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.

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

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

1. 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 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 under the clinical direction of the medical director who shall be licensed in this State and communicated to the hospital or physician by facsimile, E-mail or any other means of written communication agreed to by the payer and hospital or physician, 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 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, emergency or urgent health care services in an outpatient or other setting, including a physician's office, 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 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 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 by facsimile, E-mail or any other means of 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.

physician 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 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 , emergency or urgent health care services in an outpatient or other setting, including a physician’s office, 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 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 days beyond the time of receipt by the payer from the hospital or physician 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 request shall be deemed approved and the payer shall be responsible to the hospital or physician for the payment of the covered services delivered pursuant to the hospital or physician's contract with the payer.

d. If a hospital or physician 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 request for authorization shall be deemed withdrawn.

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

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

7. A payer, or payer's agent, shall reimburse a hospital or physician according to the provider contract for all medically necessary emergency and urgent care health care services that are covered under the health benefits plan, including all tests necessary to determine the nature of an illness or injury <u>and regardless whether the services are provided in an emergency room or other facility, or in an outpatient setting, including a physician's office</u>.

(cf: P.L.2005, c.352, s.7)

3. This act shall take effect immediately.

STATEMENT

This bill provides that, in the case of a request for authorization for a covered person who is currently receiving emergency or urgent health care services in an outpatient or other setting, including a physician's office, the payer shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or physician 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.

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

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