A Message from:

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TO: AmeriHealth Participating Ancillary Providers in New Jersey

FROM: Michael S. Zollenberg
Director, Hospital and Ancillary Services

DATE: August 30, 2006

SUBJECT: New Jersey Health Claims Act

We are writing to inform you about New Jersey Senate Bill (SB) 2824 which became effective July 11, 2006. This law, known as the Health Claims Authorization, Processing and Payment Act, establishes uniform procedures and guidelines for hospitals, physicians and health care carriers to follow in utilization management determinations and the communication of those decisions. Also included in SB 2824 are procedures for claims submission and payment determinations.

We have reviewed the new law and have made the necessary changes to be in compliance for AmeriHealth New Jersey members and providers. The following is a summary of some of the key provisions that relate to claims payment and adjustments.

Notification and Timeframe Requirements for Overpayment Refund Requests

- With the exception of claims that were submitted fraudulently, submitted by health care providers that have a pattern of inappropriate billing, or claims that were subject to coordination of benefits, AmeriHealth will not seek reimbursement for overpayment of a claim previously paid later than 18 months after the date the first payment on the claim was made. You will receive a letter from AmeriHealth containing information on the overpayment, along with a coupon and instructions that allow you the opportunity to refund the overpayment, rather than having AmeriHealth retract the claim.
- AmeriHealth may collect the overpaid funds by assessing them against payment of any future claims submitted by a health care provider after the 45th calendar day following the submission of the reimbursement request or after the provider's right to appeal has been exhausted.
- If AmeriHealth determines that the overpayment is a result of fraud committed by the health care provider and AmeriHealth has conducted an investigation and reported the fraud to the Office of Insurance Fraud Prosecutor, AmeriHealth may collect an overpayment by assessing it against the payment of any future claim submitted by the health care provider.

Time Limit for Provider Claim Adjustment Requests

- No health care provider may seek reimbursement from AmeriHealth or a covered person for underpayment of a claim later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal or the claim is subject to continual claims submission. This means that providers are now required to submit all requests to adjust underpaid claims within 18 months from the date of the initial payment.

Interest Rate Increase on Late Payments

- The interest rate on overdue claims payments will increase from 10% to 12%. Payment will be considered overdue if a correctly submitted claim for a covered service is not paid in 30 calendar days of receipt of an electronic claim and 40 calendar days of receipt of a paper claim.

Provider Claim Internal Appeals

- A health care provider may initiate an appeal on or before the 90th day following receipt of AmeriHealth's claims determination. The appeal must be submitted on an appeal form prescribed by the Commissioner of Banking & Insurance. (AmeriHealth will make the required form available to providers when it is issued by the Commissioner.) AmeriHealth will conduct a review of the appeal and notify the health care provider of its determination within 30 calendar days of receipt of the appeal form.
- If the health care provider is not notified of AmeriHealth's determination of the appeal within 30 calendar days, the health care provider may refer the dispute to arbitration.
- If AmeriHealth issues a determination in favor of the health care provider, AmeriHealth will pay the amount in dispute, if applicable, with accrued interest at the rate of 12% per annum, within 30 calendar days following the notification of AmeriHealth's determination on the appeal. Interest will begin to accrue on the day the appeal was received by AmeriHealth. If AmeriHealth issues a determination against the health care provider, AmeriHealth will notify the health care provider of its findings within 30 calendar days following the receipt of the appeal form and will include written instructions for referring the dispute to arbitration.

Appeal Arbitration

- Any dispute regarding the determination of an internal provider claim appeal may be referred to arbitration. The Commissioner of Banking & Insurance will contract with an independent organization that specializes in arbitration to conduct the arbitration proceedings.
- Any party may initiate an arbitration proceeding on or before the 90th day following the receipt of the determination that is the basis of the appeal. No dispute will be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that a health care provider may aggregate his own disputed claim amounts for the purpose of meeting the threshold requirements. The arbitrator's decision is binding and can not be appealed.
- No dispute pertaining to medical necessity that is eligible to be submitted to the Independent Health Care Appeals Program shall be the subject of arbitration.

We encourage you to review and familiarize yourself with the complete list of provisions for this bill at www.njleg.state.nj.us/2004/Bills/PL05/352_.HTM. If you have any questions, please contact your Hospital Service Coordinator at 856-778-6500 or 732-726-6700.

Thank you for your participation in our network and for the care and service you provide to our members each day.