(d) If a carrier offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
Rewrote the section.

11:22-1.4 Claim submission requirements

A carrier or its agent shall notify its participating health care providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims. Carriers or their agents may change the required information and documentation as long as participating health care providers are given at least 30 days prior notice of the change in the requirements. Carriers or their agents shall also supply participating health care providers with a street address where claim submissions can be delivered by hand or registered/certified mail.

11:22-1.5 Prompt payment of claims

(a) A carrier and its agent shall remit payment of clean claims pursuant to the following time frames:

1. Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. § 1395u(c)2(B), whichever is earlier; or

2. Forty calendar days after receipt of the claim where the claim is submitted by other than electronic means.

(b) Carriers and their agents shall pay claims that are disputed or denied because of missing information or documentation within 30 or 40 calendar days of receipt of the missing information or documentation, as applicable, pursuant to (a) above.

(c) Payment of a claim shall be considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.

(d) A carrier or its agent shall maintain an auditable record of when payments were transmitted to health care providers or covered persons whether by United States mail or otherwise.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
In (a)2, deleted "Written claims are considered received based on the U.S. mail postmark date." following the first sentence.

11:22-1.6 Denied and disputed claims

(a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5. The pending of a claim does not constitute a dispute or denial. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person when he or she will have increased responsibility for payment and the provider of the basis for its decision to deny or dispute, including:

1. The identification and explanation of all reasons why the claim was denied or disputed;

i. If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

ii. Examples of reasons why a claim cannot be entered into the claims system include: group not covered on date of service; employee/dependent not covered on date of service; non-payment of premium; missing data fields; missing or incorrect data (for example, CPT code, date of service, provider name); and ineligible provider.

iii. If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, the carrier's first review after the claim is entered shall identify all applicable reasons for any denial or disputed claim.

iv. A carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.

2. Where missing information or documentation is a reason for denying or disputing a claim, the notice shall identify with specificity the additional information or documentation that is required and the carrier shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the provider;

3. If the amount of the claim is disputed, an explanation of the reason for the dispute, including any change of coding performed by the carrier and the reasons for such change of coding; and

4. The toll free telephone number for the carrier or its agent who can be contacted by the provider or covered person to discuss the claim.

(b) A carrier or its agent that does not provide the notice required by (a) above shall waive its right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with the carrier's Fraud Prevention and Detection Plan.

(c) If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to $25.00, with the consent of the provider.

(d) If a carrier subject to the provisions of N.J.S.A. 17:33A-1 et seq. has reason to believe that the claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 or, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(e) Unless otherwise provided by law, every carrier or its agent shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by the carrier or the date of the performance by the covered person or the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable error(s) in the submission, processing or payment of a particular claim(s), and shall not be based on extrapolation, with the following exceptions:

1. Where the extrapolation, including the method, is non-binding;

2. In judicial or quasi-judicial proceedings, including arbitration;

3. In governmental administrative proceedings;

4. Where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or

5. Where there is clear evidence of claim fraud or abuse by the provider.

Amended by R.2002 d.222, effective July 15, 2002.
See: 33 N.J.R. 3239(a), 34 N.J.R. 2455(a).
Rewrote (a)1: in (c), inserted "issue an interest payment" preceding "within 14 days" and added the last sentence.
Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
Rewrote the section.
Amended by R.2003 d.328, effective August 4, 2003.
See: 34 N.J.R. 2950(a), 35 N.J.R. 3557(a).
Added (f).
Petition for Rulemaking.
See: 39 N.J.R. 3419(a), 4004(b), 5378(a).

11:22-1.7 Prompt payment of capitation payments

(a) Payment of a capitation payment to a health care provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if:

1. The health care provider is not in violation of the terms of the contract; and

2. The health care provider has supplied such information to the insurer as may be required under the contract before payment is to be made.

(b) An overdue payment shall include simple interest on the amount of the payment at the rate of 10 percent per year and shall add the interest amount to the payment when it is made.

11:22-1.8 Internal and external appeals

(a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims but not including appeals made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7. The internal appeals mechanism shall be described in the participating provider contract.

1. The internal review shall be conducted by employees of the carrier who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider.

2. The internal review shall be conducted and its results communicated in a written decision to the provider within 10 business days of the receipt of the appeal. The written decision shall include:

i. The names, titles and qualifying credentials of the persons participating in the internal review;

ii. A statement of the participating provider's grievance;

iii. The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;

iv. A description of the evidence or documentation which supports the decision; and

v. If the decision is adverse, a description of the method to obtain an external review of the decision.