CHAPTER 22

HEALTH BENEFIT PLANS

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

Authority

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

Source and Effective Date

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

11:22–1.1 Purpose and scope

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

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

Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
In (b), inserted "any organized delivery system;" following "dental plans in this State;".

11:22–1.2 Definitions

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

"ADR" means alternate dispute resolution.

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Clean claim" means:

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

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

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

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

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

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

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

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

"Department" means the Department of Banking and Insurance.

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

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

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

"Organized delivery system" or "ODS" means an organized delivery system that is either certified or licensed pursuant to N.J.S.A. 17:48H–1 et seq.

Amended by R.2003 d.446, effective November 17, 2003.
See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).
Added (b).

11:22–1.3 Acknowledgement of receipt of claims

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

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

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

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

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

(b) All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide the following:

1. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible and/or coinsurance applicable to network services; and

2. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the copayment, deductible and/or coinsurance applicable to network services.

11:22–5.7 Effect on previously-approved forms

Any form that was filed with and approved by the Commissioner prior to November 3, 2003, but does not meet the requirements of this subchapter, shall be deemed withdrawn immediately and may not be made available for sale or use.