INSURANCE

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DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
Health Benefit Plans
Adopted Amendments: N.J.A.C. 11:22-1.1, 1.2, 1.5, 1.6, 1.8, 1.9, and 1.10
Adopted Repeal and New Rule: N.J.A.C. 11:22-1.4
Adopted New Rules: N.J.A.C. 11:22-1.8, 1.9, and 1.11 through 1.15
Adopted Repeals: N.J.A.C. 11:22-1 Appendix A, A-1, B, and B-1

Proposed: August 21, 2017, at 49 N.J.R. 2729(a).
Adopted: December 20, 2017, by Richard J. Badolato, Commissioner, Department of Banking and Insurance.
Filed: December 20, 2017, as R. 2018 d.063, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).
Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17B:30-30, 31, and 33; and P.L. 1999, c. 154, and P.L. 2005, c. 352.
Effective Date: February 5, 2018.
Expiration Date: September 21, 2018.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) timely received written comments from the following:

1. Arthur Meisel on behalf of Mark Vitale, D.M.D.;
2. New Jersey Hospital Association;
3. Capital Health;
4. Medical Society of New Jersey joined by the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Society of Interventional Pain Physicians, the New Jersey Society of Pathologists, and the New Jersey State Society of Anesthesiologists;
5. New Jersey Association of Health Plans;
6. Delta Dental of New Jersey, Inc.; and
7. Home Care and Hospice Association of New Jersey.

COMMENT: One commenter requests that the Department of Banking and Insurance (Department) revise N.J.A.C. 11:22-1.2 to include the Veteran's Administration as a program listed under "health benefit plans."

RESPONSE: The Veterans Health Administration (VHA), part of the Department of Veterans' Affairs, is a system of facilities and health care providers that render care to veterans. It is not regulated by the Department because the VHA is not an insurance carrier and it does not provide or issue fully-insured health benefits plans. As such, this chapter does not, and should not be made to, apply to the services provided by the VHA.

COMMENT: Several commenters seek clarification whether the proposed rules apply to both in-network and out-of-network providers. Their concern stems from the definitions of "clean claim" and "payment dispute" as provided under N.J.A.C. 11:22-1.2. The commenters note that the definition of a "clean claim" adds the requirement that the provider is an "eligible" provider on the date of service rendered, and that the definition of a "payment dispute" is a dispute that arises under the applicable health benefits plan and provider participation agreement, if applicable. The commenters seek clarification regarding these definitions. In addition, the commenters note that there is nothing in the enabling legislation to suggest that these rules do not apply to out-of-network benefits covered by a plan.

RESPONSE: The rules apply to all providers, both in-network and out-of-network. The term "eligible provider" refers to the license status and participation status of the provider. For example, an out-of-network provider who renders a covered service to a person under a health benefits plan that does not provide out-of-network benefits without obtaining an in-plan exception would be not be an eligible provider. Moreover, the reference to "provider participation agreement" in the definition of "payment dispute" is followed by "if applicable." This reference to "if applicable" means that the participation agreement is considered only in the case of network providers. It does not mean that payment disputes are only disputes with network providers.

COMMENT: One commenter expressed concern with N.J.A.C. 11:22-1.4(a)6 and requests that the term "CPT modifiers" be replaced with the term "procedure modifiers" as home health and hospice agencies use HCPCS modifiers.

RESPONSE: Upon review, the Department agrees that this terminology is clearer, and will be made as a technical change on adoption.

COMMENT: One commenter expressed concerns with N.J.A.C. 11:22-1.4(a)9, regarding the term "carriers." The term "carrier" is a defined term under N.J.A.C. 11:22-1.2 to include both dental service corporations and dental plan organizations. The term "health carrier" is also a defined term, but does not include dental service corporations or dental plan organizations. The commenter notes that the claim submission requirements provided in N.J.A.C. 11:22-1.4 are intended to apply only to health carriers and their agents; thus, the commenter suggests that to avoid confusion, N.J.A.C. 11:22-1.4(a)9 should be revised to use the term "health carrier" instead of "carrier."

RESPONSE: Upon review, the Department has determined that this change is not required since the language in N.J.A.C. 11:22-1.4(a) makes clear that the requirements in paragraphs (a)1 through 9 apply to health carriers. However, for the purposes of clarification, the Department will make this technical change from "carrier's" to "health carrier's" in N.J.A.C. 11:22-1.4(a)9 upon adoption.

COMMENT: Several commenters expressed concerns about the notice requirement imposed under N.J.A.C. 11:22-1.4(b). The commenters suggested that the Department require carriers to provide an affirmative outreach to providers when their claims submission process is amended, as it should not be incumbent on practitioners and their office staff to keep abreast of any changes of such processes. The commenters further state that the current practice of posting changes on the carrier's website is not sufficient and suggests carriers that have providers' e-mail addresses provide notice via e-mail.

RESPONSE: Upon review, the Department has determined that no such change is required. The Health Claims Authorization, Processing and Payment Act (HCAPPA), P.L. 2005, c. 352, only requires carriers to post claim submission information on an Internet website. It does not mandate affirmative outreach to providers or their office staff. See N.J.S.A. 17B:30-51.

COMMENT: Several commenters expressed their support of various proposed rules. One commenter expressed support of N.J.A.C. 11:22-1.5, which requires the payment of claims by the date it is placed in the mail with the most recent address filed with the carrier by the provider. Two commenters expressed their support of N.J.A.C. 11:22-1.6(a), which addresses the pending of claims; N.J.A.C. 11:22-1.6(a)5, which requires notification when a claim cannot be entered into the system; N.J.A.C. 11:22-1.8(b)1, which address refund requests from carriers; and N.J.A.C. 11:22-1.8(b)4, which addresses the manner of executing recoupments. One commenter expressed their support of N.J.A.C. 11:22-1.14, regarding the reporting requirements for the prompt payment of claims. Specifically, the commenter supports the streamlining of the fourth quarter report with the annual report, the direction to file quarterly prompt payment submissions via SERFF, and the exemption from the auditing regulation for carriers with less than $5 million in annual premium. The commenter appreciates the Department's effort to reduce unnecessary "red tape" and the elimination of filing requirements that do not add to the Department's ability to regulate the market.

RESPONSE: The Department appreciates the support of this rulemaking.

COMMENT: One commenter seeks clarification of N.J.A.C. 11:22-1.5, which sets forth the interest amount to be paid for failure to pay a clean claim under a dental plan at a 10 percent interest rate. The commenter requests that this provision be revised to provide that all dental products, even those that are issued by health insurance carriers, be uniformly subject to a 10 percent interest rate.

RESPONSE: Upon review, the Department has determined that no such change is required. HCAPPA increased the interest rate on late claims from 10 percent to 12 percent for medical service corporations, hospital service corporations, health service corporations, insurance companies, and health maintenance organizations. HCAPPA did not amend the statutes governing dental service corporations and dental plan organizations and the interest rate paid by those entities on late claims remains at 10 percent.

COMMENT: Several commenters stated that, while they support the Department's rulemaking to prohibit using coordination of benefits to pend claims or delay payment absent something in the record suggesting other coverage, the commenters request that the Department consider a time requirement for indicia of current or recent coverage. The commenters believe that current or recent indicia of other coverage should be required. The commenters note that evidence of other coverage that is a few years old is likely out-of-date.

RESPONSE: Upon review, the Department has determined that no change is required. HCAPPA prohibits health carriers from denying claims while seeking coordination of benefits information, unless the payer's records indicate that other coverage exists. There is no limitation in the statute on the timeliness of said information.

COMMENT: One commenter supported the Department's intent to add the regulations as proposed in N.J.A.C. 11:22-1.5. However, the commenter expressed concern that N.J.A.C. 11:22-1.5(c), which mandates explanation of benefits (EOB) language requirements, provides a loophole for payers to avoid providing as much detail as the rule requires. The commenter states that payers are prohibited by statute and N.J.A.C. 11:22 from pending claims. Therefore, the commenter suggests that N.J.A.C. 11:22-1.5(c) should not reference the "pending" of a claim and suggests the Department use the term "disputed" to stay consistent with the other requirements of N.J.A.C. 11:22.

Furthermore, the commenter is concerned that there is no language addressing when a carrier must provide additional detailed information once the disputed claim is resolved. Absent a formal process, the commenter is concerned that carriers may avoid providing the information by disputing more claims. Therefore, the commenter recommends the Department include language that addresses the timeframe within which the carrier must provide the additional requirements under N.J.A.C. 11:22-1.5 to the consumer.

Lastly, the commenter expresses confusion as to the purpose of the changes to N.J.A.C. 11:22-1.5(c). The commenter speculates that the purpose of the regulation may be to ensure that the carrier can meet the timeframes established in N.J.A.C. 11:22-1.5(a), and if so, the commenter believes the change may be unnecessary.

RESPONSE: The language in N.J.A.C. 11:22-1.5(c) comes directly from HCAPPA, including the prohibition on pending claims while seeking information on other coverage, unless the carrier's records indicate that the covered person has coverage under other health benefits or prescription drug plans. The second two parts of the comment appear to relate to a different proposal appearing at 49 N.J.R. 2877(a) and are properly addressed in the notice of adoption pertaining to that rulemaking at 50 N.J.R. 571(a).

COMMENT: One commenter expressed concern with the requirement that a dental plan organization or a dental service corporation pay interest owed at the time an overdue claim is paid, under N.J.A.C. 11:22-1.5(e). The commenter requests that the Department remove this requirement, as interest owed on dental plan organization or dental service corporation claims involves de minimis amounts, and the expense associated with changing systems and processes to pay interest at the same time as claim payment is prohibitive, unnecessary, and would result in significant operation hardship. The commenter notes that there have not been any complaints or issues with the current practice, which involves the use of out-of-State third-party administrators to process claims and issue interest payments within 14 days of the claim payment. Alternatively, the commenter requests that the Department amend the proposed regulation to allow dental plan organizations and dental corporations to continue paying interest separately from the claim, particularly when the interest payment is de minimis (under $25.00).

RESPONSE: Upon review, the Department has determined that no change is required. The payment of interest at the time the late paid claim is reimbursed allows providers to easily verify that the interest calculation is correct and to efficiently reconcile their records and outweighs the attenuated expenses cited by the commenter.

COMMENT: One commenter expressed concern with N.J.A.C. 11:22-1.6, which references an interest rate of 10 percent. The commenter states that this is contrary to HCAPPA, which has increased the interest rate to 12 percent. The commenter suggests that this percentage be updated by the Department.

RESPONSE: Upon review, the Department has determined that no change is required. Initially, the Department notes that the reference to 10 percent interest has been removed from N.J.A.C. 11:22-1.6. The 10 and 12 percent interest rates appear in N.J.A.C. 11:22-1.5(e). HCAPPA increased late payment interest from 10 percent to 12 percent for medical service corporations, hospital service corporations, health service corporations, insurance companies, and health maintenance organizations. HCAPPA did not amend the statutes governing dental service corporations and dental plan organizations and the interest rate paid by those entities on late claims remains at 10 percent.

COMMENT: Several commenters state that while they support the language used in N.J.A.C. 11:22-1.6, which provides that "pending" a claim does not toll the payment due date, the commenters recommend that the Department require more specificity from carriers regarding when a claim is denied or more information is requested, such as references to specific policies and coding conventions.

RESPONSE: The Department disagrees that the additional language is needed. HCAPPA provides that where a claim does not contain all required information, the carrier shall notify the provider of any information required to complete adjudication of the claim. If the information being provided by carriers is not specific enough to permit the providers to respond appropriately, providers can file a complaint with the Department.

COMMENT: Two commenters requested that the Department eliminate the prohibition of carriers from pending claims that is proposed in N.J.A.C. 11:22-1.6(a). The commenters provide several reasons why a carrier may pend a claim for appropriate reasons, including: investigating potential fraud or abuse, because diagnostic materials submitted by the provider are not legible and new copies must be submitted, and the determination of whether there is alternative coverage. In the alternative, both commenters request that the Department clarify its intent regarding the pending of claims. Lastly, the commenters contend that the timeframes imposed for payment of a clean claim may not allow a carrier to undertake an appropriate investigation into the matter and may result in unnecessary denials, which would not serve the carrier or the provider. One commenter also contends that the resulting unnecessary denials may leave the patient, who is least likely to be able to cure the issue or defect, responsible for payment.

RESPONSE: Upon review, the Department has determined that no change is required. HCAPPA imposed the 30- and 40-day claim processing period because of carrier delays in payment. Allowing carriers to circumvent these deadlines by pending claims would permit carriers to evade the clear statutory requirements to pay or deny certain claims promptly. The situations cited by the commenters are not applicable as the obligation to pay a claim in 30 or 40 days applies only where the claim is submitted with all the information required on the claim form or in previously distributed instructions and where the carrier does not have reason to believe that the claim was submitted fraudulently. A claim that contains illegible diagnostic materials would not be a claim submitted with all required information. Further, the Department notes that, if there is strong evidence of fraud, and the carrier has initiated an investigation into the suspected fraud or referred the claim to the Office of the Insurance Fraud Prosecutor (OIFP), then such a claim is not subject to the 30- and 40-day processing requirement pursuant to HCAPPA's express language. See, for example, N.J.S.A. 17B:27-44.2.d(2)(d)(iv). However, the commenter's reference to needing to pend claims so it may determine whether there is alternate coverage appears troubling in that it represents a circumvention of the prohibition in HCAPPA against denying claims based on the existence of other coverage where the company's records do not indicate that there is other coverage, and would contravene the rules as proposed. If there is nothing in the company's records indicating there is other coverage, the

carrier must pay the claim and cannot pend the claim while it seeks information as to whether there may be other coverage.

COMMENT: Two commenters expressed concerns with N.J.A.C. 11:22-1.6(a)5, which provides a process for addressing claims that may not be adjudicated because of a coding problem or due to missing information. The proposed regulation requires a carrier to request any additional information to complete adjudication "within seven days of receipt of the claim." Both commenters believe that this requirement is not administratively feasible, as during peak time periods, carriers may not be able to conduct a detailed review within a seven-day period that would allow them to notice missing or illegible information. In addition, one commenter noted that the actual language of the statute requires the payer to notify the provider within seven days of the determination that a claim cannot be adjudicated because of a diagnosis coding, procedure coding, or due to missing information. This commenter requests that the Department revise N.J.A.C. 11:22-1.6(a)5 to comport with the language of the statute and require notice "within seven days of the determination." The other commenter points out that the seven-day requirement appears to curtail, if not conflict with, the 30- and 40-day prompt payment requirement. This commenter thus requests the requirement be deleted.

RESPONSE: Upon review, the Department agrees that the phrase "of receipt of the claim" was included in error and the phrase should read "within seven days of its determination that the claim is missing required information and request any information required to complete adjudication of the claim." This change will avoid conflict with the applicable statute as described by the commenter and mirror the statutory language. See, for example, N.J.S.A. 17B:27-44.2.d(3).

COMMENT: Two commenters expressed concerns about the language used in N.J.A.C. 11:22-1.6(a)6. One commenter proposed that the regulation be amended to read as follows (suggested deletions indicated in brackets [thus]):

> If the health carrier or its agent finds there is strong evidence of fraud by the provider and has initiated an investigation into the suspected fraud, the notice shall state that the health carrier or its agent finds that there is strong evidence of fraud [and, if applicable, that it has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department pursuant to N.J.S.A. 17:33A-9].

The commenter believes that the bracketed language should be removed as it is not consistent with applicable reporting standards under the New Jersey Insurance Fraud Prevention Act (the Fraud Act), N.J.S.A. 17:33A-1 et seq. The commenter contends that the Fraud Act provides that any application or claim involving a reasonable suspicion that a person has violated N.J.S.A. 17:33A-4, along with sufficient independent evidence corroborating that reasonable suspicion, shall be referred to the OIFP.

Similarly, another commenter requested that the Department eliminate the requirement in N.J.A.C. 11:22-1.6(a)6, that the carrier notify the covered person and the provider of the basis for the carrier's decision to deny or dispute a claim if the carrier finds strong evidence of fraud by the provider and has initiated an investigation into the suspected fraud. The commenter notes that such notice could hamper the carrier's investigation or jeopardize the carrier-provider and doctor-patient relationships. In addition, these investigations may take more than the 30- and 40-day timeframe allowed to generate evidence to warrant a referral to the OIFP or the Bureau of Fraud Deterrence (BFD). Lastly, this commenter believes that providing notice before the OIFP or BFD had an opportunity to review the referral could interfere with the State's investigation.

RESPONSE: The reference to an investigation and referral are required by HCAPPA. See, for example, N.J.S.A. 17B:27-44.2.d(2)(d)(iv), which provides that if a claim is not paid timely because there is strong evidence of fraud by the provider and the payer has initiated an investigation into the suspected fraud, the payer shall notify the provider and the covered person

> [T]hat the payer finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant [N.J.S.A.] 17:33A-15, or referred the claim, together with supporting documentation, to the OIFP in the Department of Law and Public Safety established pursuant to [N.J.S.A.] 17:33A-16.)

Furthermore, the Fraud Act requires that suspected fraud be reported to both the OIFP and the BFD: "Any person who believes that a violation of [the Fraud Act] has been or is being made shall notify the [BFD] and the [OIFP] immediately after discovery of the alleged violation..." N.J.S.A. 17:33A-9.a(1).

COMMENT: One commenter expressed concerns about the language used in N.J.A.C. 11:22-1.6(c) and 1.8(a)4, which requires carriers to refer claims to the BFD in the Department when appropriate. The commenter believes that the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq., details reporting requirements associated with potential insurance fraud identified by its carriers and the proposed language is not consistent with the Act.

RESPONSE: There is no inconsistency, since N.J.S.A. 17:33A-9.a(1) requires that "any person" report violations of the Insurance Fraud Prevention Act to both the BFD and the OIFP.

COMMENT: Two commenters requested that the Department change N.J.A.C. 11:22-1.6(f)1 and 1.8(a) upon adoption, which proposes to eliminate the ability of carriers, including dental carriers, to predicate reimbursement requests on non-binding extrapolation. However, these commenters believe that these regulations limit the use of extrapolation in judicial and quasi-judicial proceedings. The commenters believe that limiting extrapolation to judicial and quasi-judicial proceedings will increase carrier and provider costs and promote litigation, as providers will be required to review and produce every claim that involves a disputed issue. The commenters believe that the time necessary for the provider to produce such records and the carrier to conduct such a review would be costly and could serve to expand the issues in dispute by the parties. The commenters further state that if the parties agree to use extrapolation to reduce the time and costs associated with a claim by claim discussion, this should be encouraged, rather than prohibited. In addition, the commenters indicate that the Department codified the use of extrapolation as a tool to allow parties to achieve resolutions in complex issues in 2002, where the Department stated in response to a comment, "that if extrapolation is non-binding, then the results will only be utilized upon the agreement of both parties, therefore there is no need to regulate the process because if the process is unfair, the aggrieved party will not agree to be bound by its results." 35 N.J.R. 2557. Additionally, one commenter pointed out that the Department, in this proposal, has not provided a rationale for its new position on extrapolation. In addition, the commenters noted that the regulation at issue only applies to claims submitted to or paid on an insured basis and not those submitted to and paid on a self-funded basis, which is unworkable in its application, as it would be difficult to segregate the claims. In conclusion, the commenter requests that the Department maintain the existing language to allow carriers to use extrapolation where it is non-binding. Alternatively, the commenters requested the Department allow carriers and providers to use extrapolation for purposes of settlement without requiring them to file a complaint in a judicial proceeding or request for arbitration.

RESPONSE: Upon review, the Department has determined that no change is required as the limitations on extrapolation set forth at N.J.A.C. 11:22-1.8 are taken directly from HCAPPA. See, for example, N.J.S.A. 17B:27-44.2.d(10)(a) through (d). HCAPPA was enacted three years after, and, therefore, supersedes, the 2002 rule adoption referenced by the commenters. If carriers have been basing reimbursement requests on extrapolation in circumstances other than the four listed in HCAPPA, the Department believes that such conduct is in violation of HCAPPA.

COMMENT: Several commenters expressed concerns about the extrapolation process as described in N.J.A.C. 11:22-1.8. Under N.J.A.C. 11:22-1.8, carriers may extrapolate overpayments to providers based on the carrier's finding of "clear evidence of fraud." The commenters noted that these issues ordinarily arise over coding and billing disputes and the carrier's interpretation of the rules is not always

correct. To prevent carriers who have found "clear evidence of fraud" from extrapolating and negotiating large settlements without adjudicating the underlying issue, the commenters recommend the Department enact the following procedures. First, the carrier should provide notice to a provider regarding its belief that their coding and billing practices are inappropriate. This should be followed by outreach and training based on documentation from nationally recognized organizations such as the National Correct Coding Initiative, Centers for Medicare & Medicaid Services, and the American Medical Association's Current Procedural Terminology literature. The provider should not be surprised by the carrier's allegation of fraud because a variety of notification requirements would be in place, including utilization of the Claims Adjustment Reasons Codes. Thus, providers would be given clear notice of inappropriate coding and billing conduct and the opportunity to challenge or cure their practices. Lastly, the commenters noted that while a carrier may be able to use extrapolation as a tool, providers have no parallel right and rely entirely on the Department for enforcement.

RESPONSE: Upon review of the commenters' concerns, the Department has determined not to change this provision as suggested. HCAPPA requires that carriers provide notice to providers when claims are denied on the basis of fraud. See, for example, N.J.S.A. 17B:27-44.2.d(2)(d)(iv). If a provider believes that a carrier is improperly denying claims on the basis of fraud, the provider can submit a complaint to the Department or appeal the claim denial or reimbursement request to the State-sponsored binding arbitration program established by HCAPPA. See, for example, N.J.S.A. 17B:27-44.2.e(2).

COMMENT: One commenter requests that N.J.A.C. 11:22-1.8, which addresses recovery of claims overpayments, be revised upon adoption to exclude dental service corporations and dental plan organizations. The commenter states that the purpose of these proposed regulations is to implement HCAPPA, which does not apply to limited benefit plans that do not provide hospital or medical expense benefits. The commenter states that stand-alone dental plans fall into this category. In addition, the commenter points out that while no statutory authorization is provided by HCAPPA to recover overpayments made by dental plans, overpayments can still be recovered in accordance with the law of restitution. The commenter, thus, requests that the proposed regulation be amended prior to adoption to exclude dental service corporations and dental plan organizations from the overpayment recovery provisions established by N.J.A.C. 11:22-1.8.

RESPONSE: Upon review, the Department has determined that no change is required. First, the recovery of overpayment provisions, as proposed in N.J.A.C. 11:22-1.8, applies only to health carriers, which, as defined by HCAPPA, do not include dental service corporations or dental plan organizations. Second, HCAPPA's provisions are based on the type of carrier, not the type of insurance plan. Therefore, the recovery of overpayment provisions do apply to a stand-alone plan written by one of the entities listed in the definition of "health carrier." See *New Jersey Dental Association v. Horizon Blue Cross Blue Shield of New Jersey*, No. A-1834-12T3, 2014 *N.J. Super. Unpub. LEXIS* 1291 (App. Div. June 5, 2014), *certif. denied*, 291 *N.J.* 630 (2014).

COMMENT: One commenter expressed concerns about the notice requirement mandated for carriers, as described in N.J.A.C. 11:22-1.8(b)5ii. The commenter states the existing statutory notice requirement provides that if a provider fails to dispute an overpayment adjustment within the 45-day appeal deadline, the carrier may proceed with collecting the amount due by assessing it against future claims, an option that is not exercised by carriers until the provider has exhausted its rights or missed the deadline to appeal the adjustment request. The commenter notes that under N.J.A.C. 11:22-1.8(b)5ii, the proposed regulations insert an additional notice requirement and review period distinct from the existing statutory notice and appeal process. Specifically, the proposal requires carriers to give providers extra notice that lists the claims to be offset, and allows providers another 30 days to respond to the offset notice before a carrier can take action following the provider's failure to respond to the initial notice. The commenter objects to this process and notes that this additional requirement is not included in the statute and appears to be contrary to the intent of the notice, review, and appeal process already provided for under HCAPPA.

RESPONSE: Upon review of the commenters' concerns, the Department has determined not to change this provision. The notice requirement in N.J.A.C. 11:22-1.8(b)5 is based on provisions in HCAPPA that state that offsets are permitted following expiration of the 45-day internal appeal period or exhaustion of the internal appeal and payment arbitration process only "if the payer submits an explanation in sufficient detail so that the provider can reconcile each person's bill." See, for example, N.J.S.A. 17B:27-44.2.d(11)(a). N.J.A.C. 11:22-1.8(b)5 implements that requirement by providing a process for the carrier's explanation. Under the rule as adopted, the offset notice can be supplied prior to the expiration of the 45-day period in which to appeal a reimbursement request. The 30 days under the explanation notice and the 45-day period for appeal can run concurrently.

COMMENT: One commenter expressed concerns with the language used in N.J.A.C. 11:22-1.8(b)7iii. The commenter requests that the phrase "where a claim(s) is subject to coordination of benefits" be deleted because some carriers improperly cite "coordination of benefits" as the reason for claim denials. The commenter also indicates that negotiations between the provider and payor may continue for months after the first claim determination is made and it would be unfair to subject those claims, still in flux, to the 18-month filing rule.

RESPONSE: HCAPPA excepts from the 18-month limitation claims that were subject to coordination of benefits. See, for example, N.J.S.A. 17B:27-44.2.d(10) ("With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement of a claim previously paid ... later than 18 months after the date the first payment on the claim was made.").

COMMENT: One commenter expressed concerns with N.J.A.C. 11:22-1.9(a), which uses the term "continual claims submission." The commenter indicated that this term is unfamiliar to home care and hospice providers and a description or additional explanatory material is needed to clarify the meaning of this term and its applicability to this regulation.

RESPONSE: The phrase "continual claims submissions" refers to situations where multiple claims are submitted during a course of treatment, such as where a person has physical therapy three times a week for 10 weeks and the provider submits claims monthly. The Department does not believe there is any need to define this term since its meaning is plain.

COMMENT: Several commenters made suggestions concerning the internal appeals process set forth in N.J.A.C. 11:22-1.10. The commenters suggest that the Department require that a carrier's internal appeal procedures be posted on the carrier's external website, in addition to participation agreements, to provide access to this information to out-of-network physicians. The commenters state that this would afford the possibility of resolving claims disputes before external review. In addition, these commenters request that the Department require that the medical review, addressed in N.J.A.C. 11:22-1.10(a)4, be conducted by a same specialty physician when requested by the provider. The commenters believe this would speed necessary treatment to patients, cut down the administrative burden on practices, and lead to the satisfactory adjudication of claims.

RESPONSE: The Department agrees that access to a carrier's internal payment appeal process should be available to both in-network and out-of-network providers. The Department has made this technical change upon adoption. The Department does not believe that this will impose any additional burden on carriers as the change merely requires carriers to post existing information, already available to in-network providers, on a publicly available portion of their website, so that out-of-network providers can be made aware of the appeals process to which they are subject. Moreover, the Department believes that any de minimis burdens that may arise from this change are far outweighed by the benefits to out-of-network providers and could eliminate confusion regarding the process, thereby benefitting both carriers and providers. As it pertains to comments regarding N.J.A.C. 11:22-1.10(a)4, there is no need for an internal appeal of a payment dispute to be decided by a same specialty

physician because such disputes do not involve medical necessity determinations. Moreover, HCAPPA does not impose such a requirement on the internal payment appeal process.

COMMENT: One commenter questioned why the word "participating" appears in the final sentence of N.J.A.C. 11:22-1.10(a), when it has been deleted elsewhere.

RESPONSE: The only reference to "participating" in N.J.A.C. 11:22-1.10(a) is in the statement that the internal payment appeal mechanism should be described in the participating provider contract because non-participating providers would not have such contracts. However, the internal payment appeal process is not limited to participating or network providers.

COMMENT: One commenter expressed concern with the reporting requirement as set forth in N.J.A.C. 11:22-1.11(a)2i. The commenter requests that the Department eliminate the requirement that every internal review involving a claim payment dispute include the name, title, and qualifying credential of the person participating in the review. The commenter notes that this information is not required for a full and fair determination of the dispute and may subject the reviewer to undue pressure, influence, or harassment. The commenter requests the Department clarify the need for this information or consider a more tailored reporting obligation.

RESPONSE: Information such as the name, title, and qualifying credential of the person participating in the review is helpful to the provider in determining whether to seek payment arbitration or to accept the decision following the internal payment appeal.

COMMENT: Several commenters requested clarification of in-plan exceptions in N.J.A.C. 11:22-1.13(a)6. Specifically, the commenters request the regulation reflect a distinction between in-plan necessity appeals and in-plan exception claims payment appeals (situations where an agreement was reached with the carrier, but for which the carrier did not pay). The commenters also indicate that providers should be permitted to take these payment appeals to arbitration.

RESPONSE: In-plan necessity appeals and in-plan exceptions are the same; they are requests to obtain services from an out-of-network provider because the carrier's network does not contain a qualified, accessible, and available provider to perform a medically necessary covered service. In such cases, the covered person has the right to use an out-of-network provider with his or her liability limited to network cost sharing. The issues raised by in-plan exceptions involve determinations of medical necessity and appropriateness and, thus, are resolved through the utilization management appeal process and the Independent Health Care Appeals Program (IHCAP); accordingly, they are excepted out of the arbitration process established in N.J.A.C. 11:22-1.13 for payment disputes. However, disputes as to payment where an in-plan exception to obtain out-of-network treatment has been approved by the carrier would proceed to the carrier's internal provider payment dispute appeal process referenced in this rule.

COMMENT: Several commenters expressed concerns with N.J.A.C. 11:22-1.13(e), which gives the Department more oversight of the arbitration process. The commenters noted that paragraph (e)2 sets a threshold amount for arbitration of $1,000, but noted that there is no provision for the aggregation of like claims, as is the current practice. Citing Bulletin No. 07-14, the commenters requested that the Department revise the regulation to allow for the aggregation of claims.

RESPONSE: Upon review, the Department has determined that no change is required. Aggregation to satisfy the $1,000 threshold for payment arbitration is permitted by HCAPPA. See, for example, N.J.S.A. 17B:27-44.2.e(2). However, for clarification, the Department will revise N.J.A.C. 11:22-1.13(e)2, to include "including any aggregation of claims."

COMMENT: Several commenters expressed concerns with N.J.A.C. 11:22-1.13(e)5, which they contend requires prior consent from patients to arbitrate claims payments issues. The commenters noted that this is a new requirement and is inconsistent with the past implementation of HCAPPA. The commenters believed that this may result in these claims not being eligible for arbitration due to lack of patient consent. For this reason, the commenter requested that the Department not require patient consent for payment disputes, unless protected health information is provided.

RESPONSE: N.J.A.C. 11:22-1.13(e)5 requires consent only if the arbitration request includes confidential medical information. This has been the Department's practice since 2006, and is not a new requirement. See Bulletin No. 06-16.

COMMENT: One commenter expressed concerns with N.J.A.C. 11:22-1.14(a), which does not include Organized Delivery Systems (ODS). The commenter recommended that the Department retain ODSs in this section.

RESPONSE: The Department agrees that the inadvertent deletion of "organized delivery systems" in N.J.A.C. 11:22-1.14 and 1.15 was a technical error. The Department will restore the deleted references upon adoption as a non-substantial change since the reporting requirements imposed by N.J.A.C. 11:22-1.14 and 1.15 are already imposed on ODSs by the Healthcare Information Networks and Technologies legislation (HINT), P.L. 1999, c. 155, and do not change what is mandated by the rule or enlarge the scope of the proposed rule and its burden on those affected by it.

COMMENT: One commenter expressed concerns that the proposed regulations do not address the implementation of Sections 5 and 6 of HCAPPA, pertaining to utilization management. Section 5(a) requires carriers to provide a denial or authorization in writing. Under Section 5(c), if the payer does not respond to an authorization request within an appropriate timeframe, the request is deemed approved. The commenter believes these sections should be reflected in the proposed regulations as these regulations would be especially beneficial to consumers that are receiving emergent care.

RESPONSE: The Department believes that these statutory sections are self-implementing and do not require clarification or other regulations to make them operative.

COMMENT: Two commenters request that the regulations specifically provide whether an authorization or denial of a service must be considered for both medical necessity and whether the service is covered under the plan. The commenters point out that the definition "authorization" under Section 3 and Section 5 of the statute are very similar and must be clarified for proper implementation.

RESPONSE: Upon review of the commenters' concerns, the Department has determined not to change this provision as requested. The definition of "authorization" at N.J.S.A. 17B:30-50 refers only to a determination that the service or supply is medically necessary. Issuance of an authorization does not mean that a subsequent claim for the preauthorized service will be paid if, for instance, the covered person was no longer covered by the carrier's health benefits plan on the date of service. Issuance of an authorization means only that the carrier cannot deny a claim for the authorized service on the grounds that it was not medically necessary.

COMMENT: Several commenters point out that while they support the concept that HCAPPA's claims dispute and arbitration is permissive, there is nothing in the enabling legislation that suggests arbitration should be mandatory. As arbitration is mandated by these proposed regulations, the commenters suggest that the regulation be amended as to allow providers to make deliberate decisions about whether to use the arbitration process or whether they would prefer to initiate litigation, which would allow for the possibility of oral testimony.

RESPONSE: The Department has determined no change is necessary because HCAPPA and the implementing rule at N.J.A.C. 11:22-1.13 only establish an arbitration process for payment disputes that is available at the option of providers. Neither the statute nor the rule mandates payment arbitration and neither deprives providers of any rights they may have to sue carriers for improper claim processing.

COMMENT: One commenter seeks clarification that the claims covered by HCAPPA are limited solely to those for a service or supply covered under a health benefits plan and do not apply to dental plans. The commenter points out that the definitions of "health benefits plan," "covered service," and "covered person" do not mention dental plans. Furthermore, citing the legislative intent behind HCAPPA, amendments made to HINT legislation, and the material differences between dentistry and hospital and medical coverage, the commenter requests that any references to "dental plans" or "dental benefit plans" be deleted from the proposed regulations because they assert that HCAPPA is only

applicable to claims submitted for payment under health benefit plans and not dental plans.

RESPONSE: As noted in the response to a previous comment, HCAPPA's provisions apply based on type of carrier, not plan type. Therefore, the Department has determined that it is not appropriate to make the requested changes.

COMMENT: One commenter expressed concerns over the use of the word "offset" in the proposed regulation, as it is not defined and as it is typically used as a variant of and synonymously with "setoff." The commenter requests that the Department confirm that the words are interchangeable and have the same meaning under New Jersey law.

RESPONSE: Upon review, the Department has determined that no clarification is necessary as "offset" and "setoff" are synonymous. The Department does not believe there is any need to define these terms since their meaning is plain and well-understood.

COMMENT: One commenter seeks clarification of whether these proposed regulations include a process or timeframe for a provider to report overpayments.

RESPONSE: This comment is outside the scope of this rulemaking, as provider reporting of overpayments is not addressed by these rules.

COMMENT: One commenter noted that in the context of dental plans, the benefit payment on a claim from which an offset will be made is owed to the covered person and not to the dentist. Until payment on behalf of the covered person is received, the patient remains liable to the dentist for payment. If a non-network provider does not receive a benefit payment on behalf of the covered person because it has been "offset," in whole or in part, by the carrier, there remains a balance due for which the non-network provider may balance bill the patient on whose behalf the sums were owed, but not paid. The commenter points out that under Section 13 of HINT, health care professionals are required to file insurance claims on behalf of their patients. By filing a claim, the health care professional does not become either a participating provider or a party to the contract between the patient and the insurer. Furthermore, the commenter notes that, while HCAPPA establishes a procedure for a health care provider to dispute the reimbursement paid and appeal, the sole subject presented for resolution in that proceeding is that nature of validity of the provider's defense to request for reimbursement made on behalf of the covered person. In conclusion, the commenter stated that regardless of the outcome of the appeal, HCAPPA does not confer a right upon a payer who seeks reimbursement of an overpayment to collect the funds for the reimbursement request by assessing them against payment of any future claims by the health care provider. Rather, it allows the collection of funds for reimbursement only if the payer submits an explanation in writing to the provider in sufficient detail so that the provider can reconcile each covered person's bill.

RESPONSE: As noted in responses to prior comments, HCAPPA applies according to payer type, rather than by plan type. Moreover, the commenter has not requested any changes on adoption. The Department notes that the rules as adopted herein require the carrier to provide offset information to the provider to allow reconciliation of any remaining amounts due from covered persons and their recordkeeping in general.

Summary of Agency-Initiated Changes:

At N.J.A.C. 11:22-1.6(a) and (c), the Department is adding language pertaining to "covered persons" that was intended to be part of the adopted rule (and was included in the notice of proposal in this rulemaking). The deletion of "covered persons" proposed at 49 N.J.R. 2877(a), was adopted effective January 16, 2018 (see 50 N.J.R. 571(a)), however, this adoption of this deletion was due to a publication error, as the Department intended to not adopt those deletions since the text was needed as part of this adoption.

Federal Standards Statement

A Federal standards analysis is not required because the Department's rulemaking is not subject to any Federal standards or requirements.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.1 Purpose and scope

(a) (No change.)

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, prepaid prescription service organization, dental service corporation, and dental plan organization that issues health benefits plans, prescription drug plans, and/or dental plans in this State; any organized delivery system; and to any agent, employee or other representative of such entity that processes claims for such entity.

11:22-1.2 Definitions

(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"ADR" or "alternative dispute resolution" means any procedure, other than litigation, used in the conciliatory resolution of a dispute, including, but not limited to, mediation and arbitration, but shall not include claims payment dispute arbitration pursuant to P.L. 2005, c. 352.

"Agent" means an entity contracted by or affiliated with a carrier to perform administrative functions including, but not limited to, the payment of claims or the receipt, processing, or transfer of claims or claim information, such as an organized delivery system (ODS) as defined at N.J.S.A. 17:48H-1 et seq., or a third-party administrator (TPA) as defined at N.J.S.A. 17B:27B-1 et seq.

"Arbitration" means the process of determining a payment dispute pursuant to P.L. 2005, c. 352, between a health carrier and a provider by one or more impartial persons in a final and binding determination.

"Arbitration organization" means the nationally recognized, independent organization with which the Department of Banking and Insurance has contracted for the purpose of conducting payment arbitrations and making determinations in accordance with the requirements of this subchapter.

"Arbitrator" means an individual employed by, or under contract with, the arbitration organization who is responsible for conducting payment arbitrations and making determinations in accordance with the requirements of this subchapter.

. . .

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State, a dental service corporation or dental plan organization authorized to issue dental plans in this State, and a prepaid prescription service organization.

. . .

"Claim" means a request by a covered person or a provider for payment of benefits under a policy or contract issued by a carrier for which the financial obligation for the payment of a claim under the policy or contract rests in whole or in part with the carrier.

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan, prescription drug plan, or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person in accordance with N.J.S.A. 17B:30-51 and N.J.A.C. 11:22-1.4;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits, prescription drug, or dental plan on the date of service;

4. The health care provider providing the service or supply is an eligible provider on the date of service (that is, a health care provider whose services or supplies are covered under the health benefits, dental, or prescription drug plan); and

5. The carrier does not reasonably believe that the claim has been submitted fraudulently.

. . .

"Dental carrier" means a dental service corporation, dental plan organization, health service corporation, medical service corporation, and insurance company authorized to issue dental plans in this State.

"Dental plan" means a benefits plan that pays benefits only for dental expenses or provides only dental services and supplies and is delivered or issued for delivery in this State by or through any dental carrier in this State.

. . .

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and Medicare Advantage to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies, or contracts: accident only, credit, dental plans, disability, long-term care, CHAMPUS supplement coverage, Tri-Care, 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.

. . .

"Health carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization authorized to issue health benefits plans in this State, and a prepaid prescription service organization.

. . .

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a person covered by a health benefits plan for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease. Medical necessity disputes do not include claims payment disputes.

"Network provider" or "participating provider" means a health care provider who has entered into a contract with a carrier to provide health care services or supplies to covered persons for a predetermined fee or set of fees.

. . .

"Payment dispute" means a disagreement between a health carrier and provider over whether a claim was properly paid under the terms of the applicable health benefits plan and provider participation agreement, if applicable. A payment dispute shall not include a dispute pertaining to medical necessity that could be or could have been submitted to the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11.

"Prepaid prescription service organization" means any prepaid prescription service organization issued a certificate of authority pursuant to N.J.S.A. 17:48F-1 et seq.

"Prescription drug plan" means a benefits plan that pays benefits only for prescription drug expenses or provides only prescription drugs and is delivered or issued for delivery in this State by or through any health carrier in this State.

"Substantiating documentation" means any information specific to the particular health care service or supply provided to a covered person.

11:22-1.4 Claim submission requirements

(a) A health carrier or its agent shall provide in a clear and conspicuous manner through a *[publicly-accessible]* ***publicly accessible*** internet website information concerning the submission and processing of claims including, but not limited to, where applicable:

1. A list of the material, documents, or other information required to be submitted to the health carrier or its agent with a claim for payment for health care services or supplies;

2. A description of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description, and an explanation of the additional information required;

3. The policy or procedure for reducing the payment for multiple services or supplies provided by a health care provider on the same date;

4. The policy for payment to assistant surgeons;

5. The policy for reimbursement for administration of immunization and injectable medications;

6. The policy regarding recognition of *[CPT]* ***procedure*** modifiers;

7. Identification of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the health carrier or its agent to determine the medical necessity of health care services;

8. A street address where claim submissions can be delivered by hand or registered/certified mail if the claim is submitted by other than electronic means; and

9. The ***health*** carrier's application for a provider's internal appeal of a payment dispute.

(b) Health carriers or their agents may change the required information and documentation, as long as health care providers are given at least 30 days prior notice of the change in the requirements, which notice shall be made available on the carrier's internet website.

11:22-1.5 Prompt payment of claims

(a) (No change.)

(b) Carriers and their agent shall pay claims that are disputed or denied because of missing information or substantiating documentation within 30 or 40 calendar days of receipt of the missing information or substantiating documentation, as applicable, pursuant to (a) above.

(c) No health carrier or its agent shall deny, delay, or pend payment of a claim in whole or in part while seeking information as to whether the covered person has other insurance that may be primary, unless good cause exists for the health carrier or its agent to believe that other coverage is available to the covered person. Good cause shall exist only if the health carrier's or agent's records indicate that the covered person has coverage under another health benefits or prescription drug plan. Routine requests to determine whether additional coverage exists shall not be considered good cause.

(d) 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 postpaid envelope containing the most recent address filed by the provider with the carrier or its agent; or

2. If not paid pursuant to (d)1 above, on the date of delivery to the payee of a draft or other valid instrument equivalent to payment.

(e) If a dental plan organization or dental service corporation fails to pay a clean claim under a dental plan within the time limits set forth in this section, it shall include simple interest on the claim amount at the rate of 10 percent per year and shall add the interest amount to the claim amount when paying the claim. If a health carrier or its agent fails to pay a clean claim within the time limits set forth in this section, the health carrier or its agent shall include simple interest on the claim amount at the rate of 12 percent per year and shall include the interest amount with the claim amount at the time the overdue claim is paid. For all carriers, 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.

(f) (No change in text.)

(**Agency Note:** The text of N.J.A.C. 11:22-1.6 below incorporates changes adopted effective January 16, 2018 at 50 N.J.R. 571(a).)

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. A carrier's or its agent's characterization of a claim as pending shall not release the carrier of its obligation to either deny or dispute a claim in accordance with this section. The carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is

applicable, notify ***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. (No change in text.)

2. If the claim is incomplete, the notice shall include a statement specifically identifying the substantiating documentation or other information that is required for adjudication of the claim.

3. If the diagnosis coding, procedure coding, or any other required information required to be submitted with the claim is incorrect, the notice shall include a statement specifically identifying the information that must be corrected for adjudication of the claim;

4. If the carrier or its agent disputes the amount of the claim in whole or in part, the notice shall include a statement of the basis for that dispute, including any change of coding performed by the carrier and the reasons for such change of coding;

5. If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding, or any other data required to be submitted with the claim was missing, the carrier or its agent shall electronically notify the health care provider or its agent, within seven days of *[receipt of the claim, of that]* ***its*** determination *[and]* ***that the claim is missing required information, and*** request any information required to complete adjudication of the claim. If the missing information is subsequently submitted, the carrier or its agent shall process the claim in accordance with N.J.A.C. 11:22-1.5 and this section.

6. If the health carrier or its agent finds there is strong evidence of fraud by the provider and has initiated an investigation into the suspected fraud, the notice shall state that the health carrier or its agent finds that there is strong evidence of fraud and, if applicable, that it has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department pursuant to N.J.S.A. 17:33A-9.

7. The notice shall include the toll-free telephone number through which the carrier or its agent can be contacted by the provider ***or covered person*** to discuss the claim.

(b) (No change.)

(c) If a carrier or its agent 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 and, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department.

(d) 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 10 working days from either the receipt of such agreement by the carrier or the date the performance by ***the covered person or*** the provider of any conditions to payment set forth in the agreement, whichever is later.

11:22-1.8 Reimbursement of overpaid claims

(a) No carrier or its agent shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

1. In judicial or quasi-judicial proceedings, including arbitration;

2. In governmental administrative proceedings;

3. Where relevant records required to be maintained by the provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or

4. Where there is clear evidence of fraud by the health care provider and, if applicable, the carrier has investigated the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department pursuant to N.J.S.A. 17:33A-9.

(b) A health carrier or its agent may request reimbursement for the overpayment of a claim only if the health carrier or agent submits a written reimbursement request to the provider within 18 months of the date on which the first payment on the overpaid claim was made.

1. The written reimbursement request shall be a separate notice to the provider and shall include:

i. A clear identification of the claim;

ii. The name of the patient and the date of the service;

iii. An explanation of the basis upon which the carrier or its agent believes the amount paid on the claim was in excess of the amount due; and

iv. Notice to the provider of his or her right to contest the reimbursement request.

2. If the reimbursement request is submitted to the provider beyond 18 months of the date on which the first payment on the claim was made, the request shall include:

i. All information set forth in (b)1 above;

ii. An explanation of the legal basis relied upon in making the request beyond the 18-month period (that is, the health benefits plan is not required to comply with the statutory requirements because it is either self-funded or issued outside of the State, or the health benefits plan is required to comply with the statutory requirements, but one of the statutory exceptions applies); and

iii. A description of the appeal process related to the request.

3. No health carrier or its agent may seek more than one reimbursement for overpayment of a particular claim.

4. No health carrier or its agent in seeking reimbursement for overpayment of a claim shall collect or attempt to collect:

i. The funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;

ii. The funds for the reimbursement if the health care provider disputes the reimbursement request and initiates an appeal pursuant to N.J.A.C. 11:22-1.10 on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care provider's rights to appeal pursuant to N.J.A.C. 11:22-1.10 and 1.13 have been exhausted; or

iii. A monetary penalty against the reimbursement request, including, but not limited to, an interest charge or a late fee.

5. A health carrier or its agent may offset against a provider's future insured claims, an overpayment, to a provider on which a health carrier or its agent issued a reimbursement request pursuant to this subsection only if:

i. The offset action applies to claims submitted by the health care provider after the 45th calendar day following the submission of a reimbursement request to the provider, or after the provider has exhausted his or her rights to appeal pursuant to N.J.A.C. 11:22-1.10 and 1.13;

ii. The health carrier or its agent submits to the provider in writing a detailed offset notice so that the provider is able to reconcile each covered person's bill that is the subject of the offset action;

iii. The provider does not initiate an appeal of the reimbursement request within 45 days; and

iv. The provider was given 30 days after receipt of the offset notice to reimburse the health carrier or its agent for the overpayment and did not reimburse the health carrier or its agent.

6. A provider may contest a reimbursement request through the internal and external appeal processes set forth at N.J.A.C. 11:22-1.10 and 1.13.

7. The limitations of this subsection shall not apply:

i. Where an overpayment is the result of claims that were submitted fraudulently;

ii. Where a provider has demonstrated a pattern of inappropriate billing; or

iii. Where a claim(s) is subject to coordination of benefits (COB).

11:22-1.9 Reimbursement of underpaid claims

(a) No health care provider shall request reimbursement from a health carrier or its agent or from a covered person later than 18 months from the date the first payment on the claim was made unless the claim is the subject of an internal appeal pursuant to N.J.A.C. 11:22-1.10 or is subject to continual claims submission.

1. The written reimbursement request shall be a separate notice to the health carrier or its agent or the covered person and shall include:

i. A clear identification of the claim;

ii. The name of the health care provider's patient and the date of service; and

iii. An explanation of the basis upon which the health care provider believes the amount paid on the claim was less than the amount due.

2. No health care provider shall seek more than one reimbursement for underpayment of any particular claim from a health carrier or its agent or from a covered person.

11:22-1.10 Internal appeals—health carriers

(a) Every health carrier or its agent shall establish an internal appeals mechanism to resolve payment disputes between health carriers or their agents and health care providers, but not including appeals related to medical necessity made pursuant to N.J.A.C. 11:24-8.5, 8.6, and 8.7 and 11:24A-3.5, 3.6, and 3.7. The internal appeals mechanism shall be described in the participating provider contract ***and in a publicly available internet website***.

1. A health care provider may initiate an appeal of a health carrier's or its agent's claim determination:

i. Within 90 calendar days of receipt of the health carrier's or agent's determination that is the basis of the appeal; or

ii. Within 90 calendar days of a health carrier's or its agent's missed due date for the claim determination, including at the provider's option, a claim that has been pended.

2. A provider shall initiate an appeal by submitting to the health carrier or its agent a complete Claim Payment Appeal Form, which shall include all substantiating documentation required by the health carrier or its agent. The carrier or its agent shall not reject an appeal based on the provider's failure to notify his or her patient of the appeal. The application form and instructions, which require the applicant to submit the name and contact information, the patient's name and the claim number with a description of the reason for appeal, are available for download on the Department's website at www.dobi.nj.gov. A health carrier or its agent may make available the application form and instructions on its website to allow for electronic submission of applications.

3. The health carrier or its agent shall conduct a review of the internal appeal and notify the health care provider of its determination within 30 calendar days of receipt of the application for internal appeal. The internal review shall be conducted by employees of the health carrier or its agent 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. If the carrier or its agent fails to notify the provider of its determination within 30 calendar days of receipt of the application, the provider may initiate an arbitration proceeding in accordance with N.J.A.C. 11:22-1.13(c).

4. The health carrier or its agent shall communicate the results of the internal review in a written decision to the provider, which shall include:

i. The names, titles, and qualifying credentials of the person or persons participating in the internal review;

ii. A statement of the provider's grievance;

iii. The decision of the reviewer(s), together with a detailed explanation of the basis for such decision;

iv. A description of the substantiating documentation, which supports the decision;

v. If the payment decision is adverse to the health care provider in any respect, a description of the method to obtain an external review of the decision by arbitration pursuant to N.J.A.C. 11:22-1.13; and

vi. If the decision favors the health care provider in any respect, the health carrier or its agent shall be required to pay within 30 calendar days of the date of issuance of the health carrier's or its agent's determination of the internal appeal, the amount due as determined by the internal appeal, if applicable, with accrued interest at the rate of 12 percent per year calculated from the date of receipt of the internal appeal by the health carrier or its agent at its designated address.

11:22-1.11 Internal appeals—dental plan organizations and dental service corporations

(a) Every dental plan organization and dental service corporation shall establish an internal appeals mechanism to resolve disputes between dental carriers or their agents and participating health care providers relating to payment of claims for services or supplies covered by a dental plan. The internal appeal mechanism shall be described in the participating provider contract.

1. The internal review shall be conducted by employees of the dental 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 30 days of 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.

11:22-1.12 External appeals—alternative payment dispute resolution—dental plan organizations and dental service corporations

(a) Every dental plan organization and dental service corporation shall offer an independent, external alternative payment dispute resolution (ADR) mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1.-3. (No change.)

(b) Dental plan organizations and dental service corporations shall annually notify participating providers in writing, or by posting on their websites, of the internal appeals process and the ADR mechanism and how they can be utilized.

(c) Dental plan organizations and dental service corporations shall annually report, in a format prescribed by the Department, the number of internal and external provider appeals received and how they were resolved.

11:22-1.13 External appeals—health carriers—arbitration

(a) Any dispute regarding the determination of an internal appeal conducted pursuant to a health carrier's or its agent's internal appeal mechanism established pursuant to P.L. 2005, c. 352, and described at N.J.A.C. 11:22-1.10, may be referred to arbitration, except for the following disputes that are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11. The disputes shall involve whether:

1. A treatment or service is medically necessary;

2. A treatment or service is experimental or investigational;

3. A treatment or service is cosmetic;

4. A treatment or service is medical or dental;

5. A condition is a preexisting condition; and

6. The health carrier should authorize services to be performed by an out-of-network provider but hold the member responsible for in-network cost sharing only because the carrier's network lacks a provider who is accessible and possesses the requisite skill and expertise to perform the needed services.

(b) Any provider involved in a payment dispute for which any determination was made by a health carrier's or its agent's internal appeal mechanism created pursuant to P.L. 2005, c. 352, and described at N.J.A.C. 11:22-1.10, may initiate an arbitration proceeding within 90 calendar days of the receipt of the determination on the internal appeal.

(c) A provider who has not been notified by a health carrier or its agent within 30 days of the carrier's or its agent's receipt of an appeal to

be conducted pursuant to the internal appeal mechanism created by P.L. 2005, c. 352, and described at N.J.A.C. 11:22-1.10, may initiate an arbitration proceeding within 90 days of the carrier's or its agent's missed due date for the determination on the internal appeal.

(d) A provider shall initiate an arbitration proceeding by submitting a complete Arbitration Request Application directly to the arbitration organization with which the Department has contracted pursuant to P.L. 2005, c. 352.

(e) Upon receipt of an Arbitration Request Application, the arbitration organization, or the Department, at its option, shall review the application and make a determination regarding the eligibility of the claim(s) for arbitration and completeness of the application. The arbitration organization, or the Department, if applicable, shall accept for processing a complete application that meets the following criteria:

1. The covered person's health benefits or prescription drug plan under which the payment dispute has arisen, was delivered, or issued for delivery in New Jersey, and is not an out-of-State plan, a self-funded plan, or a Federal plan, except for Managed Medicaid;

2. The disputed claim amount shall be $1,000 or more***, including any aggregation of claims***;

3. The provider initiating the arbitration request shall have rendered a covered service to a covered person under the health benefits plan at the time of the action on which the arbitration is based;

4. The service that is the subject of the arbitration request reasonably appears to be a covered service under the health benefits or prescription drug plan that covers the covered person, and the covered person was enrolled in the plan at the time the service was rendered or the supply provided;

5. The application includes, or the covered person has previously submitted, a fully-executed Consent to Release of Medical Records for Claim Payment and Arbitration form signed by the covered person in the event that the covered person's confidential information accompanies the arbitration request, which provides a patient with the opportunity to consent to representation in utilization management appeals and to provide authorization to release information in utilization appeals and arbitration of claims and to revoke such consent and which form can be accessed on the Department's website at http://www.state.nj.us/dobi/chap352/352implementnotice.html; and

6. The provider initiating the arbitration request has submitted to the arbitration organization all information requested by the arbitration organization as necessary to conduct the arbitration proceeding in addition to the Request for Arbitration Application.

(f) The arbitration organization shall reject an Arbitration Request Application received in excess of 90 days after the provider's receipt of the health carrier's or its agent's written determination on the internal appeal conducted pursuant to the internal appeal mechanism created by P.L. 2005, c. 352, and described at N.J.A.C. 11:22-1.10, or in excess of 90 calendar days after a health carrier's or its agent's missed due date for the written determination of the provider's internal appeal conducted pursuant to the internal appeal mechanism created by P.L. 2005, c. 352, and described at N.J.A.C. 11:22-1.10.

(g) Within five business days of receipt of the Arbitration Request Application, the arbitration organization shall acknowledge receipt of the application to the health carrier or its agent and the provider and provide notice of any deficiencies in the application or accompanying documents and of the procedure for correcting the deficiencies.

(h) If a provider fails to correct any deficiencies within 15 days of receipt of notice, the Arbitration Request Application shall be deemed withdrawn.

(i) If an arbitration request is rejected in whole or in part based on information submitted with the provider's Arbitration Request Application, the arbitration organization shall retain the provider's review fee and refund the arbitration fee. If the request for arbitration is initially accepted, but later rejected as ineligible for arbitration based on information submitted in whole or in part by the health carrier or its agent, the arbitration organization shall retain the review fees of both the provider and the health carrier or its agent and refund the arbitration fees.

(j) Within 30 days of receipt of a complete Arbitration Request Application and accompanying documents as set forth in (e) above, the arbitrator shall issue a written decision addressing whether the provider requesting the arbitration was properly or improperly reimbursed for the claim(s) by the health carrier or its agent.

(k) The arbitration proceeding shall be conducted pursuant to the rules of the arbitration organization, including rules of discovery subject to confidentiality requirements established by State and Federal law.

(l) The arbitration proceeding shall be limited to only the issue(s) in dispute for which the Request for Arbitration Application was made and accepted by the arbitration organization.

(m) The only evidence admissible in an arbitration proceeding or on which the arbitrator's determination may be made are the documents submitted to, requested by, and accepted by, the arbitration organization by either the provider or the health carrier or its agent involved in the payment dispute. In-person or telephonic testimony shall not be permitted.

(n) The arbitrator shall issue a signed, written determination of the payment dispute, which shall explain each and every basis of the determination, and shall include, but not be limited to, a full and complete statement of the following:

1. The issue(s) in dispute;

2. Findings of fact;

3. Conclusions on which the determination was based, including all evidence relied on in support thereof; and

4. The amount of the award, if any, including interest, with the amount of the interest specified.

(o) The arbitrator's determination shall be nonappealable and binding on all parties to the payment dispute. The arbitrator's determination and/or award may be vacated or modified only in accordance with N.J.S.A. 2A:24-1 et seq.

(p) If the arbitrator determines that a health carrier or its agent has erroneously withheld or denied payment of a claim, the arbitrator shall order the health carrier or its agent to make payment of the claim on or before the 10th business day following the issuance of the determination, together with interest at the rate of 12 percent per annum accruing from the date the appeal was received by the health carrier or its agent for resolution through the internal appeal process or, if that date is unknown, from 45 days prior to the date of filing the Request for Arbitration Application. If the arbitrator determines that a health carrier or its agent has withheld or denied payment on the basis that information requested by the health carrier or its agent was not submitted by the provider when the claim was initially processed by the health carrier or its agent or reviewed by the health carrier or its agent pursuant to its internal appeal process, the health carrier or its agent shall not be required to pay any accrued interest.

(q) If the arbitrator determines that a provider has engaged in a pattern and practice of improper billing and a refund is due to the health carrier or its agent, the arbitrator may award the health carrier or its agent a refund, including interest accrued at the rate of 12 percent per annum. Interest shall begin to accrue on the date the appeal was received by the health carrier or its agent for resolution through the internal appeal process described at N.J.A.C. 11:22-1.10.

(r) The arbitrator shall not award legal fees or costs.

11:22-1.14 Reporting requirements

(a) A carrier ***or ODS*** shall report to the Department on a quarterly and annual basis on the timeliness of claims payments and on the reasons for denial and late payment of claims in a format set forth by bulletin or similar means and/or on the Department's website. 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 annual report.

(b) The annual report on the timeliness of claims payments and on the reasons for denial and late payment of claims shall be audited by a private auditing firm at the expense of the carrier ***or ODS***. 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 by the due date to:

New Jersey Department of Banking and Insurance

Life & Health Actuarial, 11th Floor
Prompt Payment Reports
20 West State Street (for private Express Delivery)
PO Box 325 (for regular US mail)
Trenton, New Jersey 08625-0325

(d) All quarterly reports shall be submitted by the due date as an Excel spreadsheet through the State Electronic Rate and Form Filing System.

(e) A carrier ***or ODS*** may request an exemption from the requirements to have the annual report audited and to submit a report of the auditing firm. This exemption must be obtained on an annual basis. Such an exemption may be granted if the carrier ***or ODS*** meets the following conditions:

1. The carrier ***or ODS*** must file the annual report in a timely manner. The report shall be accompanied by a request for exemption from the requirements that the report be audited and that a report of the auditing firm be submitted; and

2. The annual premiums earned by the carrier ***or ODS*** in New Jersey for all health benefits plans as defined in N.J.A.C. 11:22-1.2 were less than $5 million in the year covered by the annual report for which the exemption is requested. The carrier ***or ODS*** shall provide, in its request for exemption, a copy of the report of net earned premiums submitted to the Commissioner pursuant to N.J.A.C. 11:4-23A.8(a)1 or, alternatively, other evidence acceptable to the Commissioner that premiums are less than $5 million.

(f) After the Commissioner has reviewed the annual report and the request for exemption, the Commissioner shall either grant or disapprove the request. Any request meeting the conditions of (e) above shall be deemed granted 30 days after its receipt by the Commissioner unless disapproved. The Commissioner may disapprove a request for one or more of the following reasons:

1. (No change.)

2. The carrier ***or ODS*** has not filed a report, made a refund, or paid an assessment required by law applicable to a carrier ***or ODS***; or

3. The Commissioner finds that an audit is necessary to verify the accuracy of the report or to otherwise meet the purposes of N.J.A.C. 11:22-1.14 and N.J.S.A. 17B:30-12 et seq.

(g) A carrier ***or ODS*** which has obtained an exemption from filing an audited annual report under (e) and (f) above shall also be exempt from filing quarterly reports for the year following the year for which the exemption was obtained. If the carrier ***or ODS*** seeks an exemption from filing an audited annual report for the year following the year for which such an exemption was previously obtained, a separate request for an exemption shall be required for the audited annual report for that ensuing year.

11:22-1.15 Remediation/penalty

(a) Upon review of the reports required by N.J.A.C. 11:22-1.14, the Commissioner may require that the carrier ***[or its agent]****, **ODS, or the agent of a carrier or ODS***, at its own expense:

1.-2. (No change.)

(b) The Commissioner may impose a civil penalty of not more than $10,000 upon the carrier ***[or its agent]****, **ODS, or the agent of a carrier or ODS***, 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. (No change.)

2. A carrier ***[or its agent]****, **ODS, or the agent of a carrier or ODS*** has failed to pay interest as required pursuant to N.J.A.C. 11:22-1.7.

(c) In addition to any other penalties provided by law, the Commissioner may impose a civil penalty as set forth at N.J.S.A. 17B:30-55 against any person found in violation of this subchapter based upon their having engaged in a pattern or practice of conduct as determined by the Commissioner.

LABOR AND WORKFORCE DEVELOPMENT

(a)

DIVISION OF PUBLIC SAFETY AND OCCUPATIONAL SAFETY AND HEALTH

Boilers, Pressure Vessels, and Refrigeration

Readoption with Amendments: N.J.A.C. 12:90

Proposed: October 16, 2017, at 49 N.J.R. 3417(a).
Adopted: January 3, 2018, by Aaron R. Fichtner, Ph.D., Commissioner, Department of Labor and Workforce Development.
Filed: January 3, 2018, as R.2018 d.070, **without change.**

Authority: N.J.S.A. 34:1-20, 34:1-47, 34:1A-3, and 34:7-18; and Reorganization Plan 002-2002.

Effective Dates: January 3, 2018, Readoption;
February 5, 2018, Amendments.
Expiration Date: January 3, 2025.

Summary of Hearing Officer's Recommendations and Agency's Response:

A public hearing on the rules proposed for readoption with amendments was held on November 16, 2017, at the Department of Labor and Workforce Development, John Fitch Plaza, Trenton, New Jersey. David Fish, Executive Director, Legal and Regulatory Services, was available to preside at the hearing and to receive testimony. There were no attendees at the public hearing and the Department received no written comments. The hearing officer recommended that the Department proceed with the readoption with amendments without change.

Summary of Public Comment and Agency Response:

No comments were received.

Federal Standards Statement

The rules readopted with amendments are governed by N.J.S.A. 34:7-1 et seq., and 34:7-14 et seq., and are not subject to any Federal standards or requirements. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 12:90.

Full text of the adopted amendments follows:

CHAPTER 90
BOILERS, PRESSURE VESSELS, AND REFRIGERATION

SUBCHAPTER 2. DEFINITIONS

12:90-2.1 Definitions

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

...

(b)

INCOME SECURITY

Notice of Readoption

Definitions Used by Employment Security Agency and Special Employment Relationships

Readoption: N.J.A.C. 12:19

Authority: N.J.S.A. 34:1-20; 34:1A-3(e) and 43:21-1 et seq., specifically, 43:21-11.

Authorized By: Aaron R. Fichtner, Ph.D., Commissioner, Department of Labor and Workforce Development.