# CHAPTER 24B

# 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.2009 d.243, effective July 8, 2009.
See: 40 N.J.R. 6529(a), 41 N.J.R. 2965(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 24B, Organized Delivery Systems, expires on July 8, 2016. See: 43 N.J.R. 1203(a).

**Chapter Historical Note**

Chapter 38B, Organized Delivery Systems, was adopted as new rules by R.2004 d.70, effective February 17, 2004. See: 35 N.J.R. 545(b), 36 N.J.R. 962(a).

Pursuant to Reorganization Plan No. 005-2005, Chapter 38B of Title 8, Organized Delivery Systems, was recodified as Chapter 24B of Title 11, effective October 6, 2006. See: 37 N.J.R. 2737(a), 38 N.J.R. 4721(a).

Chapter 24B, Organized Delivery Systems, was readopted as R.2009 d.243, effective July 8, 2009. As part of R.2009 d.243, Appendix Exhibits 3 through 8 were repealed, effective August 3, 2009. See: Source and Effective Date. See, also, section annotations.

**CHAPTER TABLE OF CONTENTS**

SUBCHAPTER 1. GENERAL PROVISIONS

11:24B-1.1 Scope
11:24B-1.2 Definitions
11:24B-1.3 CODS: compliance time frames
11:24B-1.4 CODS: suspension or revocation of a certification
11:24B-1.5 LODS: recommendation to suspend or revoke a license
11:24B-1.6 CODS: penalties
11:24B-1.7 CODS: confidentiality of information regarding covered persons
11:24B-1.8 ODS: confidentiality of submitted information
11:24B-1.9 Carriers: contracts with organized delivery systems

SUBCHAPTER 2. CERTIFICATION AND REVIEW OF LICENSE APPLICATIONS

11:24B-2.1 CODS: who must file for certification
11:24B-2.2 CODS: general filing instructions for applications for certification
11:24B-2.3 CODS: Part A of the application for certification
11:24B-2.4 CODS: Part B of the application for certification
11:24B-2.5 (Reserved)
11:24B-2.6 CODS: modification of certification
11:24B-2.7 CODS: notice of changes to certification information
11:24B-2.8 Annual report and renewal
11:24B-2.9 ODS: fees
11:24B-2.10 Review of applications

SUBCHAPTER 3. FUNCTIONAL OBLIGATIONS OF AN ORGANIZED DELIVERY SYSTEM

11:24B-3.1 Carriers and CODS: mutual obligation to comply fully with certain standards
11:24B-3.2 Carriers: limitations on delegation
11:24B-3.3 CODS and LODS: Application of statutes and regulations
11:24B-3.4 ODS: performance of health care services
11:24B-3.5 ODS: network management
11:24B-3.6 ODS: credentialing
11:24B-3.7 ODS: utilization management guidelines development
11:24B-3.8 ODS: utilization management program
11:24B-3.9 Utilization management appeal mechanism
11:24B-3.10 ODS: continuous quality improvement
11:24B-3.11 ODS: provider complaint mechanism
11:24B-3.12 ODS: member complaint mechanism

SUBCHAPTER 4. MANAGEMENT AGREEMENTS WITH CARRIERS

11:24B-4.1 Scope
11:24B-4.2 General provisions
11:24B-4.3 Termination
11:24B-4.4 Network management
11:24B-4.5 Credentialing
11:24B-4.6 Utilization management guidelines development
11:24B-4.7 Utilization management program
11:24B-4.8 Utilization management appeal program
11:24B-4.9 Continuous quality improvement program
11:24B-4.10 Complaint mechanisms
11:24B-4.11 Issuance of contracts on approved forms
11:24B-4.12 Review and approval of management agreements

SUBCHAPTER 5. PROVIDER AGREEMENTS

11:24B-5.1 Scope
11:24B-5.2 General provisions
11:24B-5.3 Termination and continuity of care standards for contracts with health care professionals
11:24B-5.4 Termination and continuity of care standards for provider agreements with hospitals
11:24B-5.5 Additional standards applicable to contracts with primary care providers and specialists
11:24B-5.6 Additional standards applicable to contracts with hospitals
11:24B-5.7 Third-party rights
11:24B-5.8 Use of contract addenda to reflect requirements alternating by carrier
11:24B-5.9 Issuance of contracts on approved forms
11:24B-5.10 Review and approval of provider agreements

APPENDIX

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## SUBCHAPTER 1. GENERAL PROVISIONS

### 11:24B-1.1 Scope

(a) This chapter shall apply to all organized delivery systems required by the Act to become a certified organized delivery system, and to all organized delivery systems required by the Act to become licensed, except where the language of the chapter clearly indicates otherwise. A non-exhaustive list of examples of entities that are subject to this chapter is set forth in Exhibit 9 of the Appendix to this chapter, incorporated herein by reference.

(b) This chapter shall apply to all carriers offering health benefits plans, except where the language of the chapter clearly indicates otherwise.

**11:24B-1.2 Definitions**

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

"Act" means P.L. 1999, c.409; as codified, N.J.S.A. 17:48H-1 et seq., enacted January 18, 2000, and any subsequent amendments.

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

"Basic organizational documents" means the articles of incorporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents as appropriate to the form of business entity involved, and all amendments to such documents.

"Business subject to the Act" means activities performed by an ODS in accordance with a contract with a carrier related to the provision of health care services under one or more health benefits plans.

"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 services 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.

"Case management" means the identification and tracking of the medical condition and medical needs of a carrier's covered person in consultation with health care providers in order to assist in the provision of coordination of health care services and continuity of care.

"Certified organized delivery system" or "CODS" means an ODS that is compensated on a basis that entails no assumption of financial risk, or the assumption of a de minimus financial risk, as established by N.J.A.C. 11:22-4, so as not to require the ODS to become licensed under the Act, but rather, to become certified in accordance with the Act.

"Contract" means, in reference to a contract between an ODS and a carrier or an ODS and a health care provider or other subcontractor engaged in the provision of delivering or allocating health care services, the document representing the core agreement between the parties and all appendixes, amendments, addenda, codicils, manuals or other documents collateral thereto, whether or not specifically incorporated within the contract.

"Control" means, when referring to an ownership interest in or by an organized delivery system or an affiliate, ownership existing in any natural or other legal person through voting securities, contract or otherwise, such that the person has the authority to direct or cause the direction of the management and/or policies of the organized delivery system that is the subject of certification or licensing, or of an affiliate of such organized delivery system.

"Department" means the Department of Banking and Insurance.

"Financial risk" means financial risk as that term is defined by the Department in accordance with N.J.A.C. 11:22-4.

"Health benefits plan" means a contract or policy that pays or provides coverage for hospital or medical services, or payment for expenses therefor, and which is delivered or issued for delivery in this State by or through a carrier. The term "health benefits plan" includes Medicare supplement coverage, risk contracts with Medicare to the extent not otherwise prohibited by Federal law, and any other policy or contract not specifically excluded by statute or this definition. The term "health benefits plan" specifically excludes the following 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.

"Licensed organized delivery system" or "LODS" means an ODS that is compensated on a basis that entails the assumption of financial risk by the ODS, other than a *de minimus* financial risk, as established by N.J.A.C. 11:22-3, and that is therefore required to become licensed in accordance with the Act.

"Licensed or otherwise authorized" means licensed or certified by a jurisdiction having legal authority pursuant to statute to issue licenses or certification for the performance of medical, dental or other health care services. The term "licensed or otherwise authorized" shall not include: licensing or certification of an organized delivery system or a similar organization by another state; or, authorization by the Secretary of the State of New Jersey or similar entity in another state, to form a particular type of business structure, whether or not for the performance of, or delivery of, health care services.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangement with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.

"Management agreement" means the contract between a carrier and a CODS or LODS, except as noted at N.J.A.C. 11:24B-4.1.

Stage 1 and Stage 2 appeal, as set forth in N.J.A.C. 11:24-8 and 11:24A-3.5, including the availability of telephonic access.

1. Notwithstanding the address specified, the contract shall specify the obligation of the ODS, when corresponding with a covered person, to always identify that the ODS is acting on behalf of the carrier.

(d) The contract shall specify the information that the ODS shall maintain for the carrier, when such information shall be reported or transferred to the carrier, and the manner in which the ODS' utilization management appeal mechanism coordinates with the carrier's continuous quality improvement program.

1. The data collected by the ODS shall be at least that information that the carrier is required to report periodically to DOBI regarding appeals and the utilization management program.

Amended by R.2009 d.243, effective August 3, 2009.
See: 40 N.J.R. 6529(a), 41 N.J.R. 2965(a).
In (a), deleted "if performance only will be with respect to health benefits plans that are not managed care plans, or N.J.A.C." following "11:24A-3.5," and substituted "as applicable" for "if performance is with respect to one or more health benefits plans that are managed care plans".

### 11:24B-4.9 Continuous quality improvement program

(a) The contract shall contain provisions that assure the ODS' ability to demonstrate compliance with N.J.A.C. 11:24B-3.3(h) and (i), except that, if the ODS is agreeing to perform continuous quality improvement only with respect to health benefits plans that are not managed care plans, the contract may contain provisions that demonstrate compliance with N.J.A.C. 11:24A-3.8.

(b) The contract shall specify the composition of committees that will address continuous quality improvement activities.

(c) The contract shall specify how the ODS' continuous quality improvement program will coordinate with complaint, appeal and credentialing programs of the carrier.

(d) The contract shall specify when and how information will be transferred between the ODS and the carrier.

### 11:24B-4.10 Complaint mechanisms

(a) The contract shall contain provisions demonstrating the ODS' compliance with N.J.A.C. 11:24-3.7(b) or 11:24A-4.6(b) if addressing provider complaints, or N.J.A.C. 11:24-3.7(a) or 11:24A-4.6(a) if addressing complaints of covered persons.

(b) The contract shall specify the authority of the ODS to resolve complaints, and the carrier to be bound by the ODS' resolution of complaints when in favor of the covered person or provider.

(c) The contract shall specify the mechanism the ODS has in place to track and maintain records of complaints, including follow-up and the resolution of complaints, the duration for which records of complaints will be maintained, the data that the ODS will collect for the carrier, and the process for transferring information regarding complaints between the carrier and the ODS.

1. Complaint records shall be maintained for no less than four years.

2. The data to be collected shall be at least that information required for the carrier to submit reports to DOBI.

Amended by R.2009 d.243, effective August 3, 2009.
See: 40 N.J.R. 6529(a), 41 N.J.R. 2965(a).
In (a), substituted "11:24A-4.6(b)" for "8:38A-4.6(b)".

### 11:24B-4.11 Issuance of contracts on approved forms

(a) No ODS or carrier shall execute a contract or an amendment to a contract for a management agreement unless the form thereof has been approved by the Department.

(b) The following are amendments that may be effectuated without approval of the Department:

1. Amendments that are of a clerical nature;

2. Alterations to numbers, whether dollar amounts, enrollment amounts or the like, so long as there is no alteration of the methodologies from which the numbers were derived; and

3. The application of one variable provision in lieu of another variable provision, so long as both variable provisions were approved by the Department within the same form of management agreement.

### 11:24B-4.12 Review and approval of management agreements

(a) Management agreements submitted with the initial application for certification or an application for licensing shall be subject to the standards for submission, review and approval as set forth at N.J.A.C. 11:24B-2.

(b) Amendments to forms of management agreements shall be submitted to the Department for review and approval no less than 60 days prior to the date that the ODS intends to use any amendment.

(c) The Department shall approve or disapprove the management agreement form within 60 days of the date of receipt of the form, unless the Department extends its review period for an additional 30 days by notifying the ODS in writing of the extension.

1. In the event that the Department does not affirmatively approve or disapprove the form, or notify the ODS of the extension of the review period, prior to the end of the 60-day period, the form may be deemed approved.

2. Notwithstanding (c)1 above, neither an ODS nor a carrier shall effectuate any amendment to a management agreement deemed approved unless the ODS has submitted a statement in writing to the Department that it is deeming the amended form approved in accordance with (c)1 above, stating the date of deemed approval, and that the ODS is using it accordingly.

(d) If the Department disapproves an amendment to a management agreement, the Department shall notify the ODS in writing, specifying the reasons for the disapproval.

(e) Failure of an ODS to respond to the Department's questions regarding a management agreement within 20 business days of the date of the Department's written inquiry will result in the Department suspending any further action on the submission, and the time period for approval or deemed approval being tolled.

1. In the event that the Department determines that a submission file has become inactive, the Department shall notify the ODS in writing of the determination, which shall effectively result in disapproval of the submission.

2. A written statement from an ODS that it is deeming an amended form to be approved in accordance with (c)1 above shall have no effect following a determination that a submission file is inactive.

(f) An ODS may reactivate review of a file determined by the Department to be inactive at any time by submitting a statement in writing that it desires the submission to be reactivated, and in the same written notice, responding to the Department's written inquiry issued prior to the review of the submission being suspended.

1. Notwithstanding reactivation of the review, approval of the management agreement form shall not be deemed at any time subsequent to reactivation.

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SUBCHAPTER 5. PROVIDER AGREEMENTS

### 11:24B-5.1 Scope

This subchapter shall apply to all provider agreements for the delivery of one or more health care services to a covered person of a carrier.

### 11:24B-5.2 General provisions

(a) All provider agreement forms shall contain:

1. A provision specifying that the contract and amendments thereto are subject to prior approval of the Department, and may not be effectuated without such approval.

i. The provision may state that the following types of amendments do not require prior approval of the Department:

(1) Amendments that are of a clerical nature;

(2) Amendments that alter numbers, be they dollar amounts, enrollment amounts or the like, without altering methodologies from which the numbers were derived; and

(3) Amendments that involve the substitution of one set of variable text for another set of variable text, if both sets of variable text were previously approved by the Department for the provider agreement form;

2. A provision specifying that any sections of the contract that conflict with State or Federal law are effectively amended to conform with the requirements of the State or Federal law;

3. A provision specifying the number of days or months required by all parties to the contract to provide notice of amendments to the contract.

i. The prior notice period required for an ODS to provide notice to a provider shall not be less than 30 calendar days.

ii. The provision shall include an exception to the required notice standards to accommodate more immediate changes that may be required by State or Federal law;

iii. The provision may include an exception to the required notice standards for changes that are not material, but only if the term "material" is defined in the contract.

4. A provision specifying the compensation methodology.

i. The provision shall not provide financial incentives to the provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitated payment arrangements between an ODS and a provider.

ii. To the extent that some portion of the provider compensation is tied to the occurrence of a pre-determined event, or the non-occurrence of a pre-determined event, the event shall be clearly specified, and the ODS shall include in its contracts a right of each provider to receive a periodic accounting of the funds held, which shall be no less frequently than annually.

iii. The provision shall specify that a provider may appeal a decision denying the provider additional compensation to which the provider believes he or she is entitled under the terms of the provider agreement.

iv. Notwithstanding (a)4i above, capitation shall not be the sole method of reimbursement to providers that primarily provide supplies (for instance, prescription drugs or durable medical equipment) rather than services.

v. In no event shall the provision indicate that the compensation terms will be determined subsequent to the execution of the contract between the ODS and the provider.

5. A provision specifying that the provider's activities and records relevant to the provision of health care services may be monitored from time to time either by the ODS, the carrier, or another contractor acting on behalf of the carrier in order for the ODS or the carrier to perform quality assurance and continuous quality improvement functions;

6. A provision explaining the quality assurance program with which the provider must comply.

i. The provision shall specify whether the quality assurance program is that of the ODS and is being adopted by the carrier, is that of the carrier and is being adopted by the ODS, or is that of a separate entity and is being adopted by both the carrier and the ODS with which the provider is contracted.

ii. The provision shall specify the entity that is responsible for the day-to-day administration of the quality assurance program.

iii. The provision shall specify the entity with which the provider may lodge complaints regarding the quality assurance program, and otherwise provide information on how provider feedback regarding the operations of the ODS and carrier operations will be elicited;

7. A provision explaining the utilization management program with which the provider must comply.

i. The provision shall specify whether the utilization management program is that of the ODS and is being adopted by the carrier, is that of the carrier and is being adopted by the ODS, or is that of a separate entity and is being adopted by both the carrier and the ODS with which the provider is contracted.

ii. The provision shall explain what entity is responsible for the day-to-day operation of the utilization management program, how the provider is to comply with the UM standards, including the method for obtaining a UM decision and appealing UM decisions, and the right of the provider to have the name and telephone number of the physician, or dentist if appropriate to the services at issue, denying or limiting an admission, service, procedure or length of stay.

iii. The provision shall explain how providers may receive information regarding the UM protocols and any parameters that may be placed on the use of one or more protocols.

iv. The provision shall explain how participating providers may review and provide comment on the applicable protocols for the provider's practice area.

v. The provision shall explain that the provider has the right to rely upon the written or oral authorization of a service if made by the carrier or the entity identified as being responsible for the day-to-day operations of the utilization management program, and that the services will not be retroactively denied as not medically necessary except in cases where there was material misrepresentation of the facts to the carrier or the entity identified as being responsible for the day-to-day operations of the utilization management program, or fraud;

8. A provision explaining the rights and obligations of the provider when appealing a UM decision on behalf of a covered person, including the right to receive a written notice of the UM determination.

i. The provision shall be clear as to whether the provider must obtain consent of the covered person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J.A.C. 11:24-8 and 11:24A-3.5, or whether failure to obtain consent of the covered person results in review of the appeal using a separate complaint or provider grievance process.

ii. In the event that an appeal instituted by a provider on behalf of a covered person will be entertained as a member utilization management appeal without the covered person's consent, the provision shall explain that such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained.

iii. The provision shall not limit the right of the provider to submit an appeal on behalf of the covered person to situations in which the covered person may be financially liable for the costs of the health care services;

9. A provision specifying that the contract is governed by New Jersey law;

10. A provision specifying the term of the contract.

i. Every provider agreement shall specify the date the contract is executed, which shall not be prior to the date that the ODS is first certified to operate in New Jersey, except as N.J.A.C. 11:24B-1.3 applies.

ii. The anniversary date of the contract shall be the execution date of the contract, if no anniversary date is otherwise specified;

11. A provision specifying termination and renewal rights and obligations of the parties with respect to termination and renewal;

12. A provision prohibiting providers from billing or otherwise pursuing payment from a carrier's covered person for the costs of services or supplies rendered in-network that are covered, or for which benefits are payable, under the covered person's health benefits plan, except for

copayment, coinsurance or deductible amounts set forth in the health benefits plan, regardless of whether the provider agrees with the amount paid or to be paid, for the services or supplies rendered;

13. A provision establishing the obligation of the provider to be credentialed and otherwise eligible to participate in various programs (for example, Medicare or Medicaid), as appropriate.

i. The provision shall set forth the time periods for credentialing and recredentialing of providers, and the obligation of the provider to cooperate with the credentialing process;

14. A provision setting forth the provider's obligation to maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

i. The provision may require that the amount of malpractice insurance must be sufficient for anticipated risk, so long as the minimum amounts of $1,000,000/ $3,000,000 are specified;

15. A provision setting forth the health care services and supplies that the provider is to render to covered persons;

16. A provision specifying that providers shall have the right and obligation to communicate openly with all covered persons regarding diagnostic tests and treatment options;

17. A provision specifying that providers shall not be terminated or otherwise penalized because of complaints or appeals that the provider files on his or her own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan;

18. A provision stating that the provider shall not discriminate in his or her treatment of a carrier's covered persons.

i. The provision may permit providers to limit the total number of a carrier's covered persons that the provider treats, so long as the standards for the limitations do not result in unfair discrimination and are set forth clearly in the provider agreement.

ii. The provision may permit the provider to limit the carrier's products for which the provider will be considered a participating provider, so long as the standards for the limitations are set forth clearly in the provider agreement;

19. A provision setting forth the procedures for submitting and handling of claims, including any penalties that may result in the event that claims are not submitted timely, the standards for determining whether submission of a claim has been timely, and the process for providers to dispute the handling or payment of claims.

i. Provisions addressing claims handling shall be consistent with applicable law.

ii. The provision shall specify how interest for late payment of claims shall be remitted to the provider, but in no instance shall the provision obligate the provider to request payment of the interest before the interest will be paid;

20. A provision explaining how the provider may submit and seek resolution of complaints and grievances, separate and apart from submitting complaints and grievances on behalf of a covered person, and complaints addressing compensation and claims issues.

i. The provision shall specify the time frames for resolving complaints and grievances, which shall not exceed 30 days following receipt of the complaint or grievance.

ii. The provision shall explain the right of the provider to submit complaints and grievances to DOBI or DHS, depending upon the issue involved, if not satisfied with the resolution of the complaint or grievance through the internal provider complaint mechanism; and

21. A provision setting forth the confidentiality requirements that may apply to various records, including medical records, that the parties may maintain pursuant to their contractual relationship.

(b) Every provider agreement form may contain:

1. A provision specifying that the provider and the ODS are independent contractors as permitted by statute, regulation and/or common law.

i. The provision may specify that the carrier and ODS have no employment, partnership, joint venture, or other explicit business relationship, but shall not deny the existence of an agency relationship between the ODS and the provider;

2. A provision specifying that the provider and any carriers with which the ODS may contract are independent contractors as permitted by statute, regulation and/or common law.

i. The provision may specify that the provider and carrier(s) have no employment, partnership, joint venture or other explicit business relationship, but shall not deny the existence of an agency relationship between the provider and the carrier; and

3. Other provisions not specifically prohibited in accordance with this subchapter or other law.

(c) No provider agreement form shall contain:

1. A provision that establishes any limitation on the time period during which a provider may bring suit that is less than that set forth under the statute of limitation established by law;

2. A provision that establishes a unilateral right of the ODS, acting in its own accord, or at the request of a carrier, to amend the contract, or that otherwise requires a provider to abide by the amended terms of the contract during either a notice of termination period or a continuity of care period in the event that the provider elects to terminate the contract rather than accept the amendment.

i. The provision may allow for unilateral amendment if the amendment is required by State or Federal law;

3. A provision that states or can be interpreted to mean that the provider may not appeal a utilization management determination on behalf of a covered person with the covered person's specific consent, or otherwise limits the right of the provider to dispute a utilization management determination, except that reasonable procedural standards may be specified, including a time frame during which an appeal may be submitted;

4. A provision stating that the provider may not look to the carrier for payment for services or supplies rendered to a carrier's covered person in the event of default or bankruptcy of the ODS.

i. There may be a provision that specifies a process that the provider must follow in order to obtain payment from the carrier in the event of default or bankruptcy of the ODS, including subrogation or assignment of the provider's right to submit any claim against the assets of the ODS to the carrier following satisfaction of the claim by the carrier.

ii. There may be a provision that specifies that the carrier shall only be liable to the provider in accordance with the terms of the provider agreement between the provider and the ODS.

iii. This prohibition shall not apply to a provider agreement of a LODS if the Department is permitting the carrier to take a credit for ceding reserve liability to the LODS;

5. A provision that states or can be interpreted to mean that the provider can not dispute a reassignment or bundling of codes on a claim, or that the provider must accept any or all adjustments to a claim as payment in full when the adjustment is made as a result of the quality assurance, continuous quality improvement, utilization management, provider incentive, or similar such program;

6. A provision that states that payment to a provider with respect to a medically necessary health care service or supply will be denied if the service was not pre-certified or pre-authorized.

i. There may be a provision that allows payment to be reduced up to, but not exceeding, 50 percent of what would otherwise have been paid had pre-certification or pre-authorization been obtained for a medically necessary service, but only if the actual percentage reduction is set forth in the provider agreement;

7. A provision that states or may be interpreted to mean that a covered person lacks the ability to dispute whether a service is a covered service or whether the person was a covered person of a carrier at the time that the service was rendered;

8. A provision that requires the provider to assure that it never charges the ODS or carrier a rate that is greater than the least amount charged to another entity with which the provider contracts for similar services, or any other "most-favored-nation" type of clause;

9. A provision that requires a provider to be responsible for the actions of a non-participating provider; or

10. A provision that imposes obligations or responsibilities upon a provider that requires the provider to violate statutes or rules governing his or her license, or otherwise violate laws governing the confidentiality of patient information, in order to comply with the terms of the contract.

i. In addition, the contract shall not contain a provision that is inconsistent with laws setting forth procedures for determining whether and how specific types of confidential information may be released, including N.J.S.A. 45:14B-31 et seq.

(d) Details of contract provisions more appropriately set forth in provider manuals may be set forth accordingly, so long as the contract includes statements that the information is set forth in the provider manuals, the provider manuals are readily available to health care providers, and the provider manuals are submitted to the Department for review.

Amended by R.2009 d.243, effective August 3, 2009.
See: 40 N.J.R. 6529(a), 41 N.J.R. 2965(a).
In (a)19i, substituted "applicable law" for "P.L. 1999, c. 154 (Health Information Technology Act) as well as P.L. 1999, c. 155, and rules promulgated pursuant thereto, including N.J.A.C. 11:22-1".

### 11:24B-5.3 Termination and continuity of care standards for contracts with health care professionals

(a) Provider agreements shall specify the term of the contract, reasons for which the contract may be terminated by one or more parties to the contract, procedures for notice and effectuation of such termination, and opportunities, if any, to cure any deficiencies prior to termination.

1. If the reason(s) for which a provider may be terminated from the ODS' network is different from the reason(s) for which a provider may be removed from participation in a carrier's panel, the contract shall so specify this.

2. If the contract permits a provider to elect not to participate in a carrier's panel without also terminating the

provider agreement with the ODS, the contract shall contain a provision setting forth the standards and procedures for this.

(b) The provider agreement may specify that the contract may be terminated without cause, so long as non-cause termination is permitted by either party subject to reasonable prior notice and the terms of the provision otherwise comply with the remainder of this section.

(c) The contract shall stipulate that, when the provider's status as a participating provider in a carrier's network is being terminated, written notice shall be issued to the provider no less than 90 days prior to the date of termination, except that the 90-day prior notice requirement need not apply when the contract is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of breach, alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

1. The contract shall specify that the health care professional shall receive a written statement setting forth the reason(s) for the termination, and the procedures for obtaining such a written statement, in the event that the written notice of termination does not include a statement setting forth the reason(s) for the termination.

(d) The contract shall stipulate that the health care professional shall have the right to request a hearing following a notice that the health care professional's status as a participating provider with a carrier is being terminated, except that the contract may specify that the right to a hearing does not apply when the termination occurs on the date of renewal of the contract, or upon the contract's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

(e) The contract shall specify the procedures for requesting a hearing from a carrier when a health care professional is terminated from participation in the carrier's network, which shall be consistent with the requirements of N.J.A.C. 11:24-3.6 or 11:24A-4.9, as appropriate.

(f) The contract shall specify that when a provider's status as a participating provider is terminated, or when the contract between the ODS and the provider terminates, regardless of the party initiating the termination, the provider, if a physician, shall remain obligated to provide services for covered persons in accordance with the following:

1. For up to four months following the effective date of the termination in cases where it is medically necessary for the covered person to continue treatment with the health care professional, except as (f)2 through 5 below applies;

2. In cases of the pregnancy of a covered person, through the postpartum evaluation of the covered person, up to six weeks after delivery;

3. In the case of post-operative care, up to six months following the effective date of the termination;

4. In the case of oncological treatment, up to one year following the effective date of the termination; and

5. In the case of psychiatric treatment, up to one year following the effective date of the termination.

(g) Notwithstanding (f) above, the contract may specify an exception to the requirement for the provider to continue to provide care, and for the ODS or carrier to pay for services rendered by the provider following the effective date of termination when the termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

### 11:24B-5.4 Termination and continuity of care standards for provider agreements with hospitals

(a) Provider agreements shall specify the term of the contract, reasons for which the contract may be terminated by one or more parties to the contract, procedures for notice and effectuation of such termination, and opportunities, if any, to cure any deficiencies prior to termination.

1. If the reason(s) for which a provider may be terminated from the ODS' network is different from the reason(s) for which a provider may be removed from participation in a carrier's panel, the contract shall so specify this.

2. If the contract permits a provider to elect not to participate in a carrier's panel without also terminating the provider agreement with the ODS, the contract shall contain a provision setting forth the standards and procedures for this.

(b) The provider agreement may specify that the contract may be terminated without cause, so long as non-cause termination is permitted by either party subject to reasonable prior notice.

(c) The contract shall specify that if a hospital's status as a participating provider is terminated, regardless of who initiates the termination, or the reason for the termination, the hospital shall continue to abide by the terms of the contract for a period of at least four months from the effective date of the termination with respect to at least those covered persons enrolled with a carrier that is an HMO. The obligation shall apply to any health benefits plan underwritten by the HMO, regardless of the characterization of the health benefits plan (for example, regardless of whether the health benefits plan is

for Medicare, Medicaid, a point-of-service plan, or a closed panel plan).

### 11:24B-5.5 Additional standards applicable to contracts with primary care providers and specialists

(a) The contract shall specify the mutual responsibility of the provider and carriers to assure 24-hour, seven-day per week emergency and urgent care coverage to covered persons, and the procedures to assure proper utilization of such coverage.

(b) The contract shall specify the obligation, if any, of the provider to acquire and maintain hospital admitting privileges.

### 11:24B-5.6 Additional standards applicable to contracts with hospitals

(a) The contract shall specify the obligation of the facility to follow clear procedures for granting of admitting and attending privileges, and to notify the ODS and/or carrier when such procedures change.

1. If notification must be made separately to one or more carriers, this shall be stated in the contract.

(b) The contract shall specify the admission authorization procedures for covered persons.

(c) The contract shall specify the procedures for notifying carriers when a covered person presents at emergency rooms.

(d) The contract shall specify procedures for billing and payment, schedules and negotiated arrangements.

### 11:24B-5.7 Third-party rights

(a) There shall be a provision specifying that the carrier is a third party beneficiary of the provider agreement, with privity of contract, and a right to enforce the provisions of the provider agreement in the event that the ODS fails to do so, except that such a provision is not required for provider agreements between a carrier and an ODS (whose shareholders are composed solely of health care providers, if the ODS is certified or seeking certification solely for the provision of the performance of health care services by its shareholders).

(b) There shall be a provision in a provider agreement between a carrier and an ODS (whose shareholders are composed solely of health care providers, if the ODS is certified or seeking certification solely for the provision of the performance of health care services by its shareholders) specifying that the providers of the ODS that participate in the network of the carrier by virtue of the contract between the carrier and the ODS are third party beneficiaries of the provider agreement, with privity of contract, and a right to enforce the provisions of the provider agreement in the event that the ODS fails to do so.

(c) There shall be a provision in a provider agreement between a carrier and an ODS (whose shareholders are composed solely of health care providers, if the ODS is certified or seeking certification solely for the provision of the performance of health care services by its shareholders) that specifies that there is privity of contract between the carrier and each of the ODS' providers that participate in the carrier's network by virtue of the contract between the carrier and the ODS, and that the carrier shall have the right to enforce the terms of the contract against such providers in the event that the ODS fails to do so.

### 11:24B-5.8 Use of contract addenda to reflect requirements alternating by carrier

Whenever obligations or rights under a provider agreement vary by carrier, the ODS may use addenda to an approved core contract as outlined in N.J.A.C. 11:24B-2, to set forth the variances in the obligations or rights, so long as the provisions of the contract where variances are permissible specify that addenda set forth the separate obligations or rights in separate addenda for each carrier in whose network the provider participates, and the variances have been approved by the Department as set forth in N.J.A.C. 11:24B-5.10.

### 11:24B-5.9 Issuance of contracts on approved forms

(a) No ODS shall issue and execute a contract or an amendment to a contract for a provider agreement unless the form thereof has been approved by the Department in accordance with N.J.A.C. 11:24B-5.10.

(b) The following are amendments that may be effectuated without approval of the Department:

1. Amendments that are of a clerical nature;

2. Alterations to numbers, whether dollar amounts, enrollment amounts or the like, so long as there is no alteration of the methodologies from which the numbers were derived; and

3. The application of one variable provision in lieu of another variable provision, so long as both variable provisions were approved by the Department within the same form of management agreement.

### 11:24B-5.10 Review and approval of provider agreements

(a) Provider agreements submitted with the initial application for certification or an application for licensing shall be subject to the standards for submission, review and approval as set forth at N.J.A.C. 11:24B-2.

(b) New forms of provider agreements and amendments to previous forms of provider agreements shall be submitted to the Department for review and approval no less than 60 days prior to the date that the ODS intends to use the new or amended form(s).

(c) The Department shall approve or disapprove the provider agreement form within 60 days of the date of receipt of the form, unless the Department extends its review period for an additional 30 days by notifying the ODS in writing of the extension.

1. In the event that the ODS does not receive notice of approval, disapproval or extension of the review period from the Department by the end of the 60-day period, the ODS may submit a written notice to the Department stating that the ODS intends to use the form on a basis that it has been deemed approved, and the form shall be deemed approved as of the date of receipt of the notice by the Department, except that no notice shall be effective if received by the Department prior to the end of the 60-day period.

(d) In order to expedite the review process, every ODS may submit with each of its forms of provider agreements or amendments thereto, a certification signed by an officer of the ODS attesting that the form is or continues to be in compliance with the requirements of this subchapter.

1. A certification shall be accompanied by a checklist or outline specifying where in the form the required information is set forth, or specifying how the amendment is to be inserted into a form without causing the form to become non-compliant.

2. The Department may rely upon the certification in determining to approve a form of provider agreement, or amendments to forms of provider agreements, but in so doing does not waive its right or authority to review the forms or amendments to forms as the Department considers necessary or appropriate for monitoring purposes, because of defect in a certification, or for other reasons.

(e) If the Department disapproves a new form of provider agreement or an amendment to a provider agreement, the Department shall notify the ODS in writing, specifying the reasons for the disapproval.

(f) Failure of an ODS to respond to the Department questions regarding a provider agreement within 20 business days of the date of the Department's written inquiry will result in the Department suspending any further action on the submission, and the time period for approval or deemed approval being tolled.

1. In the event that the Department determines that a submission file has become inactive, the Department shall notify the ODS in writing of the determination, which shall effectively result in disapproval of the submission.

2. A written statement from an ODS that it is deeming an amended form to be approved in accordance with (c)1 above shall have no effect following a determination that a submission file is inactive.

(g) An ODS may reactivate review of a file determined by the Department to be inactive at any time by submitting a statement in writing that it desires the submission to be reactivated, and in the same written notice, responding to the Department's written inquiry issued prior to the review of the submission being suspended.

1. Notwithstanding reactivation of the review, approval of the provider agreement form shall not be deemed at any time subsequent to reactivation.