

health care professional licensed pursuant to Title 45 of the Revised Statutes; a hospital and other health care facility licensed pursuant to Title 26 of the Revised Statutes; and/or a purveyor of prescription, pharmaceutical products or durable medical goods or equipment.

“Health care transaction” or “transaction,” for purposes of this subchapter only, means the exchange of information between two or more parties to carry out the financial and administrative activities related to coverage under a health benefits or dental plan, including, but not limited to, health claims and equivalent encounter information, health care payment and admittance advice, health claims status, enrollment and disenrollment in a health plan, eligibility for a health plan, health or dental plan premium payments, first report of injury, deferral certification and authorization and health care attachments.

“Health insurance coverage” means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care, under any hospital or medical expense policy or certificate or health maintenance organization contract offered by a health benefit payer. The following shall constitute excepted benefits:

1. Coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverages, as specified by Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
2. Benefits provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the group health plan benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified by Federal regulation;
3. Benefits offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; and
4. Benefits offered as a separate insurance policy, certificate or contract of insurance, Medicare supplement insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1) and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.), and similar supplemental coverage provided in addition to coverage under a group health plan.

“Small Employer Health Benefits Plan” means, for purposes of this subchapter only, any plan identified as such

by N.J.S.A. 17B:27A-17 or a “small health plan” pursuant to 45 CFR § 160.103.

“Standard” means a prescribed set of rules, conditions, transaction sets or requirements concerning classification of components, specification of materials, performance or operations, or delineation of procedures, in describing products, systems, services or practices.

“System” or “system for the electronic receipt and transmission of health care claim information” means that electronic network established in accordance with 42 U.S.C. §§ 1320d et seq. for the transaction of health care related information including:

1. Health claims or equivalent encounter information, including institutional, professional, pharmacy and dental health claims;
2. Enrollment and disenrollment in a health plan;
3. Eligibility for a health plan;
4. Health care payment and remittance advice;
5. Health care premium payments;
6. First report of injury;
7. Health claim status; and
8. Referral certification and authorization.

Amended by R.2004 d.460, effective December 20, 2004.

See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

In “Health benefit payer”, amended the N.J.A.C. reference; added “Health insurance coverage”.

Amended by R.2006 d.200, effective June 5, 2006.

See: 37 N.J.R. 4169(a), 38 N.J.R. 2501(a).

Inserted definition “Clearinghouse”.

11:22-3.3 Standard enrollment/change request forms and application/change request forms

(a) 45 C.F.R. 162.1101, Subpart K, the Health Care Claims or Equivalent Encounter Information Standard, and 45 CFR 162.1501, Subpart O, the Enrollment and Disenrollment in a Health Plan Standard, are adopted by the Department, in consultation with the Department of Health and Senior Services, as the electronic standard format for enrollment, disenrollment and claim forms, and are incorporated and made a part herein by reference.

(b) The UB-04, CMS 1450 (the uniform claim form for use by health care institutions and facilities) and the CMS-1500 (the uniform claim form for use by health care providers) are recognized and adopted by the Department, in consultation with the New Jersey Department of Health and Senior Services, as the paper standard format for claims by medical institutions, facilities and providers. Information concerning these forms is located at the website maintained by the Centers for Medicare and Medicaid Services (CMS), www.cms.gov and incorporated herein by reference.

(c) The paper standard formats for a universal enrollment/change request form and application/change request form for health insurance coverage can be accessed via the Department's website at <http://highpoint.state.nj.us/dobi/formlist.htm#insuranceformsandapps>.

1. The enrollment/change request form requests or contains the following information:

- i. The type of activity (for example, new enrollee/subscriber, a change in covered person(s), removal or termination of a covered person(s) or request for continuation of coverage);
- ii. Employee information;
- iii. Plan option;
- iv. Individuals covered;
- v. Pre-existing conditions statement;
- vi. Other/previous insurance;
- vii. Dependent information;
- viii. Race/ethnicity (optional);
- ix. Employee signature;
- x. Employer verification;
- xi. Instructions for completion of the form;
- xii. A conditions of enrollment statement; and
- xiii. A misrepresentation statement.

2. The application/change request form requests or contains the following information:

- i. The type of activity (for example, new enrollee/subscriber, a change in covered person(s) or removal or termination of a covered person(s));
- ii. Applicant information;
- iii. Plan option;
- iv. Individuals covered;
- v. Pre-existing conditions statement;
- vi. Previous insurance;
- vii. Dependent information;
- viii. Availability of other coverage;
- ix. Race/ethnicity (optional);
- x. Payment information;
- xi. Applicant signature;
- xii. Broker/general agent information;
- xiii. Eligibility requirements;
- xiv. Instructions for completion of the form;

xv. A conditions of enrollment statement; and

xvi. A misrepresentation statement.

(d) Subchapter Appendix Exhibit 3, incorporated herein by reference, is designated as the standard paper claim format to be used for all dental benefit claims.

(e) Payers may add a company name and logo to these standard paper forms.

Amended by R.2004 d.460, effective December 20, 2004.

See: 36 N.J.R. 1282(a), 36 N.J.R. 5913(a).

Rewrote (c).

Amended by R.2011 d.256, effective October 17, 2011.

See: 43 N.J.R. 1236(a), 43 N.J.R. 2668(b).

Rewrote (b) and the introductory paragraph of (c), and added (c)1 and (c)2.

11:22-3.4 Health care providers; claims

(a) On or after October 1, 2002, all payers shall require that all providers file all claims for payment unless the patient, at his or her option, files the claim directly.

(b) Where a claim is being filed by the health care provider on behalf of the patient without an assignment of benefits, the provider shall file the claim within 60 days of the last date of service of that course of treatment.

(c) Where the provider is filing a claim under an assignment of benefits from the patient, the provider shall file the claim within 180 days of the last date of service of the course of treatment.

(d) In the event a health care provider does not file the claim within 180 days of the last date of service of a course of treatment referred to in (c) above, the third party payer and/or health benefit payer shall in accordance with N.J.A.C. 11:22-1.6 reserve the right to deny or dispute the claim and the health care provider shall be prohibited from seeking payment in whole or in part directly from the patient.

(e) When a health benefit payer takes action in accordance with (d) above, the health benefit payer shall advise the health care provider that payment of the claim, in whole or in part, will be made based upon consideration of the following factors that shall be addressed by the provider:

1. The good faith use of information provided by the patient to the health care provider with respect to the identity of the patient's health benefits payer;

2. Delays encountered in filing a claim related to the coordination of benefits among third party payers;

3. Whether the health care provider has previously filed untimely claims or has an established pattern of untimely claim practices;

4. Any prejudice to the rights of the patient and/or the health benefits provider in determination of the medical necessity of the services and care being billed for; and