(c) Payment for a contested claim, or contested portion of a claim that is subsequently perfected shall be overdue if the HMO makes payment on the claim later than 90 calendar days following the date that the HMO receives all of the information required to perfect the claim.

(d) Payment of a claim previously denied incorrectly shall be overdue if payment by the HMO is made more than 10 calendar days following the date that the previously denied claim is determined a clean claim, or a portion of the claim is determined a clean claim, unless specified otherwise by an order of the Commissioner or a court of competent jurisdiction regarding any challenge of the denial of the claim.

8:38–16.5 Use of intermediaries

An HMO's use of subcontractors, secondary contractors or primary contractors to perform one or more of the HMO's claims handling functions shall not in any way mitigate an HMO's responsibility to comply with all of the terms of this subchapter.

8:38–16.6 Contracts currently in effect

(a) A contractual arrangement in effect as of October 1, 1998 which is inconsistent with this subchapter (unless more favorable to participating providers) shall be read and interpreted to be in compliance with N.J.S.A. 26:2J–5.1 and this subchapter as of October 1, 1998, but shall be amended as expeditiously as possible by the HMO as is necessary for the contractual arrangement to become physically compliant.

(b) HMOs shall administer, or assure the administration of, all contractual arrangements for its network in order to be in compliance as of October 1, 1998, and any claims not settled as of October 1, 1998 shall be treated in accordance with this subchapter.

8:38–16.7 Penalties

HMOs that fail to comply with the terms of this subchapter shall be subject to penalty and fine of no less than $250.00 nor no more than $10,000 per day of violation, as set forth at N.J.S.A. 26:2J–24, and penalties and fines in accordance with N.J.S.A. 17B:30–1 et seq., in addition to any other remedies available under law.

APPENDIX

Exhibit 1

Notice of Contested Claim

The information below is with respect to a single patient (see Part B) identified on a claim filed by your office with us on ___/___/___. Those services marked with an asterisk (*) under the column "HMO Payment" are contested. The reasons for which the claim, or a portion of the claim, is contested and the information we need to make a final determination on the claim are set forth in Part D. Please contact the individual(s) identified in Part E if you have additional questions regarding this notice. If there are portions of a claim which we are not contesting, the "HMO Payment" column indicates the amount we are paying or will pay you for the services rendered, and the "Patient Copay" column indicates whether a copayment should have been collected by you from the patient. The information contained in Parts A, B and C are derived from the claim filed by your office.

Part A: Service information

	Procedure codes	Date of service	Provider	Billed amount	HMO Payment	Patient Copay
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Part B: Patient Information

Name: _____

Age: _____ Gender: M / F

SSN: _____

Address: _____

_____

Phone (Home): _____

Subscriber Name and SSN: _____

_____

Part C: Provider Information

Name: _____

HMO ID: _____

Address: _____

_____

Phone: _____ FAX: _____

Patient Acct # (if any): _____

Part D: Reasons for contesting the claim, or portion of a claim, and additional information needed

Specific services, if listed, are listed by number in the order stated in Part A:

_____

_____

_____

_____

_____

_____

_____

_____

Additional pages are attached.

Part E: HMO and Contact Person Information

HMO Name: _____
Address: _____
_____
_____

Contact: _____
Title (as applicable): _____
Address: _____
_____
_____

Phone: _____ FAX: _____
E-mail: _____

New Rule, R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).