New Jersey Hospital Association
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Health Claims Authorization, Processing and Payment Act

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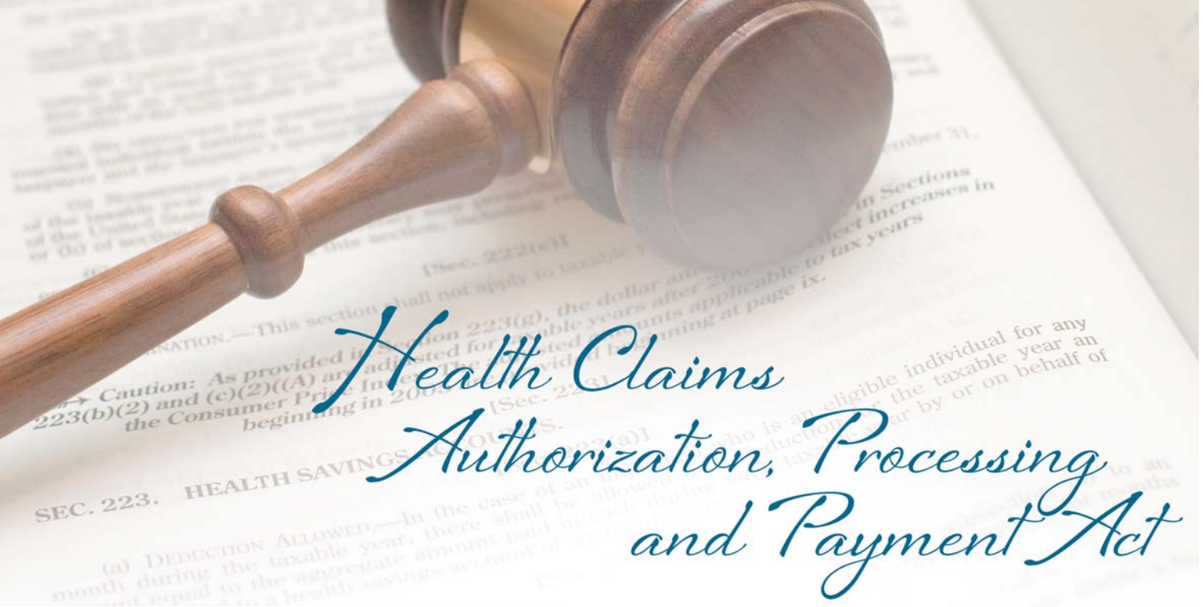

Health Claims Authorization, Processing and Payment Act

PICPA is distinctly different than the utilization management appeals process.

The Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, established a process by which providers and carriers could arbitrate claims payment disputes. This process referred to as the Program for Independent Claims Payment Arbitration (PICPA), deals only with issues surrounding appropriate payment and violations of the HCAPPA law. ***It is distinctly different than the utilization management appeals process.*** This process is only to be used for issues concerning claims payment or violations of HCAPPA, not for any issues that are impacted by the utilization management process.

The process includes two stages of appeal, an internal appeal process with the managed care organization and a second stage process of arbitration through an independent organization under contract with the Department of Banking and Insurance. At this time, the contracted organization is Maximus. Below are several notable provisions from the law that rule how the process works. Currently, there are no regulations governing this process.

- An arbitration decision must be issued within 30 calendar days of receipt of the request.
- Arbitration requests will not be considered unless the total disputed amount is $1,000 or more. Healthcare providers may aggregate disputed claim amounts in order to meet the threshold.
- An MCO cannot seek reimbursement for overpayment of a claim later than 18 months after the date the first claim payment was made. Payers must also provide written documentation that identifies the error in the processing or payment of the claims.
- An MCO cannot collect reimbursement for an overpayment prior to the 45th calendar day following notification of the overpayment to the provider.
- An MCO cannot collect reimbursement for an overpayment in the event a provider files an appeal within the 45 calendar days following notification until the provider has exhausted the appeal process.
- All arbitration decisions are nonappealable and binding on all parties. The IURO's determination is binding on all parties.
- If the IURO's determination finds for the patient the managed care organization must provide the benefits without delay. The managed care organization has 10 business days of receipt of the determination to submit a written report to the IURO, the patient, the provider if they made the appeal on the patient's behalf, and DOBI indicating how the IURO's determination will be implemented.

Appeal of Claims Payment/HCAPPA Violation Dispute		
Payers must have an internal appeal mechanism to resolve any dispute concerning claims payments or HCAPPA violations that is accessible to both contracted and non-contracted providers. *http://www.state.nj.us/dobi/chap352/352genapplication.doc*		
Ensure the appeal is not greater than **90 days old**.		Date of payer's claim determination _____
File the appeal on the appropriate form as prescribed by DOBI.		
A payer must issue a determination within 30 calendar days.	If not received within 30 days, provider may access arbitration.	Anticipated Date: _____
Ensure that any determinations in your favor include 12 percent interest.	If not, file appropriate letter.	Y/N
Determine if claim is appropriate for arbitration.		Y/N
Arbitration		
The arbitration process is overseen by Maximus under contract with DOBI; all decisions will be binding on all parties.		
Ensure the request for arbitration is filed within 90 calendar day following receipt by the health care provider of the payer's claims determination.		Date of Appeal Determination:
Ensure the amount in dispute is greater than $1,000.		Y/N
Access the Maximus Website to file your request. (no manual process)	https://njpicpa.maximus.com	
Ensure the arbitration decision is issued within 30 calendar days.		Anticipated Date:
Ensure the determination is: Signed by the arbitrator; Issued in writing, on a form prescribed by DOBI; and Included a statement of the issues in dispute and the findings and conclusions on which the determination is based.		Y/N
Determine if you can/will bill the patient?		Y/N