CHAPTER 24

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-54, 26:2J-21 and 26:2S-18.

Source and Effective Date

R.2008 d.60, effective February 15, 2008.
See: 39 N.J.R. 3466(a), 40 N.J.R. 1668(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 24, Health Maintenance Organizations, expires on February 15, 2015. See: 43 N.J.R. 1203(a).

Chapter Historical Note

Chapter 38, Health Maintenance Organizations, was adopted as R.1974. d.320, effective November 20, 1974. See: 6 N.J.R. 8(b), 6 N.J.R. 473(a).

Pursuant to Executive Order No. 66(1978), Chapter 38 expired on April 3, 1994.

Chapter 38, Health Maintenance Organizations, was adopted as R.1994 d.365, effective July 18, 1994. See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a).

Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, was adopted as R.1996 d.194, effective April 15, 1996. See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider Network, Subchapter 7, Continuous Quality Improvement, Subchapter 8, Utilization Management, Subchapter 9, Member Rights and Responsibilities, Subchapter 10, Medical Records, Subchapter 11, Financial Standards and Reporting, Subchapter 12, Rehabilitation, Conservation and Liquidation, Subchapter 13, Licensing of Representatives and Advertising, and Subchapter 15, Provider Agreements and Risk Transference, were adopted as new rules. All repeals, amendments, and other new rules became operative July 1, 1997. See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Subchapter 17, Plan Documents for Group Contracts, was adopted as new rules by R.2000 d.183, effective May 1, 2000. See 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Subchapter 18, Drug Formularies, was adopted as new rules by R.2001 d.8, effective January 2, 2001, (operative July 1, 2001). See: 32 N.J.R. 211(a), 33 N.J.R. 46(a).

Chapter 38, Health Maintenance Organizations, expired on July 16, 2002.

Chapter 38, Health Maintenance Organizations, was adopted as new rules by R.2002 d.265, effective August 19, 2002. See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38 of Title 8, Health Maintenance Organizations, was recodified as Chapter 24 of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24, Health Maintenance Organizations, was readopted as R.2008 d.60, effective February 15, 2008. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. SCOPE AND DEFINITIONS

11:24-1.1 Scope

(a) The rules in this chapter were developed by the Commissioner of Health and Senior Services in collaboration with the Commissioner of Banking and Insurance and govern the establishment and operation of health maintenance organizations in New Jersey pursuant to the authority set forth in N.J.S.A. 26:2J-1 et seq. These rules are only applicable to managed care plans that constitute a health maintenance organization as defined herein and in N.J.S.A. 26:2J-1 et seq.

(b) The provisions of these rules shall apply, except where in conflict with:

1. Any individual contract issued by a health maintenance organization (HMO) to the extent that the contract is formulated in accordance with the provisions of the New Jersey Individual Health Coverage Program established pursuant to N.J.S.A. 17B:27A-1 et seq.; or

2. Any contract issued to a small employer by a HMO to the extent that the contract is formulated in accordance with the provisions of the New Jersey Small Employer Health Coverage Program established pursuant to N.J.S.A. 17B:27A-17 et seq.

(c) The provisions of these rules shall apply to any services of the HMO which are subcontracted to other entities.

(d) Nothing contained in these rules shall be construed to limit the authority of the Division of Medical Assistance and Health Services of the Department of Human Services to impose, in any contract to provide HMO services to New Jersey Medicaid recipients, standards that exceed those set forth in this chapter.

Law Review Journal Commentary

A patients' bill of rights — Be careful what you ask for. William F. Megna and Charles B. Lynch, 211 N.J.Law. 34 (2001).

11:24-1.2 Definitions

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

"Authorized payor" means a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing a health insurance business, a hospital service corporation, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society.

"Basic comprehensive health care services" means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 11:24-5, including all services listed at N.J.A.C. 11:24-5.2.

"Capitation" means a fixed payment for the provision of medical services not based on frequency or severity of services or supplies provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E-1 et seq.

"Claims" means a request for payment of charges for services rendered or supplies provided by a provider to a member.

"Commissioner" means the State Commissioner of Banking and Insurance or his or her designee.

"Consumer Price Index" or "CPI" means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined as published by the Commissioner of Banking and Insurance in the New Jersey Register.

"Continuous quality improvement" means an ongoing and systematic effort to measure, evaluate, and improve an organization's process to continually improve the quality of health care services provided to members.

"Contract holder" means an employer or organization which purchases a contract for services.

"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 layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical 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.

"Evidence of coverage" means a statement of the essential features and services of the HMO coverage which is given to the subscriber by the HMO or by the group contract holder.

"External quality review organization (EQRO)" means an organization approved by the Department pursuant to this chapter to perform external quality audits of HMOs.

"Financial incentive arrangement" means a formal mechanism instituted by an HMO 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.

"Formulary" means a list of prescription medications that are preferred for use through the provision of differential benefits or other means.

"GAAP" means Generally Accepted Accounting Principles.

"Gatekeeper system" means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is rendered by the member's primary care provider, or the member's access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO's contract with the subscriber or contractholder.

"Group health contract" means a contract, filed by or with the New Jersey Department of Banking and Insurance or the

Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term "group health contract" shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Banking and Insurance, or determined incomplete by the Small Employer Health Benefits Program Board of Directors, as appropriate.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State. Health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States Government, Medicare supplement, coverage for Medicaid services pursuant to a contract with the State of New Jersey, 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 expenditures" means the cost, on an incurred basis, of health care services and supplies rendered by a participating provider or a nonparticipating provider which are the responsibility of the HMO in accordance with the contracts the HMO has issued to contract holders.

"Health center" means a facility owned or leased by an HMO, used by members to receive medical and ancillary services including but not limited to: lab, radiology, and pharmacy.

"Health maintenance organization (HMO)" means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to members.

"Indemnity" means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

"Independent utilization review organization (IURO)" means an independent organization, comprised of physicians and other health care professionals representative of the active practitioners in New Jersey, with which the Department contracts in accordance with N.J.A.C. 11:24-8.8 to conduct independent medical necessity or appropriateness of services appeal reviews brought by a member or provider on behalf of the member, with the member's consent.

"Insurer" means any insurance company authorized to transact the business of insurance in New Jersey.

"Managed hospital payment" means agreements between the HMO and a hospital under which the financial risk primarily related to the degree of utilization rather than to the cost of services is transferred to the hospital.

"Master policy" means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

"Medicaid marketing representative" means any person who is registered as a limited insurance representative pursuant to N.J.S.A. 17:22A-16 and who is authorized to solicit, negotiate or effect contracts with Medicaid recipients as an agent for a Medicaid-contracting HMO, and performs no other service for the HMO that would otherwise require that person to be authorized and licensed as an insurance producer.

"Medical screening examination" means an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel pursuant to requirements in N.J.A.C. 8:43G-12, which are necessary to determine whether or not an emergency medical condition exists.

"Member" means an individual who is enrolled in an HMO.

"Network" means all participating providers under contract or other agreement acceptable to the Department to furnish health care services to members of the HMO.

"Net worth" means the excess of the admitted assets over total liabilities of an HMO.

"Out-of-network covered services" means indemnity benefits for covered services rendered to an HMO member by someone other than the HMO's contracted health care providers.

"Participating provider" means a provider which, under contract or other arrangement acceptable to the Department with the HMO or with its contractor or subcontractor, in accordance with the provisions of this chapter, has agreed to provide health care services to members with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from the HMO.

"Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

"Plan documents" mean contract, evidence of coverage, certificate, and member handbook, collectively.

"Point of service contract" means a contractual arrangement between an HMO and a member, subscriber or contract holder whereby the HMO makes provision for the rendering of covered services to its members through a network of health care providers as well as an out-of-network covered services option.

"Primary care provider (PCP)" means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care and meets the qualifications in N.J.A.C. 11:24-6.2.

"Primary contractor" means a provider that agrees directly with an HMO to provide one or more services or supplies directly to an HMO's members.

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

"Reinsurance-type contract" means a contract between an insurer and an HMO whereby the insurer agrees to indemnify the HMO for all expenses incurred by the HMO's members under a POS contract for out-of-network covered services, and further, the insurer agrees that it will indemnify the HMO's members for expenses incurred for out-of-network covered services for the duration of the period for which premiums are or have been paid by the contract holders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation.

"SAP" means Statutory Accounting Practices.

"Secondary contractor" means a person who agrees to arrange for the provision of one or more services or supplies for an HMO's members. A primary contractor may also 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 members.

"Secondary network" means a distinct delivery system developed by an HMO to be offered with one or more of its products in addition to, as an alternative to, or a substitute for, the delivery system(s) for which the HMO obtained its initial certificate of authority.

"Service area" means the geographic area for which the HMO has been issued a certificate of authority, in accordance with this chapter.

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

"Uncovered health care expenditures" means costs to the HMO for health care services that are the obligation of the HMO for which a member may be liable in the event of an HMO's insolvency and for which no alternative arrangements (that guarantee, insure or provide assumption by a person or organization other than the HMO for the provision of services or benefits) have been made that are acceptable to the Commissioner.

"Urgent care" means a non-life-threatening condition that requires care by a provider within 24 hours.

"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 member 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 or ambulatory care procedures and retrospective review.

Amended by R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).
Inserted "Claims", "Clean claim" and "Contested claim".
Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In "Emergency", substituted "a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to" for "absence of immediate medical attention could reasonably" following "such that" in the first sentence; in "Health maintenance organization (HMO)", substituted a reference to members for a reference to enrollees; rewrote "Independent utilization review organization (IURO)" and "Utilization management"; inserted "Plan documents" and "Secondary network"; and in "Provider", inserted a reference to other health care professionals.
Amended by R.2001 d.8, effective January 2, 2001 (operative July 1, 2001).
See: 32 N.J.R. 211(a), 33 N.J.R. 46(a).
Inserted "Formulary" and "Health benefits plan".
Amended by R.2002 d.265, effective August 19, 2002.
See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).
Deleted "Clean claim" and "Contested claim".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 40 N.J.R. 1937(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 41 N.J.R. 1275(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 42 N.J.R. 674(c).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 43 N.J.R. 751(b).

Case Notes

Health maintenance organization's (HMO's) asset purchase agreement with for-profit corporation and health services agreement with limited liability corporation that was to facilitate administration of medical services to HMO enrollees were not contracts with providers as required for confidentiality under the HMO Act; corporations not "providers" since they were not authorized to furnish health care services and internal management of HMO still maintained ultimate responsibility for the affairs of the HMO. HIP of New Jersey, Inc. v. New Jersey Dept. of Banking and Ins., 707 A.2d 1044, 309 N.J.Super. 538.

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

11:24-2.1 Certificate of need and licensing

Any health maintenance organization (HMO) which proposes the establishment and/or operation of a health care facility or any change in or expansion of a health care facility, or the institution of new health care services as defined in the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) shall comply with all pertinent provisions of the Act, as amended and N.J.A.C. 8:33, Certificate of Need application and Renewal process, and all applicable health planning and licensing rules and regulations.

11:24-2.2 Application for a new or amended certificate of authority

(a) Any person, organization or corporation desiring to establish and/or operate an HMO shall apply to the Commissioner for a certificate of authority, pursuant to N.J.S.A. 26:2J-1 et seq. Applications for a certificate of authority may be obtained from:

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

1. Two copies of the entire application shall be submitted to the Department at the above address; and

2. If the applicant proposes to be a Medicaid program participant, one copy of the application shall be submitted to:

New Jersey Department of Human Services
Office of Managed Health Care
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625-0712

(b) The applicant shall submit to the Department a nonrefundable fee of $100.00, or as specified in N.J.S.A. 26:2J-23, as may be amended, payable to the New Jersey Department of Banking and Insurance for the filing of an application for a certificate of authority as an HMO, or for any renewal or amendments thereto.

(c) The application for a certificate of authority shall be deemed complete only when filed on forms prescribed by the Department and when accompanied by the following:

1. A copy of the basic organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

2. A copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of persons who are to be responsible for the conduct of the affairs of the HMO including names, addresses, official positions and a biographical affidavit for each person, including all officers and directors;

4. A specimen copy of the contract between the HMO and each participating provider, and an attestation by the HMO's CEO as to the execution of contracts by participating providers consistent with the information submitted by the HMO to demonstrate network adequacy and made in accordance with N.J.A.C. 11:24-15, including a description of any compensation program involving incentive or disincentive payment arrangements permitted under the laws of this State. As required by N.J.S.A. 26:2J-26, any copies of any contract made between the HMO and any provider, insurer, hospital or medical service corporation shall be considered confidential;

i. Executed signature pages shall be made available to the Department upon request, but such documents shall otherwise remain confidential;

5. A copy of any merger or acquisition documents of the applicant or the applicant's parent if the merger or acquisition is with respect to the parent, management agreements for administrative services, and asset sale agreements.

6. A copy of the form of evidence of coverage to be issued to the subscriber;

7. A copy of the form of the individual and group contract, if any, which is to be issued to subscribers and contract holders;

8. The most recent audited financial statements (or other documentation as specified by N.J.A.C. 11:24-11 for newly-formed applicants) showing the applicant's assets, liabilities, sources of financial support, a statement as to the sources of funding and all other financial requirements as delineated in N.J.A.C. 11:24-11;

9. A description of the proposed method of marketing and financing;

10. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served;

11. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

3. Fraud or material misrepresentation affecting coverage, including misuse of a member identification card; or

4. The group of which the individual is a member is not renewed in accordance with the HMO's underwriting guidelines or is cancelled for failure to pay premiums.

(b) Before a member's coverage can be terminated for (a)1 and 2 above, the member shall be given written notice of the violation and a reasonable opportunity to come into compliance. Following any decision to terminate a member's coverage, the HMO shall notify the member of his or her right to appeal such decision as set forth in N.J.A.C. 11:24-3.7.

Amended by R.2002 d.265, effective August 19, 2002.
See: 34 N.J.R. 885(a), 34 N.J.R. 3014(a).
In (b), neutralized gender reference and revised N.J.A.C. reference.

11:24-3.5 Provider contract termination

(a) The HMO shall establish a policy governing termination of health care professionals and other providers. The policy shall include at least:

1. Standards by which the HMO will provide notice to the provider of termination of his or her participation in the time and manner specified in the provider's contract.

i. In instances in which the contract is terminated prior to the contract's renewal date, the HMO shall provide health care professionals with at least 90-days written notice of the termination, specifying the health care professional's right to a hearing before a panel appointed by the HMO.

(1) The HMO shall provide in writing the reasons for the termination, if requested by the health care professional, within no more than 15 days of receipt of the request if the reason is not otherwise stated in the written notice of termination.

ii. HMOs 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 HMO's medical director that the health care professional represents an imminent danger to a patient or the public health, safety and welfare.

(1) An HMO that terminates a contract based on a determination of fraud shall report the fraud, with the basis for the determination of fraud, to the appropriate administrative agency (that is, the health care professional's licensing entity, such as the Board of Medical Examiners, the Board of Pharmacy, the Board of Chiropractic, and the Division of Criminal Justice).

(2) An HMO 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.

2. Methods by which the termination policy shall be made known to providers upon initial participation and at the time of renewal of the provider's contract.

(b) HMOs shall provide written notification to each member at least 30 business days prior to the termination or withdrawal from the HMO's provider network of a member's PCP and any other physician or provider from which the member is currently receiving a course of treatment.

1. The 30-day prior notice to members may be waived in cases of immediate termination of a provider based on breach of contract by the provider, a determination of fraud, or where the HMO's medical director is of the opinion that the provider is an imminent danger to a patient or the public health, safety or welfare.

(c) The HMO shall assure continued coverage of covered services at the contract price by a terminated health care professional for up to four months in cases where it is medically necessary for the member to continue treatment with the terminated health care professional except as set forth below.

1. In cases of the pregnancy of a member, 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 member, 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 of 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 HMO is not required to continue coverage for services obtained through a terminated health care professional in those instances in which the health care professional has been terminated based upon: the opinion of the HMO's medical director that the health care professional is an imminent danger to a patient or the public health, safety and welfare, a determination of fraud, or a breach of contract by the health care professional, 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 member's continued treatment with a terminated health care professional shall be subject to the appeal procedures set forth at N.J.A.C. 11:24-8.5 through 8.7.

(d) The HMO shall include in its agreements with providers, other than hospital providers, that, regardless of which party terminates the agreement, or the reasons for the termination, the HMO and the provider shall abide by the terms of the provider agreement, including reimbursement terms, for four months following the date of the termination, but the agreement may state that the provider has no obligation under the agreement to provide, and the HMO has no obligation to reimburse at the contracted rate, services which are not medically necessary to be provided by the provider on and after the 31st day following the date of termination.

(e) In the event that a hospital's contract is not renewed, or is terminated by either party, the hospital and the HMO shall continue to abide by the terms of the most current contract for a period of four months from a severance date mutually agreed upon by both parties as required by N.J.S.A. 26:2J-11.1. In such an event, the HMO shall provide written notification within the first 15 business days of the four month extension to all health care providers with which it has contracted and members who reside in the county in which the hospital is located or in an adjacent county within the HMO's service area. The notice to members shall also advise them of available options with respect to their health care coverage.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote the section.

11:24-3.6 Hearings for provider terminations

(a) A health care professional shall have the right to request in writing a hearing within 10 business days following the date of receipt of notice of termination of the health care professional occurring prior to the date of termination from an HMO's network stated in the provider agreement.

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. 11:24-3.5(a)1ii.

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 become effective, whichever date is latest.

(b) The HMO 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 HMO.

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 HMO shall not preclude the provider from being present at the hearing, nor shall the HMO 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 the rendering of its decisions to both the HMO 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 HMO 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 HMO shall then provide notice of the termination to members in accordance with N.J.A.C. 11:24-3.5(b).

New Rule, R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Former N.J.A.C. 8:38-3.6, Complaint and appeal system, recodified to N.J.A.C. 8:38-3.7.

11:24-3.7 Complaint and appeal system

(a) Every HMO shall establish and maintain a system to provide for the presentation and resolution of complaints brought by members or by providers acting on behalf of a member and with the member's consent, regarding any aspect of the HMO's health care services, including, but not limited to, complaints regarding quality of care, choice and accessibility of providers, and network adequacy. All such general complaint systems must, at a minimum, incorporate to the satisfaction of the Commissioner, the following components:

1. Written notification to all members and providers of the telephone numbers and business addresses of the HMO employees 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 an HMO member services representative to assist members, as requested, with complaint procedures;

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

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

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

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

8. A mechanism for notifying members and providers in writing that they may contact the Department, in the case of Medicaid enrollees, the Division of Medical Assistance and Health Care Services within the Department of Human Services, or, in the case of Medicare beneficiaries, the Health Care Financing Administration within the United States Department of Health and Human Services, if dissatisfied with the resolution reached through the HMO's internal complaint system.

(b) Every HMO shall provide for the presentation to the HMO and resolution by the HMO of complaints brought by providers in accordance with N.J.A.C. 11:24-3.7(a)2, 7.1(a)9 and 7.1(f).

(c) In addition to the complaint process delineated above, every HMO shall establish and maintain a system for the presentation and resolution of appeals brought by members or by providers acting on behalf of a member and with the member's consent, with respect to the denial, termination or other limitation of covered health care services, hereinafter referred to as utilization management determinations. The appeals process for utilization management determinations shall comply with all of the provisions of N.J.A.C. 11:24-8.4 through 8.7.

(d) A description of the systems for filing complaints and for appealing utilization management determinations shall be included in the evidence of coverage and member handbook issued to members.

(e) No member or provider who exercises the right to file a complaint and/or appeal under this section shall be subject to disenrollment or otherwise penalized solely due to such complaint and/or appeal.

Recodified from N.J.A.C. 8:38-3.6 and amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote (a)8. Former N.J.A.C. 8:38-3.7, Submission of documents and data, recodified to N.J.A.C. 8:38-3.8.

11:24-3.8 Submission of documents and data

(a) The HMO shall submit all membership, utilization, financial, and descriptive plan information to the Department as requested. This shall include, but is not limited to:

1. A quarterly report on forms prescribed by the Department and specified at N.J.A.C. 11:24-11.6(d). This report shall be submitted within 45 days after the end of each quarter; and

2. An annual report, a current directory of providers, and a record of all member and provider complaints, inclusive of all malpractice actions, on forms prescribed by the Department, as specified at N.J.A.C. 11:24-11.6. These reports shall be submitted by March 1 of the following year. The record of member and provider complaints referred to above shall include at least the following:

i. The total number of complaints and utilization management appeals filed within the last year, categorized by cause and disposition;

ii. The average length of time for resolution of each complaint and utilization management appeal by cause or category; and

iii. The number, amount and disposition of malpractice claims settled or adjudicated during the year in which the HMO was a named party to the suit.

(b) The HMO shall submit a copy of its internal performance indicators to the Department on an annual basis.

(c) The HMO shall submit continuous quality improvement information as required in N.J.A.C. 11:24-7 to the Department, including, but not limited to:

1. A copy of the continuous quality improvement plan and all subsequent revisions to the plan on an annual basis;

2. A copy of the reports from the continuous quality improvement plan submitted to the Board of Directors on an annual basis;

3. A copy of the performance and outcome data as prescribed by the Department in N.J.A.C. 11:24-7; and

4. A copy of the member mailing list as requested by the Department, in accordance with N.J.A.C. 11:24-7.3(f).

Recodified from N.J.A.C. 8:38-3.7 and amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

11:24-3.9 Provider application for participation and the review panel

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

1. The HMO 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, but the HMO shall not be required to combine the functions of this review committee with the functions of any committee whose function includes credentialing standards.

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

3. 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) Unless the committee shall notify the applicant within 60 days following receipt of the application that the application is incomplete, specifying in writing the information that is missing, the application shall be deemed complete.

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

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 HMO, the committee shall set forth in its notice the remaining procedures to be completed prior to the applicant becoming a participating provider, if at all.

(c) The HMO 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 HMO shall be confidential information.

(d) The HMO may establish its own application forms, but if it does not elect to establish its own form, the HMO shall make available, upon request, a written notice of what 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.

New Rule, R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

SUBCHAPTER 4. MEDICAL DIRECTOR

11:24-4.1 Designation of a medical director

(a) The HMO shall designate a physician to serve as medical director.

(b) The medical director or his or her designee shall be designated to serve as the medical director for medical services provided to the HMO's New Jersey members. This physician shall be licensed to practice medicine in New Jersey and may also serve as the overall medical director of the HMO as required in (a) above.

11:24-4.2 Medical director's responsibility

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to members, including, but not limited to:

1. Defining responsibilities and inter-relationships of professional services;

2. Coordinating, supervising and overseeing the functioning of professional services;

3. Evaluating the medical aspects of provider contracts;

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

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

6. Establishing policies and procedures covering all health care services provided to members;

7. Establishing a committee that has the following responsibilities:

i. Establishing mechanisms for ensuring review of provider credentials;

ii. Delineating qualifications of participating providers;

iii. Reviewing credentials of physicians and other providers who do not meet the HMO's established credentialing standards; and

iv. Establishing a system for verification of provider's credentials, recertification, performance reviews and obtaining information about any disciplinary action against the provider available from the New Jersey Board of Medical Examiners or any other state licensing board applicable to the provider, or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99-660 (42 U.S.C. § 1101 et seq.);

8. Implementing a procedure that provides participating providers an opportunity to review and comment on all applicable medical, surgical and dental protocols of the HMO applicable to the area of practice of the provider; and

9. Implementing a system through which a member may readily change his or her PCP outside of an annual open enrollment period, and is made aware of this right, which system shall be applicable to all of the HMO's contracts including its POS contracts, regardless of whether referral through the PCP is required in order to access specialty care in-network or to receive benefits out-of-network.

2. Provide the Department with information on the performance of HMOs for regulatory oversight;

3. Support efforts to inform consumers about HMO performance;

4. Promote the standardization of data reporting by HMOs and providers; and

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

(b) The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to HMOs, providers, and the Department, performance measures shall incorporate, when possible, data routinely collected or available to the Department from other sources. Data for these performance measures may include, but not be limited to, the following:

1. Indicator data collected by HMOs from chart reviews and administrative data bases;

2. Member and patient satisfaction surveys;

3. Provider surveys;

4. Quarterly and annual reports submitted by HMOs to the Department as specified in N.J.A.C. 11:24-3.7;

5. Computerized health care encounter data; and

6. Data collected by the Department for administrative, epidemiological and other purposes, such as the State cancer registry, vital records, and hospital UB-92 records.

(c) HMOs shall submit such performance and outcome data as the Department may request from time to time.

(d) The Department shall make, when appropriate, statistically valid adjustments to account for demographic variations among HMOs. Each HMO shall have opportunity to comment on the compilation and interpretation of the data before its release to consumers.

(e) The Department shall conduct audits of each HMO's performance and outcome data including desk and on-site audits.

(f) The Department shall conduct or arrange for periodic member satisfaction surveys. The HMO shall provide the Department with the member mailing list, upon request, to be used to select samples of the HMO's membership for the surveys.

(g) The Department shall ensure the confidentiality of patient specific information.

(h) The Department shall take all necessary measures to reduce duplicative reporting of information to State agencies.

11:24-7.4 Healthcare Data Committee

(a) 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 HMO members as described in N.J.A.C. 11:24-7.3.

1. The HeDaC shall be comprised and shall perform the functions as set forth at N.J.A.C. 11:24A-4.13(e).

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (a), added 1; and deleted former (b) and (c).

SUBCHAPTER 8. UTILIZATION MANAGEMENT

11:24-8.1 Utilization management program

(a) The HMO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of the medical director or his or her designee, who shall be a physician, and shall be based on a written plan that is reviewed at least annually by the HMO, and is available for review by the Department upon request. The plan shall identify at least:

1. Scope of utilization management activities;

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

3. Mechanisms to detect underutilization and overutilization;

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

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

6. Development of outcome and process measures for evaluating the utilization management program;

7. System for providers and members to appeal utilization management determinations in accordance with the procedures set forth at N.J.A.C. 11:24-8.4 through 8.7; and

8. A mechanism to evaluate member satisfaction with the complaint and appeals systems set forth at N.J.A.C. 11:24-3.6 and at 11:24-8.4 through 8.7. Such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program set forth in N.J.A.C. 11:24-7.

(b) Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the network and based upon generally accepted medical standards. These criteria and protocols shall be periodically reviewed and updated, and shall,

with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to members and participating providers in the relevant practice areas.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (a), inserted "by the HMO, and is available for review by the Department upon request" at the end of the second sentence in the introductory paragraph.

11:24-8.2 Utilization management staff availability

(a) A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(b) For routine utilization-related inquiries, the HMO shall provide all members and providers with a toll free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis.

(c) All members must have immediate phone access seven days a week, 24 hours a day, to their primary care provider or his or her authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

11:24-8.3 Utilization management determinations

(a) The HMO shall have written policies and procedures that address responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay.

(b) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 11:24-8.1(b) and the evidence of coverage.

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

(d) An HMO shall not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

(e) A member or provider acting on behalf of a member shall receive upon request a written notice of any determination to deny coverage or authorization for services required in this subchapter or in the evidence of coverage, which shall be subject to appeal in accordance with N.J.A.C. 11:24-8.5, 8.6 and 8.7. The written notice of determination shall include an explanation of the appeal process.

Petition for Rulemaking.
See: 32 N.J.R. 3340(a).

11:24-8.4 Appeals of utilization management determinations

(a) All HMO members, and any provider acting on behalf of a member with the member's consent, may appeal any utilization management determination resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions of N.J.A.C. 11:24-8.5 through 8.7. All members and providers shall be provided with a written explanation of the appeal process in the member handbook and upon the conclusion of each stage in the process as described in N.J.A.C. 11:24-8.5 through 8.7. The appeal process shall consist of an informal internal review by the HMO (stage 1 appeal), a formal internal review by the HMO (stage 2 appeal), and a formal external review (stage 3 appeal) by an independent utilization review organization (IURO) through the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11, as further described at N.J.A.C. 11:24A-5.

(b) Nothing in the HMO's policies, procedures or provider agreement shall prohibit a member or provider (on behalf of a member) from discussing or exercising the right to an appeal available under N.J.A.C. 11:24-8.5 through 8.7.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (a), added "through the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11, as further described at N.J.A.C. 8:38A-5" at the end.

11:24-8.5 Informal internal utilization management appeal process (Stage 1)

Each HMO shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any member, or any provider acting on behalf of a member, with the member's consent, who is dissatisfied with any HMO utilization management determination, shall have the opportunity to speak to and appeal that determination with the HMO medical director and/or physician designee who rendered the determination. All such stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergency care (including all situations in which the member is confined as an inpatient), and five business days in the case of

all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the HMO shall provide the member and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
Rewrote the second and third sentences.

11:24-8.6 Formal internal utilization management appeal process (Stage 2)

(a) Each HMO shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the HMO who have not been involved in the utilization management determination at issue.

(b) The formal internal utilization management appeal panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the member and/or provider.

(c) All such stage 2 appeals shall be acknowledged by the HMO, in writing, to the member or provider filing the appeal within 10 business days of receipt.

(d) All such stage 2 appeals shall be concluded as soon as possible after receipt by the HMO in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the member is confined as an inpatient) and, except as set forth in (e) below, 20 business days in the case of all other appeals.

(e) The HMO may extend the review for up to an additional 20 business days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written progress report and explanation for the delay to the satisfaction of the Department, with notice to the member and/or provider within the original 20 business day review period.

(f) If the stage 2 appeal is denied, the HMO shall provide the member and/or provider with written notification of the denial and the reasons therefor together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

(g) In the event that the HMO fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in N.J.A.C. 11:24-8.5 or 8.6, or in the event that the HMO for any reason expressly waives its rights to an internal review of any appeal, then the member and/or provider shall be relieved of his or her obligation to complete the HMO internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 11:24-8.7.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (d), inserted "(including all situations in which the member is confined as an outpatient)" following "care".

11:24-8.7 External appeals process

(a) Any HMO member, and any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the results of the internal appeal process set forth at N.J.A.C. 11:24-8.5 through 8.6 above, shall have the right to pursue his or her appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below (stage 3 appeal). Except as set forth in N.J.A.C. 11:24-8.6(g), the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of the HMO internal appeal process set forth at N.J.A.C. 11:24-8.5 and 8.6.

(b) To initiate an external appeal, a member and/or provider shall, within 60 days from receipt of the written determination of the stage 2 internal appeal panel under N.J.A.C. 11:24-8.6(f), file a written request with the Department. The request shall be filed on the forms automatically provided to the member in accordance with N.J.A.C. 11:24-8.6(f), and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to the following address:

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

(c) The fee for filing an appeal shall be $25.00, payable by check or money order to the "New Jersey Department of Banking and Insurance." Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

(d) Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO in accordance with N.J.A.C. 11:24-8.8, for review.

(e) 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 or is a member of the HMO;

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 member;

3. Except as set forth at N.J.A.C. 11:24-8.6(g), the member has fully complied with both the stage 1 and stage 2 appeals available pursuant to N.J.A.C. 11:24-8.5 and 8.6; and

4. The member has provided all information required by the IURO and Department to make the preliminary determination including the appeal form and a copy of any information provided by the HMO regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the HMO and any other relevant health care provider.

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

(g) Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the HMO's utilization management determination, the member was deprived of medically necessary covered services. In reaching this determination the IURO shall take into consideration all 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 HMO pursuant to N.J.A.C. 11:24-8.1(b).

(h) The full review referenced in (g) above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

(i) 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 in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, except that in no event shall it render its determination later than 90 days following receipt of a completed application. In the event the IURO needs to extend its review period, it shall, prior to the conclusion of the 30 business day review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reasons for the delay.

1. 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.

(j) If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the HMO and the Department, the appropriate covered health care services the member should receive.

(k) Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, member and provider if the provider made the appeal on behalf of the member with the member's consent, and the Department indicating whether the HMO will accept and implement or reject the recommendations of the IURO in whole or in part.

1. The written report of the HMO shall state with specificity the reasons for rejection, in whole or in part, of the recommendation(s) of the IURO, and the HMO's report shall not be complete unless such reasons are set forth in the report.

(*l*) Nothing in this section shall limit the authority of the Division of Medical Assistance and Health Services (DMAHS) or the Department of Human Services (DHS) to adopt in any contract to provide HMO services to Medicaid recipients, its own process for appeals of utilization management determinations. At the request of the Commissioner of Human Services, the Commissioner shall adopt, in accordance with N.J.S.A. 52:14B-1 et seq. and N.J.A.C. 1:30, any such appeals process proposed by DMAHS or DHS as the exclusive appeals process for all Medicaid HMO members, if he or she find that it meets or exceeds the standards set forth in this chapter.

Amended by R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).
In (b), substituted a reference to 60 days for a reference to 30 business days in the first sentence; in (c), rewrote the second sentence; and rewrote (i) and (k).

Case Notes

Beneficiary's claims under 29 U.S.C.S. § 1132(a)(1)(B) and (3) that insurers had improperly classified eating disorders as non-biologically based mental illnesses under Employee Retirement Income Security Act plans were not subject to Burford abstention based on the availability of review of benefit denials by an Independent Utilization Review Organization under N.J.A.C. 11:24-8.7; the mere availability of state administrative review did not warrant abstention. DeVito v. Aetna, Inc.,

536 F.Supp.2d 523, 2008 U.S. Dist. LEXIS 15615, 43 Employee Benefits Cas. (BNA) 2247 (D.N.J. 2008).

11:24-8.8 General requirements for independent utilization review organizations

(a) The Department shall, from time to time, enter into contracts with as many independent utilization review organizations as it deems necessary to conduct the external appeals provided for under N.J.A.C. 11:24-8.7. The physician re-

viewers of the IUROs selected by the Department shall be experienced in managed care utilization review. The contracts shall set forth all terms which the Department deems necessary to ensure a member's right of appeal under N.J.A.C. 11:24-8.7 including, but not limited to, an assessment of separate costs to the HMO for the initial IURO review under N.J.A.C. 11:24-8.7(e) and the full review under N.J.A.C. 11:24-8.7(g).

(b) As a part of the contract process set forth in (a) above, all IUROs shall submit to the Department and shall maintain current, a list identifying all HMOs, health insurers, health care facilities and other health care providers with whom the IURO maintains any health related business arrangements. This list shall include a brief description of the nature of any such arrangement.

(c) Upon receipt of any request for an external appeal under N.J.A.C. 11:24-8.7(d) above, the Department shall assign that appeal to one of the approved IUROs on a random basis. The Commissioner reserves the right to deny any assignment to any IURO if, in his or her determination, such an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety. In reaching such a determination, the Commissioner shall take into consideration the list required of IUROs in (a) above.

11:24-8.9 Department review of HMO actions on IURO recommendations

(a) The Department shall review records of HMO reports submitted pursuant to N.J.A.C. 11:24-8.7(k) at least annually to determine whether a carrier exhibits a pattern of noncompliance with the recommendations of an IURO as well as possible violations of patient rights or other applicable laws.

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

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

2. Whether the HMO's noncompliance is with a specific IURO (in the event more than one IURO participates in the external appeal program); and

3. The HMO's utilization management program.

(c) If the Department determines that the HMO's utilization management program is not in compliance with either the HMO's utilization management standards set forth in accordance with N.J.A.C. 11:24-8.1, or other relevant laws, the Department shall take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24-2.14.

(d) If the Department determines that the HMO is in violation of member rights or other applicable requirements, the Department shall take action(s) as deemed appropriate, in the discretion of the Commissioner, if any, pursuant to N.J.A.C. 11:24-2.14.

(e) A pattern of noncompliance shall include, but not be limited to, 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 HMO to provide covered services or benefits therefor to a member.

New Rule, R.2000 d.183, effective May 1, 2000.
See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

SUBCHAPTER 9. MEMBER RIGHTS AND RESPONSIBILITIES; DISCLOSURES TO CONSUMERS

11:24-9.1 Policies and procedures

(a) The HMO shall establish and implement written policies and procedures regarding the rights of members and the implementation of these rights.

(b) The HMO shall provide each member with a current copy of a member's benefit handbook, including at least:

1. A complete statement of the member's rights;

2. A description of all complaint and grievance procedures, including the address and telephone numbers of the complaint offices of the HMO and of the Department; and

3. A clear and complete summary of the evidence of coverage, including limitations, exclusions, and procedures for accessing out of network services, as required by N.J.S.A. 26:2J-8(b), and the responsibility of the subscriber to pay copayments, deductibles and coinsurance, as appropriate, in terms relevant to the type of product(s) purchased.

i. HMOs shall clearly distinguish any differences in the member's financial responsibility for accessing services within and outside of the HMO's network.

ii. HMOs shall explain the member's responsibility to pay for charges incurred that are not covered under or authorized pursuant to the policy or contract.

iii. With respect to point of service contracts, HMOs shall explain the member's responsibility to pay for charges that exceed what the HMO determines are customary and reasonable (usual and customary, or usual, customary and reasonable, as appropriate) for services that are covered under the out-of-network component of the contract.

(c) HMOs shall, upon request, provide a written document to consumers setting forth the information required to be disclosed to members.

1. The HMO shall not be required to provide the consumer with the same level of detail that is provided to members in the provider directory pursuant to (d)6 below, but the HMO 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 HMO's network;

iii. The approximate percentage of the medical providers in the HMO'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 HMO utilizes in its selection of providers for participation in the HMO's network, if any, including a statement that no such criteria apply in those instances in which the HMO 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 current provider directory (if not already included), and the process by which consumers may obtain the information free of charge.

(1) HMOs 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, except that when an HMO uses multiple documents for its provider lists, the HMO shall cross reference in each provider lists all other lists of health care providers for which the HMO is required to provide coverage, or benefits therefor, pursuant to statute or rule.

(d) The statement of the member's rights shall include at least the right:

1. To available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions. The statement shall include a reminder that the "911" emergency response system should be called whenever a member has a potentially life-threatening condition. This information shall also be provided on the membership identification cards;

2. To be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy;

3. To be provided with information concerning the HMO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;

4. To choose a primary care provider within the limits of the covered benefits and availability and included as participating providers in the plan network;

5. To be afforded a choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients;

6. To obtain a current directory of participating providers in the HMO network upon request, including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English;

7. To obtain assistance and referral to providers with experience in treatment of patients with chronic disabilities;

8. To receive from the member's physician(s) or provider, in terms that the member understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, whether or not these are covered benefits. If the member is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record;

9. To be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

10. To formulate and have advance directives implemented;

11. To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands;

12. To prompt notification, as required in this chapter, of termination or changes in benefits, services or provider network; and

13. To file a complaint or appeal with the HMO or the Department and to receive an answer to those complaints within a reasonable period of time.

(e) The HMO shall establish and implement written policies and procedures regarding the responsibilities of members, such as financial responsibilities, including copayments and deductibles. A complete statement of these responsibilities shall be included in the member's benefit handbook.