ASSEMBLY, No. 2382

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 1, 2018

Sponsored by:
Assemblyman GARY S. SCHAER
District 36 (Bergen and Passaic)

SYNOPSIS

Requires carriers to classify medically necessary procedures as covered benefits and remit certain payments to hospitals for services rendered.

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 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, as well as a determination that the health care services thereby provided are covered services under that member's health benefits plan.

"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 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**]** Medicare Advantage 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

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.

Health and Medical Program for the Uniformed Services, CHAMPUS] TRICARE 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.

"Hospital" means a general acute care facility licensed by the Commissioner of Health 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 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 under contract or other agreement with a carrier to furnish health care services to covered persons.

"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 Banking and Insurance 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.

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

"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.2012, c.17, s.71)

2. 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 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 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:

(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 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.

b. If the hospital is a network provider of the payer, health care services shall be reimbursed at the contracted rate for the services provided <u>and based on the setting in which the services are delivered</u>.

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 without providing written justification.

<u>d. A payer shall reimburse a hospital for all medically necessary services rendered to the covered person at the contracted rate for services provided if it has reimbursed another health care provider for rendering medically necessary services to that same covered person at the hospital.</u>

<u>e. If a payer has determined that a covered person, who is an inpatient in a hospital, requires medically necessary health care services that are not available or provided at the hospital or are less than the acute level of care provided at the hospital, the payer shall be responsible for identifying an available contracted health care provider that offers the required covered services and that will accept the covered person. The payer shall pay the hospital in accordance with the contracted acute care rate until an appropriate placement of the patient can be made.</u>
(cf: P.L.2005, c.352, s.6)

3. This act shall take effect on the 90th day after the date of enactment.

STATEMENT

This bill amends the "Health Claims Authorization, Processing and Payment Act" by requiring health insurance carriers to classify health care services that are deemed authorized by the insurance carrier as a covered benefit. Currently, carriers that receive a request for authorization from a health care provider are only required to respond to the request with a determination as to whether the health care service is medically necessary under the member's health benefits plan. This bill provides that carriers that provide authorization are determining that the health care services are a covered benefit under the insured's health benefits plan, in addition to being medically necessary.

The bill requires carriers to remit payment to a hospital if the carrier remits payment to a health care provider who performs services on a patient in that hospital. In certain instances, a carrier may remit payment to a health care provider who renders care to a patient in the hospital, but will deny a hospital's claim for reimbursement for services rendered in connection with those same services rendered by a health care provider to the patient. This bill requires carriers to remit payment to a hospital and a health care provider for rendering related services to the same patient at that hospital.

Finally, the bill provides that while a patient remains in the hospital awaiting authorization from the carrier to be transferred to another facility to receive medically necessary health care services that are not rendered by that hospital, the carrier shall remit payment to the hospital in connection with the contracted acute care rate until the patient is transferred to another health care facility. Currently, if it is determined that a patient needs to be transferred to another health care facility, carriers will begin to remit payment to a hospital at a rate that is less than the amount contracted for between the hospital and the carrier. This bill provides that the carrier shall remit payment to the hospital at a rate based on the actual setting of care (e.g., inpatient rate while the patient remains in the hospital).