INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Prompt Payment of Claims
Denied and Disputed Claims

Adopted Amendments: N.J.A.C. 11:22-1.3, 1.5, 1.6 and 1.8.

Proposed: July 15, 2002 at 34 N.J.R. 2365(a)

Adopted: June 13, 2003 by Holly C. Bakke, Commissioner,
Department of Banking and Insurance

Filed: June 13, 2003 as R. 2003 d.279, **with substantive and technical 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, 17:1-15e, 17B:26-9.1, 17B:30-13.1, 17B:30-23 et seq. and 26:2J-15b.

Effective Date: July 7, 2003

Expiration Date: November 6, 2005

Summary of Public Comments and Agency Responses:

The Department received 17 written comments on the reproposed amendments during the comment period. Comments were received from three carriers (Delta Dental Plan of New Jersey, HealthNet and Oxford Health Plans), 10 providers (Carrier Clinic, Healthcare Financial Management Association, Holy Name Hospital, Liberty Healthcare Management, LLC, Magellan Behavioral Health, Ocean County Hospital, St. Barnabas Health Care System, St. Joseph's Regional Medical Center, The Revenue Maximization Group, Inc., and The Valley Hospital) and four trade associations (Medical Society of New Jersey, New Jersey Association of Health Plans, New Jersey Hospital Association, and the New Jersey Podiatric Medical Society).

COMMENT: Several commenters expressed support for the Department's proposed amendment to N.J.A.C. 11:22-1.3(a). This amendment requires carriers to acknowledge receipt of all claims and to include the date that the carrier or its agent received the claim. The commenters stated that this provision should reduce the administrative burden for both payers and providers by eliminating the need for providers to take the additional step of actively requesting acknowledgement for submitted claims, and eliminating the need for payers to track which claim must be acknowledged versus claims for which no acknowledgement was requested.

RESPONSE: The Department appreciates the commenters' support for this provision.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:22-1.3(a)2, which states that if a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim. The commenters noted that the Department's proposal eliminates the requirement that a written claim be considered received based on the U.S.P.S. date.

The commenters also stated that the amendment eliminating the reference in N.J.A.C. 11:22-1.5(a)2 to the postmark date will result in the rule failing to address the need for a method to track claims in order to ensure compliance with payment deadlines for written claims. One commenter contends that several behavioral health and Medicaid managed care plans are currently not equipped to receive electronic claims; hence, providers are forced to submit paper claims. In addition, the commenter stated that to further complicate matters, after the October 2002 deadline for compliance with the State's HINT regulations, providers will be required to submit all claims on behalf of their patients, unless the patients choose to do it themselves. This

requirement will result in an increase in the amount of paper claims that providers must manually submit, since the HINT regulations do not require that payers change to electronic claims if they currently use paper.

Finally, the commenter contends that, currently, the only way for a provider to prove the date a payer received a claim is to send it registered mail with a return receipt. The commenter stated that this puts the onus and financial burden on the provider to compensate for the fact that the payer has not put in place a system that can receive electronic claims or a means of accurately or efficiently providing an acknowledgement of paper claims. The commenter argues that there is no incentive for a payer to move to the more efficient electronic format.

RESPONSE: The Department disagrees with the commenter. The Department recognized 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. Therefore, the Department believes that the proposed amendments, which incorporate a commenter's suggestions regarding the previously proposed amendments to N.J.A.C. 11:22-1.3 (see 34 N.J.R. 2455(a)), provide the best solution for determining when a carrier is actually in receipt of a written claim and when the processing of a claim can begin.

Further, these amendments provide that, if a carrier remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment constitutes acknowledgement of receipt. These amended rules also permit carriers to

acknowledge receipt of a claim by providing claim status information, including the date of receipt, by a web-based access system or an automated telephone system. If a carrier chooses to use one of these systems, it will be able to comply with N.J.A.C. 11:22-1.3 without having to also issue a written acknowledgement of a claim. Finally, N.J.S.A 17B:26-9.1 requires health insurers, or a subsidiary that processes health care benefits claims as a third party administrator, to be able receive and transmit health care transactions electronically.

COMMENT: One commenter stated that N.J.A.C. 11:22-1.5(c)1 allows a postmark date to be used to document when a payment has been made by a payer; therefore, there is no reason not to use a postmark to document when a claim is received. The commenter contends that using any other method for tracking receipt of claims (or remaining silent on the issue) would be inconsistent with N.J.A.C. 11:22-1.5(c)1.

RESPONSE: N.J.A.C. 11:22-1.3 as proposed requires that a carrier or its agent acknowledge the receipt of all claims and that the acknowledgement include the date that it was received. This provision establishes how claim submissions are acknowledged, and specifies how long after receipt a carrier has to promptly pay a claim in accordance with these rules. The Department's amendments also address and provide methods for acknowledging when a claim has been received. N.J.A.C. 11:22-1.5 establishes the time period after a claim has been received within which a carrier or its agent must pay the claim in order for it to be considered promptly paid in accordance with these rules. Therefore, these amendments are not inconsistent with N.J.A.C. 11:22-1.5(c)1. Further, as was discussed above, a postmark is not an accurate indicator of the date of receipt of the mailed material by the addressee. Rather, it reflects the date on which a mailing was processed by the United States Postal Service. Because N.J.A.C. 11:22-1.5 is

concerned with the date a payment is made, as opposed to the date it is received, it is appropriate for the reference to the postmark date to be retained in that provision notwithstanding its having been deleted from N.J.A.C. 11:22-1.3 through these amendments.

COMMENT: Several commenters objected to the proposed amendment to delete the current provisions of N.J.A.C. 11:22-1.3(b). The commenters stated that under this proposed amendment, health plans can render determinations about what care a patient should and can receive, and yet bear no responsibility for communicating their decisions to those individuals that pay a premium to cover the cost of their care. The commenters argued that HMOs must take responsibility for communicating with their beneficiaries regarding the decisions that are being made to allow or deny medical care coverage. The commenters contend that, as proposed, this responsibility falls on the provider, who has no control over the actions of a health plan other than through an appeal process.

The commenters stated that they recognize that the Department's intent in eliminating the requirement that patients be notified of a denial is to reduce the chance of alarming a patient by informing him or her about a reimbursement dispute between the payer and provider. The commenters further stated that patients are going to be informed of a denial if a provider elects to appeal that denial, so a patient is not going to be "shielded" from communications taking place between their provider and health plan. The commenters contend that the issue becomes who is responsible for notifying the patient that a denial or dispute has been issued by a health plan. The commenters argued that HMOs must take responsibility for communicating the decisions that are made to allow or deny coverage with their beneficiaries.

The commenter contends that in order to address the Department's concern about causing undue stress to a patient who is notified of a claim denial, perhaps patients can be notified of a denial or dispute (regardless of their financial obligation) only in cases in which the denial is related to medical necessity, including the downcoding of diagnosis of care. If the patient has no financial obligation, then the health plan can simply indicate such in their notification letter.

The commenter suggested that the Department review its proposed amendment that absolves health plans of responsibility for their decisions.

RESPONSE: The language deleted from N.J.A.C. 11:22-1.3(b) remains in N.J.A.C. 11:22-1.6(a), which requires that notification of the denial or dispute of a claim be provided to the covered person when he or she will have increased responsibility for payment. N.J.A.C. 11:22-1.6(a)2 further provides that where missing information or documentation is the basis for denying or disputing a claim, the carrier shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the provider. The Department notes that these rules govern claims and do not address utilization management determinations to deny or limit an admission, service, procedure or extension of stay.

COMMENT: One commenter expressed other concerns about N.J.A.C. 11:22-1.3(b). The commenter stated that the proposed language suggests that the notification of an adjudication of a claim will be sent to a patient only if the claim is disputed and/or the patient has a financial responsibility. The commenter contends that notification to a member of a payment, historically known as the Explanations of Benefits (EOB), is in fact, just that – an explanation of how the patient's benefits were applied, regardless of whether the payment was partial or full – approved

or denied. The commenter stated that this may not be solely linked to denial of medical care, but an interpretation of benefit rules and their application to a specific provider contract. The commenter stated that not allowing a patient the opportunity to review an EOB denies them the privilege of understanding their benefits and hinders their ability to dispute payments. The commenter believes that if payment is made to a provider in full, but a member wants to challenge payment by his own insurance company, he should have that ability. The commenter requested that the Department add language to require plans to supply an EOB to all their members regardless of whether a member has any financial responsibility

Another commenter expressed concern with N.J.A.C. 11:22-1.3(b) because it believes that payers have incorporated hold harmless provisions into their contracts with providers. The commenter contends that these provisions have been broadly interpreted by 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 alternate levels of care. The commenter stated that the Department of Health and Senior Service (DHSS) disagrees with the payers on this issue and has instructed them to keep patients apprised when a denial of care is issued regardless of patient financial liability. Therefore, the commenter stated that it is inconsistent for the Department to require that the patient only be informed when a claim is denied or disputed when they have increased financial liability. The commenter argued that patients pay premiums to payers for health benefits and have a right to know when a benefit is not being paid regardless of whether personal out-of-pocket costs are increased.

RESPONSE: N.J.A.C.11:22-1.3(a) as proposed does not address the notification of adjudication of a claim to a patient if the claim is disputed and the patient has increased financial responsibility. This provision only addresses "acknowledgement of receipt of claims." N.J.A.C.

11:22-1.6, Denied and disputed claims, is the provision that contains the requirement to notify the covered person when he will have increased responsibility for payment as a result of the carrier's decision to deny or dispute a claim. The Department believes that this notification is reasonable and appropriate. This provision avoids requiring that a covered person receive a notification, for example, in cases where the claim was submitted and denied or disputed because it could not be entered into the system due to an erroneous CPT code, or something else that can be corrected and then resubmitted. The Department's rules only require the notification in cases where the covered person will have increased responsibility for payment. Thus, carriers do not have to incur the additional costs of notifying covered persons on every denial or disputed claim. However, these rules do not prevent carriers from notifying a covered person whenever a claim is denied or disputed.

COMMENT: Several commenters objected to the Department's proposed amendment to N.J.A.C. 11:22-1.6(a)1ii, which provides examples of reasons why a claim cannot be entered into a claims system.

The commenters expressed concern that the proposed amendment allows payers to identify virtually any reason why a claim cannot be entered in the system, which will likely result in lengthy delays in processing a claim. The commenter contends that the current language allows payers to take up to the allowed 30 days to deny a claim simply because it could not be entered into the system. The commenter stated that payers are able to identify the reasons within hours or, at most, days of receiving the claim. The commenter stated that the Department's proposed language would permit payers to deny claims for a host of reasons that are not relevant to processing the claim. For example, claims were rejected if they were missing

the patient's middle initial even when the patient's first and last name, as well as the social security number, were included on the claim, which is the primary manner in which payers verify the identity of a patient.

The commenter stated that in order to maintain the integrity and intent behind establishing prompt payment requirements, the Department should add language establishing a deadline of not more than five working days by which payers must alert providers that a claim cannot be entered into the system. Otherwise, the proposed 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 allowing payers another 30 days to deny the claim based on deficiencies (such as missing documentation), then allowing another 30 days for the final adjudication of the claim after the deficiency is addressed. What was once a 30-day deadline has now become a three-month process, rendering these rules ineffective and defeating the true objective behind their adoption.

Additionally, the commenter requested that the Department require payers to explicitly define in their contract with providers all the reasons why a claim cannot be entered into their system. The commenter stated that if providers know in advance the types of problems that prohibit the entering of a claim, they can work with their vendor and clearinghouse (while the payer works with its own clearinghouse) to reduce the likelihood that a claim would not meet the payer's requirements before submitting the claim.

RESPONSE: These rules provide examples of reasons why a claim cannot be entered into the claim system. Additionally, N.J.A.C. 11:22-1.6(a)1i requires that if a claim cannot be entered into the claims system, then all the reasons why the claim cannot be entered into the claims system shall be included. N.J.A.C. 11:22-1.6(a)1iv provides that a carrier or its agent shall not

deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and leads to additional reasons to deny or dispute the claim. At this time, the Department does not believe that it is necessary to impose a deadline of five working days by which payers must alert providers that a claim cannot be entered into the system. Furthermore, such a revision would constitute a substantive change to the amendments as proposed, requiring republication. The Department will monitor carriers' compliance with the amended rules and, if it determines that additional amendments are necessary, take appropriate action.

COMMENT: One commenter stated that the Department's amendments to N.J.A.C. 11:22-1.6(a)1ii refer to claims that "cannot be entered into the claims system." The commenter stated that technically speaking, the reasons listed would not prevent the claims from being "entered" in the system. However, the commenter stated that it would prevent claims from being "processed" or "recognized" by the system. The commenter suggested that the provision by amended to include either of the latter words.

RESPONSE: The Department disagrees with the commenter. A claim may not be processed because the company's computer system is down, or because the company did not enter the eligibility file of a particular employer, or for other reasons unrelated to the eligibility of the provider or recipient of the care, or the sufficiency of the data supplied when the claim was submitted. The situations listed in N.J.A.C. 11:22-1.6(a)1ii are examples of reasons why a carrier cannot enter a claim into the claims system, as that phrase is used in the rule.

COMMENT: One commenter expressed a different concern with N.J.A.C. 11:22-1.6(a)1ii. The commenter stated that the Department recognizes that there are some cases when all the denial reasons cannot be provided. However, the Department links the inability of providing all denial reasons to only those claims that "cannot be entered into the claims system." The commenter stated that the Department rules provide examples of why a claim cannot be entered into the claims system. The commenter argued that none of the examples that the Department provides necessarily prevents a claim from entering a carrier's claims system upon receipt. Nevertheless, in each of the examples given, the carriers' claims systems would likely only be able to provide an initial denial for the specific defect (that is, no CPT code) and rarely if ever any other potential denial reasons.

The commenter stated that it recently received a complaint from a member who stated that his provider's claims were denied twice, each time for a different reason. The commenter stated that upon initial receipt, the claims in question were entered into the system. The diagnosis code submitted by the provider indicated that the member had a hearing loss, while the procedure code indicated that the member received behavioral health services. The commenter stated that the carrier correctly denied the claims for incorrect coding. The provider then corrected the coding and resubmitted the claims. The claims were subsequently denied again because the services that were actually provided were not authorized. In this case the carrier would be in violation of N.J.A.C. 11:22-1.6(a)1 under both the amended and reproposed amendments, because it did not initially provide all the denial reasons on a claim that was entered into the system.

The commenter requested that the Department amend this provision by adding the following language "or cannot be processed by the claims system" immediately following

"cannot be entered into the claims system" in N.J.A.C. 11:22-1.6(a)1i, (a)1ii and (a)1iii. In addition, the commenter stated that the Department should strike "after the claim is entered" in N.J.A.C. 11:22-1.6(a)1iv.

RESPONSE: The Department disagrees with the commenter. A claim may not be processed because the company's computer system is down, or because the company did not enter the eligibility file of a particular employer or for other reasons that are not the fault or responsibility of the provider submitting the claim. The Department also believes that after the first review, the carrier or its agent should be able to determine if other reasons exist to deny or dispute a claim in accordance with N.J.A.C. 11:22-1.6(a)1iv.

COMMENT: One commenter urged the Department to consider modifying N.J.A.C. 11:22-1.6(a) to allow the pending of claims where the carrier has complied with the applicable provision of ERISA in seeking missing information/documentation.

The commenter stated that the Department's prompt pay rules apply to insured healthcare claims, whether or not they are subject to ERISA. The commenter argued that the United States Department of Labor (DOL) Benefits Claim Procedure Regulations (29 C.F.R. 2560.503-1) apply to all ERISA claims whether or not "insured." Thus, the commenter contends that the New Jersey and Federal regulations overlap as to insured ERISA claims. The commenter stated that if N.J.A.C. 11:22-1.6 was revised, the overlap would effectively preclude carriers from giving a claimant more than a day (perhaps two) to supply missing documentation, increasing the costs to claimants and carriers alike.

The commenter stated that existing N.J.A.C. 11:22-1.6(a) requires the carrier to "engage in a good faith effort to expeditiously obtain information or documentation by, among other

things, telephoning the provider." The commenter stated that the DOL regulation imposes no such obligation on the plan (or its carrier). The commenter stated that when the plan (or its carrier) requests an ERISA claimant to provide missing information, and extends its time to adjudicate the claim beyond 30 days, the plan or carrier must take an extension of time, pend the claim, and allow the ERISA claimant at least 45 days to furnish the missing information. The commenter noted that DOL regulations provide that if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension should describe the required information, and the claimant should be afforded at least 45 days from receipt of the notices within which to provide the specified information.

Finally, the commenter stated that if the carrier determines that the claim is incomplete, the Department's proposed rules require the carrier to seek the information, but prohibit the carrier from taking the ERISA extension. The commenter stated that the ERISA extension requires carriers to pend the claim for at least 45 days, which the commenter stated is an express violation of the Department's rules. The commenter contends that the only way a carrier can comply with both sets of rules is to give the ERISA claimant an extremely short time period to supply the missing information and to immediately deny the claim if the missing information is not received. Some carriers may elect to follow that approach, ultimately resulting in incurring the costs of reprocessing a new claim once the missing information has been supplied or incurring the expense of the claim appeal process under the DOL regulation (the claimant is entitled to supply the missing information during any such appeal). Other carriers may prefer to pend such determinations as permitted by 29 C.F.R. 2560-503.1(f)(2)(iii) where doing so is more efficient and more beneficial to the claimant. The commenter stated that the Department may therefore wish to consider allowing carriers to elect to pend incomplete claims so long as they do

so "consistent with the procedure required by 29 C.F.R. 2560-503(f) and document the claim accordingly."

RESPONSE: The Department's rules set forth claims payment standards relating to health benefit plans and dental plans issued in New Jersey by licensed insurance companies, health, medical, dental and hospital service corporations, and health maintenance organizations. There may be some health plans that are subject to ERISA and these rules. The commenter stated that when a claim is "incomplete," the Department's rules require the carrier to seek the information, but prohibit the carrier from taking the ERISA extension. The commenter noted that, pursuant to 29 C.F.R. 2560-503.1(f)(2)(iii)(B), ERISA carriers are allowed to pend the claim for at least 45 days. N.J.S.A. 17B:26-9.1d(2)(e) provides that when a claim submission is incomplete, the carrier shall, within 30 days, notify the provider in a statement as to what substantiating documentation is required to complete the adjudication of the claim. The proposed regulations must be, and are, consistent with the intent of the New Jersey Legislature on this issue. The Department's current rules (see N.J.A.C. 11:22-1.6(a)) require a carrier or its agent to either deny or dispute a claim, in full or in part, or to pay the claim. The amendatory language to this provision states that "the pending of a claim does not constitute a dispute or denial." The purpose of this language is to clarify that the pending of a claim does not stop the clock from running in terms of processing a claim. Pursuant to N.J.S.A. 17B:26-9.1, the Department's rules provide that when a carrier denies or disputes a claim, they must identify and explain in the notification supplied to the provider all of the reasons why a claim is being denied or disputed. The Department's rules are, therefore, consistent with the enabling statutes, and are specific in what carriers must do in cases where they deny or dispute a claim based upon missing (i.e., incomplete) information or documentation.

COMMENT: One commenter requested clarification of N.J.A.C. 11:22-1.6(a)1iv. The commenter stated that it would like the rules to be clarified to reflect that the information or documentation relevant to the claim being received may come from any source. The commenter stated that it receives relevant information, including eligibility and benefits information, from many sources, including health plans, and wants to ensure that this information may be used to deny or dispute a claim where appropriate.

RESPONSE: N.J.A.C. 11:22-1.6(a)1iv does not specifically limit from the source(s) where additional information or documentation may come. A carrier is permitted to consider additional information or documentation that may come from any source, provided it is relevant to the claim, is received after the first review, and leads to additional reasons to deny or dispute the claim that were not evident during the first review.

COMMENT: Several commenters stated that N.J.A.C. 11:22-1.6(b) provides that where a health plan does not provide the required initial notice of denial or dispute of a claim within the time allowed, or does not list all reasons for denial in that initial notice, the health plan waives its right to later contest or deny that claim. The commenter stated that this provision provides an undeserved windfall to the provider who submits a claim for a procedure that is not covered under the terms of the insured's contract with the health plan, but is processed in such a way that the initial notice of denial is a day late or neglects to list the proper reason for denial.

The commenter requested that the Department eliminate this provision upon adoption, or through a reproposal if the Department deems that necessary.

RESPONSE: The commenter's suggestion is beyond the scope of this reproposal, since no amendments were proposed to N.J.A.C. 11:22-1.6(b). The Department will consider the suggestion and, after reviewing the claims payment practices and patterns of health plans, may act upon it in the future.

COMMENT: One commenter urged the Department to reconsider whether the ceiling on the amount of unpaid interest that a provider can agree to be aggregated should be placed at $25.00, as proposed in N.J.A.C. 11:22-1.6(c). The commenter stated that providers should have the flexibility to limit the frequency with which they receive aggregate interest payments. Their reason for agreeing to such limitations is to avoid the administrative expense of recording, depositing and allocating the payments, potentially from dozens of carriers. The carriers have an even greater financial incentive, since the costs involved in preparing the check, together with their banks' fees, are likely to be in the range of $10.00 to $15.00 per check. The commenter stated that there is definitely a cost savings in aggregating up to $25.00, but there would be significant additional cost savings if a higher ceiling were permitted (and agreed to by the provider and carrier.) Therefore the commenter urged the Department to delete "up to $25.00" from N.J.A.C. 11:22-1.6(c) upon adoption.

The commenter also urged the Department to make it clear that its rules do not require carriers to pay de minimis interest (that is, interest on a claim where the interest is less than $1.00) so long as the carrier maintains auditable records.

RESPONSE: The Department reproposed these amendments with a ceiling of $25.00 on interest amounts that carriers are permitted to aggregate, with the consent of the provider. The Department amended this provision as initially proposed and raised the amount from the

proposed “under a dollar” to $25.00, based on comments received on its September 17, 2001 proposal. See 33 N.J.R. 3239(a). The 10 percent interest is a “penalty” for failing to pay a clean claim within the limits set forth in N.J.A.C. 11:22-1.5. The option exists for carriers and their agents to pay interest at the time payment is made, thus eliminating the need for additional checks. Further, if clean claims are paid timely and carriers are in compliance, the financial burden is minimized. Therefore, the Department believes that the $25.00 ceiling is appropriate and reasonable.

COMMENT: One commenter expressed support for the rule provisions requiring that all reasons for denial of a claim, both substantive and process oriented (that is., missing fields, incorrect data, etc.), must be identified and explained within the appropriate timeframe. The commenter also supported the Department’s proposal that allows carriers to deny or dispute a claim because it cannot be entered into the claims system and, once those errors are cured, that the carrier can then deny or dispute the claim for substantive reasons that were known to the carrier at the initial submission. The commenter stated that this will prevent the “ping-pong” denial and resubmission of claims.

According to the commenter, however, there are some issues concerning the electronic filing of claims that are not addressed by these amendments. The commenter stated that it is concerned that certain carriers have instituted policies that in many instances prevent the submission of electronic claims. The commenter stated that these actions are contrary to the law's intent to encourage the electronic submission of claims. The commenter stated that it is aware of one company which requires that referrals be made on paper and that the resulting claims be submitted on paper, not electronically. The commenter stated that another provider

will allow the electronic submission of claims for specialty services, but does not allow electronic billing of primary care services. The commenter stated that carriers should allow for the electronic submission, of all claims by providers. By requiring paper claim submissions, these carriers are defeating the intention of the underlying law to promote electronic submissions of claim information.

RESPONSE: N.J.A.C. 11:22-1.6(a)1iv as proposed prohibits carriers or their agents from denying or disputing a claim for reasons other than those identified in the first review after the claim is entered, unless relevant information is received following the first review and provides additional reasons to deny or dispute that were not present at the time of the first review. The commenter's additional remarks address provisions found in N.J.A.C. 11:22-3 and the Health Information Electronic Data Interchange Technology Act (HINT), and are beyond the scope of this reproposal.

COMMENT: Several commenters remarked about the proposed amendments to N.J.A.C. 11:22-1.8, Internal and external appeals, and requested that the Department retain the requirement that payers submit a copy of the provider appeal report to the Department. The commenters believe that a key element in gauging the efficacy of the Department's rules is the ability of providers to continue to have access under New Jersey's "Right to Know Act" to the payers' reports detailing the number and disposition of appeals filed by providers.

RESPONSE: The Department agrees with the commenters and has determined not to adopt the proposed amendments to N.J.A.C.11:22-1.8(d).

COMMENT: One commenter stated that a mechanism is needed whereby providers can report directly to the Department any insurance carriers who do not comply with these rules. The commenter stated that the internal appeals process simply sends the issue back to the same entity that denied the claim in the first place. The commenter contends that a clerical person who does not have the qualifications, training, or credentials equaling those of the provider submitting the claim usually conducts the carrier's internal review process. Internal appeals mechanisms also do not address claims that are in limbo (that is, claims that the carrier cannot locate, denies receiving, claims that are pending, etc.). The external appeals process is cost prohibitive and is an additional burden to the provider, who has to pay out money to secure compensation for services that have already been provided and remain uncompensated (not to mention staffing costs to do the paperwork). In addition, the ADR mechanism is non-binding.

The commenter further stated that responses to provider complaints to the Department have been form letters stating that the Department does not address individual provider complaints. When insurance carriers utilize the services of third party administrators, the provider is "ping-ponged" back and forth between the two entities with no recourse and no resolution of the issues. The commenter stated that another example is when a patient has multiple insurers and each carrier denies payment and the claim goes back and forth between two or three carriers with no resolution. The carriers, as well as the third party administrators, need to be held accountable for their actions to a higher authority (that is, the Department).

Finally, the commenter stated that the annual provider reports, which can be made available to the Department per their request, do not account for claims not processed, or claims in limbo as described in the above scenarios. These reports are also not available to providers or the public. The commenter asked: if the Department does not accept complaints from providers

notifying them of the problems with the carriers, what would prompt the Department to request an annual report from the carrier?

Therefore, the commenter requested that the Department amend this provision to specifically address the issue of where and how providers report non-compliance with the Department's rules.

RESPONSE: The Department believes that the mechanisms providing for internal and external appeals as required by N.J.A.C. 11:22 1.8 are reasonable and appropriate, and encourage providers to pursue any such issue(s) accordingly. Delayed payment complaints and other matters related to N.J.A.C. 11:22 that demonstrate broad-based problems may be brought to the attention of providers' professional organizations which, in turn, will advise the Department of companies that appear to be violating applicable rules. Further, providers that encounter carriers or their agents who do not afford them the ability to resolve a dispute relating to payment of claims, excluding appeals made pursuant to N.J.A.C. 8:38-8.5 through 8.7 and N.J.A.C. 8:38A-3.6 through 3.7, or who have an unreasonably large or disproportionate number of eligible claims that continue to be disputed, denied or not paid in accordance with the time frames in N.J.A.C. 11:22-1.5, or not paid with interest as required pursuant to N.J.A.C. 11:22-1.6, may file a complaint with the Department through Consumer Protection Services and provide the specifics of the problem(s) encountered.

Federal Standards Analysis

As a result of a comment received during the comment period, the Department is providing a Federal Standards Analysis to these amendments, instead of the Federal Standards Statement that was included in the proposal.

There may be some health plans that are subject to ERISA as well as these rules. The Department's rules implement the statutory requirements and follow the guidelines set forth in N.J.S.A. 17B:26-9.1 and 17B:30-23 et seq. N.J.S.A. 17B:26-9.1d(2) addresses denied and disputed claims. This statutory provision also provides that when a claim submission is incomplete, the carrier shall notify the provider through delivery of a written statement indicating what substantiating documentation is required to complete the adjudication of the claim. The Department's rules (see N.J.A.C. 11:22-1.6(a)) require a carrier or its agent to either deny or dispute a claim in full or in part or pay the claim. The Department's amendatory language to this provision states that "the pending of a claim does not constitute a dispute or denial." The purpose of this language is to clarify that the pending of a claim does not stop the clock from running for purposes of processing a claim within the time frames specified in N.J.A.C. 11:22-1.6. In cases where the Department's rules impose shorter time frames than the maximum time frames for processing or paying claims permitted under ERISA, it is noted that these rules are in accordance with the provisions of N.J.S.A. 17B:26-9.1. The Department does not believe that carriers will incur any additional costs by complying with this procedural provision.

Summary of Agency-Initiated Change

The Department is amending N.J.A.C. 11:22-1.8(c) to reflect correctly where the reports of this section shall be submitted.

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

11:22-1.8 Internal and external appeals

(a) - (c) (No change.)

(d) Carriers shall *[maintain and make available at the request of the Department, the annual provider]* ***annually*** report, in a format prescribed by the Department, *[which includes]* the number of internal and external provider appeals received and how they were resolved.

11:22-1.9 Reporting requirements

(a) - (b) (No change.)

(c) The report shall be submitted to the Department by the due date to:

New Jersey Department of Banking and Insurance
[Office of Enforcement and Consumer Protection]
Life & Health Actuarial
Prompt Payments Reports
20 West State Street
PO Box 329
Trenton, New Jersey 08625-0329

(d) (No change.)

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