

- i. The contract shall not provide financial incentives to the provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitated payment arrangements between a carrier and provider.
 - ii. To the extent that some portion of the provider compensation is tied to the occurrence of a pre-determined event, or the nonoccurrence of a pre-determined event, the event shall be clearly specified, and the HMO shall include in its contracts a right of each provider to receive a periodic accounting (no less frequently than annually) of the funds held.
 - iii. The contract shall include a process whereby a provider may appeal a decision denying the provider additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event.
 - iv. Notwithstanding (b)5i above, capitation shall not be used as the sole method of reimbursement to providers who primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services;
6. The services and/or supplies to be provided by the provider and for which benefits will be paid by the carrier;
7. A provision whereby the provider shall hold the covered person harmless for the cost of any service or supply for which the carrier provides benefits, whether or not the provider believes its compensation for the service or supply from the carrier (directly or through a secondary contractor) is made in accordance with the reimbursement provision of the provider agreement, or is otherwise inadequate.
- i. Members shall not be held harmless for payment of required copayments, deductibles or coinsurance, if any.
 - ii. Providers shall not balance bill members who have obtained covered services or supplies through the HMO network mechanism.
 - iii. An HMO's contractual agreement with a secondary contractor shall provide that the secondary contractor's contract with its network providers shall include a provision whereby the provider is required to hold the carrier's members harmless for the cost of any service or supply covered by the carrier, subject to (b)6i and ii above, whether or not the provider believes the compensation received is adequate;
8. That providers shall not discriminate in their treatment of HMO patients;
9. That providers shall comply with the HMO's quality assurance and utilization review programs;
10. That providers shall maintain licensure, certification and adequate malpractice coverage.
- i. With respect to a physician and dentist malpractice insurance shall be at least \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.
 - ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year.
 - iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate per year;
11. That patient information shall be kept confidential, but that the HMO and the provider shall have a mutual right to a member's medical records, as well as timely and appropriate communication of patient information, so that both the providers and the HMO may perform their respective duties efficiently and effectively for the benefit of the member;
12. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 8:38-3.7; and
13. That the provider shall have the right to communicate openly with a patient about all diagnostic testing and treatment options.
- (c) In addition to (b) above, all primary care provider contracts and contracts with specialists shall specify:
1. The responsibility, if any, of the provider with respect to acquiring and maintaining hospital admission privileges; and
 2. The mutual responsibility of the provider and HMO to assure 24 hour, seven-day a week emergency and urgent care coverage to members, and the procedures to assure proper utilization of such coverage consistent with the requirements of N.J.A.C. 8:38-5.2.
- (d) In addition to (b) above, all health care facility contracts shall specify:
1. The responsibility of the health care facility to follow clear procedures for granting of admitting and attending privileges to physicians, and to notify the HMO when such procedures are no longer appropriate;
 2. The admission authorization procedures for members;
 3. The procedures for notifying the HMO when members present at emergency rooms; and

4. The procedures for billing and payment, schedules, and negotiated arrangements.

(e) No contract with any provider shall impose obligations or responsibilities upon a provider which require the provider to violate the statutes or rules governing licensure of that provider if the provider is to comply with the terms of the contract.

(f) In addition to (b) through (e) above, the contract between an HMO and a secondary contractor shall specify that the HMO is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and a secondary contractor's contract(s) with health care providers shall provide that the HMO shall have privity of contract with the health care providers such that the HMO shall have standing to enforce the secondary contractor's contract(s) with the health care providers in the absence of enforcement by the secondary contractor.

(g) In lieu of (f) above, the HMO shall contract separately with each health care provider under contract with the secondary contractor, and such contracts shall be in accordance with (b) through (e) above.

Petition for Rulemaking.

See: 30 N.J.R. 1640(b).

Amended by R.2000 d.183, effective May 1, 2000.

See: 31 N.J.R. 953(a), 32 N.J.R. 1544(a).

Rewrote (b).

8:38-15.3 Review and approval

(a) The form(s) of the provider agreement(s), and any amendments thereto, shall be submitted to the Departments of Health and Senior Services and Banking and Insurance at the addresses specified at N.J.A.C. 8:38-11.6(i), for prior approval by the Department, following the receipt of comments from the Department of Banking and Insurance.

(b) Provider agreements in effect upon May 1, 2000 shall be deemed withdrawn on May 1, 2000 if not in compliance with this subchapter.

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.

8:38-15.4 Penalties

Every person acting as a secondary contractor in violation of this subchapter shall be subject to penalty and fine by the Department of Banking and Insurance under the insurance laws of this state as an unauthorized insurer in accordance with N.J.S.A. 17:51-1 et seq., or 17B:33-1 et seq., as may be appropriate.

SUBCHAPTER 16. CLAIMS PAYMENTS

Authority

N.J.S.A. 17B:30-1 et seq., 26:2J-5.1 and 26:2J-15.

Source and Effective Date

R.1998 d.458, effective September 8, 1998.

See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).

8:38-16.1 Prompt investigation and settlement of claims

(a) An HMO shall establish and maintain an auditable system for recording of all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identifier of the office handling the claim on behalf of the HMO.

(b) An HMO shall pay clean claims promptly but no later than 60 calendar days after the date the HMO receives written or electronic notice of the claim.

1. If, for whatever reason, a claim is submitted electronically and in written form, the date of the earlier submission of the claim shall be the date of notice from which the HMO shall calculate the 60-day period.

2. Notwithstanding (b)1 above, if an HMO and a provider have agreed in writing to the submission of claims by a specific mode of transmission, the HMO shall calculate the 60-day period beginning on the date that the claim is received in the agreed-upon mode.

(c) An HMO shall provide written or electronic notice to the provider of a determination by the HMO that the claim is a contested claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38-16.3.

(d) If an HMO determines that a part of a claim is a contested claim, the HMO shall provide written or electronic notice of that determination to the person submitting the claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim, and shall proceed to pay the portion of the claim determined by the HMO to be a clean claim promptly, but no later than 60 calendar days following the date that the HMO received written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38-16.3.

(e) In no instance shall an HMO contest a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the HMO's ability to adjudicate the claim.

(f) If an HMO determines that a claim provides sufficient information for the HMO to deny the claim, the HMO shall provide written or electronic notice of this determination to the person submitting the claim or member, if different from the person submitting the claim, promptly but in no instance later than 60 calendar days following the date that the HMO receives written or electronic notice of the claim, including the following information: