October 20, 2017

Denise Illes, Chief
Office of Regulatory Affairs
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Re: Proposed new rules and amendments implementing the Health Claims Authorization, Processing & Payment Act (HCAPPA), N.J.S.A. 17B:30-48 et. seq., including new rule N.J.A.C. 11:22-1.4 and N.J.A.C. 11:22-1.8, 1.9, 1.11-15; 49 N.J.R. 2729 (a), PRN 2017-207.

Dear Ms. Illes:

The Medical Society of New Jersey (MSNJ) is the largest physician organization in the state, representing medical students, residents and physicians from all specialties. We have long supported the Health Claims Authorization Processing & Payment Act (HCAPPA) and appreciate this rulemaking to formalize bulletins and interpretations of the law since its passage in 2006. We are joined in our comments by New Jersey Association of Osteopathic Physicians & Surgeons, New Jersey Society of Interventional Pain Physicians, New Jersey Society of Pathologists, and the New Jersey State Society of Anesthesiologists.

We generally support this rulemaking endeavor, but note our concerns and requests for clarification as follows:

Arbitration

We support N.J.A.C. 11:22-1.13(e) which gives the Department more oversight of the arbitration process. However, we are concerned about subsection (e)(2) which sets a threshold amount for arbitration at $1,000; there is no provision for the aggregation of like claims. The current arbitration system, bulletins and guidance have allowed like claims to be aggregated to achieve the $1,000 threshold. See Bulletin 07-14 (http://www.nj.gov/dobi/bulletins/blt07_14.pdf). This is an important provision as bringing numerous small, but like, claims outside of the state's arbitration process will be more expensive for providers. We urge the Department to allow aggregation of like claims as has been the practice since the law was passed.

We respectfully request that N.J.A.C. 11:22-1.13(e)(5) be furthered reviewed and modified to be consistent with past implementation of HCAPPA. Prior consent from patients to arbitrate is not necessary for the arbitration of a claims payment issue. This appears to be a new requirement. The past practice, supported by the Department's bulletins, Q&A's, and guidance has been to require consent from patients for medical necessity review or in situations where patient records are shared. We see no reason to require patients to consent to arbitration for payment disputes. To do so might result in these claims not being eligible for arbitration, if a patient does not consent. We urge the Department not to require patient consent for payment disputes, unless protected health information is provided.

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We strongly support the concept that the HCAPPA's claims dispute and arbitration process is permissive. While we urge physicians to take advantage of the dispute and arbitration process there is nothing in the enabling legislation to suggest that the process is mandatory. Indeed, it would be infirm if mandatory because the arbitration process does not allow the possibility of oral testimony. Providers must be allowed to make a deliberate decision about whether to use the permissive, streamlined arbitration process or to initiate litigation.

Network Status

We wish to clarify that the regulations apply to both in-network and out-of-network providers. Concern is stirred by N.J.A.C. 11:22-1.2's definition of a clean claim which adds the requirement that the provider "is an *eligible* provider on the date of service (that is, a health care provider whose services or supplies are covered under the health…plan)." However, the definition of a payment dispute in the same section sheds light on the issue by stating that the dispute arises under the applicable health benefits plan and provider participation agreement, *if applicable*. There is nothing in the enabling legislation or the implementation of the HCAPPA to date to suggest that it does not apply to out-of-network benefits when covered by a plan

Pending Claims

MSNJ and our co-signers support the language in N.J.A.C. 11:22-1.6 stating that "pending" a claim does not toll the payment due date. Otherwise, carriers could routinely pend claims and extend the payment due date, contrary to the statutory prompt pay provision. We recommend that more specificity be required from carriers, such as references to specific policies and coding conventions, when claims are denied or more information is requested.

MSNJ and our co-signors support the proposal's prohibition on using coordination of benefits (COB) to pend claims or to delay payment which is found in N.J.A.C 11:22-1.4(b). The proposal prohibits coordination of benefits delay unless there is something in the record to suggest other coverage. Please consider a time requirement for indicia of other coverage. Current or recent indicia of other coverage should be required. A suggestion of other coverage that is more than a few years old is likely out of date unless there have been no claims adjudication in that time period. Since HIPAA's electronic transmissions requirements now apply, COB information should transmit more rapidly.

Notice

We urge the Department to require more meaningful notice to providers on the claims submission process found in N.J.A.C. 11:22-1.4(b). It should not be incumbent on busy practitioners and office staff to scour carrier websites to determine if claims submission processes have been amended. Simply posting changes on a website is not sufficient. Carriers routinely communicate in newsletters, bulletins and by e-mail. We urge the Department to require an affirmative outreach to providers, when claims submission requirements are changed. Where the carrier has an e-mail address, an e-mail notice should be provided.

Internal Appeals

We have two suggestions concerning Internal Appeals found at N.J.A.C. 11:22-1.10. We urge the Department to require that internal appeal procedures be posted on carrier's external websites, not

just in the participation agreement, to ensure that out-of-network physicians know appeal rights/procedures. Access to the internal appeal procedure should be readily available to both in and out-of-network providers. This affords the possibility of resolving claims disputes before external review. In addition, MSNJ urges the Department to require that medical review, N.J.A.C. 11:22-1.10(a)(4), be conducted by a same specialty physician, when requested by the provider. MSNJ members consistently report that their claims are adjudicated to their satisfaction when they are able to speak to a New Jersey licensed physician of the same specialty. This speeds necessary treatment to patients and cuts down on the administrative burden on practices.

Extrapolation

MSNJ and our co-signers have significant concern about the misuse of extrapolation by carriers to negotiate fees or to punish physicians. N.J.A.C. 11:22-1.8 allows carriers to extrapolate overpayments based on the ***carrier's*** finding of "clear evidence of fraud." Presumably, if there is clear evidence of fraud and the matter has been referred, then the Fraud Prosecutor will take up the case. These issues ordinarily arise over coding and billing disputes and the carrier is not always correct in their interpretation of the rules. We urge the Department to require a more deliberate process before a carrier may allege clear evidence of fraud, extrapolate, and negotiate a large settlement amount without an adjudication of the underlying issue.

We recommend that the Department require carriers to provide notice to a practice regarding its belief that the coding and billing practices are inappropriate. Outreach and training should be conducted and should include references to specific guidance documents including: National Correct Coding Initiative, Centers for Medicare & Medicaid Services, American Medical Association Current Procedural Terminology, and other nationally recognized guidance. A practice should not be surprised by an allegation of fraud because the carrier would have been communicating its position of inappropriate billing in a variety of ways, including through standardized Claims Adjustment Reason Codes (CARC). Providers should be given clear notice of coding and billing conduct that is considered inappropriate and an opportunity to challenge or to cure the billing practice.

We note that a carrier may extrapolate where there is clear evidence of fraud, but providers have no parallel right. If a provider is systematically underpaid, for example because of long-standing computer platform or systems issues, his remedy is limited to interest and the hope of an enforcement action. This is not a sufficient deterrent to bad conduct by carriers. If "any person" may be penalized for a pattern or practice in violation of the subchapter, N.J.A.C. 11:22-1.15, we recommend that it be applied to carriers. Carriers have a "self-executing" remedy with the extrapolation tool. Providers have no such tool and must rely on the Department to enforce.

In-Plan Exception

Finally, with regard to in-plan exceptions, under N.J.A.C. 11:22-1.13(a)(6) these issues may go to arbitration if an in-plan exception was denied. There should be a distinction between in-plan necessity appeals and in-plan exception claims payment appeals—situations where an agreement was reached with the carrier, but for which the carrier subsequently did not pay. Providers should be able to take these payment appeals to arbitration.

MSNJ and our co-signers, listed below, appreciate your consideration of our comments.

Respectfully submitted,

Melinda R. Martinson, Esq.
General Counsel
Medical Society of New Jersey

Together with the following co-signers:
New Jersey Association of Osteopathic Physicians & Surgeons
New Jersey Society of Interventional Pain Physicians
New Jersey Society of Pathologists
New Jersey State Society of Anesthesiologists