

(d) If a carrier offers providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).
Rewrote the section.

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.

(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.

(c) Payment of a claim shall be considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or
2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.

(d) A carrier or its agent shall maintain an auditable record of when payments were transmitted to health care providers or covered persons whether by United States mail or otherwise.

Amended by R.2003 d.279, effective July 7, 2003.
See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).

In (a)2, deleted "Written claims are considered received based on the U.S. mail postmark date." following the first sentence.

11:22-1.6 Denied and disputed claims

(a) A carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. 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. The pending of a claim does not constitute a dispute or denial. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person when he or she will have increased responsibility for payment and the provider of the basis for its decision to deny or dispute, including:

1. The identification and explanation of all reasons why the claim was denied or disputed;

- i. If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

- ii. Examples of reasons why a claim cannot be entered into the claims system include: group not covered on date of service; employee/dependent not covered on date of service; non-payment of premium; missing data fields; missing or incorrect data (for example, CPT code, date of service, provider name); and ineligible provider.

- iii. If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, the carrier's first review after the claim is entered shall identify all applicable reasons for any denial or disputed claim.

- iv. A carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.

2. Where missing information or documentation is a reason for denying or disputing a claim, the notice shall identify with specificity the additional information or documentation that is required and the carrier shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the provider;

3. If the amount of the claim is disputed, an explanation of the reason for the dispute, including any change of coding performed by the carrier and the reasons for such change of coding; and

4. The toll free telephone number for the carrier or its agent who can be contacted by the provider or covered person to discuss the claim.

(b) A carrier or its agent that does not provide the notice required by (a) above shall waive its right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with the carrier's Fraud Prevention and Detection Plan.

(c) If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to \$25.00, with the consent of the provider.

(d) If a carrier subject to the provisions of N.J.S.A. 17:33A-1 et seq. has reason to believe that the claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 or, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(e) Unless otherwise provided by law, every carrier or its agent shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by the carrier or the date of the performance by the covered person or the provider of any conditions to payment set forth in the agreement, whichever is later.

(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable error(s) in the submission, processing or payment of a particular claim(s), and shall not be based on extrapolation, with the following exceptions:

1. Where the extrapolation, including the method, is non-binding;
2. In judicial or quasi-judicial proceedings, including arbitration;
3. In governmental administrative proceedings;
4. Where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or
5. Where there is clear evidence of claim fraud or abuse by the provider.

Amended by R.2002 d.222, effective July 15, 2002.

See: 33 N.J.R. 3239(a), 34 N.J.R. 2455(a).

Rewrote (a)1; in (c), inserted "issue an interest payment" preceding "within 14 days" and added the last sentence.

Amended by R.2003 d.279, effective July 7, 2003.

See: 34 N.J.R. 2365(a), 35 N.J.R. 2899(a).

Rewrote the section.

Amended by R.2003 d.328, effective August 4, 2003.

See: 34 N.J.R. 2950(a), 35 N.J.R. 3557(a).

Added (f).

Petition for Rulemaking.

See: 39 N.J.R. 3419(a), 4004(b), 5378(a).

Petition for Rulemaking.

See: 41 N.J.R. 899(a).

11:22-1.7 Prompt payment of capitation payments

(a) Payment of a capitation payment to a health care provider shall be deemed to be overdue if not remitted to the provider on the fifth business day following the due date of the payment in the contract, if:

1. The health care provider is not in violation of the terms of the contract; and
2. The health care provider has supplied such information to the insurer as may be required under the contract before payment is to be made.

(b) An overdue payment shall include simple interest on the amount of the payment at the rate of 10 percent per year and shall add the interest amount to the payment when it is made.

11:22-1.8 Internal and external appeals

(a) Every carrier shall establish an internal appeals mechanism to resolve disputes between carriers or their agents and participating health care providers relating to payment of claims but not including appeals made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and 8:38A-3.6 and 3.7. The internal appeals mechanism shall be described in the participating provider contract.

1. The internal review shall be conducted by employees of the carrier who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider.

2. The internal review shall be conducted and its results communicated in a written decision to the provider within 10 business days of the receipt of the appeal. The written decision shall include:

- i. The names, titles and qualifying credentials of the persons participating in the internal review;
- ii. A statement of the participating provider's grievance;
- iii. The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;
- iv. A description of the evidence or documentation which supports the decision; and
- v. If the decision is adverse, a description of the method to obtain an external review of the decision.

(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).

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

See: 39 N.J.R. 1322(a).

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

See: 40 N.J.R. 1937(a).

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 Treatment as domestic insurer

Regardless of the state in which it is incorporated, pursuant to N.J.S.A. 17:48H-16 and 26 a licensed organized delivery system shall be treated as a domestic insurer subject to N.J.S.A. 17:27A-1 et seq. and 17B:32-31 et seq.

New Rule, R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.10, Suspension or revocation, recodified to N.J.A.C. 11:22-4.11.

11:22-4.11 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.

Recodified from N.J.A.C. 11:22-4.10 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.11, Plan for insolvency, recodified to N.J.A.C. 11:22-4.12.

11:22-4.12 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.

Recodified from N.J.A.C. 11:22-4.11 by R.2008 d.179, effective July 7, 2008.

See: 40 N.J.R. 1604(a), 40 N.J.R. 4221(a).

Former N.J.A.C. 11:22-4.12, Confidentiality, recodified to N.J.A.C. 11:22-4.13.

11:22-4.13 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