CHAPTER 22

HEALTH BENEFIT PLANS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e and P.L. 1999, c.339.

Source and Effective Date

R.2000 d.452, effective November 6, 2000.
See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

Executive Order No. 66(1978) Expiration Date

Chapter 22, Health Benefit Plans, expires on November 6, 2005.

Chapter Historical Note

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452, effective November 6, 2000. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

Authority

N.J.S.A. 17:1–8.1, 17:1–15c, 17:29B–1 et seq., 17B:30–13.1, 26:2J–15b and 17B:30–23 et seq.

Source and Effective Date

R.2001 d.13, effective January 2, 2001.
See: 32 N.J.R. 1985(a), 33 N.J.R. 105(a).

11:22–1.1 Purpose and scope

(a) This chapter implements N.J.S.A. 17B:30–26 through 34, which sets standards for the payment of claims relating to health benefit plans and dental plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State and to any agent, employee or other representative of such entity that processes claims for such entity.

11:22–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"ADR" means alternate dispute resolution.

"Agent" means any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H–1 with which a carrier has contracted to perform claims processing or claims payment services.

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a carrier, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

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

4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and

5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

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

"Covered service or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.

"Dental plan" means a benefits plan which pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this State by or through any carrier in this State.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" or "provider" means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

11:22–1.3 Acknowledgement of receipt of claims

(a) A carrier or its agent shall acknowledge receipt of all claims. The acknowledgement shall include the date the carrier or its agent received the claim.

1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which the carrier received the claim.

2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If a carrier or its agent remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If a carrier offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.

(b) Every carrier shall offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1. The ADR mechanism shall be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism shall be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.

2. The ADR mechanism, including the method to submit a claim through such mechanism, shall be described in the participating provider contract and in the final internal decision denying or disputing the participating health care provider's claim, in full or in part.

3. The decision of the ADR mechanism shall be nonbinding unless the parties agree otherwise.

(c) Carriers shall annually notify participating providers in writing of the internal appeals process and the ADR mechanism and how they can be utilized.

(d) Carriers shall annually report, in a format prescribed by the Department, which includes the number of internal and external provider appeals received and how they were resolved.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
In (c), substituted "Life & Health Actuarials" for "Office of Enforcement and Consumer Protection"; in (d), substituted "annually" for "maintain and make available at the request of the Department, the annual provider".
Administrative correction.
See: 35 N.J.R. 3558(a).

11:22–1.9 Reporting requirements

(a) A carrier shall report to the Department quarterly on the timeliness of claims payments in the format set forth in Appendix A to this subchapter, incorporated herein by reference, and on the reasons for denial and late payment of claims in the format set forth in Appendix B to this subchapter, incorporated herein by reference, on an annual and quarterly basis. Instructions for these documents are provided in subchapter Appendix A–1 and Appendix B–1, respectively, incorporated herein by reference. Due dates for the reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and March 31 for the fourth quarter for Appendix A and the annual report for Appendix B.

(b) The annual report shall be audited by a private auditing firm at the expense of the carrier. The annual report shall be accompanied by the report of the auditing firm that reviewed the report. In addition to the Department, copies of the audited annual report shall be sent to the Governor and the majority and minority offices of the Legislature.

(c) The report shall be submitted to the Department by the due date to:

New Jersey Department of Banking and Insurance
Life & Health Actuarial
Prompt Payment Reports
20 West State Street
PO Box 329
Trenton, New Jersey 08625–0329

(d) Reports shall be submitted in hard copy and as an Excel spreadsheet by one of the following media:

1. CD–ROM;

2. Zip diskette; or

3. Floppy diskette.

Administrative correction.
See: 35 N.J.R. 3558(a).

11:22–1.10 Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22–1.9, the Commissioner may require that the carrier, at its own expense:

1. Implement a plan of remedial action; and/or

2. Have the claims processing procedures of the carrier or its agent be monitored by a private auditing firm for a period to be determined by the Commissioner.

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58–1 et seq. if following the remediation measures in (a) above, the Commissioner determines that:

1. An unreasonably large or disproportionate number of eligible claims continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22–1.5; or

2. A carrier or its agent has failed to pay interest as required pursuant to N.J.A.C. 11:22–1.7.

APPENDIX A

NEW JERSEY CLAIMS PAYMENT EXHIBIT

Company _____ NAIC # _____ Payment Month/Yr _____

Commercial _____ Medicare _____ Medicaid _____ In Pat _____ All Oth _____

Number of Claims Paid in Month

Service Month	Report Month PM	PM-1	PM-2	PM-3	PM-4	PM-5	PM-6 and before
PM							
PM-1							
PM-2							
PM-3							
PM-4							
PM-5							
PM-6							
PM-7							
PM-8							
PM-9							
PM-10							
PM-11							
PM-12 and before							

Total Claims Paid (Number) _____ (Must equal Total of all above cells)

Dollar Amount of Claims paid in Month (in $000's)

Service Month	Report Month PM	PM-1	PM-2	PM-3	PM-4	PM-5	PM-6 and before
PM							
PM-1							
PM-2							
PM-3							
PM-4							
PM-5							
PM-6							
PM-7							
PM-8							
PM-9							
PM-10							
PM-11							
PM-12 and before							

Total Claims Paid (in 000 $'s) _____ (Must equal Total of all above cells)

Name of Person completing report (Print or Type) _____

Title _____ Phone Number _____

Email: _____

Signature of Person completing report _____

Affiliation (if not an employee of the company) _____

Address _____

APPENDIX A–1

INSTRUCTIONS
NEW JERSEY CLAIMS PAYMENT EXHIBIT

Reports should be submitted quarterly. Monthly reports for all months in the reporting quarter should be submitted by the reporting due date for that quarter.

Complete one Form for each payment month in the reporting quarter, and for each combination, if applicable, of Commercial/ Medicare/Medicaid and Inpatient/All Other. For example, if a report is required for claims paid in June, 1999, a company doing commercial business only will complete 2 forms for that month: Commercial Inpatient and Commercial All Other.

Indicate Company Name, Company NAIC ID#, Payment Month and Year, and check one of Commercial/Medicare/Medicaid and one of Inpatient/All Other.

Inpatient claims should be consistently defined by the company. For HMO's, Inpatient claims should use the same definition as Line 12 of Report #2 of the HMO Statement Blank.

Uncapitated payments are all claims payments other than those to providers, medical groups, or traditional IPA's where payment is on a per-member basis. Uncapitated payments include global capitation paid to intermediary organizations or secondary contractors.

Amounts should be entered in thousands of dollars.

Fill in the Total Claims Paid (number and amount) on contracts issued in New Jersey in the month covered by the report. Include all claims actually paid in that month, regardless of month of incurral.

For each dollar of claim paid in the Total, determine the month of service of that claim and the claim reporting month (date initial report received). Determine the lag from incurral to payment and from reporting to payment. Include that dollar in the total for the row with the given incurral lag and the column with the given report lag. The report lag must be less than or equal to the incurral lag (no claim can be reported before incurred).

PM refers to "Payment Month," this is the month for which the report is prepared. If the report is for Claims Paid in July, 1999, then PM is July, 1999. PM-x, where x is a number, refers to x months before the Payment Month. So, if the report is prepared for July 1999, PM-2 refers to May, 1999. This is the case whether May, 1999 is a "service month" or a "report month."

For example, suppose that the Report is being prepared for payments made in July of 1999. A claim of $70.00 was incurred in Mar. of 99, and reported in June of 99. This $70.00 would be on row PM-4, and column PM-1, because March is four months before July, and June is 1 month before July. (Note that the upper left hand corner is for claims that are reported and paid in the month of incurral.) Since every dollar paid in the payment month has precisely one incurral and one report month, the sum of all entries will be the Total Claims.