

CHAPTER 24A**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.2011 d.097, effective March 1, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, expires on March 1, 2018. See: 43 N.J.R. 1203(a).

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

Pursuant to Reorganization Plan No. 005-2005, Chapter 38A of Title 8, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was recodified as Chapter 24A of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24A, Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations, was readopted as R.2011 d.097, effective March 1, 2011. As a part of R.2011 d.097, the chapter Appendix was repealed, effective April 4, 2011. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS**11:24A-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. 11:24A-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.

11:24A-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 Banking and Insurance.

“Continuous quality improvement” or “CQI” means an ongoing 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."

11:24A-1.3 (Reserved)

Repealed by R.2011 d.097, effective April 4, 2011.

See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

Section was "Compliance time frames".

SUBCHAPTER 2. PROVISIONS APPLICABLE TO ALL CARRIERS

11:24A-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.

11:24A-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. A carrier's Selective Contracting Arrangement (SCA) application filed with the Department pursuant to N.J.A.C. 11:4-37 shall meet the requirements of this section.

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. 11:24A-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 in force 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.

Amended by R.2011 d.097, effective April 4, 2011.

See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

In the introductory paragraph of (a), inserted the last sentence.

11:24A-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;

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

Amended by R.2011 d.097, effective April 4, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

In (a)l ii, deleted “both” following “notify” and “and the Department of Banking and Insurance” preceding “of the request”.

SUBCHAPTER 3. UTILIZATION MANAGEMENT

11:24A-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.

11:24A-3.2 Disclosure requirements

(a) In addition to the requirements of N.J.A.C. 11:24A-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.

11:24A-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.

11:24A-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. 11:24A-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. 11:24A-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.

(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. 11:24A-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.

Amended by R.2011 d.097, effective April 4, 2011.

See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

Deleted (c)2.

11:24A-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.

11:24A-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. 11:24A-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. The application form can be accessed on the Department’s website at <http://www.state.nj.us/dobi/chap352/352ihcapform.doc>. The application requests the name of the covered person/subscriber, the person filing the appeal, the name of the provider, information regarding any prior appeal(s), a summary of the appeal issues and authorization by the covered person for release of information.

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 Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 325
Trenton, New Jersey 08625-0325

(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 Banking and Insurance.”

(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. 11:24A-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,".
Amended by R.2011 d.097, effective April 4, 2011.
See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

In the introductory paragraph of (b), deleted "as set forth in Exhibit 1 of the chapter Appendix, incorporated herein by reference" following "with the Department", and inserted the last two sentences.

11:24A-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.

11:24A-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) 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, 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.

(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.

Amended by R.2011 d.097, effective April 4, 2011.

See: 42 N.J.R. 2920(a), 43 N.J.R. 880(a).

In the introductory paragraph of (b), substituted "A" for "No later than June 30, 2000, a".

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

11:24A-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.

11:24A-4.2 Disclosures to covered persons

(a) Carriers shall provide to a covered person no later than the effective date of coverage a current directory of participating providers. Carriers shall, annually thereafter, provide written notice to covered persons that the carrier's current directory is available on its website, and provide instructions for accessing the website. Carriers' websites shall prominently display clear instructions as to how to access the directory. The notice shall also state that covered persons without internet access may obtain, upon request, a written current directory pursuant to the requirements set forth at N.J.A.C. 11:24A-4.3.

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. 11:24A-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 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. Carriers shall, annually thereafter, provide written notice to covered persons that the financial