

(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.

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.

#### 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.

(b) Every carrier shall offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1. The ADR mechanism shall be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism shall be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.

2. The ADR mechanism, including the method to submit a claim through such mechanism, shall be described in the participating provider contract and in the final internal decision denying or disputing the participating health care provider's claim, in full or in part.

3. The decision of the ADR mechanism shall be non-binding unless the parties agree otherwise.

(c) The report shall be submitted to the Department by the due date to:

New Jersey Department of Banking and Insurance  
 Life & Health Actuarial  
 Prompt Payments Reports  
 20 West State Street  
 PO Box 329  
 Trenton, New Jersey 08625-0329

(d) Carriers shall annually report, in a format prescribed by the Department, which includes the number of internal and external provider appeals received and how they were resolved.

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

In (c), substituted "Life & Health Actuarials" for "Office of Enforcement and Consumer Protection"; in (d), substituted "annually" for "maintain and make available at the request of the Department, the annual provider".

#### 11:22-1.9 Reporting requirements

(a) A carrier shall report to the Department quarterly on the timeliness of claims payments in the format set forth in Appendix A to this subchapter, incorporated herein by reference, and on the reasons for denial and late payment of claims in the format set forth in Appendix B to this subchapter, incorporated herein by reference, on an annual and quarterly basis. Instructions for these documents are provided in subchapter Appendix A-1 and Appendix B-1, respectively, incorporated herein by reference. Due dates for the reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and March 31 for the fourth quarter for Appendix A and the annual report for Appendix B.

(b) The annual report shall be audited by a private auditing firm at the expense of the carrier. The annual report shall be accompanied by the report of the auditing firm that reviewed the report. In addition to the Department, copies of the audited annual report shall be sent to the Governor and the majority and minority offices of the Legislature.

(c) The report shall be submitted to the Department by the due date to:

New Jersey Department of Banking and Insurance  
 Office of Enforcement and Consumer Protection  
 Prompt Payment Reports  
 20 West State Street  
 PO Box 329  
 Trenton, New Jersey 08625-0329

(d) Reports shall be submitted in hard copy and as an Excel spreadsheet by one of the following media:

1. CD-ROM;
2. Zip diskette; or
3. Floppy diskette.

#### 11:22-1.10 Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-1.9, the Commissioner may require that the carrier, at its own expense:

1. Implement a plan of remedial action; and/or
2. Have the claims processing procedures of the carrier or its agent be monitored by a private auditing firm for a period to be determined by the Commissioner.

(b) The Commissioner may impose a civil penalty of not more than \$10,000 upon the carrier, to be collected pursuant to "the penalty enforcement law," N.J.S.A. 2A:58-1 et seq. if following the remediation measures in (a) above, the Commissioner determines that:

1. An unreasonably large or disproportionate number of eligible claims continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22-1.5; or
2. A carrier or its agent has failed to pay interest as required pursuant to N.J.A.C. 11:22-1.7.

APPENDIX A

NEW JERSEY CLAIMS PAYMENT EXHIBIT

Company \_\_\_\_\_ NAIC # \_\_\_\_\_ Payment Month/Yr \_\_\_\_\_

Commercial \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ In Pat \_\_\_\_\_ All Oth \_\_\_\_\_

Number of Claims Paid in Month

Service Month	Report Month PM	PM-1	PM-2	PM-3	PM-4	PM-5	PM-6 and before
PM							
PM-1							
PM-2							
PM-3							
PM-4							
PM-5							
PM-6							
PM-7							
PM-8							
PM-9							
PM-10							
PM-11							
PM-12 and before							

Total Claims Paid (Number) \_\_\_\_\_ (Must equal Total of all above cells)

Dollar Amount of Claims paid in Month (in \$000's)

Service Month	Report Month PM	PM-1	PM-2	PM-3	PM-4	PM-5	PM-6 and before
PM							
PM-1							
PM-2							
PM-3							
PM-4							
PM-5							
PM-6							
PM-7							
PM-8							
PM-9							
PM-10							
PM-11							
PM-12 and before							

Total Claims Paid (in 000 \$'s) \_\_\_\_\_ (Must equal Total of all above cells)

Name of Person completing report (Print or Type) \_\_\_\_\_

Title \_\_\_\_\_ Phone Number \_\_\_\_\_

Email: \_\_\_\_\_

Signature of Person completing report \_\_\_\_\_

Affiliation (if not an employee of the company) \_\_\_\_\_

Address \_\_\_\_\_

## APPENDIX A-1

INSTRUCTIONS  
NEW JERSEY CLAIMS PAYMENT EXHIBIT

Reports should be submitted quarterly. Monthly reports for all months in the reporting quarter should be submitted by the reporting due date for that quarter.

Complete one Form for each payment month in the reporting quarter, and for each combination, if applicable, of Commercial/Medicare/Medicaid and Inpatient/All Other. For example, if a report is required for claims paid in June, 1999, a company doing commercial business only will complete 2 forms for that month: Commercial Inpatient and Commercial All Other.

Indicate Company Name, Company NAIC ID#, Payment Month and Year, and check one of Commercial/Medicare/Medicaid and one of Inpatient/All Other.

Inpatient claims should be consistently defined by the company. For HMO's, Inpatient claims should use the same definition as Line 12 of Report #2 of the HMO Statement Blank.

Uncapitated payments are all claims payments other than those to providers, medical groups, or traditional IPA's where payment is on a per-member basis. Uncapitated payments include global capitation paid to intermediary organizations or secondary contractors.

Amounts should be entered in thousands of dollars.

Fill in the Total Claims Paid (number and amount) on contracts issued in New Jersey in the month covered by the report. Include all claims actually paid in that month, regardless of month of incurral.

For each dollar of claim paid in the Total, determine the month of service of that claim and the claim reporting month (date initial report received). Determine the lag from incurral to payment and from reporting to payment. Include that dollar in the total for the row with the given incurral lag and the column with the given report lag. The report lag must be less than or equal to the incurral lag (no claim can be reported before incurred).

PM refers to "Payment Month," this is the month for which the report is prepared. If the report is for Claims Paid in July, 1999, then PM is July, 1999. PM-x, where x is a number, refers to x months before the Payment Month. So, if the report is prepared for July 1999, PM-2 refers to May, 1999. This is the case whether May, 1999 is a "service month" or a "report month."

For example, suppose that the Report is being prepared for payments made in July of 1999. A claim of \$70.00 was incurred in Mar. of 99, and reported in June of 99. This \$70.00 would be on row PM-4, and column PM-1, because March is four months before July, and June is 1 month before July. (Note that the upper left hand corner is for claims that are reported and paid in the month of incurral.) Since every dollar paid in the payment month has precisely one incurral and one report month, the sum of all entries will be the Total Claims.