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BULLETIN NO. 13-09

TO: **ALL HEALTH INSURANCE COMPANIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS IN NEW JERSEY, ALL DENTAL SERVICE CORPORATIONS, DENTAL PLAN ORGANIZATIONS AUTHORIZED TO ISSUE DENTAL PLANS IN NEW JERSEY, AND ALL LICENSED AND CERTIFIED ORGANIZED DELIVERY SYSTEMS IN NEW JERSEY**

FROM: **KENNETH E. KOBYLOWSKI, COMMISSIONER**

RE: **ACCURACY OF DENIAL REASONS IN EXPLANATION OF BENEFITS FORMS**

New Jersey's Unfair Claims Settlement Practices Act at N.J.S.A. 17B:30-13.1n requires all insurance companies, health service corporations, hospital service corporations, medical service corporations, health maintenance organizations, dental service corporations and dental plan organizations and other persons paying claims to "promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement." Similarly, N.J.A.C. 11:22-1.6(a)1 obligates all the above listed carriers and their agents to identify and explain all reasons why a claim is denied or disputed. Further, several laws applicable to certain carriers require health insurance policies and contracts that include coverage for health care services provided by a physician to be deemed to also include health care services provided by other types of licensed providers when the provider performs an eligible service within the scope of their practice so long as they are not being compensated by a hospital or other health care facility. See, e.g., P.L. 1971, c. 144, P.L. 1975, c. 125, P.L. 1979, c. 158 and P.L. 1985, c. 236 (collectively "scope of practice laws").

It has come to the Department's attention that some carriers and their agents may be issuing explanations of benefits (EOBs), remittance advice forms, or other types of written statements that explain how a claim was processed, but that do not accurately or completely state the reason for denials of claims. For example, a carrier may state that providers of a certain type or specialty cannot perform the service for which the claim was made, or that no payment is allowed for the service when performed by a provider practicing in a particular specialty, when such statement is contrary to the scope of practice laws referenced above. In some cases, payment may actually have been denied for a reason other than the stated reason, including the provider's submission of a claim with a code that is incompatible with the carrier's

coding system, or a claim for providing a service that the carrier considers not medically necessary.

The purpose of this Bulletin is to remind carriers and their agents of their obligation to issue EOBs or similar claims payment statements that convey correct, detailed information relative to a claim and, if applicable, describe with accuracy all reasons why the total original charges were not paid in full, in order to maximize the value of such statements to patients and their providers. EOBs and similar claims payment statements that fail to do so will not be considered to be in compliance with the statutes and regulation cited above.

May 3, 2013
Date

Kenneth E. Kobylowski, Commissioner

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