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STATE OF NEW JERSEY

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PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

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SYNOPSIS

"New Jersey Respect for Physicians Act;" requires prompt response by insurers to requests for prior authorization of health care services.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning health insurance authorizations and amending and supplementing P.L.2005, c.352.

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

1. This act shall be known and may be cited as the "New Jersey Respect for Physicians Act."

2. 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**]** <u>48 hours</u> 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 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**]** <u>48 hours</u> 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

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 <u>thus</u> is new matter.

hospital or physician by facsimile, E-mail or any other means of written communication agreed to by the payer and hospital or 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**]** 48 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;

(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 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**]** 48 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.

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.

e. With respect to a request for authorization pursuant to paragraphs (1) or (3) of subsection a. of this section, a payer shall

make reasonable attempts to contact the hospital and physician, as appropriate, by telephone to discuss the request within four hours of the request being made.

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

3. This act shall take effect immediately.

STATEMENT

This bill, entitled the “New Jersey Respect for Physicians Act” amends the "Health Claims Authorization, Processing and Payment Act” to require health insurance carriers to contact the hospital and physician within four hours to discuss a decision to authorize certain health care services and to reduce the amount of time in which a carrier must respond to requests for prior authorization.

In the case of a request for prior authorization for a covered person who will be receiving inpatient hospital services or health care services in an outpatient or other setting, current law requires the insurance carrier to 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. This bill would reduce that to a time frame appropriate to the medical exigencies of the case but no later than 48 hours following the time the request was made. The bill similarly reduces the amount of additional time permitted if the payer needs additional information.

With respect to authorizations for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department of a hospital, the law would remain the same and a denial or limitation shall be communicated no later than 24 hours following the time the request was made.