INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans

Readoption with Amendment: N.J.A.C. 11:22

Proposed: October 3, 2005 at 37 N.J.R. 3779(a).

Adopted: April 25, 2006 by Steven M. Goldman, Commissioner, Department of Banking and Insurance.

Filed: April 26,2006 as R. 2006 d. 199, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B-30-13.1, and 17B:30-23 et seq.

Effective Date: April 26, 2006, Readoption;
June 5, 2006, Amendments.

Expiration Date: April 26, 2011.

Summary of Public Comments and Agency Response:

The Department received comments from the New Jersey Hospital Association, Englewood Hospital and Medical Center, Saint Barnabas Health Care System, St. Francis Medical Center and the Valley Hospital.

COMMENT: One commenter expressed concern with N.J.A.C. 11:22-1.3(a)2. The commenter stated that the prior elimination of the provision that required a hard copy claim to be considered received based on the U.S. postmark date has been problematic, because now there is no definable method for tracking these claims for purposes of ensuring compliance with payment deadlines. The commenter believed that, since the postmark date is the standard that is used to document when a payment has been made, it should also be the standard by which claim receipt is measured. The commenter stated that by not specifying a standard, payers are allowed to

acknowledge receipt in any manner they choose. The commenter stated that it has sent hard copy claims many times, and the claim is not acknowledged as "received" until the claim is entered into the payer's claim system and can be "seen" by a claims representative. The commenter contends that, in some instances, this has taken upwards of 45 days from the date the claim was mailed, especially in cases where a PPO repricing arrangement is involved. The commenter stated that the Department's rules need to address the inconsistency between claim receipt and payment receipt timeframes by using the postmark date for both.

RESPONSE: The Department recognizes that there are problems with using the postmark date as the date for determining when written claims are received by carriers. The postmark date does not accurately reflect the actual date a written claim is received by the carrier. Rather, it indicates the day it was processed by the Post Office. The postmark date could actually be several days prior to the date a claim is actually received (in the possession of) the carrier. Until the claim is in the carrier's possession, it cannot begin to process the claim. The Department believes that the current provision provides the best solution for confirming when a carrier is actually in receipt of a written claim.

COMMENT: One commenter objected to the readoption of N.J.A.C. 11:22-1.6(a). The commenter stated that this provision requires payers to notify covered persons of a denied or disputed claim only in instances where the covered person has additional financial liability. The commenter noted that payers have incorporated patient hold harmless provisions into their provider contracts. These provisions have been broadly interpreted by many payers and have been used as an "excuse" not to inform patients when hospital stays are denied or when acute hospital days are approved at an alternate level of care. The commenter stated that Department

of Health and Senior Services (DHSS) has disagreed with payers on this issue and has instructed them to keep patients apprised when a denial of care is issued regardless of a patient's financial liability. The commenter believes that it is inconsistent for the Department's rules to stipulate that patients only need to be informed when a claim is denied or disputed if they have increased financial liability. Patients pay premiums and have a right to know when a benefit dollar is not being paid regardless of whether personal out of pocket costs are increased or not. The commenter stated that the Department's rules should require payers to notify patients of payment disputes or denials regardless of financial liability because it is consistent with DHSS position of requiring payers to inform patients about utilization management denials.

RESPONSE: P.L. 2005, c. 352, which was signed into law January 12, 2006, and is effective July 11, 2006, amends provisions of N.J.S.A. 17B:30-26, regarding the prompt payment of claims and the processing of payments and notifications of claims for the reimbursement of health care services. This Act also requires changes to N.J.A.C. 11:22-1. In the interim, N.J.A.C. 11:22-1.6(a) will be readopted in its current form. A determination not to adopt this rule would result in the chapter containing no provision requiring notification to covered persons of a denied or disputed claim regardless of whether he or she had increased financial liability. The Department will be proposing amendments in the near future to N.J.A.C. 11:22-1 in order to make the provisions consistent with P.L. 2005, c. 352. The Department will consider the commenter's suggestions when it formulates proposed amendments to N.J.A.C. 11:22-1. Moreover, making the amendments suggested by the commenter upon the readoption of Chapter 22 could cause the industry to unnecessarily make system adjustments/changes now, and then again, once the amendments to be proposed to implement P.L. 2005, c. 352 were adopted.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:22-1.6(a), which allows payers to take up to 30 days to deny a claim simply because it could not be entered into the system. The commenters believe that this is something that payers are able to identify within hours or, at most, days after receiving the claim. The commenters stated that this provision undermines the integrity and intent behind establishing prompt pay requirements. The commenter believes that this provision in effect relaxes the 30-day deadline by allowing payers to take 30 days to deny a claim for reasons that are apparent early on in the process, then allows payers another 30 days to deny the claim based on deficiencies (such as missing documentation) realized during the review after the claim is entered, and then allows another 30 days for the final adjudication of the claim after the deficiency is addressed. The commenters contend that what was once a 30-day deadline has now become a three-month process, thereby rendering the Department's rules ineffective and defeating the true objective behind their adoption. The commenter does not believe that there should be a distinction made between a claim that cannot be entered into a payer's system and a claim that is denied for some other reason. The commenter recommends that language be added to establish a deadline of not more than five working days by which payers must alert providers that a claim cannot be entered into its system.

RESPONSE: P.L. 2005, c. 352 requires that, so long as a claim meets the standards set forth in the Act, it should be paid within 30 days, if the claim was submitted electronically, or 40 days if it was submitted by other than electronic means. If a claim is not paid within 30 or 40 days, as applicable, the payer shall communicate to the health care provider the reasons the claim will not be paid. As a result of the Act, the Department will be proposing amendments in the near future to its rules, in order to make them consistent with P.L. 2005, c. 352. In the interim, N.J.A.C. 11:22-1.6(a) will be readopted in its current form. The Department will be proposing

amendments in the near future to N.J.A.C. 11:22-1, in order to make its provisions consistent with P.L. 2005, c. 352. Therefore, the Department will consider the commenters suggested amendments as it evaluates amendments to N.J.A.C. 11:22-1. As a result the Department is avoiding making amendments on adoption that may cause the industry to make unnecessary system adjustments/changes now and then again once the Department proposes its amendments.

COMMENT: One commenter stated the Department's rules should require payers who accept claims electronically to accept all claims electronically. The commenter further stated that there are still payers who will not accept high dollar claims ($100,000 in charges) electronically. The commenter noted that some payers have electronic claim restrictions whereby their systems will not accept a claim with more than a certain number of line items (especially problematic for patients who receive recurring services like radiation therapy, PT/OT/ST, etc). The commenter stated that the Department's rules should require payers with electronic claims capabilities to accept all claims electronically regardless of dollar amount or the number of line items on the claim.

RESPONSE: The Department notes that P.L. 2005, c. 352, signed into law on January 12, 2006 and effective July 11, 2006, will require changes to the Department's rules. Therefore, the Department will, in the near future, be proposing changes to N.J.A.C. 11:22-1 consistent with P.L. 2005, c. 352 and will consider the issue raised in this comment as it evaluates P.L. 2005, c. 325 and the changes needed in order to make N.J.A.C. 11:22-1 consistent with the new statutory requirements.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:22-1.6(c). The commenters stated they have experienced significant administrative burdens in attempting to obtain and reconcile interest payments from payers. Some carriers still do not pay interest on late payments. The commenters contend that when interest is paid, it arrives as a separate payment with little information included on the remittance to allow it to be reconciled with the correct patient account. The commenter stated that the dollar amounts associated with the interest payments are inconsequential to the payers and more expensive, from an administrative perspective, for hospitals to collect than they are worth. The commenters recommended that the Department either require payers to make interest payments at the time the late payment is made or simply assign a late payment fine of $100.00 per claim.

RESPONSE: P.L. 2005, c. 352 provides that a claim shall be considered overdue if the submitting health care provider is not paid or notified of nonpayment within the time frames established in the Act. The Act provides that overdue claims shall accrue interest at 12 percent per annum. The Department will consider the issue raised by the commenter as it evaluates amendments to N.J.A.C. 11:22-1, in order to make these rules consistent with the new statutory requirements.

COMMENT: Several commenters stated that they have found that providers are not utilizing the appeal process due to several reasons: because payers have not supplied instructions to providers about how to initiate an appeal; the process is administratively burdensome; and providers do not believe that the process is independent since the alternate dispute resolution firm that would conduct the review at the second stage of an appeal is contracted by the payer. The commenters contend that the Department is aware that payers have been slow to provide instructions to

hospitals that request them, and that the instructions are often confusing or do not accurately reflect the regulatory requirements. The commenters noted that the Department levied monetary fines in 2003 on a payer for failing to comply with the appeal requirements. The commenters recommended that the Department post carriers' prompt pay appeal instructions on its website and significantly revise the existing appeal process found at N.J.A.C. 11:22-1.8. The commenters suggested that changes to the appeal process should include contracting with a nationally recognized independent organization that specializes in arbitration to conduct second level reviews, rather than allowing the payer to select the arbitration firm. The commenters noted that the Department already has such a process in place for disputes related to Personal Injury Protection insurance for automobile accidents.

RESPONSE: P.L. 2005, c. 352 establishes a two part-appeal process to resolve disputes concerning compliance with the provisions regarding utilization, management and the processing and payment of claims. The process also involves an internal appeal mechanism and, if applicable, binding arbitration conducted by an independent arbitrator contracted by the Commissioner. The Department will be proposing amendments in the near future to N.J.A.C. 11:22-1, in order to make its provisions consistent with P.L. 2005, c. 352 and will consider the commenters suggested amendments as it evaluates amendments to N.J.A.C. 11:22-1. In the interim, N.J.A.C. 11:22-1.8 will be readopted in its current form.

COMMENT: Several commenters stated that the Department's rules define carriers to include insurance companies, health maintenance organizations, and health service corporations. However, the commenters noted that the rules do not state that they apply to organized delivery systems (ODSs). The commenters stated that through the adoption of rules by the Department

and the DHSS related to the licensing and certifying of ODSs, the State recognized a new entity that functions the same as a carrier in determining the benefits provided to enrollees, assuming risk for the payment of claims and negotiating contracts with providers. The commenters stated that, as such, the Department has included ODSs in many of its rules that apply to carriers. The commenters recommended that the Department's rules be amended to apply to organized delivery systems to ensure that all entities that provide healthcare coverage for consumers are held to the same standards.

RESPONSE: N.J.S.A. 17:48H-33.1 subjects organized delivery systems to the rules governing the prompt payment of claims. In addition, N.J.A.C. 11:22-1.1(b) explicitly provides that this chapter applies to any organized delivery system. However, since organized delivery systems do not provide coverage, the commenters' suggestion is inappropriate with respect to other rules that apply to carriers that do provide coverage.

Federal Standards Statement

A Federal standards analysis is not required because the rules readopted with amendments, are not subject to any Federal requirements or standards.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:22.

Full text of the adopted amendment follows: