

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).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 22, Health Benefit Plans, expires on May 5, 2006. See: 37 N.J.R. 3779(a).

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.

“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.

“Department” means the Department of Banking and Insurance.

“Health benefits plan” means an individual or group contract issued by a carrier that provides hospital and medical expense benefits or services. Health benefits plan does not include the following types of policies or contracts: health benefit plans subject to N.J.S.A. 17B:27A-2 et seq. (Individual Health Coverage Program) or N.J.S.A. 17B:27A-17 et seq. (Small Employer Health Program); accident only, credit, disability, hospital confinement indemnity, long-term care, vision only, dental only, prescription only, CHAMPUS supplement, Medicare supplement, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers’ compensation or similar law, automobile medical payment insurance or other liability-based medical payment insurance, or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.

“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 plan. Health care provider includes, but is not limited to, the health professions specified in N.J.S.A. 17B:48E-12, N.J.S.A. 17B:27-50 and N.J.S.A. 17B:27-51.1a.

“Health wellness promotion program” means services or benefits for services rendered by a health care provider, which services or benefits are consistent with this subchapter, and any bulletins and public notices that may be issued in accordance with this subchapter as a supplement to this subchapter.

“Schedule” means the number of times a test, screen or other service must be covered or benefits provided therefor in a specified period.

### 11:22-2.3 Provision of a health wellness promotion program

(a) Every health benefits plan issued by a carrier shall provide benefits for a health wellness promotion program, which shall include, at a minimum, the following tests and services:

1. For all persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level;

2. For all persons 35 years of age or older, a glaucoma eye test every five years;

3. For all persons 40 years of age or older, an annual stool examination for presence of blood;

4. For all persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;

5. For all women 20 years of age or older, a pap smear as required by N.J.S.A. 17:48-60, 17:48E-35.12, 17B:27-46.1n, or 26:2J-2.12, as applicable;

6. For all women 40 years of age or older, a mammogram examination as required by N.J.S.A. 17:48-6g, 17:48-7f, 17:48E-35.4, 17B:26-2.1e, 17B:27-46.1f, or 26:2J-4.4, as applicable;

7. For all adults, recommended immunizations according to the latest edition of the Guide for Adult Immunization, third ed., published by the American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106-1572 ([www.acponline.org](http://www.acponline.org)) incorporated herein by reference, as amended and supplemented; and

8. For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

(b) Notwithstanding the provisions of (a) above to the contrary, if a health care provider recommends that it would be medically appropriate for a covered person to receive a different schedule of tests and services than that provided for under this section, the carrier shall provide payment for the tests or services actually provided, within the limits of the amounts provided for in N.J.A.C. 11:22-2.4.

(c) The health benefits plan shall provide, without consideration of a separate deductible, copayment or coinsurance amount, services or benefits at least up to the dollar amounts as specified in accordance with N.J.A.C. 11:22-2.4.

(d) In the event health wellness promotion program benefits are changed or added by the Legislature, health benefit plans issued or renewed after the effective date of the change or addition shall be revised to comply with the law.

### 11:22-2.4 Dollar amounts to be provided for services or benefits

The Department and the Department of Health and Senior Services for HMO’s, in consultation with the Department of Treasury, shall calculate the maximum dollar amount of services or benefits to be provided no later than July 1 annually, and shall publish the results of the calcula-

tio: a public notice in the New Jersey Register and post it on the web site of each Department.

Public Notice: Mandated adjustments to benefit payments and value for services schedule.

See: 35 N.J.R. 1596(b).

Public Notice: Health Wellness Promotion Act.

See: 36 N.J.R. 2090(a).

Public Notice: Health Wellness Promotion Act.

See: 37 N.J.R. 915(b).

### SUBCHAPTER 3. ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH CARE CLAIMS

#### Authority

N.J.S.A. 17:1-8.1, 17:1-15e and P.L. 1999, c.154—The Health Information Electronic Data Interchange Technology Act (“HINT”).

#### Source and Effective Date

R.2001 d.364, effective October 1, 2001.

See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).

#### 11:22-3.1 Purpose and scope

(a) Pursuant to N.J.S.A. 17B:30-23 et seq., P.L. 1999, c.154 (the Health Information Electronic Data Interchange Technology Act (“HINT” or “the Act”)), the purpose of this subchapter is to establish timetables for the introduction and implementation of systems for the electronic receipt and transmission of health care claim information, including, but not limited to, eligibility, premium payments, reports of injury, claim status, referral requests, authorization for referral, enrollment, disenrollment, and other health care claims transactions in accordance with the standards developed by the United States Department of Health and Human Services (hereinafter referred to as “DHHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (“HIPAA”) for the electronic administration of health care benefits.

(b) In accordance with N.J.S.A. 17B:30-23b, this subchapter also establishes one set of standard health care enrollment and claim forms in paper and electronic formats to be used by all health care benefit payers referred to in (d) below.

(c) Pursuant to N.J.S.A. 45:1-10.1 and 26:2H-12.12, this subchapter also establishes rules requiring health care professionals, institutions and facilities to file claims on behalf of their patients when seeking payment or reimbursement of health care claims.

(d) The subchapter applies to all hospital service corporations; medical service corporations; health services corporations; health insurers issuing individual policies of insurance; health insurers issuing group policies of insurance; health maintenance organizations; dental service corporations; dental plan organizations; and prepaid prescription service organizations; as well as any subsidiary or agent of any such entity, company or organization that may process health benefit information on behalf of a payer.

#### 11:22-3.2 Definitions

The following words, phrases and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

“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.

“Claim” or “insured 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.

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Covered person” means a person on whose behalf a payer has an obligation to pay benefits for health care services pursuant to a plan, policy, contract, certificate, or any other document.

“Covered service or supply” means a health care service or supply provided to a covered person under a health benefits or dental plan for which the payer is obligated to pay benefits or provide services or supplies subject to any applicable deductible, coinsurance or co-payment.

“Health benefit payer” or “payer” means those entities identified in N.J.A.C. 11:22-3.1(d) that are subject to the provisions of this chapter.

“Health care provider” or “provider” means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service or supply defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist or other health care professional licensed pursuant to Title 45 of the Revised Statutes; a hospital and other health care facility licensed pursuant to Title 26 of the Revised Statutes; and/or a purveyor of prescription, pharmaceutical products or durable medical goods or equipment.

“Health care transaction” or “transaction,” for purposes of this subchapter only, means the exchange of information between two or more parties to carry out the financial and administrative activities related to coverage under a health benefits or dental plan, including, but not limited to, health claims and equivalent encounter information, health care payment and admittance advice, health claims status, enrollment and disenrollment in a health plan, eligibility for a health plan, health or dental plan premium payments, first report of injury, deferral certification and authorization and health care attachments.

“Health insurance coverage” means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care, under any hospital or medical expense policy or certificate or health maintenance organization contract offered by a health benefit payer. The following shall constitute excepted benefits:

1. Coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverages, as specified by Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

2. Benefits provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the group health plan benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified by Federal regulation;

3. Benefits offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; and

4. Benefits offered as a separate insurance policy, certificate or contract of insurance, Medicare supplement insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1) and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.), and similar supplemental coverage provided in addition to coverage under a group health plan.

“Small Employer Health Benefits Plan” means, for purposes of this subchapter only, any plan identified as such by N.J.S.A. 17B:27A-17 or a “small health plan” pursuant to 45 CFR § 160.103.

“Standard” means a prescribed set of rules, conditions, transaction sets or requirements concerning classification of components, specification of materials, performance or operations, or delineation of procedures, in describing products, systems, services or practices.

“System” or “system for the electronic receipt and transmission of health care claim information” means that electronic network established in accordance with 42 U.S.C. §§ 1320d et seq. for the transaction of health care related information including:

1. Health claims or equivalent encounter information, including institutional, professional, pharmacy and dental health claims;

2. Enrollment and disenrollment in a health plan;

3. Eligibility for a health plan;
4. Health care payment and remittance advice;
5. Health care premium payments;
6. First report of injury;
7. Health claim status; and
8. Referral certification and authorization.

Amended by R.2004 d.460, effective December 20, 2004.  
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

In “Health benefit payer”, amended the N.J.A.C. reference; added “Health insurance coverage”.

### 11:22-3.3 Standard enrollment/change request forms and application/change request forms

(a) 45 C.F.R. 162.1101, Subpart K, the Health Care Claims or Equivalent Encounter Information Standard, and 45 CFR 162.1501, Subpart O, the Enrollment and Disenrollment in a Health Plan Standard, are adopted by the Department, in consultation with the Department of Health and Senior Services, as the electronic standard format for enrollment, disenrollment and claim forms, and are incorporated and made a part herein by reference.

(b) The UB-92, HCFA 1450 (the uniform claim for use by health care institutions and facilities) and the HCFA 1500 (the uniform claim for health care providers) are recognized and adopted by the Department, in consultation with the New Jersey Department of Health and Senior Services, as the paper standard format for claims by medical institutions, facilities and providers. These forms are located at the website maintained by the Federal Health Care Financing Administration ([www.hcfa.gov/forms/](http://www.hcfa.gov/forms/)) and incorporated herein by reference.

(c) The paper standard formats for a universal enrollment/change request form and application/change request form for health insurance coverage are located at subchapter Appendix Exhibits 1A and 1B and are incorporated herein by reference.

(d) Subchapter Appendix Exhibit 3, incorporated herein by reference, is designated as the standard paper claim format to be used for all dental benefit claims.

(e) Payers may add a company name and logo to these standard paper forms.

Amended by R.2004 d.460, effective December 20, 2004.  
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

Rewrote (c).

### 11:22-3.4 Timetable and operational status reports

(a) On or before October 1, 2002, health benefit payers shall use the standard electronic claim and enrollment forms adopted at N.J.A.C. 11:22-3.3(a).

(b) On or before March 30, 2002, health benefit payers shall file with the Department the First Operational Status Report, in the form set forth in subchapter Appendix Exhibit 2 incorporated herein by reference, demonstrating that they will be capable of implementing the timetable established in (a) above or will be requesting an extension of time pursuant to N.J.A.C. 11:22-3.5.

(c) On or before July 28, 2002, health benefit payers shall file an Interim Operational Status Report in the form set forth in Appendix Exhibit 2 in which the payer shall report that:

1. It expects to comply with the timetable established by this subchapter; or
2. It encountered unexpected delays and may not comply with the timetable. In such circumstances, the payer shall:
  - i. Explain the cause of the delay;
  - ii. Provide an estimate of when compliance will be achieved; and
  - iii. Explain why the delay was not anticipated when the First Operational Status Report was filed pursuant to (b) above.

(d) On or before October 1, 2002, all health benefit payers shall file the Final Operational Status Report in the form set forth in Appendix Exhibit 2, which certifies the then current status of the payer's system for electronic receipt and transmission of standard health care claims and enrollment forms pursuant to (a) above.

(e) If, at the time the Final Operational Status Report is filed, a payer is not able to certify that it has a functioning system for the electronic receipt and transmission of health care claim information in accordance with N.J.S.A. 17B:30-23, the payer shall file the required report together with supporting documents stating:

1. When compliance will be achieved; and
2. The reason(s) for the failure to comply.

(f) When those payers described in (e) above achieve compliance, a Final Operational Status Report shall be filed within seven days of achieving compliance.

(g) All reports described above in this section shall be filed at:

Department of Banking and Insurance  
Attention: HINT/HIPAA Compliance  
PO Box 325  
20 West State Street  
Trenton, NJ 08625-0325

#### 11:22-3.5 Extensions of time and exemptions from compliance

(a) Health benefit payers may petition the Commissioner for an extension of the time limits set forth in N.J.A.C. 11:22-3.4 and/or to seek a waiver of the obligation to comply with the Act at any time after the filing of the First Operational Status Report filed in accordance with N.J.A.C. 11:22-3.4(b).

(b) Health benefit payers seeking an extension and/or exemption shall demonstrate that compliance with the timetable or these requirements will result in an undue hardship to the health benefit payer, a provider or a covered person.

(c) Small employer health benefit plans shall, upon application and approval by the Department, be granted an additional six months for compliance with the provisions of N.J.A.C. 11:22-3.4. To qualify, the group plan shall have less than 50 participants and/or less than \$5 million in annual gross receipts.

#### 11:22-3.6 Health care providers; claims

(a) On or after October 1, 2002, all payers shall require that all providers file all claims for payment unless the patient, at his or her option, files the claim directly.

(b) Where a claim is being filed by the health care provider on behalf of the patient without an assignment of benefits, the provider shall file the claim within 60 days of the last date of service of that course of treatment.

(c) Where the provider is filing a claim under an assignment of benefits from the patient, the provider shall file the claim within 180 days of the last date of service of the course of treatment.

(d) In the event a health care provider does not file the claim within 180 days of the last date of service of a course of treatment referred to in (c) above, the third party payer and/or health benefit payer shall in accordance with N.J.A.C. 11:22-1.6 reserve the right to deny or dispute the claim and the health care provider shall be prohibited from seeking payment in whole or in part directly from the patient.

(e) When a health benefit payer takes action in accordance with (d) above, the health benefit payer shall advise the health care provider that payment of the claim, in whole or in part, will be made based upon consideration of the following factors that shall be addressed by the provider:

1. The good faith use of information provided by the patient to the health care provider with respect to the identity of the patient's health benefits payer;
2. Delays encountered in filing a claim related to the coordination of benefits among third party payers;

3. Whether the health care provider has previously filed untimely claims or has an established pattern of untimely claim practices;

4. Any prejudice to the rights of the patient and/or the health benefits provider in determination of the medical necessity of the services and care being billed for; and

5. Potential adverse impact to the public.

(f) Providers failing to file a claim within 180 days in accordance with (d) above whose claim for payment has been denied in whole or in part may, in the discretion of a Judge of the Superior Court, be permitted to refile the claim where there has not been substantial prejudice to the health benefit payer. Application to the Superior Court for permission to refile a claim shall be made within 14 days of the notification of denial of payment and shall be made upon motion based upon affidavit(s) showing sufficient reason(s) for the failure to file the claim with the third party payer within the required time.

#### 11:22-3.7 Additional timetables

(a) On or before October 1, 2002, all payers shall file with the Department a plan for the sequential implementation of usage of the following standard transactions, code sets and forms described below:

1. 45 CFR 162.1201, Subpart L—Eligibility for a Health Plan;

2. 45 CFR 162.1301, Subpart M—Referral Certification and Authorization;

3. 45 CFR 162.1401, Subpart N—Health Care Claim Status;

4. 45 CFR 162.1601, Subpart P—Health Care Payment and Remittance Advice;

5. 45 CFR 162.1701, Subpart Q—Health Plan Premium Payments;

6. 45 CFR 162.1801, Subpart R—Coordination of Benefits; and

7. 277 Transactions, ANSI ASC X12.317, Version 003070, Release 7, Sub-release O, October 1996, Electronic Health Care Claim Status Notification.

(b) The plan referred to in (a) shall provide for full implementation of a system for the use of those electronic transaction and code sets referred to therein no later than October 16, 2002.

(c) In accordance with N.J.A.C. 11:22-1.3, payers receiving an electronically filed claim shall individually acknowledge receipt of each claim by responding with a 277 acknowledgement described in (a)7 above. Nothing in this section shall prevent payers from also using any other responses including, but not limited to, the 997 Functional Acknowledgement of batch transfers in addition to providing a 277 acknowledgement.

(d) In the event a provider's system is unable to receive a 277 acknowledgement, the payer shall establish a mutually agreeable alternative means of acknowledgement with the provider.

#### 11:22-3.8 Use of clearinghouses in electronic transactions

(a) When computing the number of days for purposes of acknowledging an electronic claim and/or any other health care transactions required by this subchapter, the following shall apply:

1. When the provider chooses to use a clearinghouse for the transmission of claims to a payer, notice delivered by the payer to the clearinghouse shall constitute notice to the provider.

2. When a payer uses a clearinghouse for the receipt of any electronic transactions required by this subchapter, notice sent by the payer through the clearinghouse shall not constitute notice to a provider until it is delivered to the provider by the clearinghouse, or is available for pickup from the provider's mailbox at the clearinghouse.

3. When a payer and provider use the same clearinghouse for the transmission and receipt of health care transactions, notice that is sent by one party to the clearinghouse shall also constitute notice to the other party.

#### 11:22-3.9 Information protection practices

All information and materials coming into the possession of health benefits payers, health care providers and their agents and vendors for the administration of the health care transactions described in this subchapter are subject to and shall comply with practices and requirements established in N.J.S.A. 17:23A-1 et seq., the Insurance Information Practices Act.

#### 11:22-3.10 Fraud prevention and detection

(a) All payers shall deploy as part of any system for the electronic receipt and transmission of claims an anti-fraud program, resident system and/or software that is approved by the Department's Division of Anti-Fraud Compliance.

(b) The anti-fraud system described in (a) above shall be capable, at a minimum, of the following activities:

1. Screening all claims, pre-payment and/or post-payment, for data patterns associated with fraudulent activity;

2. Responding to audit specific inquiries to facilitate fraud investigations;

3. Identifying phantom vendors, employees, patients and providers;

4. Identifying inappropriate or inconsistent charges;  
and

5. Scanning provider claims for unnecessary and repetitive charges.

(c) The anti-fraud efforts described in this section shall be made a part of and incorporated into a payer's fraud prevention and detection plan when required pursuant to N.J.A.C. 11:16-6, as applicable.

(d) Those payers not required to have a fraud prevention and detection plan under N.J.A.C. 11:16-6 shall file a description of the system required by this section with:

New Jersey Department of Banking and Insurance  
Division of Anti-Fraud Compliance  
Attn: HINT/HIPAA-Fraud Prevention and Detection Plans  
PO Box 324  
20 West State Street  
Trenton, NJ 08625-0324

(e) Payers shall comply with the requirements of N.J.S.A. 17:33A-1 et. seq. regarding the obligation to report suspected fraud to the New Jersey Office of Insurance Fraud Prosecutor.

#### 11:22-3.11 Penalties

Failure to comply with this subchapter may result in the imposition of penalties as authorized by law, including suspension or revocation of the payer's authority to do business in the State of New Jersey.

## APPENDIX

### Exhibit 1

(RESERVED)

Repealed by R.2004 d.460, effective December 20, 2004.  
See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

(e) A licensed organized delivery system shall deposit with the Commissioner in accordance with the procedures set forth in N.J.A.C. 11:2-32, cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to 50 percent of the highest calendar quarterly compensation of the most recent four quarters, but in no event less than \$25,000, which amount shall be adjusted annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the system in the determination of net worth. The deposit amount, above the \$25,000 minimum, shall be payable over a two-year period, with 50 percent of the required amount above the minimum required amount payable at the end of the 12th month after it was issued a license.

(f) All income from deposits shall be an asset of the licensed organized delivery system. A licensed organized delivery system may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the Commissioner.

(g) If a licensed organized delivery system is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.A. 17B:32-31 et seq.

(h) A licensed organized delivery system shall maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than \$100,000.

(i) Any organized delivery system that pursuant to the terms of the contract, accepts risk in an amount represented by 50 percent or more of any carrier's consideration received to provide services or benefits, shall satisfy all net worth and financial requirements set forth in N.J.A.C. 8:38-11.

(j) For purposes of determining net worth and deposit requirements set forth in this section, "compensation" shall mean amounts paid to the ODS by a carrier or other ODS for specified health care benefits (for example, hospital/medical, dental, radiology, etc.) provided to the policyholders or members of the carrier pursuant to agreements whereby the ODS assumes financial risk.

(k) For purposes of determining net worth and deposit requirements set forth in this section, "health care expenditures" means amounts paid for provider services provided under a contractual arrangement and includes salaries, including fringe benefits, paid to providers for delivery of health care services; capitation payments paid by the ODS to providers for delivery of health care services; and fees paid to providers on a fee-for-service basis for delivery of health care services, including capitated referrals; and net of reinsurance recoveries. Annual health care expenditures do not include expenses for the time of providers devoted to administrative tasks.

Amended by R.2003 d.186, effective May 5, 2003.

See: 34 N.J.R. 3593(a), 35 N.J.R. 1918(a).

In (a), substituted "Two" for "Six" in 1, added 2ii; in (e), added the third sentence; added (j) and (k).

Public Notice: Increase in Medical Component of the Consumer Price Index.

See: 36 N.J.R. 1837(a).

Public Notice: Increase in medical component of the Consumer Price Index.

See: 37 N.J.R. 1090(a).

Public Notice: Department of Banking and Insurance; Division of Insurance; Office of the Commissioner: minimum net worth requirements for Organized Delivery Systems: increase in medical component of the Consumer Price Index.

See: 38 N.J.R. 1607(b).

#### 11:22-4.9 Financial reports

(a) A licensed organized delivery system shall file an annual report for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b) with the Commissioner, on or before March 1 of each year, for the immediately preceding calendar year, completed as prescribed by the National Association of Insurance Commissioners (NAIC) Health Annual Statement Instructions, and completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, incorporated herein by reference, as amended and supplemented (NAIC, 2301 McGee Street, Kansas City, MO 64108). The annual report shall be submitted using the NAIC health blank in effect at the time of the calendar year reported. Annual statements shall be accompanied by a fee in the amount of \$100.00.

(b) A licensed organized delivery system shall submit, no later than June 1, audited annual financial reports for the immediately preceding calendar year for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b), and shall also file a report with respect to all of its operations, completed on a generally accepted accounting principles basis, certified by an independent certified public accountant, in accordance with N.J.A.C. 11:2-26. In addition, a statement by a qualified actuary setting forth the actuary's opinion as to the adequacy of reserves shall be filed with the annual report filed pursuant to (a) above, which shall satisfy the requirements set forth in N.J.A.C. 8:38-11.6(a)2.

(c) A licensed organized delivery system shall file quarterly reports for the segregated account established pursuant to N.J.A.C. 11:22-4.8(b) with the Commissioner, no later than 45 days following the close of each of the first three calendar quarters (that is, May 15, August 15, and November 15, respectively), completed as prescribed by the NAIC Health Annual Statement Instructions, and completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, incorporated herein by reference, as amended and supplemented. The quarterly report shall be submitted using the NAIC health blank in effect at the time of the quarter submitted.

**11:22-4.10 Suspension or revocation**

(a) The Commissioner may suspend or revoke the license issued to an organized delivery system upon a finding that:

1. The licensed organized delivery system is operating in contravention of its basic organizational documents;
2. The licensed organized delivery system is unable to fulfill its obligations to the carriers with whom it contracts;
3. The net worth of the licensed organized delivery system is less than that required by this subchapter, or the licensed organized delivery system has failed to correct any deficiency in its net worth as required by the Commissioner;
4. The continued operation of the licensed organized delivery system would be hazardous to the health and welfare of the enrollees or contract holders with whom it has contracted to provide health care services or detrimental to a carrier with whom it has contracted to provide the services;
5. The licensed organized delivery system has failed to file any report required by N.J.S.A. 17:48H-1 et seq. or this subchapter;
6. The licensed organized delivery system has failed to provide the health care services for which it has been licensed or has provided health care services which are in contravention of the contract or contracts filed with the Commissioner;
7. The licensed organized delivery system is unable to maintain the standards set forth in this subchapter;
8. The licensed organized delivery system has failed to comply with the provisions of N.J.S.A. 26:2S-1 et seq.;
9. The licensed organized delivery system has otherwise failed to comply with N.J.S.A. 17:48H-1 et seq., or with other applicable law, including this subchapter; or
10. There are other reasonable grounds that warrant suspension or revocation.

(b) If the Commissioner has cause to believe that grounds exist for the suspension or revocation of a license, the Commissioner shall notify the licensed organized delivery system, in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If a license is revoked, the licensed organized delivery system shall submit a plan to the Commissioner within 15 days of

the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The Commissioner may, by written order, permit such further operation of the system as the Commissioner finds to be in the best interest of individuals receiving health care services from the system.

(c) The Commissioner shall notify all carriers with contracts with the system that are on file with the Department of the proceedings.

**11:22-4.11 Plan for insolvency**

In connection with the plan for insolvency required as part of an application for licensure, a licensed organized delivery system shall maintain insurance to cover the expenses to be paid for continued benefits following a determination of insolvency, or make other arrangements acceptable to the Commissioner to ensure that benefits are continued for the period determined in the insolvency plan.

**11:22-4.12 Confidentiality**

(a) Any data or information relating to the diagnosis, treatment or health of an enrollee, prospective enrollee or contract holder obtained by a licensed organized delivery system from the carrier, contract holder, enrollee, prospective enrollee or any provider shall be confidential and shall not be disclosed to any person except as provided by N.J.S.A. 17:48H-30.

(b) In addition to (a) above, the following documents shall be confidential and shall not be considered public documents pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A-2:

1. Pending applications for a license;
2. In biographical affidavits, the affiant's social security number and residence address;
3. The applicant's business plan;
4. Compensation formulas and fee schedules; and
5. With respect to an examination of a licensed ODS, all information as set forth in N.J.S.A. 17:23-24f and N.J.A.C. 11:1-36.6.

**11:22-4.13 Penalties**

Failure to comply with the provisions of this subchapter shall result in the imposition of penalties as provided in N.J.S.A. 17:48H-22, 17:48H-29, 17B:30-17, 17:27A-1 et seq., 26:2S-1 et seq., and P.L. 1999, c.154, and P.L. 1999, c.155.