

**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 and to any agent, employee or other representative of such entity that processes claims for such entity.

**11:22-1.2 Definitions**

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.

### 11:22-1.3 Acknowledgment of receipt of claims

(a) A carrier or its agent shall acknowledge receipt of a claim by the same means it was received upon request from a health care provider or covered person either:

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

2. If submitted by written notice, no later than 15 working days following receipt of a claim submitted by other than electronic means. Written claims are considered received based on the U.S. mail postmark date.

(b) The carrier or its agent shall provide written notice to the provider and the covered person within 30 days of receipt of the claim if the carrier disputes or denies a claim, in full or in part. The notice shall comply with the requirements of N.J.A.C. 11:22-1.6. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5.

### 11:22-1.4 Claim submission requirements

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

### 11:22-1.5 Prompt payment of claims

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

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

2. Forty calendar days after receipt of the claim where the claim is submitted by other than electronic means. Written claims are considered received based on the U.S. mail postmark date.

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

“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](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-

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