based on business size. Moreover, as stated in the Social and Economic Impact statements, all parties affected by these requirements have been complying with them since the 2006 effective date of the HCAPPA.

Housing Affordability Impact Analysis

The Department does not expect this rulemaking to have any impact on housing affordability or the average costs of housing because this rulemaking addresses the prompt payment of claims made by health and dental carriers to providers.

Smart Growth Development Impact Analysis

The Department does not expect this rulemaking to evoke a change in the housing production in Planning Areas 1 or 2, or within the designated centers, under the State Development and Redevelopment Plan in New Jersey because this rulemaking addresses the prompt payment of claims made by health and dental carriers to providers.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:22-1.4 and 11:22 Appendices A, A-1, B, and B-1.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; 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 benefits plans, **prescription drug plans,** and/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 "**[alternate] **alternative** dispute resolution**" means any procedure, other than litigation, used in the conciliatory resolution of a dispute, including, but not limited to, mediation and arbitration, but shall not include claims payment dispute arbitration pursuant to P.L. 2005, 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 entity 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 (TPA) 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 health carrier and a provider by one or more impartial persons in 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 payment arbitrations and making determinations 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 payment arbitrations and making determinations 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**, and a prepaid prescription service organization**.

...

"Claim" means a request by a covered person[, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person,] **or a provider** 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. The claim is for a service or supply covered by the health benefits plan, **prescription drug plan,** or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person **in accordance with N.J.S.A. 17B:30-51 and N.J.A.C. 11:22-1.4**;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits, **prescription drug,** or dental plan on the date of service;

4. The health care provider providing the service or supply is an eligible provider on the date of service (that is, a health care provider whose services or supplies are covered under the health benefits, dental, or prescription drug plan); and

[4.] **5.** 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.]

...

"Dental carrier" means a dental service corporation, dental plan organization,

health service corporation, medical service corporation, and insurance company authorized to issue dental plans in this State.

"Dental plan" means a benefits plan [which] **that** pays **benefits only for** dental expenses or provides **only** dental services and supplies and is delivered or issued for delivery in this State by or through any **dental** carrier in this State.

...

"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] **Medicare Advantage** 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, **dental plans,** disability, long-term care, CHAMPUS supplement coverage, **Tri-Care**, 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.

...

"Health carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization authorized to issue health benefits plans in this State, and a prepaid prescription service organization.

...

[(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 or her prudent clinical judgment, would provide to a person covered by a health benefits plan 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. Medical necessity disputes do not include claims payment disputes.

"Network provider" or "participating 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 disagreement between a health carrier and provider over whether a claim was properly paid under the terms of the applicable health benefits plan and provider participation agreement, if applicable. A payment dispute shall not include a dispute pertaining to medical necessity that could be or could have been 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.

“Prescription drug plan” means a benefits plan that pays benefits only for prescription drug expenses or provides only prescription drugs and is delivered or issued for delivery in this State by or through any health carrier in this State.

"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 health carrier or its agent shall provide in a clear and conspicuous manner through a publicly-accessible internet website information concerning the submission and processing of claims including, but not limited to, where applicable:

1. A list of the material, documents, or other information required to be submitted to the health 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 multiple services or supplies provided by a health care provider on the same date;

4. The policy for payment to assistant surgeons;

5. The policy for reimbursement for administration of immunization and injectable medications;

6. The policy regarding recognition of CPT modifiers;

7. Identification of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the health carrier or its agent to determine the medical necessity of health care services;

8. A street address where claim submissions can be delivered by hand or registered/certified mail if the claim is submitted by other than electronic means; and

9. The carrier's application for a provider's internal appeal of a payment dispute.

(b) Health carriers or their agents may change the required information and documentation, as long as health care providers are given at least 30 days prior notice of the change in the requirements, which notice shall be made available on the carrier's internet website.

11:22-1.5 Prompt payment of claims

(a) (No change.)

(b) Carriers and their 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 health carrier or its agent shall deny, delay, or pend payment of a claim in whole or in part while seeking information as to whether the covered person has other insurance that may be primary, unless good cause exists for the health carrier or its agent to believe that other coverage is available to the covered person. Good cause shall exist

only if the health carrier's or agent's records indicate that the covered person has coverage under another health benefits or prescription drug plan. Routine requests to determine whether additional coverage exists shall not be considered good cause.

[(c)] **(d)** Payment of a claim shall be considered to have been made:

1. 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)1] **(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 plan organization or dental service corporation fails to pay a clean claim under a dental plan within the time limits set forth in this section, it shall include simple interest on the claim amount at the rate of 10 percent per year and shall add the interest amount to the claim amount when paying the claim. If a health carrier or its agent fails to pay a clean claim within the time limits set forth in this section, the health carrier or its agent 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.

[(d)] **(f)** (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. [The pending of a claim does not constitute a dispute or denial.] **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 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:

1. 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.] **i.** (No change in text.)

[2. Where missing information or documentation is a reason for denying or disputing a claim, the carrier or its agent shall provide notice to the provider within the

timeframes and in the manner required by P.L. 2005, c. 352;

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.

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 or its agent shall process the claim in accordance with N.J.A.C. 11:22-1.5 and this section.

6. If the health carrier or its agent finds there is strong evidence of fraud by the provider and has initiated an investigation into the suspected fraud, the notice shall

state that the health carrier or its agent finds that there is strong evidence of fraud and, if applicable, 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, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department pursuant to N.J.S.A. 17:33A-9.

[4.] **7.** The [toll free] **notice shall include the toll-free** telephone number [for] **through which** the carrier or its agent [who] can be contacted by the provider or covered person to discuss the claim.

(b) (No change.)

[(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] **and**, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety **and the Bureau of Fraud Deterrence in the Department**.

[(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.]

11:22-1.8 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 fraud by the health care provider and, if applicable, 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 and the Bureau of Fraud Deterrence in the Department pursuant to N.J.S.A. 17:33A-9.

(b) A health carrier or its agent may request reimbursement for the overpayment of a claim only if the health 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.

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. If the reimbursement request is submitted to the provider beyond 18 months of the date on which the first payment on the claim was made, the request shall include:

i. All information set forth in (b)1 above;

ii. An explanation of the legal basis relied upon in making the request beyond the 18-month period (that is, the health benefits plan is not required to comply with the statutory requirements because it is either self-funded or issued outside of the State, or the health benefits plan is required to comply with the statutory requirements, but one of the statutory exceptions applies);

and

iii. A description of the appeal process related to the request.

3. No health carrier or its agent may seek more than one reimbursement for overpayment of a particular claim.

4. No health 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 1.13 have been exhausted; or

iii. A monetary penalty against the reimbursement request, including, but not limited to, an interest charge or a late fee.

5. A health carrier or its agent may offset against a provider's future insured claims, an overpayment, to a provider on which a health 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 1.13;

ii. The health 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 initiate an appeal of the reimbursement request within 45 days; and

iv. The provider was given 30 days after receipt of the offset notice to reimburse the health carrier or its agent for the overpayment and did not reimburse the health carrier or its agent.

6. 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 1.13.

7. The limitations of this subsection shall not apply:

i. Where an overpayment is the result of claims that were submitted fraudulently;

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 health 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.

1. The written reimbursement request shall be a separate notice to the health carrier or its agent or the covered person and shall include:

i. A clear identification of the claim;

ii. The name of the health care provider's patient and the date of service; and

iii. An explanation of the basis upon which the health care provider 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 from a health carrier or its agent or from a covered person.

11:22-[1.8]**1.10** Internal [and external] appeals **– health carriers**

(a) Every **health** carrier **or its agent** shall establish an internal appeals mechanism to resolve **payment** disputes between **health** carriers or their agents and [participating] health care providers [relating to payment of claims]**,** but not including appeals **related to medical necessity** made pursuant to N.J.A.C. 11:24-8.5 [through]**, 8.6, and** 8.7 and 11:24A-3.5 [through]**, 3.6, and** 3.7. The internal appeals mechanism shall be described in the participating provider contract.

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

i. Within 90 calendar days of receipt of the health carrier's or agent's determination that is the basis of the appeal; or

ii. Within 90 calendar days of a health 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 health carrier or its agent a complete Claim Payment Appeal Form, which shall include all substantiating documentation required by the health 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, which require the applicant to submit the name and contact information, the patient's name and the claim number with a description of the reason for appeal, are available for download on the Department's website at www.dobi.nj.gov. A health carrier or its agent may make available the application form and instructions on its website to allow for electronic submission of applications.

[1.] **3. The health carrier or its agent shall conduct a review of the internal appeal and notify the health care provider of its determination within 30 calendar days of receipt of the application for internal appeal.** The internal review shall be conducted by employees of the **health** carrier **or its agent** 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. **If the carrier or its agent fails to notify the provider of its determination within 30 calendar days of receipt of the application, the provider may initiate an arbitration proceeding in accordance with N.J.A.C. 11:22-1.13(c).**

[2.] **4.** The **health carrier or its agent shall communicate the results of the** internal review [shall be conducted and its results communicated] in a written decision to the provider [within 10 business days of the receipt of the appeal. The written decision]**, which** shall include:

i. The names, titles**,** and qualifying credentials of the **person or** persons participating in the internal review;

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; [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. 11:22-1.13; and**

vi. If the decision favors the health care provider in any respect, the health carrier or its agent shall be required to pay within 30 calendar days of the date of issuance of the health carrier's or its agent's determination of the internal 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 health carrier or its agent at its designated address.

11:22-1.11 Internal appeals – dental plan organizations and dental service corporations

(a) Every dental plan organization and dental service corporation shall establish an internal appeals mechanism to resolve disputes between dental carriers or their agents and participating health care providers relating to payment of claims for services or supplies covered by a dental plan. The internal appeal mechanism shall be described in the participating provider contract.

1. The internal review shall be conducted by employees of the dental carrier 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.

2. The internal review shall be conducted and its results communicated in a written decision to the provider within 30 days of receipt of the appeal. The written decision shall include:

i. The names, titles, and qualifying credentials of the persons participating in the internal review;

ii. A statement of the participating provider's grievance;

iii. The decision of the reviewers, along with a detailed explanation of the contractual and/or medical basis for such decision;

iv. A description of the evidence or documentation which supports the decision; and

v. If the decision is adverse, a description of the method to obtain an external review of the decision.

11:22-1.12 External appeals - alternative payment dispute resolution – dental plan organizations and dental service corporations

[(b)] **(a)** Every [carrier] **dental plan organization and dental service corporation** shall offer an independent, external **alternative payment dispute resolution** (ADR) mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1.-3. (No change.)

[(c)] **(b)** [Carriers] **Dental plan organizations and dental service corporations** shall annually notify participating providers in writing**, or by posting on their websites,** of the internal appeals process and the ADR mechanism and how they can be utilized.

[(d)] **(c)** [Carriers] **Dental plan organizations and dental service corporations** 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.

11:22-1.13 External appeals – health carriers - arbitration

(a) Any dispute regarding the determination of an internal appeal conducted pursuant to a health 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 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. The disputes shall involve whether:

1. A treatment or service is medically necessary;

2. A treatment or service is experimental or investigational;

3. A treatment or service is cosmetic;

4. A treatment or service is medical or dental;

5. A condition is a preexisting condition; and

6. The health carrier should authorize services to be performed by an out-of-network provider but hold the member responsible for in-network cost sharing only because the carrier's network lacks a provider who is accessible and possesses the requisite skill and expertise to perform the needed services.

(b) Any provider involved in a payment dispute for which any determination was made by a health 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 on the internal appeal.

(c) A provider who has not been notified by a health carrier or its agent within 30 days of the carrier's or its agent's receipt of an 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 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 Arbitration Request Application directly to the arbitration organization with which the Department has contracted pursuant to P.L. 2005, c. 352.

(e) Upon receipt of an Arbitration Request 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) for arbitration and completeness of the application. The arbitration organization, or the Department, if applicable, shall accept for processing a complete application that meets the following criteria:

1. The covered person's health benefits or prescription drug 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;

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 or prescription drug plan that covers the covered person, and the covered person was enrolled in the plan at the time the service was rendered or the supply provided;

5. The application includes, or the covered person has previously submitted, a fully-executed Consent to Release of Medical Records for Claim Payment and Arbitration form signed by the covered person in the event that the covered person's confidential information accompanies the arbitration request, which provides a patient with the opportunity to consent to representation in utilization management appeals and to provide authorization to release information in utilization appeals and arbitration of claims and to revoke such consent and which form can be accessed on the Department's website at http://www.state.nj.us/dobi/chap352/352implementnotice.html; and

6. 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 an Arbitration Request Application received in excess of 90 days after the provider's receipt of the health 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 health 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 Arbitration Request Application, the arbitration organization shall acknowledge receipt of the application to the health 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 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 Arbitration Request 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 submitted in whole or in part by the health carrier or its agent, the arbitration organization shall retain the review fees of both the provider and the health carrier or its agent and refund the arbitration fees.

(j) Within 30 days of receipt of a complete Arbitration Request Application and accompanying documents as set forth in (e) above, the arbitrator shall issue a written decision addressing whether the provider requesting the arbitration was properly or improperly reimbursed for the claim(s) by the health carrier or its agent.

(k) The arbitration proceeding shall be conducted pursuant to the rules of the arbitration organization, including rules of discovery subject to confidentiality requirements established by State and Federal law.

(l) 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 health carrier or its agent involved in the payment dispute. In-person or telephonic testimony shall not be permitted.

(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 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.

(p) If the arbitrator determines that a health carrier or its agent has erroneously withheld or denied payment of a claim, the arbitrator shall order the health carrier or its agent to make payment of the claim on or before the 10th 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 health 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 health carrier or its agent has withheld or denied payment on the basis that information requested by the health carrier or its agent was not submitted by the provider when the claim was initially processed by the health carrier or its agent or reviewed by the health carrier or its agent pursuant to its internal appeal process, the health carrier or its agent shall not be required to pay any accrued interest.

(q) If the arbitrator determines that a provider has engaged in a pattern and practice of improper billing and a refund is due to the health carrier or its agent, the arbitrator may award the health 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 health carrier or its agent for resolution through the internal appeal process described at N.J.A.C. 11:22-1.10.

(r) The arbitrator shall not award legal fees or costs.

11:22-[1.9]**1.14** 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] **a** format 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.] **by bulletin or similar means and/or on the Department's website.** 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 [in hard copy and] **by the due date** as an Excel spreadsheet [by one of the following media:

1. CD-ROM;

2. Zip diskette; or

3. Floppy diskette] **through the State Electronic Rate and Form Filing System**.

(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.] **2.** 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]**1.14** 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]**1.15** Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-[1.9]**1.14**, the Commissioner may require that the carrier or [ODS] **its agent**, at its own expense:

1.-2. (No change.)

(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.