ASSEMBLY, No. 3334

STATE OF NEW JERSEY

214th LEGISLATURE

INTRODUCED OCTOBER 7, 2010

Sponsored by:
Assemblyman JOHN F. MCKEON
District 27 (Essex)
Assemblywoman LINDA STENDER
District 22 (Middlesex, Somerset and Union)

SYNOPSIS

Expands scope of claims subject to "Health Claims Authorization, Processing and Payment Act," and modifies certain claims procedures.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health claims and amending P.L.2005, c.352.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.2005, c.352 (C.17B:30-49) is amended to read as follows:

2. The Legislature finds and declares that:

a. Health care services available under health benefits plans must be promptly provided to covered persons under all circumstances, along with timely reimbursement to hospitals **[**and**]**, physicians and other health care providers for their services rendered;

b. However, confusion still exists among consumers, hospitals, physicians and other health care providers, and carriers with respect to time frames for communication of determinations by carriers to deny, reduce or terminate benefits under the provisions of a health benefits plan based upon utilization management decisions;

c. Since it is the declared public policy of the State that hospital and related health care services be of the highest quality and demonstrated need and be efficiently provided and properly utilized at a reasonable cost, the hospital care and related health care services must be appropriate to the condition of the patient and payment must be for services that were rendered to the patient;

d. Because it is fair and reasonable for hospitals **[**and**]** , physicians and other health care providers to receive reimbursement for health care services delivered to covered persons under their health benefits plans and inefficiencies in any area of the health care delivery system reflect poorly on all aspects of the health care delivery system, and because those inefficiencies can harm the consumers of health care, it is appropriate for the Legislature now to establish uniform procedures and guidelines for hospitals, physicians and other health care providers, and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers.

(cf: P.L.2005, c.352, s.2)

2. Section 3 of P.L.2005, c.352 (C.17B:30-50) is amended to read as follows:

3. As used in sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54):

"Authorization" means a determination required under a health benefits plan, that, based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

"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.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Generally accepted standards of medical or clinical practice" means standards that are based on: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas; and any other relevant factor as determined by the commissioner by regulation.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered 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+Choice contracts to the extent not otherwise prohibited by federal law. For the purposes of sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54), health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Civilian Health and Medical Program for the Uniformed Services, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means a hospital, occupational therapist, physical therapist, physician, or speech-language pathologist.

"Hospital" means a general acute care facility licensed by the Commissioner of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric and long-term acute facilities.

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person 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 or clinical 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.

"Network provider" means a participating [hospital or physician] health care provider under contract or other agreement with a carrier to furnish health care services to covered persons.

"Occupational therapist" means an occupational therapist licensed pursuant to the "Occupational Therapy Licensing Act," P.L.1993, c.85 (C.45:9-37.51 et seq.).

"Payer" means a carrier which requires that utilization management be performed to authorize the approval of a health care service and includes an organized delivery system that is certified by the Commissioner of Health and Senior Services or licensed by the commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer's agent" or "agent" means an intermediary contracted or affiliated with the payer to provide authorization for service or perform administrative functions including, but not limited to, the payment of claims or the receipt, processing or transfer of claims or claim information.

"Physical therapist" means a physical therapist licensed pursuant to the "Physical Therapist Licensing Act of 1983," P.L.1983, c.296 (C.45:9-37.11 et seq.).

"Physician" means a physician licensed pursuant to chapter 9 of Title 45 of the Revised Statutes.

"Speech-language pathologist" means a speech-language pathologist as defined by, and licensed pursuant to, P.L.1983, c.420 (C.45:3B-1 et seq.).

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

(cf: P.L.2005, c.352, s.3)

3. Section 4 of P.L.2005, c.352 (C.17B:30-51) is amended to read as follows:

4. a. A payer shall provide the following information concerning utilization management and the processing and payment

of claims in a clear and conspicuous manner through an Internet website no later than 30 calendar days before the information or policies or any changes in the information or policies take effect:

(1) a description of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of health care services, which shall include, but not be limited to, information concerning the computer algorithms utilized to make a determination and the development of those algorithms;

(2) a list of the material, documents or other information required to be submitted to the payer with a claim for payment for health care services;

(3) a description of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description;

(4) the payer's policy or procedure for reducing the payment for a duplicate or subsequent service provided by a health care provider on the same date of service; and

(5) any other information the commissioner deems necessary.

b. Any changes in the information or policies required to be provided pursuant to subsection a. of this section shall be clearly noted on the Internet website.

(cf: P.L.2005, c.352, s.4)

4. Section 5 of P.L.2005, c.352 (C.17B:30-52) is amended to read as follows:

5. a. A payer shall respond to a **[**hospital or physician**]** health care provider request for authorization of health care services by either approving or denying the request based on the covered person's health benefits plan. Any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a **[**physician**]** health care provider licensed to practice in the same field of practice as the requesting health care provider under the clinical direction of the medical director who shall be licensed in this State and communicated to the **[**hospital or physician**]** health care provider by facsimile, E-mail or any other means of written communication agreed to by the payer and **[**hospital or physician**]** health care provider, as follows:

(1) in the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the **[**hospital or physician**]** health care provider within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made;

(2) in the case of a request for authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the **[**hospital or physician**]** health care provider within a time frame appropriate to the medical exigencies of the case but no later than 24 hours following the time the request was made;

(3) in the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility or nursing home, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the **[**hospital or physician**]** health care provider within a time frame appropriate to the medical exigencies of the case but no later than 15 days following the time the request was made; and

(4) if the payer requires additional information to approve or deny a request for authorization, the payer shall so notify the **[**hospital or physician**]** health care provider by facsimile, E-mail or any other means of written communication agreed to by the payer and **[**hospital or physician**]** health care provider within the applicable time frame set forth in paragraph (1), (2) or (3) of this subsection and shall identify the specific information needed to approve or deny the request for authorization.

If the payer is unable to approve or deny a request for authorization within the applicable time frame set forth in paragraph (1), (2) or (3) of this subsection because of the need for this additional information, the payer shall have an additional period within which to approve or deny the request, as follows:

(a) in the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services, within a time frame appropriate to the medical exigencies of the case but no later than 15 days beyond the time of receipt by the payer from the **[**hospital or physician**]** health care provider of the additional information that the payer has identified as needed to approve or deny the request for authorization;

(b) in the case of a request for authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, no more than 24 hours beyond the time of receipt by the payer from the **[**hospital or physician**]** health care provider of the additional information that the payer has identified as needed to approve or deny the request for authorization; and

(c) in the case of a request for authorization for a covered person who will be receiving health care services in another setting, within a time frame appropriate to the medical exigencies of the case but no more than **[**15**]** three days beyond the time of receipt by

the payer from the ⟦hospital or physician⟧ health care provider of the additional information that the payer has identified as needed to approve or deny the request for authorization.

b. Payers and hospitals shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the time frames established pursuant to subsection a. of this section.

c. If a payer fails to respond to an authorization request within the time frames established pursuant to subsection a. of this section, the ⟦hospital or physician's⟧ health care provider's request shall be deemed approved and the payer shall be responsible to the ⟦hospital or physician⟧ health care provider for the payment of the covered services delivered pursuant to the ⟦hospital or physician's⟧ health care provider's contract with the payer.

d. If a ⟦hospital or physician⟧ health care provider fails to respond to a payer's request for additional information necessary to render an authorization decision within 72 hours, the ⟦hospital or physician's⟧ health care provider's request for authorization shall be deemed withdrawn.

(cf: P.L.2005, c.352, s.5)

5. Section 6 of P.L.2005, c.352 (C.17B:30-53) is amended to read as follows:

6. a. When a ⟦hospital or physician⟧ health care provider complies with the provisions set forth in section 5 of P.L.2005, c.352 (C.17B:30-52), no payer, or payer's agent, shall deny reimbursement to ⟦a hospital or physician⟧ the health care provider for covered services rendered to a covered person on grounds of medical necessity in the absence of fraud or misrepresentation if the ⟦hospital or physician⟧ health care provider:

(1) requested authorization from the payer and received approval for the health care services delivered prior to rendering the service;

(2) requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the ⟦hospital or physician⟧ health care provider within the time frames established pursuant to section 5 of P.L.2005, c.352 (C.17B:30-52); or

(3) received authorization for the covered service for a patient who is no longer eligible to receive coverage from that payer and it is determined that the patient is covered by another payer, in which case the subsequent payer, based on the subsequent payer's benefits plan, shall accept the authorization and reimburse the ⟦hospital or physician⟧ health care provider.

b. If the [hospital] health care provider is a network provider of the payer, health care services shall be reimbursed at the contracted rate for the services provided.

c. No payer, or payer's agent, shall amend a claim by changing the diagnostic code assigned to the services rendered by a [hospital or physician] health care provider without providing written justification.

(cf: P.L.2005, c.352, s.6)

6. This act shall take effect on the first day of the seventh month next following enactment, but the Commissioner of Banking and Insurance may take any anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill expands the scope of claims subject to sections 3 through 7 of the "Health Claims Authorization, Processing and Payment Act" (hereafter "claims act"), P.L.2005, c.352 (C.17B:30-50 through 17B:30-54), to include prompt authorization for claims involving benefits provided by occupational therapists, physical therapists, and speech-language pathologists.

Further, regarding utilization management of all claims subject to the claims act, it requires that carriers and organized delivery systems, in addition to the utilization management information they already provide via Internet website pursuant to the act, include information concerning the computer algorithms and the development of such algorithms used to make utilization management decisions concerning the medical necessity of health care services.

Finally, the bill, under section 4:

- requires that any carrier or organized delivery system denial of, or limitation imposed upon, a request for authorization be made by a licensed health care provider in the same field of practice as the requesting health care provider; and

- reduces the time frame under which a carrier or organized delivery system shall respond to a health care provider's request for authorization to provide services to a covered person, in those instances when the carrier or organized delivery system is initially unable to approve or deny a request for authorization because of the need for additional information, and requests this additional information from the health care provider. The carrier or organized delivery system, upon receipt of any additional information, shall respond within three days to the requesting health care provider, instead of the 15 days as currently provided under the law.