CHAPTER 38A

HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, AND MEDICAL SERVICE CORPORATIONS

Authority

N.J.S.A. 26:2S-1 et seq.

Source and Effective Date

R.2005 d.418, effective October 27, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).

Chapter Expiration Date

Chapter 38A, Health Care Quality Act: General Implementation, expires on October 27, 2010.

Chapter Historical Note

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was adopted as R.2000 d.183, effective May 1, 2000. See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was transferred to the Department of Banking and Insurance, effective August 29, 2005. See: 37 N.J.R. 2737(a).

Chapter 38A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted by R.2005 d.418, effective October 27, 2005. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:38A-1.1 Scope and purpose

(a) The purpose of this chapter is to set forth the minimum standards which carriers, as defined at N.J.A.C. 8:38A-1.2, must meet in order to be in compliance with the requirements of the Health Care Quality Act, P.L. 1997, c.192, enacted August 8, 1997.

(b) A carrier shall comply with each of the subchapters of this chapter as appropriate to the types of health benefits plans delivered or issued for delivery by the carrier in this State.

(c) The provisions of this chapter shall apply to any services or functions of a carrier that the carrier may subcontract to another entity just as if the carrier were performing those services or functions itself, and no carrier shall be relieved of assuring full compliance with any applicable provision because one or more functions or services are subcontracted.

(d) A carrier that complies with this chapter shall not be relieved of its obligation to comply with all applicable Federal, State and local laws, rules and regulations.

8:38A-1.2 Definitions

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise.

"Act" means the Health Care Quality Act, P.L. 1997, c.192 (as codified: N.J.S.A. 26:2S-1 et seq.; 26:2J-4.16, 18.1 and 24; 17:48-6r, 17:48A-7p, 17:48E-35.15, 17B:26-2.1n, 17B:27-46.1q, 17B:27A-2.3 and 17B:27A-19.5; and 34:13A-31).

"Carrier" means a insurance company authorized to transact the business of insurance in this State and doing a health insurance business in accordance with N.J.S.A. 17B:17-1 et seq., a hospital service corporation authorized to do business pursuant to N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to do business pursuant to N.J.S.A. 17:48A-1 et seq. or a health service corporation authorized to do business pursuant to N.J.S.A. 17:48E-1 et seq.

"Commissioner" means the Commissioner of the New Jersey Department of Health and Senior Services.

"Continuous quality improvement" or "CQI" means an on-going and systematic effort to measure, evaluate, and improve either a carrier's process of providing quality health care services to covered persons with respect to managed care plans, or the carrier's process of performing utilization management functions with respect to health benefits plans in which utilization management has been incorporated.

"Contract holder" means an employer or organization that purchases a contract or policy for the provision of health care services covered under the terms of the policy or contract or for the payment of benefits therefor.

"Covered person" means the person on whose behalf a carrier is obligated to pay benefits or provide health care services pursuant to the health benefits plan.

"Department" means the New Jersey Department of Banking and Insurance.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Financial incentive arrangement" means a formal mechanism instituted by a carrier or a secondary contractor that exposes a provider, or group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

"Financial risk" means participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.

"Gatekeeper system" means a system in which a covered person's level of benefits for all or a specified set of health care services under a policy or contract is dependent upon the covered person obtaining appropriate referrals for the services through a primary care provider or the carrier.

"Health benefits plan" means a policy or contract for the payment of benefits for hospital and medical expenses or the provision of hospital and medical services delivered or issued for delivery in this state by a carrier. The term "health benefits plan" specifically includes:

1. Medicare supplement coverage and risk contracts for the provision of health care services covered by Medicare to the extent that state regulation of such contracts or policies is not otherwise preempted by Federal law; and

2. Any other policy or contract not otherwise specifically excluded by statute or this definition.

The term "health benefits plan" specifically excludes:

1. Accident only policies;

2. Credit health policies;

3. Disability income policies;

4. Long-term care policies;

5. CHAMPUS supplement coverage;

6. Hospital confinement indemnity coverage;

7. Coverage arising out of a workers' compensation law or similar such law;

8. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.; and

9. Coverage for medical expenses contained in a liability insurance policy.

"IHC Program" means the Individual Health Coverage Program set forth at N.J.S.A. 17B:27A-2 et seq., and any rules promulgated pursuant thereto.

"Independent Health Care Appeals Program" means the external appeals process for a covered person or provider on behalf of the covered person with the covered person's consent, to appeal a decision of a carrier to deny, reduce or terminate services or payment of benefits resulting from a decision by a carrier with respect to the covered person which services are otherwise covered under the health benefits plan.

"Independent utilization review organization" or "IURO" means an independent organization with which the Department contracts to provide independent reviews through the Independent Health Care Appeals Program of carrier

determinations regarding medical necessity or appropriateness of services which are contested by the covered person or a provider on behalf of the covered person.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangement with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.

"Participating provider" means a provider which, under contract or other arrangement acceptable to the Department with the carrier, its contractor or subcontractor, has agreed to provide health care services or supplies to covered persons in the carrier's managed care plan(s) for a predetermined fee or set of fees.

"Primary care provider" or "PCP" means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care for the members.

"Primary contractor" means a provider that agrees directly with a carrier to provide one or more services or supplies directly to a carrier's covered persons.

"Provider" means any physician or other health care professional, hospital, facility or other person who is licensed or otherwise authorized to provide health care services or other services in the state or jurisdiction in which the services are furnished.

"Secondary contractor" means a person who agrees to arrange for the provision of one or more services or supplies for a carrier's covered persons. A primary contractor also may be a secondary contractor when acting as a broker or administrator for the rendering of services or supplies that, in scope of licensure, type or quantity, the primary contractor (provider) alone could not offer directly to the carrier's covered persons.

"SEH Program" means the Small Employer Health Benefits Program set forth at N.J.S.A. 17B:27A-17 et seq., and any rules promulgated pursuant thereto.

"Subscriber" means, in the case of a group policy or contract, an individual whose employment or other status, except family status, is the basis for eligibility for coverage under the policy or contract or, in the case of an individual policy or contract, the person in whose name the contract is issued.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In "Department" definition, substituted "Banking and Insurance" for "Health and Senior Services."

8:38A-1.3 Compliance time frames

(a) For disclosures required to be made on or about the effective date of coverage (whether or not annual disclosure is required thereafter), carriers shall make the disclosure to new subscribers no later than July 30, 2000.

(b) For disclosures required to be made on or about the effective date of coverage (whether or not annual disclosure is required thereafter), carriers shall make the disclosures to current subscribers or covered persons no later than the anniversary date of the contract or policy under which they are covered first occurring on or after July 30, 2000.

(c) For disclosures required to be made upon request, carriers shall begin providing those disclosures no later than July 30, 2000.

(d) With respect to form filings required to be made for inforce policies and contracts, carriers shall make the required filings no later than July 30, 2000.

SUBCHAPTER 2. PROVISIONS APPLICABLE TO ALL CARRIERS

8:38A-2.1 Scope and applicability

(a) This subchapter shall apply to all carriers that have delivered and inforce, or are offering for delivery, health benefits plans in this State.

(b) This subchapter shall apply to all health benefits plans of a carrier that have been or will be delivered or offered for delivery in this State.

8:38A-2.2 HCQA Registration Form

(a) Carriers shall complete and submit to the Department the HCQA Registration Form, available from the Department upon request, describing, if required, the carrier's internal appeal process, by which covered persons, or a provider on behalf of a covered person (with the covered person's consent), may appeal a carrier's UM decision, and the carrier's notice to covered persons of the right to appeal a carrier's final UM decision to the Independent Health Care Appeals Program.

1. Carriers shall file the HCQA Registration Form at least 30 days prior to the date that the carrier will begin to offer any health benefits plan issued under a policy or contract form for which an HCQA Registration Form has not previously been filed.

2. Completion of the HCQA Registration Form with respect to the description of the carrier's internal appeals mechanism and its notice of a covered person's right to appeal through the Independent Health Care Appeals Program shall be consistent with the requirements of N.J.A.C. 8:38A-3.5.

3. Carriers shall file a copy of the HCQA Registration Form with the Department at the following address:

New Jersey Department of Banking and Insurance
Valuations Bureau
Life and Health Division
PO Box 325
Trenton, NJ 08625-0325

(b) Carriers shall submit a revised HCQA Registration Form pursuant to (a)3 above no later than 10 business days following the date of any substantive change to the information contained in the prior HCQA Registration Form submission.

1. In lieu of resubmission of the entire HCQA Registration Form, carriers may submit an HCQA Registration Form indicating the revisions only, and specifying for unchanged sections "No change from the submission of (specify date)."

(c) The HCQA Registration Form shall include a request for the following information:

1. General information about the carrier, including the carrier's name and NAIC number, address, the name of the person completing the form and the means by which that person may be contacted, an explanation of what type of carrier the carrier is, a statement as to whether the carrier has health benefits plans inforce in New Jersey, or the date the carrier intends to begin offering health benefits plans in New Jersey, and the name of the person responsible for the carrier's operations in New Jersey, with specification of how that person may be contacted;

2. A statement as to whether the carrier does or will administer any of its health benefits plans using utilization management features, and whether any of the carrier's health benefits plans are managed care plans;

3. If a carrier's health benefits plans incorporate utilization management features or are managed care plans, a statement identifying the carrier's medical director for those health benefits plans, and any other persons responsible for the carrier's utilization management program, along with a description of the appeal process that the carrier uses for its health benefits plans;

4. If a carrier's health benefits plans incorporate utilization management features or are managed care plans, a general description of the nature of each product, including its form number and market name; and

5. A certification that the answers contained in the form are accurate.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In the introductory paragraphs of (a) and (a)3, deleted "and the Department of Banking and Insurance"; in (a)3, deleted the address to the New Jersey State Department of Health and Senior Services and rewrote the address to the New Jersey Department of Banking and Insurance.

8:38A-2.3 Disclosure requirements

(a) Carriers shall provide to each subscriber within no more than 30 days following the effective date of coverage, and upon request thereafter, through a handbook, certificate or other evidence of coverage designed for covered persons, information describing the following:

1. The services or benefits therefor to which a covered person is entitled under the policy or contract, including:

i. All exclusions and limitations with respect to at least physical and occupational therapy, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services;

ii. All restrictions on accessing covered services, such as the requirement to obtain prior authorization, preadmission certification, or periodic review of ongoing treatment;

iii. A full and clear description of the carrier's policies and procedures governing the provision of emergency and urgent care services or the payment of benefits therefor, including a statement that emergency or urgent care services are not covered, if that is the case; and

iv. All dollar, day, visit or procedure limitations applicable to at least those services set forth at (a)1i above, and the method for exchanging inpatient for outpatient services or vice versa, when such exchanges are permitted under the policy or contract;

2. The responsibility of the covered person to pay deductibles, coinsurance or copayments, as appropriate.

i. Carriers shall clearly distinguish any differences in the covered person's financial responsibility for accessing services within and outside of a carrier's network, when applicable;

ii. Carriers shall explain the covered person's responsibility to pay for charges incurred that are not covered under the policy or contract.

iii. Carriers shall explain the covered person's responsibility to pay for charges that exceed what the carrier determines are customary and reasonable charges (usual and customary, or usual, customary and reasonable, as appropriate to the carrier) for services that are covered under the policy or contract in those instances in which service is rendered by an out-of-network provider;

3. Where and in what manner covered services may be obtained.

i. Even in the instance in which the contract or policy is not subject to any network requirements or differentials, carriers shall specify if benefits are payable for certain services only when rendered by a specified class or classes of provider(s);

4. Use of the "911" emergency response system whenever a covered person has a potentially life-threatening condition, and a statement that "911" information is included on the covered person's insurance identification card.

i. In addition to (a)4 above, carriers shall provide "911" information on all insurance identification cards.

ii. In complying with (a)4i above, carriers may elect to phase-in the 911 information on insurance identification cards, so long as all covered persons of a carrier has an insurance identification card that meets the requirements of (a)4i above no later than 24 months following (the operative date of this chapter);

5. The right of the covered person to obtain information concerning the carrier's policies and procedures required pursuant to N.J.A.C. 8:38A–2.5(b);

6. The right to prompt written notification of changes to or termination of benefits, or services which in no event shall be provided no later than 30 days following the date of any change or termination; and

7. The right of the covered person to file a complaint with the Department or the Department of Banking and Insurance.

(b) A carrier shall provide written notice to subscribers of any additions of any services or benefits therefor to the contract or policy within no more than 30 days following the date that the change is effective.

(c) All information provided to subscribers shall meet the readability requirements of N.J.S.A. 17B:17–17 et seq. (the Life and Health Insurance Policy Language Simplification Act), and any rules promulgated pursuant thereto.

8:38A–2.4 Submission of disclosure statements to the Department

(a) The Department shall deem approved those disclosures required by this chapter that a carrier makes within a contract, policy or certificate form submitted to and filed by the New Jersey Department of Banking and Insurance, or otherwise deemed approved by that State agency in accordance with the statutes and rules of this State.

(b) The Department shall deem approved those disclosures required by this chapter to be made by carriers for individual standard health benefits plans if the IHC Program Board of Directors (as authorized by N.J.S.A. 17B:27A–2 et seq.) has promulgated standard disclosure statements meeting the requirements of N.J.A.C. 8:38A–2.3 which are to be included within the standard health benefits plan forms or other standard materials that carriers are required to provide to all covered persons in accordance with the rules of the IHC Program at N.J.A.C. 11:20.

(c) The Department shall deem approved those disclosures required by this chapter to be made by carriers for small employer standard health benefits plans if the SEH Program Board of Directors (as authorized by N.J.S.A. 17B:27A–17 et seq.) has promulgated standard disclosure statements meeting the requirements of N.J.A.C. 8:38A–2.3 which are to be included within the standard health benefits plans and/or other standard material that carriers are required to provide to all covered persons under small employer health benefits plans in accordance with the rules of the SEH Program at N.J.A.C. 11:21.

(d) In the event the carrier uses a form for its disclosures that is not required to be submitted to the Department of Banking and Insurance, or is not subject to the rules of the IHC or SEH Programs, the carrier shall submit the form to the Department, and shall include with the submission of each disclosure form a statement of the policy or contract form(s) to which the disclosure is applicable, listed by form number and market name, if any, and a certification that the disclosure meets the requirements of N.J.A.C. 8:38A–2.3.

1. A carrier may use the disclosure until such time as the Department disapproves the disclosure and provides notice of the disapproval to the carrier, with the reasons for the disapproval set forth in writing.

2. The Department may disapprove the form for failing to meet the requirements of this subchapter, or because it is deceptive, misleading, or contrary to the public policy of this State.

3. The Department may disapprove the form for failing to meet the readability requirements of N.J.S.A. 17B:17–17 et seq. (the Life and Health Insurance Policy Language Simplification Act).

8:38A–2.5 Other rights of covered persons

(a) Every carrier shall establish and implement written policies and procedures regarding the rights of covered persons and the implementation of these rights.

(b) Carriers' policies and procedures shall address at least the following:

1. The right of covered persons to receive all of the disclosures set forth at N.J.A.C. 8:38A–2.3;

2. The right of covered person to have access to services, and payment of appropriate benefits therefor, when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions, if covered;

3. The right of covered persons to be treated with courtesy, consideration, and with respect to the covered person's dignity and need for privacy; and

4. The right of covered persons to obtain information regarding the carrier's policies and procedures concerning (b)1 through 3 above.

8:38A–2.6 Emergency and urgent care services

(a) If a carrier's policy or contract provides benefits for emergency or urgent care services, the carrier shall include benefits for the coverage of trauma services at any designated Level I or II trauma center as medically necessary, which shall be continued at least until, in the judgment of the attending physician, the covered person is medically stable, no longer requires critical care, and can be transferred safely to another facility.

(b) In addition to (a) above, the contract or policy shall pay for coverage of a medical screening examination provided upon a covered person's arrival in a hospital, as required to be performed by the hospital in accordance with Federal law and as specified at N.J.A.C. 8:43G–12, but only as necessary to determine whether an emergency medical condition exists.

8:38A–2.7 Violations

(a) The Commissioner may issue an order directing a carrier to cease and desist from an act or omission that violates a provision of the rules of this chapter that are applicable to the carrier, which order shall serve as constructive written notice to the carrier of an intent to levy a penalty for the violation of the rules, notwithstanding that a specific statement to that effect is not included in the order, if the order is followed by a written notice in compliance with (b)3 below.

1. A carrier shall have the right to request a hearing on the order within 20 days following the date of service of the order on the carrier, which shall be conducted in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. When requesting a hearing, the carrier shall specify in writing all reasons for which it disputes the order to cease and desist, enclose a copy of the order and verification of the date on which the order was served.

ii. When requesting a hearing, the carrier shall notify both the Department and the Department of Banking and Insurance of the request, providing the information set forth in (a)1i above.

2. The agency that issued the order to cease and desist shall determine whether to transfer the case to the Office of Administrative Law based upon the papers before it.

3. In the event that a civil penalty is to be levied in the circumstance in which an order to cease and desist is issued, the civil penalty shall not be effective until the rendering of a final agency decision on the matter in favor of the Department or the Department of Banking and Insurance, as applicable.

4. In the event that a civil penalty is to be levied in the circumstance in which an order to cease and desist is issued, the request for a hearing shall not toll the time for calculation of the penalty.

(b) If the Commissioner intends to levy a civil penalty against a carrier for violation of an applicable rule, the Commissioner shall provide the carrier with written notice of an intent to levy a penalty at least five business days prior to the date that the penalty shall be effective, except as (b)3 below applies.

1. Except as (b)3 below applies, written notice of an intent to levy a penalty shall provide the following information:

i. The rules the carrier has violated or is violating;

ii. The facts upon which the Commissioner is relying in determining that the carrier is in violation of a rule applicable to the carrier;

iii. The known duration of the violation, including a statement of whether the violation is believed to be continuing;

iv. The daily dollar amount of the penalty, which shall be no less than $250 and no more than $10,000 per day; and

v. The date upon which the levy of the penalty shall be effective.

2. In addition to (b)1 above, the Commissioner may, through the written notice of intent to levy a penalty, provide the carrier with an opportunity to reduce or eliminate the civil penalty, or toll the violation period through correction of the violation within a specified period of time, in which event, the written notice shall contain the following information:

i. The time period for correction of the violation, which shall be no less than 30 calendar days from the date of the written notice;

ii. The minimum actions that the carrier is required to take in order to determine at the end of the period whether the carrier has corrected the violation; and

iii. The effect of correction of the violation upon the levying of the civil penalty.

3. An order to cease and desist shall serve as a written notice of an intent to levy a penalty if followed within no more than five business days of the date of service of the order to cease and desist with a written notice including all of the statements required in (b)1 above, except that the effective date of the penalty may be the same as the date of the written notice.

(c) In accordance with the provisions of the act, the Commissioner may seek injunctive relief against a carrier.

SUBCHAPTER 3. UTILIZATION MANAGEMENT

8:38A-3.1 Scope and applicability

(a) This subchapter shall apply to all carriers that incorporate UM in the administration of one or more of their health benefits plans that have been or will be delivered or offered for delivery in this State.

(b) This subchapter shall apply to all health benefits plans in which UM is performed by or on behalf of the carrier in the administration of the health benefits plan.

8:38A-3.2 Disclosure requirements

(a) In addition to the requirements of N.J.A.C. 8:38A-2.3, carriers shall include in the disclosure statements a covered person's right to appeal to the carrier a denial, reduction or termination of health care services or the payment of benefits therefor resulting from a utilization management decision by or on behalf of a carrier, setting forth:

1. A description of the internal appeal procedure, including the address and toll-free telephone number through which the covered person may contact the carrier;

2. The amount of time for a final decision on the appeal; and

3. The process for expediting appeals in urgent or emergency situations.

(b) The statement that a covered person has a right to appeal a carrier's utilization management decision at the option of the covered person through the Independent Health Care Appeals Program, including:

1. The cost to the covered person of making such an appeal (that is, the cost of the application fee), and the right of the covered person to request a waiver from the Department for financial hardship;

2. A statement that the carrier shall bear the costs of the review by the Independent Health Care Appeals Program;

3. A statement that the covered person must file the application for review of the carrier's final decision within 60 days following the date the final decision was issued by the carrier; and

4. A statement that the decision of the Independent Health Care Appeals Program is binding upon the carrier.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a)
Rewrote (b)4.

8:38A-3.3 Designation of a medical director

(a) The carrier shall designate a physician licensed to practice medicine in New Jersey to serve as the medical director for the carrier with respect to its contracts or policies delivered in this State to which a utilization management program applies.

(b) The medical director shall be responsible for at least the following:

1. Overseeing the continuing in-service education of professional staff;

2. Providing clinical direction and leadership to the continuous quality improvement and utilization management programs;

3. Establishing policies and procedures covering all utilization management determination criteria and protocols applicable to health care services for which benefits are payable under a carrier's health benefits plans; and

4. Establishing policies and procedures covering all health care services provided to covered persons when the carrier is authorized, and elects, to engage in the direct or indirect provision of health care services.

8:38A-3.4 Utilization management program

(a) A carrier's UM program shall be under the direction of the medical director, or his or her designee (who shall be a physician licensed to practice medicine in the State of New Jersey), and shall be based on a written plan, reviewed annually by the carrier, and available for review by the Department upon request, specifying at least:

1. The scope of the carrier's UM activities;

2. The procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

3. The mechanisms to detect underutilization and over utilization of services;

4. The clinical review criteria and protocols used in decision-making;

5. The mechanisms to ensure consistent application of review criteria and uniform decisions;

6. The development of measures for evaluating the carrier's UM program, including outcome and process measures when the carrier utilizes a gatekeeper system or practice guidelines for its managed care product(s);

7. A system for covered persons, and providers on behalf of covered persons (with the covered person's consent) to appeal UM determinations in accordance with the procedures set forth at N.J.A.C. 8:38A-3.5; and

8. A mechanism to evaluate the satisfaction of covered persons with the appeals system, which mechanism shall coordinate with the carrier's CQI program required pursuant to N.J.A.C. 8:38A-3.8.

(b) Carriers shall ensure that UM determinations are based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers and based upon generally accepted medical standards.

1. The carrier shall periodically review (no less than annually) and update these criteria as necessary.

2. The carrier shall make the criteria readily available, upon request, to covered persons and interested providers except that internal or proprietary quantitative thresholds for UM is not required to be released to covered persons or providers pursuant to this subchapter.

i. When the request is related to specific treatment or services for which benefits are being sought, the information provided may be limited to all criteria and protocols by which the carrier performs UM relevant to only that treatment or services.

(c) The carrier shall provide access to UM services as follows:

1. For routine utilization-related inquiries, covered persons and providers shall have access to UM staff on, at a minimum, a five-day, 40 hours a week basis through a toll-free telephone number.

2. If the carrier requires preauthorization for use of emergency departments or for reimbursement of services rendered under an emergency or urgent situation, the carrier shall have a registered professional nurse or physician immediately available by phone seven days a week, 24 hours a day to render UM determinations to providers.

(d) The carrier shall have written policies and procedures, available for review by the Department upon request, that address the responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay meeting the following:

1. All determinations to deny or limit an admission, service, procedure or extension of stay, or benefits therefor, shall be made in accordance with the clinical and medical necessity criteria developed in accordance with (b) above, and rendered by a physician under the clinical direction of the medical director required pursuant to N.J.A.C. 8:38A-3.3.

i. The physician shall communicate the determination directly to the provider or, if this is not possible, the physician shall supply his or her name, telephone number and where he or she may be reached so that the provider may contact the physician for further discussion.

ii. The physician rendering the determination shall be available immediately to the treating provider in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation.

2. All determinations shall be made on a timely basis, as required by the exigencies of the situation.

(e) A carrier shall not deny reimbursement retroactively for a covered service provided to a covered person by a provider who relied upon the written or oral authorization of the carrier (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

(f) A carrier shall provide written notice within five days, or sooner if the medical exigencies dictate, upon request, of any determination to deny coverage or authorization of services or payment of benefits therefor otherwise covered under the contract or policy of the covered person, and shall include an explanation of the appeal process.

8:38A-3.5 Internal utilization management appeals process

(a) A carrier shall establish an appeal process whereby a covered person or a provider acting on behalf of the covered person, with the covered person's consent, may appeal any UM decision resulting in a denial, termination or limitation of services or the payment of benefits therefor covered under the contract or policy.

(b) Carriers shall detail the appeal process in a writing provided to covered persons at the time of coverage (and periodically as changes occur), upon the occurrence of a utilization management decision adverse to the request of the covered person, upon the conclusion of each stage of the appeal process, and upon request.

(c) Carriers shall provide a written description of the appeal process and the carrier's decision on an appeal to providers upon request, and upon the conclusion of each stage of the appeal process, when the provider is making the appeal on behalf of a covered person with the covered person's consent.

(d) The carrier shall not establish nor maintain any policies or procedures that prohibit or discourage a covered person from discussing or exercising the right to an appeal, including the right to designate a provider to act on behalf of the covered person in the appeal process.

(e) Carriers shall establish an appeal process in two stages, with the stage 1 appeal being an informal process, and stage 2 being a formal process.

(f) Carriers shall provide in stage 1 for a covered person (or his or her designated provider if the covered person has consented to having a provider act in his or her behalf) to have an opportunity to speak, regarding an adverse service or benefits determination, with the carrier's medical director, or the medical director's designee who rendered the adverse determination.

1. Stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, but in no event shall exceed:

i. 72 hours in the case of an appeal from a determination regarding urgent or emergency care (which shall include all situations in which the covered person is confined in an inpatient facility); and

ii. Five business days in the case of all other appeals.

2. At the conclusion of stage 1, the carrier shall include a written explanation of the covered person's right to make a stage 2 appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

(g) Carriers shall provide in stage 2 appeals for a covered person (or the covered person's designated provider, if the covered person has consented to have a provider act in his or her behalf) to pursue his or her appeal before a panel of physicians and/or other providers selected by the carrier who have not been involved in the UM decision at issue.

1. The panel shall have access to consultant providers who are trained or who practice in the same specialty as would typically manage the case at issue, or such other licensed provider as may be mutually agreed upon by the parties.

i. The consulting provider(s) shall not have been involved in the UM decision at issue.

ii. The carrier shall allow the consulting provider(s) to participate with the panel in the review of the case if so requested by the covered person (or the covered person's designated provider if the covered person has consented to having a provider act in his or her behalf).

2. The carrier shall send to the covered person (or designated provider if the covered person has consented to having a provider act in his or her behalf) an acknowledgment of the filing of a stage 2 appeal in writing within no more than 10 business days of receipt by the carrier of the appeal.

3. The carrier shall conclude the stage 2 appeal as soon as possible after receipt of the appeal by the carrier in accordance with the medical exigencies of the case, but in no event shall exceed:

i. 72 hours in the case of appeals of determinations regarding urgent or emergent care (which shall include all situations in which the covered person is confined in an inpatient facility); and

ii. 20 business days in the case of all other appeals.

4. Notwithstanding (g)3ii above, a carrier may extend the review period for up to an additional 20 business days where the carrier can demonstrate reasonable cause for the delay beyond its control, but only if the carrier provides a written progress report and explanation for the delay to the satisfaction of the Department and written notice to the covered person and provider, as appropriate, within the original 20 business day review period.

5. In the event the stage 2 appeal results in a denial, the carrier shall provide the covered person and/or provider, as appropriate, with written notification of the denial and the reasons therefor together with a written notification of his or her right to proceed to an appeal through the Independent Health Care Appeals Program, including:

i. Specific instructions as to how the covered person and/or provider, as appropriate, may pursue such an appeal; and

ii. The form(s) required to initiate such an appeal.

6. A carrier shall not provide a stage 2 appeal to any covered person (or the covered person's designated provider if the covered person has consented to having a provider act in his or her behalf) until a covered person's right to a stage 1 appeal is exhausted.

8:38A–3.6 Independent health care appeals process

(a) Any covered person, and any provider acting on behalf of a covered person with the covered person's consent, who is dissatisfied with the final results of a carrier's internal appeals process shall have the right to pursue his or her appeal through the Independent Health Care Appeals Program to an independent IURO.

1. A covered person and any provider acting on behalf of a covered person with the covered person's consent shall exhaust all appeal rights he or she may have under the policy or contract with the carrier prior to making application to pursue an appeal through the Independent Health Care Appeals Program, except that the covered person and any provider acting on behalf of a covered person with the covered person's consent shall be relieved of the carrier's internal appeal process and may pursue an

appeal through the Independent Health Care Appeals Program if:

i. A determination on any appeal regarding urgent or emergency care is not forthcoming from the carrier within 72 hours of receipt by the carrier of notice (in the manner required under the policy or contract) of the appeal;

ii. A determination on an initial appeal, other than one regarding urgent or emergency care, is not forthcoming from the carrier within five business days of the date that the carrier received notice (in the manner required under the policy or contract) of the appeal; or

iii. A determination of a subsequent level of appeal, other than one regarding urgent or emergency care, is not forthcoming from the carrier within 20 business days of the date that the carrier received notice (in the manner required under the policy or contract) of the appeal, except as N.J.A.C. 8:38A–3.5(g)4 applies.

2. A covered person and any provider acting on behalf of a covered person with the covered person's consent dissatisfied with the carrier's appeal process for reasons set forth in (a)1i, ii, or iii above shall certify on the appeal form that one or more determinations from the carrier have exceeded the time frames set forth in (a)1i, ii or iii above, and that the covered person or the covered person's provider have in no way hindered the carrier in making the determination by failing to provide the carrier with all requested information relevant to the determination.

3. A covered person and any provider acting on behalf of a covered person with the covered person's consent who has exhausted all of his or her appeal rights shall certify on the application that he or she has exhausted all levels of appeal to which he or she is entitled under the contract or policy.

(b) To initiate an appeal through the Independent Health Care Appeals Program, a covered person or provider acting on behalf of a covered person with the covered person's consent shall, within 60 days from the date of receipt of the carrier's final determination, or the last date of filing of an appeal by the covered person or provider in the situation in which the covered person or provider acting on behalf of a covered person with the covered person's consent believes the carrier has failed to meet required time frames, file an application with the Department, as set forth in Exhibit 1 of the chapter Appendix, incorporated herein by reference.

1. The covered person or provider acting on behalf of a covered person with the covered person's consent shall complete the application, including the certification applicable to the covered person's situation, and shall submit with the application:

i. The fee as specified in (c) below, along with evidence demonstrating financial hardship, if appropriate; and

ii. A general release executed by the covered person for all medical records pertinent to the appeal.

2. The covered person or provider acting on behalf of a covered person with the covered person's consent shall mail the application to:

Department of Health and Senior Services
Office of Managed Care
Division of Health Care Systems Analysis
PO Box 360
Trenton, New Jersey 08625–0360

(c) The covered person or provider acting on behalf of a covered person with the covered person's consent shall submit a fee of $25.00 per application, unless there is submitted with the application a demonstration of the covered person's financial hardship, in which event, the covered person may submit no fee until a decision is made by the Department as to whether the covered person qualifies for a reduced fee based on financial hardship.

1. The Department will determine a covered person eligible for a reduced fee on the basis of financial hardship if the covered person submits evidence that one or more members of the household is receiving assistance from the Pharmaceutical Assistance to the Aged and Disabled program, Medicaid, NJ KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

2. A covered person determined to be eligible for a reduced fee because of financial hardship shall submit a fee of $2.00.

3. The fee for filing an appeal shall be made payable by check or money order to the "New Jersey Department of Health and Senior Services."

(d) Upon receipt of the application, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO meeting the requirements of N.J.A.C. 8:38A–5.

(e) Upon receipt of the application, the IURO shall conduct a preliminary review of the application and accept it for processing if it determines that:

1. The individual was or is a covered person of the carrier specified;

2. The service that is the subject of the appeal reasonably appears to be a service covered under the terms of the contract or policy for which some level of benefit is payable;

3. The covered person or provider acting on behalf of a covered person with the covered person's consent has fully complied with the internal appeals process of the carrier, except as (a)1i, ii or iii above may apply; and

4. The covered person or provider acting on behalf of a covered person with the covered person's consent has provided all information required by the IURO and the Department to make a preliminary determination, including a copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the covered service or payment of benefits therefor, and an executed release of necessary medical records from the carrier and any relevant provider.

(f) Upon completion of the preliminary review, the IURO immediately shall notify the member and/or provider in writing as to whether the application has been accepted for processing of the appeal, and if not, the reasons therefor.

(g) Upon acceptance of the application for processing of the appeal, the IURO shall conduct a full review to determine whether, as a result of the carrier's decision, the carrier inappropriately denied services, or the payment of benefits therefor, for the provision of medically necessary treatment or supplies that were/are covered under the contract or policy, taking into consideration the following:

1. All pertinent medical records, consulting physician reports and other documents submitted by the parties;

2. Applicable generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations; and

3. Applicable clinical protocols and/or practice guidelines developed or used by the carrier, if any.

(h) The IURO shall conduct its initial full review through a registered professional nurse or physician licensed to practice in New Jersey, and, when necessary, shall refer all cases for review to a consultant physician in the specialty or area of practice that generally would manage the type of treatment that is the subject of the appeal, but shall not render a final recommendation except with the approval of the IURO's medical director.

(i) The IURO shall complete its review and issue its decision in writing as soon as possible consistent with the medical exigencies of the case, but in no instance later than 30 business days following the date of receipt of the appeal application, unless additional review time is necessitated by circumstances beyond the control of the IURO.

1. In the event that the IURO may not complete its review within 30 business days, the IURO shall provide written notice to the covered person and his or her provider, the Department and the carrier of this fact prior to the completion of the 30 business day review, but in no event shall the IURO render its decision later than 90 days following receipt of a complete application.

2. The IURO shall specify in the written notice the reasons for the delay, the status of the review, and the anticipated completion date of the full review.

(j) Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

(k) The IURO shall set forth in its written decision whether the IURO has determined that the covered person was deprived of receipt of or benefits for medically necessary services otherwise covered under his or her contract or policy, and, if so, shall specify the services the covered person should receive or receive benefits therefor.

1. The IURO shall submit its decision to the covered person and his or her provider (if the provider assisted in filing the appeal with the covered person's consent), the carrier and the Department.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In (i) and throughout (k), substituted "decision" for "recommendation"; in the introductory paragraph of (k), added ", if so,".

8:38A-3.7 Carrier action on the IURO decisions

(a) A carrier shall submit a written report to the covered person and his or her provider (if the provider assisted in filing the appeal), the Department and the IURO describing how the carrier will implement the IURO's decisions within 10 business days of the date that the carrier first receives the decision of the IURO.

1. The carrier shall specify its intentions sooner if the medical exigencies of the case warrant a more rapid response.

(b) A carrier that implements one or more of the recommendations of an IURO shall not be liable in any action for damages to any person for any action taken to implement a recommendation.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
Rule heading was "Carrier action on the IURO recommendations"; rewrote introductory paragraphs of (a) and (b); deleted (a)2.

8:38A-3.8 Continuous quality improvement

(a) Carriers shall have or employ a CQI program to monitor the quality of their UM program under the direction of the carrier's medical director.

(b) No later than June 30, 2000, a carrier shall set forth its system for its CQI program in a plan reviewable upon request by the Department specifying the following:

1. The scope and purpose of the program;

2. The organizational structure of quality improvement activities;

3. The duties and responsibilities of the medical director (or designee);

4. Contractual arrangements, if any, for delegation of quality improvement activities;

5. Confidentiality policies and procedures;

6. Specifications of standards for the assessment of the adequacy and appropriateness of health care resources utilized;

7. A system of on-going evaluation activities;

8. A system of monitoring satisfaction of covered persons; and

9. A system for evaluation of the effectiveness of the CQI program.

(c) The carrier shall establish a multidisciplinary CQI committee to be responsible for the implementation and operation of the CQI program, which shall be composed of representatives of the carrier's medical, nursing and administrative staff, with substantial involvement of the carrier's medical director.

1. The committee shall maintain minutes of its meetings, and such minutes shall be reviewable, upon request, by the Department.

2. The committee shall monitor provider and member access to utilization management services including waiting times to respond to phone requests for service authorization, member urgent care inquiries, and other services required for the carrier's UM program.

3. The committee shall prepare an annual report on the carrier's CQI activities, which shall be available for review upon request by the Department and the Department of Banking and Insurance, delineating quality improvements, performance measures used and their results, and demonstrated improvements in service quality, corrective action recommendations, including corrections to policies and procedures of the carrier, and educational activities for covered persons.

(d) The carrier shall follow-up on the findings of its CQI committee to assure that recommendations made are implemented effectively, and shall document the corrective actions taken and the results of their outcome, which documentation shall be reviewable upon request by the Department or the Department of Banking and Insurance.

(e) The carrier shall coordinate its CQI activities with other performance monitoring activities it may have, if any.

(f) The Department's review of a carrier's health benefits plan that has been approved as a selective contracting arrangement is not intended to be duplicative of, but complementary to, the review of the carrier's utilization review program and quality assurance program made pursuant to N.J.A.C. 11:4-37.4(c)11, 12 and 13.

SUBCHAPTER 4. PROVISIONS APPLICABLE TO CARRIERS OFFERING ONE OR MORE HEALTH BENEFITS PLANS THAT ARE MANAGED CARE PLANS

8:38A-4.1 Scope and applicability

(a) This subchapter shall apply to all carriers that have delivered, will deliver or offer for delivery in this State a health benefits plan that is a managed care plan.

(b) This subchapter shall apply to the health benefits plans that have been or will be delivered or offered for delivery in this State by a carrier that are managed care plans.

8:38A-4.2 Disclosures to covered persons

(a) Carriers shall provide to a covered person no later than the effective date of coverage, and at least annually thereafter a current directory of participating providers.

1. The directory shall include all of the medical providers and hospital providers participating in the carrier's network, and may contain other participating providers at the discretion of the carrier.

2. The directory shall distinguish participating providers by provider category or specialty and by county.

3. For participating providers who provide primary care (which may include providers other than providers practicing family or internal medicine, if so designated by the carrier), the directory also shall include:

i. The office address of the participating provider;

ii. The participating provider's hospital affiliation(s); and

iii. An indication of which participating providers have the capacity to communicate in languages other than English.

4. The directory shall include a statement providing the approximate percentage of the carrier's participating physicians that are board certified, and the date on which that percentage was last calculated.

5. If a carrier does not include all of its participating providers within its directory of medical and hospital providers, the carrier shall include a statement in its directory of medical and hospital providers setting forth the categories of other participating providers in the carrier's network, and the means by which a covered person may obtain a written list or lists of such participating providers, distinguished by category and county, free of charge.

(b) In addition to the requirements of N.J.A.C. 8:38A–2.3 and 3.2, a carrier shall provide a statement to covered persons in a handbook or certificate, no later than the effective date of the subscriber's coverage, and at least annually thereafter, regarding its financial arrangements with its providers, and the possible financial arrangements between its providers and the health care facilities with which the providers are affiliated.

1. Every carrier shall make the following disclosure, using the variable text as appropriate to the carrier's circumstance for a health benefits plan:

"[Different] providers in our network have agreed to be paid [in different ways by us. Your provider may be paid] [each time s/he treats you ("fee for service"][, or may be paid] [a set fee each month for each member whether or not the member actually receives services ("capitation")][, or may receive] [a salary]."

2. The carrier shall add the following statement if the carrier contracts directly or indirectly with providers to participate in financial incentive arrangements (this includes financial incentive arrangements between an intermediate entity and a physician or physician group):

"These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: member satisfaction, quality of care, and control of costs and use of services among them."

3. Each carrier shall make the following statement:

"If you desire additional information about how our primary care physicians or any other provider in our network are compensated, please call us (or carrier name) at (telephone number) or write (address)."

4. Every carrier shall make the following statement:

"The laws of the State of New Jersey, at N.J.S.A. 45:9–22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which s/he has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504–6200 OR (800) 242–5846."

(c) With respect to the disclosures required pursuant to (b) above:

1. Carriers may propose alternate stylistic language for the statements but may utilize such changes only with the prior written approval from the Department.

i. Any modification must be written in plain language and cannot substantively alter the meaning and/or intent of the required statements.

ii. Notwithstanding (c) above, the carrier may substitute the term "insured" or "covered person" for the term "member" without seeking prior written approval of the language changes.

2. All statements shall be prominently displayed and printed in at least the same point and print as used for other material contained in the handbook, other than captions or headings.

3. Carriers shall provide information in response to requests made by disclosing the method by which a specific provider is compensated, but shall not be required to state the dollar amount of compensation or otherwise provide more specific information about the compensation arrangement it has with a specific provider.

(d) In addition to (a) through (c) above, the carrier shall provide a statement to covered persons in a handbook, no later than the effective date of coverage, and in a separate document (at the carrier's discretion) at least annually thereafter, that the general public may obtain results of independent consumer satisfaction surveys and results of analyses of quality outcomes for health care services provided under managed care plans in this State by contacting the Department.

1. This requirement shall not be enforced for at least three calendar months following the initial date that these reports actually become available from the Department.

(e) In those instances in which covered persons are required to select a primary care provider in accordance with the terms of the managed care plan, regardless of whether the primary care provider in any way controls access to services in a gatekeeper system, the carrier shall provide written notification to covered persons of the termination of their primary care provider from the network at least 30 days prior to the termination date.

1. The carrier is not required to provide 30 days prior written notice in those instances in which the termination is for breach of contract, or the opinion of the carrier's medical director is that the primary care provider represents an imminent danger to an individual patient or the public health, safety or welfare, or there is a determination of fraud.

2. In the event that the carrier does not provide 30 days prior written notice pursuant to (e)1 above, the carrier shall provide written notice to the covered person as expeditiously as possible, and in no event later than 30 days following the date of termination.

(f) The carrier shall, upon request, provide the following information to a covered person:

1. A statement as to whether a specific provider in the carrier's network is board certified;

2. A statement as to whether a specific provider in the carrier's network is accepting new patients, or the means by which the covered person may obtain this information on his or her own at no cost to the covered person; and

3. A statement setting forth the carrier's standards for waiting times for appointments for routine and urgent care that the carrier uses in selecting physicians to participate in its network(s).

8:38A–4.3 Disclosures to consumers

(a) Carriers shall, upon request, provide a written document to consumers setting forth the information required to be disclosed pursuant to N.J.A.C. 8:38A–4.2(a) through (c).

1. The carrier shall not be required to provide the consumer with the same level of detail that is provided to subscribers in the provider directory pursuant to N.J.A.C. 8:38A–4.2(a), but the carrier shall provide at least the following information:

i. The number of medical providers categorized by specialty by county in the carrier's network;

ii. The number of hospitals categorized by county in the carrier's network;

iii. The approximate percentage of the medical providers in the carrier's network that are board certified, and the date on which the calculation of the percentage was last performed;

iv. The waiting time criteria that the carrier utilizes in its selection of providers for participation in the carrier's network, if any, including a statement that no such criteria apply in those instances in which the carrier does not consider patient waiting times for appointments for routine and urgent care in selecting participating providers;

v. A statement that consumers can check with providers directly to find out if the provider is a participating provider; and

vi. A statement that the consumer may obtain more detailed information, including a provider directory (if not already included), and the process by which consumers may obtain the information free of charge.

(1) Carriers that elect to make their lists of participating providers available through an electronic database accessible to the public shall not substitute electronic access to the information as the only means by which consumers may obtain the information free of charge.

2. The information provided to consumers may be in a single document or multiple documents.

(b) The carrier shall, upon request, provide to consumers the same information required to be made available to covered persons pursuant to N.J.A.C. 8:38A–4.2(d).

8:38A–4.4 Submission of disclosures

Carriers shall submit the forms of the written disclosures required to be made pursuant to N.J.A.C. 8:38A–4.2 and 4.3 for filing with the Department, in accordance with N.J.A.C. 8:38A–2.4 and may use such forms until disapproved by the Department, except as N.J.A.C. 8:38A–4.2(b) applies.

8:38A–4.5 Designation of a medical director

(a) The carrier shall designate a physician licensed to practice medicine in New Jersey to serve as the medical director for the carrier with respect to its contracts or policies delivered in this State to which a utilization management program applies.

(b) The medical director shall be responsible for the same functions set forth at N.J.A.C. 8:38A–3.3(b).

(c) In addition to (b) above, the medical director shall be responsible for:

1. Defining responsibilities and inter-relationships of professional services for health benefits plans offered with a gatekeeper system;

2. Coordinating, supervising and overseeing the functioning of medical services for health benefits plans offered with a gatekeeper system;

3. Evaluating the medical aspects of provider contracts;

4. Establishing and overseeing a committee to perform the following functions:

i. Establishment of a mechanism for ensuring review of provider credentials;

ii. Delineation of qualifications of participating providers;

iii. Review of credentials of physicians and other providers who do not meet the carrier's standard credentialing requirements; and

iv. Establishment of a mechanism for:

(1) Verifying provider credentials, recertifications, and performance reviews; and

(2) Obtaining information regarding any disciplinary action against a provider available from the New Jersey Board of Medical Examiners or any other state licensing board applicable to the provider, or from the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, Pub. L. 99–660 (42 U.S.C. §§ 1101 et seq.);

5. Implementing a procedure that provides participating providers an opportunity to review and comment on all medical, surgical and dental protocols of the carrier applicable to the class of provider used for the purpose of utilization management, and protocols for practice guidelines if the carrier imposes practice guidelines upon its participating providers;

6. Implementing a system to assure that covered persons have a choice of providers available to render services covered in-network under the carrier's contracts and policies; and

7. With respect to carrier contracts and policies in which the covered person may be required to select a primary care provider (whether or not referral through the primary care provider also is required in order to access specialty care in-network, or to receive benefits out-of-network), implementing a system through which the covered person may readily change his or her primary care provider at a time other than an open enrollment period, and covered persons are made aware of this right.

i. A carrier shall make a change in PCP effective no later than 14 days following the date that a covered person elects to change his or her provider selection, when such change is discretionary, and shall make the change effective immediately when the change is the result termination of a covered person's PCP from the network.

8:38A–4.6 Complaint system

(a) A carrier shall establish and maintain a system for the presentation and resolution of complaints brought by covered persons regarding the carrier's contracts or policies, choice and accessibility of network providers, and network adequacy, incorporating to the satisfaction of the Department at least the following components:

1. Written notification to all covered persons and network providers of the telephone numbers and business addresses of the carrier's business unit(s) responsible for complaint resolution;

2. A system to record and document the status of all complaints, which shall be maintained for at least three years;

3. Availability of a service representative to assist covered persons with complaint procedures upon request;

4. Establishment of a specified response time for complaints, not to exceed 30 days from receipt of the complaint by the carrier.

i. Carriers may specify that the 30–day period does not run until receipt of the complaint by the carrier in writing, but shall not require that the complaint be submitted on a specific form or any similar requirement prior to the start of the 30–day period;

5. A written process describing how complaints are processed and resolved;

6. Procedures for follow-up action including the methods to inform the complainant of resolution of the complaint;

7. Procedures for notifying the CQI program of all valid complaints related to quality of care; and

8. A mechanism for notifying covered persons and providers in writing that they may contact the Department or the Department of Banking and Insurance if dissatisfied with the resolution reached through the carrier's complaint system.

(b) Every carrier shall provide for the presentation to and resolution by the carrier of complaints brought by providers, which shall be a part of the carrier's CQI program.

(c) In addition to the complaint process delineated in (a) and (b) above, every carrier shall establish and maintain a system for the presentation and resolution of appeals brought by covered persons or by providers acting on behalf of a covered person with the covered person's consent, with respect to utilization management determinations made by the carrier, which appeals process shall comply with all N.J.A.C. 8:38A–3.5.

(d) The carrier shall describe the systems for filing complaints in a handbook or certificate provided to covered persons.

(e) The carrier shall not discontinue coverage for or otherwise penalize any covered person or provider for exercising his or her right to file a complaint.

8:38A–4.7 Provider application for participation

(a) No later than August 29, 2000,, a carrier shall establish a committee to review applications submitted by licensed providers to become members of the carrier's network.

1. The carrier may combine the functions of this committee with another committee, so long as when performing its application review functions, the committee meets the requirements of this section.

2. The carrier shall not be required to combine the functions of this review committee with the functions of any committee whose function includes credentialing standards.

3. The committee shall be composed of no less than three people.

4. At least one of the committee members reviewing a specific application shall be health care providers with knowledge in the applicant provider's scope of professional practice.

(b) The committee shall complete its review of a complete application within no more than 90 days of receipt of the complete application.

1. If the committee determines an application is incomplete, it shall notify the applicant as expeditiously as possible, but in no event later than 60 days following the date of receipt of the application, and inform him or her of the information that is missing.

2. The committee shall provide notice of its action on a complete application to the provider in writing.

3. If the committee's acceptance of a complete application does not constitute the offer of a contract to the applicant by the carrier, the committee shall set forth in its notice to the applicant the remaining procedures to be completed prior to the applicant becoming a participating provider, if at all.

(c) The carrier may establish the factors to be considered by the committee in determining whether an application is complete and whether to accept or reject a complete application.

1. The factors considered by the committee shall be in writing, and shall be available for review by applicants upon request.

2. The formulas or methods of weighting of factors as specified by the carrier shall be confidential information.

(d) The carrier may establish its own application forms, but if it does not elect to establish its own form, the carrier shall make available, upon request, a written notice of the information it requires to be submitted to determine an application is complete.

(e) All applications, notices and guidelines required by this section shall be reviewable upon request by the Department and the Department of Banking and Insurance.

8:38A–4.8 Termination of providers from a network

(a) A carrier shall give a health care professional written notice at least 90–days prior to termination of the provider's contract, specifying the health care professional's right to a hearing before a panel appointed by the carrier.

1. The carrier shall set forth in writing the reasons for the termination if requested by the health care professional and the reason is not otherwise stated in the written notice of termination.

(b) A carrier shall not be required to provide 90–days prior written notice and the opportunity for a hearing for terminations of health care professionals based on: nonrenewal of the contract, a determination of fraud, breach of contract by the health care professional, or the opinion of the carrier's medical director that the health care professional represents an imminent danger to a covered person or the public health, safety and welfare.

1. A carrier that terminates a contract based on a determination of fraud shall report the fraud, with the basis of the determination of fraud, to the appropriate administrative agency.

2. A carrier that terminates a contract based on a determination that the health care professional represents an imminent danger to the patient or the public health, safety and welfare shall report the determination to the appropriate State licensing board, and reports to the State Board of Medical Examiners shall be subject to N.J.S.A. 45:9–19.5.

(c) With respect to contracts and policies in which covered persons are required to select a PCP and there is a gatekeeper system, carriers shall provide written notification to each covered person within at least 30 business days prior to the termination or withdrawal from the carrier's provider network of a covered person's PCP and any other physician or provider from which the covered person is currently receiving a course of treatment.

1. The 30–day prior notice to covered persons may be waived in cases of immediate termination of a health care professional for: breach of contract by the health care professional, a determination of fraud of the health care professional, or where the carrier's medical director is of the opinion that the health care professional is an imminent danger to one or more covered persons or public health, safety or welfare.

2. In those instances in which the 30–day prior notice requirement may be waived, the carrier shall provide notice to covered persons as expeditiously as possible, and in no event later than 30 days following termination of the health care professional.

3. The carrier shall honor referrals made by a terminated PCP if the referral is made prior to the date of the PCP's termination, or after the date of termination if continued care is required in accordance with (d) below).

(d) The carrier shall assure continued provision of covered services by a terminated health care professional at the in-network benefit level for up to four months in cases where it is medically necessary for the covered person to continue treatment with the terminated provider except as set forth below. Nothing in this subsection shall be construed to limit the applicability of N.J.S.A. 17:48E–10.

1. In cases of the pregnancy of a covered person, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated health care professional shall continue to the postpartum evaluation of the covered person, up to six weeks after delivery.

2. In the case of care post-operative care, coverage of services by the terminated health care professional shall continue for a period up to six months.

3. In the case of oncological treatment, coverage of services by the terminated health care professional shall continue for a period up to one year.

4. In the case of psychiatric treatment, coverage of services by the terminated health care professional shall continue for a period of up to one year.

5. The carrier is not required to continue coverage in those instances in which the health care professional has been terminated based upon: the opinion of the carrier's medical director that the provider is an imminent danger to one or more covered persons or the public health, safety and welfare, a determination of fraud, or a breach of contract by the provider or the health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

6. The determination as to the medical necessity of a covered person's continued treatment with a terminated health care professional shall be subject to the appeal procedures set forth at N.J.A.C. 8:38A-4.12.

7. Notwithstanding (d) above, when termination is by the health care professional, the contract shall include a provision requiring the health care professional to continue to provide services at the contracted price to covered persons who are patients of the health care professional immediately prior to the date of termination for 30 days following the date of termination, but for the remainder of the four-month period only in cases where it is medically necessary for the covered person to continue treatment with the terminated health care professional, except as (d)1 through 4 above may apply.

(e) The carrier shall establish policies regarding the termination of providers other than health care professionals.

(f) The carrier shall establish a policy and procedure, reviewable upon request by the Department or the Department of Banking and Insurance, addressing the following:

1. Methods by which the termination policy shall be made known to providers upon initial participation and on renewal; and

2. Methods by which the termination policy regarding providers shall be made known to covered persons at the time of enrollment and on a periodic basis.

8:38A-4.9 Hearings for provider terminations

(a) A health care professional shall have the right to request a hearing in writing with respect to termination of the health care professional from a carrier's network within 10 business days following the date of the notice.

1. A contract shall be deemed to have terminated, creating the right to a hearing, whenever a contract terminates on any date other than a designated renewal or anniversary date of the contract, except that no such right shall exist with respect to terminations described at N.J.A.C. 8:38A-4.8(b).

2. If no renewal or anniversary date is specified in the contract, then the renewal or anniversary date shall be deemed to be the month and day in each calendar year on which the contract was originally signed by both parties, or became effective, whichever date is latest.

(b) The carrier shall hold a hearing within 30 days following receipt of a written request for a hearing by a terminated health care professional before a panel appointed by the carrier.

1. The panel shall consist of no less than three people.

2. At least one person on the panel shall be a clinical peer in the same or substantially similar discipline and specialty as the provider requesting the hearing.

3. The carrier shall not preclude the provider from being present at the hearing, nor shall the carrier preclude the provider from being represented by counsel at the hearing.

(c) The panel shall render a decision on the matter in writing within 30 days of the close of the hearing unless the panel provides notice of a need for an extension for rendering its decision, and provides the notice to both the carrier and the health care professional prior to the date the panel's decision would otherwise be due.

1. The panel's decision shall set forth the relevant contract provisions and the facts upon which the carrier and the provider have relied at the hearing.

2. The panel shall recommend that the provider be terminated, reinstated or provisionally reinstated.

3. The panel shall specify its reasons for its recommendations, including the reasons for any conditions for provisional reinstatement.

4. The panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences of a failure to meet the conditions.

5. In the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of duration of the contract at issue.

(d) In the event that the panel recommends that the health care professional be terminated, the carrier shall then provide notice of the termination to covered persons in accordance with N.J.A.C. 8:38A-4.8(c), as necessary.

8:38A-4.10 Network adequacy

(a) Except with respect to any selective contracting arrangement approved on or before May 1, 2000 pursuant to N.J.A.C. 11:4-37, a carrier shall maintain an adequate

network, as set forth in (b) below, of PCPs, specialists and other ancillary providers to assure that covered persons are able to access services in-network and take full advantage of the in-network benefits levels when the policy or contract specifies that there is a differential between the in-network and out-of-network benefits levels for one or more covered services, or the policy or contract is subject to a gatekeeper system.

1. The requirement that the network meet the adequacy standards of (b) below shall apply only to those services for which there is an in-network benefit, and if no in-network benefit exists for a specific service, the carrier is not required to meet the network adequacy standards with respect to the type of provider who typically renders that service.

2. Notwithstanding that a contract or policy may not be subject to a gatekeeper system, if the contract or policy requires that each covered person select or have a PCP, the carrier shall comply with (b) below with respect to the offering of that policy or contract.

(b) The carrier shall meet the following requirements for network adequacy:

1. The carrier shall have a sufficient number of physicians to assure that at least two physicians eligible as PCPs are within 10 miles or 30 minutes driving time or public transit time (if available), whichever is less, of 90 percent of the carrier's covered persons.

i. The carrier shall demonstrate sufficiency of network PCPs to meet the adult, pediatric and primary ob/gyn needs of the current and/or projected number of covered persons by assuming:

(1) Four primary care visits per year per member, averaging one hour per year per member; and

(2) Four patient visits per hour per PCP.

ii. To demonstrate PCP availability, a carrier shall verify that the PCP has committed to providing a specific number of hours for new patients that cumulatively add up to projected clinic hour needs of the projected number of covered persons by county or service area.

iii. The carrier shall demonstrate that the network of PCPs is sufficient to ensure that:

(1) If the carrier provides benefits for emergency services:

(A) Emergencies shall be triaged immediately through the PCP or by a hospital emergency department through medical screening or evaluation;

(B) Urgent care shall be provided within 24 hours of notification of the PCP or carrier; and

(C) In both emergent and urgent care, PCPs shall be required to provide seven day, 24 hour access to triage services;

(2) Routine appointments can be scheduled within at least two weeks; and

(3) Routine physical exams can be scheduled within at least four months.

2. The carrier shall have a sufficient number of the medical specialists, as applicable to the services covered in-network, to assure access within 45 miles or one hour driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area.

i. The carrier shall contract with a sufficient number of optometrists to assure access to an optometrist consistent with the requirements of (b)2 above, and the carrier shall not require that covered persons use the services of an opthalmologist rather than an optometrist in order to obtain benefits, unless referral by a PCP is determined to be medically required, and the care needed outside the scope of practice of an optometrist.

3. For institutional providers, the carrier shall maintain contracts or other arrangements acceptable to the Department sufficient to meet the medical needs of covered persons, and maintain geographic accessibility of the services provided through institutional providers, subject to no less than the following:

i. The carrier shall have a contract or arrangement with at least one licensed acute care hospital with licensed medical-surgical, pediatric, obstetrical and critical care services in any county or service area that is no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of covered persons within the county or service area.

ii. The carrier shall have a contract or arrangement with surgical facilities, including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices available in each county or service area that are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of covered persons within the county or service area.

iii. The carrier shall have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or II trauma centers designated by the Department, with the provision of benefits at the in-network level.

iv. The carrier shall have contracts or arrangements for the provision of the following specialized services at in-network benefit levels (if covered by one or more of the carrier's health benefits plans in network, and determined to be medically necessary), so that services

will be available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area:

(1) At least one hospital providing regional perinatal services;

(2) A hospital offering tertiary pediatric services;

(3) In-patient psychiatric services for adults, adolescents and children;

(4) Residential substance abuse treatment centers;

(5) Diagnostic cardiac catheterization services in a hospital;

(6) Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies; and

(7) Comprehensive rehabilitation services.

v. The carrier shall have a contract or arrangement so that the following specialized services may be provided at in-network benefit levels (if covered by one or more of the carrier's health benefits plans in network, and determined to be medically necessary), so that services will be available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area:

(1) A licensed long-term care facility with Medicare-certified skilled nursing beds;

(2) Therapeutic radiation;

(3) Magnetic resonance imaging center;

(4) Diagnostic radiology, including x-ray, ultrasound, and CAT scan;

(5) Emergency mental health service, including a short term care facility for involuntary psychiatric admissions;

(6) Outpatient therapy for mental health and substance abuse conditions; and

(7) Licensed renal dialysis.

vi. The carrier shall have a contract or arrangement with at least one home health agency licensed by the Department to serve each county where 1,000 or more covered persons reside.

vii. The carrier shall have a contract or arrangement with at least one hospice program certified by Medicare in any county where 1,000 or more covered persons reside, if hospice care is covered under the health benefits plan in-network.

(c) With respect to the provider specifications of (b)4 above, the carrier may request, and will receive, relief from the mileage requirements where the carrier can document to the satisfaction of the Department that appropriate access to alternative sites is available, but documentation shall address travel accommodations and travel times, financial hardship placed on families and other logistical details as requested by the Department from the carrier in order to be a valid request.

(d) In any county or approved service area in which 20 percent or more of a carrier's projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times set forth in the specifications of (b) above shall be based upon average transit time using public transportation, and the carrier shall demonstrate how it will meet the requirements in its application.

(e) The carrier shall not deny any registered pharmacy or pharmacist the right to participate as a preferred provider if the carrier provides pharmacy services, prescription drugs, or a prescription drug plan and the pharmacy meets the carrier's standards for participation.

1. Carriers shall comply with rules, if any, promulgated by the Department of Banking and Insurance applicable to the type of carrier.

(f) Those providers qualified to function as PCPs may include:

1. A licensed physician who has successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics;

2. A licensed physician who does not meet the standards of (f)1 above, but who has been evaluated by the carrier's committee charged with setting standards for and reviewing provider credentialing under the direction of the carrier's medical director, and is found by that committee to demonstrate through training, education and experience, equivalent expertise in primary care;

3. Nurse practitioners/clinical nurse specialists certified by the State Board of Nursing in accordance with N.J.S.A. 45:11-45 et seq. in advance practice categories comparable to family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics, and in hospitals or other facilities;

4. Physician assistants licensed by the New Jersey Board of Medical Examiners;

5. Certified nurse midwives registered by the New Jersey Board of Medical Examiners; and

6. At the discretion of the carrier, appropriate, licensed medical specialists for specified individual covered persons or patient groups who, due to health status or chronic illness, would benefit from medical care management by such a medical specialist.

Amended by R.2005 d.418, effective November 21, 2005.

See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In (b)3iii, deleted "pursuant to N.J.A.C. 8:33P"; in (f)2, substituted "(f)1" for "(e)1."

8:38A-4.11 Utilization management program

(a) A carrier shall comply with N.J.A.C. 8:38A-3.4.

(b) In addition to (a) above, the carrier shall comply with the following:

1. The carrier shall develop its UM criteria and protocols with involvement from its participating providers in accordance with N.J.A.C. 8:38A-4.14; and

2. For contracts or policies in which emergency and/or urgent care services are covered, and preauthorization may be required, the carrier shall establish a mechanism to ensure that covered persons have immediate access to their PCP or his or her authorized on-call back-up provider, and that all covered persons have access to a registered nurse or physician on the UM staff to respond to inquiries concerning emergency or urgent care seven days per week, 24 hours per day.

8:38A-4.12 Internal utilization management appeal process

(a) A carrier shall establish an internal appeal mechanism whereby a covered person or a provider acting on behalf of a covered person, with the covered person's consent, may appeal any decision to deny, reduce or terminate services or the payment of benefits therefor covered under the contract or policy, in compliance with N.J.A.C. 8:38A-3.5.

(b) In addition to the requirements set forth in (a) above, a carrier shall provide a written explanation of the appeal process to all of its network providers, and to other providers upon request, as well as at the conclusion of each stage of the appeal process.

(c) In addition to (a) and (b) above the carrier shall not establish or maintain policies, procedures or set forth anything in provider agreements that prohibit or discourage a covered person or provider from discussing or exercising the right to an appeal available under this subchapter, or the right to an external appeal through the Independent Health Care Appeals Program at N.J.A.C. 8:38A-3.6.

8:38A-4.13 Continuous quality improvement

(a) In addition to complying with N.J.A.C. 8:38A-3.8, carriers shall comply with the requirements of N.J.A.C. 8:38-7.1 not otherwise included in N.J.A.C. 8:38A-3.8.

(b) A carrier shall have performed and shall submit to the Department, by May 1, 2002 or entrance of the carrier into the managed care plan market, and every 36 months thereafter, documentation of its most recent external quality audit performed by an external quality audit review organization approved by the Department.

1. The carrier shall submit the documentation to the Department within 60 days of its receipt in final form by the external quality review organization.

2. The carrier shall make such documentation available to the Department of Banking and Insurance upon request.

(c) The documentation shall describe in detail the carrier's conformance to the standards of the external quality review organization, other standard-setting bodies for carriers of the category to which the carrier belongs, and/or the rules of this State applicable to the carrier and its managed care plans.

1. The documentation also shall describe any recommended corrective actions for the carrier, and whether or not the corrective actions have been undertaken by the carrier and approved, in whole or in part, by the external quality review organization.

(d) The Department shall grant a deferral to a carrier, upon its request, of the requirements of (c) above for up to a 12-month period if it is the initial three years of start-up of the carrier's operations in New Jersey, and it demonstrates a financial or operational hardship.

(e) The Department shall establish a Healthcare Data Committee (HeDaC) to assist the Department in developing a performance measurement and assessment system for monitoring the quality of care provided to covered persons as described in N.J.A.C. 8:38A-3.8, the quality of care provided to the covered persons of carriers subject to this subchapter, and the quality of care provided to members of HMOs.

1. The HeDaC shall include no more than 15 and no less than 12 members who shall be appointed by, and serve at the pleasure of, the Commissioner. The members shall include providers, consumers, at least four insurer representatives, no more than two HMO representatives, and two other persons representing the interests of carriers. In addition to the above, a representative of the New Jersey State Health Benefits Commission and the Departments of Banking and Insurance and Human Services shall serve as additional ex-officio members. The HeDaC shall be chaired by the Commissioner or his or her designee. Additional experts may be invited to participate on an invitational ad hoc basis as needed.

2. The HeDaC shall advise the Commissioner on the development of a uniform data reporting system to obtain reliable, standardized and comparable information from all carriers subject to this subchapter, and HMOs. In the process of developing this system, the HeDaC shall address the following:

i. The relevance, validity and reliability of each measure selected to be an indicator of performance;

ii. The protection of confidentiality of patient-specific information;

iii. The cost and difficulty of data collection;

iv. The measures to reduce duplicative reporting of information to state agencies; and

v. The public release of data in formats useful to purchasers and/or consumers.

3. The HeDaC shall advise the Commissioner as to the data reporting established pursuant to (e)2 above that should be applicable to carriers that are subject to N.J.A.C. 8:38A-3.8, if any, and shall advise the Commissioner as to the appropriate data reporting to obtain from such carriers.

8:38A-4.14 Provider input on protocols

(a) A carrier shall develop written clinical criteria and protocols and shall base its UM determinations upon such clinical criteria and protocols.

1. The carrier shall develop its clinical criteria and protocols with the input of practicing physicians and other health care providers within the carrier's network.

2. The carrier's clinical criteria and protocols shall be based upon generally accepted medical standards.

(b) A carrier shall periodically review and update its clinical criteria and protocols, and maintain evidence of such periodic reviews.

(c) A carrier's clinical criteria and protocols, as well as evidence of its most recent review and updating (if appropriate) of its clinical criteria and protocols, shall be made available, upon request, to covered persons and participating providers in relevant practice areas, as well as the Department.

(d) Notwithstanding (c) above, a carrier's internal or proprietary quantitative thresholds for UM shall be confidential, and shall not be required to be released pursuant to (c) above.

8:38A-4.15 Minimum standards for provider contracts

(a) Both primary contractor and secondary contractor agreements shall be consistent with laws regarding confidentiality of information and shall not be so worded that compliance with the terms of the contract would cause any health care provider to violate his or her professional licensing standards, including, but not limited to, N.J.S.A. 45:14B-31 et seq., and shall comply with the standards of (b) through (e) below.

(b) In addition to complying with N.J.A.C. 11:4-37, all provider contracts shall specify:

1. The term of the contract and reasons for which the contract may be terminated by one or more parties to the contract, including the procedures for notice and effectuation of such termination, and opportunities, if any to cure any deficiencies prior to termination, subject to the following:

i. Provisions regarding notice of termination shall specify that if the contract is terminated prior to the contract's renewal date, the carrier shall give the provider at least 90 days prior written notice; and, that in the event of such a termination, the provider has a right to request a hearing following such notice except in enumerated circumstances consistent with N.J.A.C. 8:38A-4.9;

ii. Provisions regarding contents of the notice of termination to be provided shall specify that the notice shall contain a statement as to the right of the provider to obtain a reason for the termination in writing from the carrier if the reason is not otherwise stated in the notice; the right of the provider to request a hearing, and any exceptions to that right; and, the procedures for exercising either right;

iii. Provisions regarding the hearing shall set forth the procedures for requesting a hearing, and otherwise shall be consistent with the standards set forth at N.J.A.C. 8:38A-4.9;

iv. Provisions regarding the hearing shall include a statement that a provider's participation in the hearing process shall not be deemed to be an abrogation of the provider's legal rights; and

v. Provisions regarding the right of the provider to request from the carrier the reasons for the termination shall specify the procedure for the provider to make the request, and that the carrier's reason in response to the request shall be in writing;

2. That no provider may be terminated or penalized because of filing a complaint or appeal as permitted by these rules;

3. That no provider may be terminated or penalized for acting as an advocate for the patient in seeking appropriate, medically necessary health services;

4. That a provider shall continue to provide services to covered persons at the contract price following termination of the contract, in accordance with N.J.A.C. 8:38A-4.8;

5. The method of reimbursement, including the method, events and timing of application of any penalties, bonuses or other types of compensation arrangements, subject to the following:

i. The contract shall not provide financial incentives to the provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitation arrangements between the carrier and provider;

ii. To the extent that some portion of the provider compensation is tied to the occurrence of a predetermined event, or the nonoccurrence of a predetermined event, the event shall be clearly specified, and the carrier shall include in its contracts a right of

each provider to receive a periodic accounting (no less frequently than annually) of the funds held;

iii. The contract shall include a process whereby a provider may appeal a decision denying the provider additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event; and

iv. Notwithstanding (a)5i above, capitation shall not be used as the sole method of reimbursement to providers who primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services;

6. The services and/or supplies to be provided by the provider and for which benefits will be paid by the carrier;

7. That providers shall not discriminate in their treatment of the carrier's covered persons;

8. That providers shall comply with the carrier's utilization review program, and quality assurance program as applicable to the provider;

9. That patient information shall be kept confidential, but that the carrier and the provider shall engage in timely and appropriate communication of patient information, so that both the providers and the carrier may perform their respective duties efficiently and effectively for the benefit of the covered person;

10. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 8:38A-4.6(b); and

11. That the provider shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.

(c) In addition to (b) above, all primary care provider contracts and contracts with specialists shall specify:

1. The responsibility, if any, of the provider with respect to acquiring and maintaining hospital admission privileges; and

2. The mutual responsibility of the provider and carrier to assure 24 hour, seven-day a week emergency and urgent care services and benefits therefor to covered persons, as appropriate to the carrier's managed care plans, and the procedures to assure proper utilization of such coverage.

(d) In addition to (b) above, all health care facility contracts shall specify:

1. The responsibility of the health care facility to follow clear procedures for granting of admitting and attending privileges to physicians, and to notify the carrier when such procedures are no longer appropriate;

2. The admission authorization procedures for covered persons;

3. The procedures for notifying the carrier when covered persons present at emergency departments, if notice is necessary to assure payment of benefits (other than a screening fee); and

4. The procedures for billing and payment, schedules, and any negotiated arrangements.

(e) No contract with any provider shall impose obligations or responsibilities upon a provider which require the provider to violate the statutes or rules governing licensure of that provider if the provider is to comply with the terms of the contract.

(f) The form(s) of the provider agreements, and any amendments thereto, shall be submitted to the Department for prior approval.

(g) Provider agreements in effect on May 1, 2000 that are not in compliance with the requirements of this subchapter shall be deemed withdrawn on May 1, 2001.

8:38A-4.16 Reporting of quality outcome measures and compensation arrangements

(a) Carriers shall comply with the reporting requirements established by the HeDaC, which shall be promulgated by the Department in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., which shall include independent consumer satisfaction survey results and an analysis of quality outcomes of health care services.

1. The Department may use the information collected to:

i. Assist carriers and their providers in quality improvement efforts;

ii. Obtain information on the performance of carriers for regulatory oversight;

iii. Support efforts to inform consumers about carrier performance with respect to managed care health benefits plans;

iv. Promote the standardization of data reporting by carriers and providers; and

v. Any other purpose consistent with this chapter and N.J.S.A. 26:2S-1 et seq.

2. The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction.

3. When possible, the performance measures shall be designed to incorporate data routinely collected or available to the Department from other sources.

4. When appropriate, the Department shall make statistically valid adjustments to account for demographic variations among carriers.

5. Carriers shall have an opportunity to comment on the compilation and interpretation of the data before its release to consumers.

6. Each carrier shall provide the Department with a mailing list of covered persons, upon request, so that the Department may conduct or arrange for periodic member satisfaction surveys using a select sample of the carrier's covered persons.

7. Carriers shall submit data established by the HeDaC and other information required by this subsection as the Department may request from time to time.

8. The Department shall ensure the confidentiality of patient-specific information, and shall make every attempt to reduce duplicative reporting of information to agencies in New Jersey.

(b) Carriers shall comply with the requirements of N.J.A.C. 8:38-11.7, submitting the information in conjunction with their financial statements required to be filed annually on March 1.

1. For purposes of complying with this requirement, carriers shall submit information for all of its managed care plan business by line, separated by Medicaid (if any), Medicare (if any), Medicare supplement (if any) and non-Medicare business if the carrier has different compensation arrangements for these lines of business.

2. A carrier with an HMO affiliate shall submit its data for its HMO and non-HMO affiliates separately.

8:38A-4.17 Requirement to offer a managed care plan without a gatekeeper system

(a) A carrier may offer a managed care plan with a gatekeeper system, but a managed care plan with a gatekeeper system shall not be the only type of managed care plan that the carrier offers in this State, except as (b) below may apply to the carrier.

(b) A carrier that offers a managed care plan with a gatekeeper system shall be deemed to be in compliance with (a) above if:

1. The carrier also offers a selective contracting arrangement approved in accordance with N.J.A.C. 11:4-37;

2. The approved policy or contract allows a covered person to receive services covered under the policy or contract or receive payment of benefits therefor from providers not in the carrier's network of participating providers without obtaining a referral or prior authorization from the carrier; and

3. The carrier provides subscribers under all group health plans in which the contractholder offers one of the carrier's contracts or policies provided in conjunction with an approved selective contracting arrangement an opportunity to elect coverage under the contract(s) or policy(ies) provided in conjunction with a selective contracting arrangement on at least an annual basis following a written notice to the subscribers setting forth the details of the contract(s) and policy(ies) provided in conjunction with the selective contracting arrangement.

SUBCHAPTER 5. INDEPENDENT HEALTH CARE APPEALS PROGRAM

8:38A-5.1 General requirements

(a) The Department shall be responsible for the operation of the Independent Health Care Appeals Program.

1. The Department shall combine the Independent Health Care Appeals Program with the External Appeals program set forth under N.J.A.C. 8:38-8.7, but, in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., may amend the standards set forth at N.J.A.C. 8:38-8.7 as necessary to make the appeal process more effective for covered persons insured through contracts or policies of carriers that are not HMOs.

2. The general qualifications of and standards of practice for IUROs participating in the Independent Health Care Appeals Program are set forth at N.J.A.C. 8:38-8.8.

3. The Department shall establish a per case reimbursement schedule for all IUROs that participate in the Independent Health Care Appeals Program, based on the bids obtained by IUROs.

(b) Carriers who are the subject of an appeal through the Independent Health Care Appeals Program shall be responsible for paying the cost of the appeal.

1. The carrier shall be responsible to pay the per case cost that is applicable on the date that the preliminary review of the appeal is completed by the IURO.

2. The carrier shall submit payment to the IURO for the appeal no later than 30 days following the date that the IURO renders its determination on the appeal in writing to the Department.

Amended by R.2005 d.418, effective November 21, 2005.
See: 37 N.J.R. 2174(a), 37 N.J.R. 4536(a).
In (a)1, rewrote "8-7" as "8.7"; in (b)2, substituted "determination on the appeal" for "final recommendation."

8:38A-5.2 Department review of carrier actions on IURO recommendations

(a) The Department shall periodically review records of carrier reports submitted pursuant to N.J.A.C. 8:38A-3.7 to

determine whether a carrier exhibits a pattern of non-compliance with the recommendations of an IURO as well as possible violations of patient rights or other applicable laws.

(b) If the Department determines that a carrier exhibits a pattern of noncompliance with the recommendations of an IURO, the Department shall review:

1. Whether the carrier's noncompliance is with a specific set of recommendations;

2. Whether the carrier's noncompliance is with a specific IURO (in the event more than one IURO participates in the Independent Health Care Appeals Program); and

3. The carrier's utilization management program, if any.

(c) If the Department determines that the carrier's utilization management program is not in compliance with the utilization management standards set forth at N.J.A.C. 8:38A-3.4 and 4.11, as applicable, or other relevant laws, the Department shall:

1. Notify the Department of Banking and Insurance of the violation; and

2. Take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 8:38A-2.7.

(d) If the Department determines that the carrier is in violation of patient rights or other applicable regulations, the Department shall:

1. Notify the Department of Banking and Insurance of the violation; and

2. Take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 8:38A-2.7.

(e) A pattern of noncompliance shall mean the occurrence of multiple incidents of refusal to follow the recommendations of the IURO, in whole or in part, within a 12 month period, when such recommendations require the carrier to provide services or benefits therefor to a covered person.

APPENDIX

Exhibit 1

New Jersey Department of Health and Senior Services
Office of Managed Care
PO Box 360
Trenton, NJ 08625-0360

AN EXPLANATION OF THE INDEPENDENT HEALTH CARE APPEAL PROCESS

A covered person, and any provider acting on behalf of a covered person with the covered person's consent, who is dissatisfied with the results of a carrier's internal appeal process shall have the right to pursue his or her appeal to an Independent Utilization Review Organization (IURO).

A covered person, or a provider acting on behalf of a covered person, MUST comply with the carrier's internal appeal process BEFORE an appeal can be made to an IURO.

An appeal to the IURO must be made within 60 days of the date a final decision was issued by the carrier. An IURO designated by the New Jersey Department of Health and Senior Services will determine whether the covered person was deprived of a medically necessary covered service, as a result of the carrier's utilization management determination. The Department shall assign appeal requests to an approved IURO.

Preliminary Review:

Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

1. The individual was a covered person of the carrier at the time of the action on which the appeal is based;
2. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the covered person;
3. The covered person, or provider acting on behalf of the covered person, has completed the carrier's internal appeals process; and
4. The covered person, or provider acting on behalf of the covered person with the covered person's consent, has provided all information required by the IURO and Department to make the preliminary determination. This information includes the appeal form, a copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the carrier and any other relevant health care provider.

The IURO will complete the preliminary review and notify the covered person and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor within 5 business days of receipt of the request.

Full Review of Appeal:

Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the carrier's utilization management determination, the covered person was deprived of medically necessary covered services. In reaching this determination the IURO shall take into consideration all information submitted by the parties and information deemed appropriate in the opinion of the IURO including: pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines

developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the carrier.

1. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for herein, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review.

2. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event the IURO shall, prior to the conclusion of the 30 business day review period, provide written notice to the covered person and/or provider and to the carrier and Department setting forth the status of its review and the specific reasons for the delay.
3. The IURO will notify the Department when a carrier is non-compliant with requests for information and any other aspect of the external review process.
4. The IURO's written appeal decision must be sent to the covered person and/or provider, the carrier, and the Department of Health and Senior Services, Office of Managed Care, with a cover letter of transmittal signed by a responsible representative of the IURO. The written decision of the IURO must be signed by the medical director and shall indicate each and every basis of the IURO's recommendation.
5. If the IURO determines that the covered person was deprived of medically necessary covered services, the IURO shall recommend in writing to the covered person and/or provider, the carrier and the Department, the appropriate covered health care services the covered person should receive.
6. Within ten days of the receipt of the determination of the IURO, the carrier shall submit a written report to the IURO, the covered person and/or provider, and the Department indicating whether it will accept and implement or reject the recommendations of the IURO. In the case of a rejection, the carrier shall specifically indicate in writing each and every basis for its rejection of the IURO's recommendation.
7. The IURO shall conduct emergent and urgent reviews, and will disclose the method and basis for rendering such decisions.

BEFORE YOU MAIL YOUR APPEAL:

__Attach the filing fee of $25.00.
Make Check or Money order payable to "New Jersey Department of Health and Senior Services." Send check or money order only; DO NOT SEND CASH! (NOTE: The filing fee is reduced to $2.00 if there is financial hardship. You may show financial hardship by submitting evidence of participation in either Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance.)
__Attach a copy of the final written decision from the carrier.
__Attach copy of Summary of Insurance Coverage from the covered person's Handbook, if available.
__Sign the form.
__For providers filing on behalf of a covered person, have the covered person sign the form.
__Attach a copy of all medical records and correspondence to be reviewed by the Independent Utilization Review Organization.

IMPORTANT: Send *copies* of any requested documents. Do not send original documents as they ***WILL NOT*** be returned.

IF YOU HAVE QUESTIONS, PLEASE CALL 1-609-633-0660.

DETACH AND RETAIN THIS PAGE.

IT CONTAINS IMPORTANT INFORMATION REGARDING THE IURO APPEAL PROCESS.

PHOTOCOPY AND RETAIN A COPY OF THE "REQUEST FOR CARRIER APPEAL BY INDEPENDENT UTILIZATION REVIEW ORGANIZATION (IURO)" FORM FOR YOUR RECORDS.

-HCQA-

New Jersey Department of Health and Senior Services
Office of Managed Care
PO Box 360
Trenton, NJ 08625-0360

FOR NJDHSS USE ONLY
Date Rec'd _____
File No. _____
Category _____
IURO _____

REQUEST FOR CARRIER APPEAL BY INDEPENDENT UTILIZATION REVIEW ORGANIZATION (IURO)

This form must be filed within 60 days of the date the final decision is issued by the Carrier.

Instructions:
Read and complete the entire form (2 pages). Form must be signed and dated.
Forward completed form, including fee and attachments, to the above address.

(Please print or type)

COVERED PERSON/SUBSCRIBER INFORMATION

Name of Covered Person | Covered Person's ID Number

Name of Subscriber | Subscriber ID Number

Street Address of Covered Person | City | State | Zip Code

Name of Carrier

Home Telephone Number ( ) | Business Telephone Number ( )

Coverage Through:
Employer-State Employer-Federal Employer-Private
Individual Health Access Medicaid Medicare

Attach a copy of Summary of Insurance Coverage from the Handbook.

INDIVIDUAL FILING APPEAL

Name of Person Filing Appeal (if different from above) | Filing Type: Consumer Provider*

PROVIDER INFORMATION

Name of Health Care Provider

Street Address | City | State | Zip Code

Name of Contact Person for Provider | Telephone Number ( )

FILING FEE

There is a $25.00 filing fee except in cases of financial hardship:

$25.00 attached $2.00 attached (submit evidence of financial hardship)

INTERNAL CARRIER APPEAL PROCESS

1. Have you utilized the Carrier's Appeal process? Yes No
   a. Have you received a final written decision from the Carrier? Yes** No
2. If you checked "Medicare," have you filed an appeal with Medicare? Yes No

***Attach a copy of the final written decision.*

SUMMARY OF APPEAL

Summarize the appeal issue:

_____

_____

_____

_____

_____

(Continue on reverse side)

REQUEST FOR CARRIER APPEAL BY
INDEPENDENT UTILIZATION REVIEW ORGANIZATION (IURO)
(Continued)

Name of Covered Person	Covered Person's ID Number

Summarize the Appeal Issue (continued):

(Attach additional sheets, if necessary)

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT FOR PROVIDER APPEAL

I understand that a copy of this form and any enclosures may be sent to the Independent Utilization Review Organization (IURO) and the Carrier named in the appeal and I authorize the release to the IURO selected by the New Jersey Department of Health and Senior Services, any medical and/or administrative records pertinent to this appeal. I also give my consent for a provider to appeal on my behalf.

Signature of Covered Person/Patient	Date

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