

ASSEMBLY, No. 1854

STATE OF NEW JERSEY 219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Assemblywoman HOLLY T. SCHEPISI

District 39 (Bergen and Passaic)

SYNOPSIS

Requires insurers to reimburse for medically necessary emergency and urgent care health care services in outpatient settings.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



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1 AN ACT concerning certain authorizations for health care services
2 and amending P.L.2005, c.352.

3

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

6

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

9 5. a. A payer shall respond to a hospital or physician request
10 for authorization of health care services by either approving or
11 denying the request based on the covered person's health benefits
12 plan. Any denial of a request for authorization or limitation
13 imposed by a payer on a requested service shall be made by a
14 physician under the clinical direction of the medical director who
15 shall be licensed in this State and communicated to the hospital or
16 physician by facsimile, E-mail or any other means of written
17 communication agreed to by the payer and hospital or physician, as
18 follows:

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

25 (2) in the case of a request for authorization for a covered
26 person who is currently receiving inpatient hospital services,
27 emergency or urgent health care services in an outpatient or other
28 setting, including a physician's office, or care rendered in the
29 emergency department of a hospital, the payer shall communicate
30 the denial of the request or the limitation imposed on the requested
31 service to the hospital or physician within a time frame appropriate
32 to the medical exigencies of the case but no later than 24 hours
33 following the time the request was made;

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

42 (4) if the payer requires additional information to approve or
43 deny a request for authorization, the payer shall so notify the
44 hospital or physician by facsimile, E-mail or any other means of
45 written communication agreed to by the payer and hospital or

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.

1 physician within the applicable time frame set forth in paragraph
2 (1), (2) or (3) of this subsection and shall identify the specific
3 information needed to approve or deny the request for
4 authorization.

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

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

17 (b) in the case of a request for authorization for a covered
18 person who is currently receiving inpatient hospital services ,
19 emergency or urgent health care services in an outpatient or other
20 setting, including a physician's office, or care rendered in the
21 emergency department of a hospital, no more than 24 hours beyond
22 the time of receipt by the payer from the hospital or physician of the
23 additional information that the payer has identified as needed to
24 approve or deny the request for authorization; and

25 (c) in the case of a request for authorization for a covered
26 person who will be receiving health care services in another setting,
27 within a time frame appropriate to the medical exigencies of the
28 case but no more than 15 days beyond the time of receipt by the
29 payer from the hospital or physician of the additional information
30 that the payer has identified as needed to approve or deny the
31 request for authorization.

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

36 c. If a payer fails to respond to an authorization request within
37 the time frames established pursuant to subsection a. of this section,
38 the hospital or physician's request shall be deemed approved and the
39 payer shall be responsible to the hospital or physician for the
40 payment of the covered services delivered pursuant to the hospital
41 or physician's contract with the payer.

42 d. If a hospital or physician fails to respond to a payer's request
43 for additional information necessary to render an authorization
44 decision within 72 hours, the hospital or physician's request for
45 authorization shall be deemed withdrawn.

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

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1 2. Section 7 of P.L.2005, c.352 (C.17B:30-54) is amended to
2 read as follows:

3 7. A payer, or payer's agent, shall reimburse a hospital or
4 physician according to the provider contract for all medically
5 necessary emergency and urgent care health care services that are
6 covered under the health benefits plan, including all tests necessary
7 to determine the nature of an illness or injury and regardless
8 whether the services are provided in an emergency room or other
9 facility, or in an outpatient setting, including a physician's office.
10 (cf: P.L.2005, c.352, s.7)

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12 3. This act shall take effect immediately.

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STATEMENT

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17 This bill provides that, in the case of a request for authorization
18 for a covered person who is currently receiving emergency or
19 urgent health care services in an outpatient or other setting,
20 including a physician's office, the payer shall communicate the
21 denial of the request or the limitation imposed on the requested
22 service to the hospital or physician within a time frame appropriate
23 to the medical exigencies of the case but no later than 24 hours
24 following the time the request was made.

25 The bill also provides that the current requirement that a health
26 insurance carrier shall reimburse a hospital or physician according
27 to the provider contract for all medically necessary emergency and
28 urgent care health care services that are covered under the health
29 benefits plan, including all tests necessary to determine the nature
30 of an illness or injury applies regardless whether the services are
31 provided in an emergency room or other facility, or in an outpatient
32 setting, such as a physician's office.

33 The intent of this bill is, for the purposes of utilization
34 management, to treat medically necessary emergency and urgent
35 care health care services the same regardless of whether they arise
36 in a hospital or in a physician's office.