

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.

“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 mammo-gram 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) 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-

tion as 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).

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(c) 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.

“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.

11:22-3.3 Standard enrollment and claim 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/) and incorporated herein by reference.

(c) The paper standard format for a universal enrollment form is located at subchapter Appendix Exhibit 1 and is 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.

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

[Carrier Logo] Enrollment/Change Request [Carrier Name]

[Employer] Group Information - To Be Completed by [Employer]

Table with 3 columns: Group Name, Group Number, Class Code

A. Type of Activity - To Be Completed by [Employer] Refer to instructions on back before completing this form. Print clearly.

Form A: Enrollment, Change, Remove or Terminate, Continuation of Coverage. Includes checkboxes for various actions and dates.

B. [Employee] Information - Complete Sections [B - H].

Form B: Personal information including Social Security Number, Home Address, Work Address, and Telephone numbers.

C. Plan Option - Your selection must be offered by your [employer].

Form C: Plan selection area with a checkbox for 'Check One' and a space for plan names/copays/deductibles.

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time college student].

Table D: Individuals Covered. Columns include Name, Sex, Birthdate, Social Security Number, and various coverage checkboxes.

E. Pre-Existing Conditions Statement

Form E: Pre-Existing Conditions Statement. Includes a note and two numbered questions with multiple choice options.

F. Other Insurance

Form F: Other Insurance. Questions about spouse and other health coverage.

G. Dependent Information

Form G: Dependent Information. Questions about dependent addresses and names.

H. [Employee] Signature

If you have questions concerning the benefits and services provided by or excluded under this [Agreement], contact a [Member Services] representative at [phone number] before signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the [employee] copy of this application.

Form H: Signature and Date fields for the employee.

I. [Employer] Verification - To Be Completed by [Employer]

Form I: Employer verification signature and date fields.

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier Name] prior to visiting a specialist or admission to a hospital.]

Instructions**[Employer]**

- Complete the **[Employer] Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section [I] - [Employer] Verification** in the lower right corner of the form.
- **[Employer]** must complete this section for all new enrollments, coverage changes and terminations.
- **[Employer]** must sign and date the application in order for it to be processed.

[Employee] - Complete Sections [B - H].**Section B - [Employee] Information:**

Complete **all** information in order for your application to be processed.

Section C - Plan Option:

- [Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).]
- Select **only** an option offered by your [employer].

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the "Yes" box(es) and complete Section [F] - Other Insurance.
- [From the appropriate provider directory, locate the [6-digit] ²³ office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.] ^(12, 14, 15)
- [If you are a current patient, please check the "Current Patient" box.]

[Section E] - Pre-Existing Conditions Statement:

Complete this section for all new enrollments. **Exception:** For Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 [employees], and to late entrants.]

Section [F] - Other Insurance:

Complete this section for all new enrollments or coverage changes.

Section [G] - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section [H] - [Employee] Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- **[Employee]** must sign and date the application in order for it to be processed.

Section [I] - [Employer] Verification:

- **[Employer]** must complete this section for all new enrollments, coverage changes and terminations.
- **[Employer]** must sign and date the application in order for it to be processed.

Conditions of Enrollment**[Applicant] Acknowledgments and Agreements**

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
 - b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier Name] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
 - c) I know that I have a right to receive a copy of this authorization if I request one.
 - d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] [plan or group policy], coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

MBNL

Explanation of Brackets

{Information identified in this format is offered only to explain reasons for textual changes made (usually because some element of required data for the 834 electronic enrollment form was not present on the written form). This text should be deleted before publication of this form.}

- 1. Replace bracketed text with carrier's logo.
2. Replace bracketed text "carrier name" with carrier's full name throughout document.
3. If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout document.
...
23. Identify the number in the manner appropriate to the director.

EXHIBIT 2

New Jersey Department of Banking and Insurance

ATTN: HINT Status Reports

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

HINT Operational Status Report

- 1. This is the: (Indicate one):
[] First Report due on
[] Interim Report due on
[] Final Report due on
2. The current status of the implementation of HINT electronic filing reports for health care benefit payment systems is:
3. If compliance is not yet achieved, indicate when the requirements of N.J.A.C. 11:22-3 will be accomplished:

- 4. What specific obstacles have been identified that may cause the filer NOT to comply with the timetable set forth in N.J.A.C. 11:22?
5. Is the filer requesting an extension of time to comply with the timetable now or in the future?
6. Is the filer requesting a waiver from compliance with the HINT Electronic System request now or in the future?

7. Will the filer comply with the timetable for implementation of the additional transaction identified in N.J.A.C. 11:22-3.7?

_____ hereby certifies that the foregoing statements of fact are true and understand that he/she is subject to punishment for any intentional misstatements of fact.

8. Other issues:

Date

Name

Agency

Title of Signatory

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
 2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.
 - 3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.
 - 8-11, 16. Patient name address, city, state, and zip code: Include the patient's legal name.
 12. Patient date of birth: Necessary to determine eligibility.
 13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
 14. Sex: Necessary for identification purposes and for statistical analysis.
 15. Patient phone number: Necessary if questions arise that require immediate attention.
 17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
 18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
 19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
 20. Employer name: Self explanatory.
 21. Group number: Refers to the master contract policy number assigned to the employer group.
 - 22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.
 31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
 32. Policy #: Refers to master contract policy number assigned to the employer group.
 - 33-35. Other subscriber's information: Refers to employee with policy number in box #32.
 36. Plan/Program name: Necessary to identify national programs such as TRICARE.
 37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
 38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
 39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
 40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
 41. Employee/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
 - 42-43, 46, 50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
 44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N.).
 45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
 47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
 48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
 49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
 53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
 54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
 55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
 56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
 57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
 58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
 59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
 60. Identify all missing teeth with "x".
 61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
 62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
 - 63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52. For administrative use only: Area where carrier calculates benefits.
- Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17:48H-1 et seq.

Source and Effective Date

R.2002 d.336, effective October 21, 2002.
See: 34 N.J.R. 20(a), 34 N.J.R. 3607(a).

11:22-4.1 Purpose and scope

(a) This subchapter sets forth the filing and requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.

(b) This subchapter applies to any entity seeking to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.; or an existing organized delivery system required to obtain a license to operate pursuant to N.J.S.A. 17:48H-11. A non-exhaustive list of examples of entities and arrangements that are subject to these rules is set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

11:22-4.2 Definitions

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

“Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

“Capitation” means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services 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., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq. or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

“Certified organized delivery system” means an organized delivery system that is compensated on a basis which does not entail the assumption of more than de minimis financial risk by the organized delivery system and that is certified by the DHSS in accordance with N.J.S.A. 17:48H-1 et seq.

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

“Comprehensive health care services” means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists, emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

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

“Department” means the New Jersey Department of Banking and Insurance.

“DHSS” means the New Jersey Department of Health and Senior Services.

“Financial risk” means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or health care services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not per se be considered financial risk. A financial risk shall exist if, under an agreement between the organized delivery system and the carrier, the financial obligations of the organized delivery system for payment of benefits or for providing treatment or health care services does or potentially may exceed any payments that may be received from the carrier. Financial obligation shall include the attendant administrative costs related to providing the treatment or services.

“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 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 subchapter, 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 N.J.S.A. 39:6A-1 et seq. or hospital confinement indemnity coverage.