

SENATE, No. 661

STATE OF NEW JERSEY 219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Senator SAMUEL D. THOMPSON

District 12 (Burlington, Middlesex, Monmouth and Ocean)

SYNOPSIS

Requires health insurers to cover treatment ordered by health care provider for covered person based on generally accepted standards of health care practice, subject to appeal; creates Carrier Appeals Program.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** concerning health benefits coverage and supplementing
2 and repealing various sections of P.L.1997, c.192 (C.26:2S-1 et
3 seq.).
4

5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*
7

8 1. a. Notwithstanding the provisions of this or any other
9 statute or regulation to the contrary, and in accordance with
10 regulations to be adopted by the Department of Health and Senior
11 Services, when a health care provider, in the course of providing
12 health care services to a covered person, determines that a particular
13 form of care or treatment is medically necessary or appropriate and
14 can furnish reasonable evidence that the care or treatment is based
15 upon generally accepted standards of health care practice, the
16 carrier shall cover any health care service provided to the covered
17 person as part of that care or treatment and shall not deny, reduce or
18 terminate a health care benefit or deny payment for a health care
19 service associated with that care or treatment; except that:

20 (1) The provisions of this section shall not be construed to
21 require a carrier to provide a benefit that is not covered by a
22 covered person's health benefits plan; and

23 (2) A carrier may appeal a health care provider's order of a
24 health care service for a covered person to the Carrier Appeals
25 Program established pursuant to subsection b. of this section on the
26 grounds that the service is not medically necessary or appropriate.

27 b. There is established the Carrier Appeals Program in the
28 department to provide an independent review of an appeal by a
29 carrier of one or more health care services for a covered person
30 which the carrier contends is not medically necessary or
31 appropriate.

32 (1) A carrier may apply to the Carrier Appeals Program for a
33 review of a health care provider's order of a health care service for a
34 covered person which the carrier contends is not medically
35 necessary or appropriate, within 30 days of the date that the order
36 was entered by the provider, in a manner determined by the
37 Commissioner of Health and Senior Services.

38 (2) As part of the application, the carrier shall provide the
39 department with:

40 (a) the name and business address of the carrier;

41 (b) a brief description of the covered person's medical condition
42 for which the health care provider ordered the health care service in
43 question;

44 (c) a copy of any information provided by the health care
45 provider regarding the order of the health care service, including, in
46 the case of a carrier which offers a managed care plan, any
47 information provided by an out-of-network physician that the
48 provider or covered person may have consulted on the matter;

1 (d) a copy of the pertinent medical records of the covered
2 person, which the health care provider shall be required to furnish
3 to the carrier as a condition of the carrier providing coverage for the
4 health care service in question; and

5 (e) any other information required by the department.

6 (3) The cost of the appeal review shall be borne by the carrier
7 pursuant to a schedule of fees established by the commissioner.

8 (4) The commissioner shall contract with one or more
9 independent utilization review organizations in the State that meet
10 the requirements of this subsection to review appeals pursuant to
11 this subsection. The independent utilization review organization
12 shall be independent of any carrier, health care facility or health
13 care provider organization. The commissioner may establish
14 additional requirements, including conflict of interest standards,
15 consistent with the purposes of this subsection that an organization
16 shall meet in order to qualify for participation in the Carrier
17 Appeals Program.

18 (5) The commissioner shall establish procedures for transmitting
19 the completed application for an appeal review to the independent
20 utilization review organization.

21 (6) The independent utilization review organization shall
22 promptly review the pertinent medical records of the covered
23 person to determine the appropriate, medically necessary health
24 care services that the covered person should receive, based on
25 applicable, generally accepted practice guidelines developed by the
26 federal government, national or professional medical societies,
27 boards or associations and any applicable clinical protocols or
28 practice guidelines developed by the carrier. The organization shall
29 complete its review and make its determination within 45 days of
30 receipt of a completed application for an appeal review or within
31 less time, as prescribed by the commissioner.

32 In making its determination regarding the appropriate, medically
33 necessary health care services that the covered person should
34 receive, the organization shall place the burden of proof on the
35 carrier to demonstrate that any service ordered by the covered
36 person's health care provider is not medically necessary or
37 appropriate

38 Upon completion of the review, the organization shall state its
39 findings in writing and shall convey to the carrier, health care
40 provider and covered person its decision regarding the appropriate,
41 medically necessary health care services that the person should
42 receive, which shall be binding on the carrier and provider with
43 respect to payment for the health care service. If the covered
44 person is not in agreement with the organization's decision, the
45 covered person may seek the desired health care services outside of
46 his health benefits plan, at his own expense.

47 (7) If the commissioner determines that a carrier has failed to
48 comply with the decision of an independent utilization review

1 organization or is otherwise in violation of a patient's rights or other
2 applicable regulations, the commissioner may impose such penalties
3 and sanctions on the carrier, as provided by regulation, as the
4 commissioner deems appropriate.

5 (8) The commissioner shall require the independent utilization
6 review organization to establish procedures to provide for an
7 expedited review of a carrier's appeal when a delay in receipt of a
8 health care service could seriously jeopardize the health or well-
9 being of the covered person.

10 (9) The covered person's medical records provided to the Carrier
11 Appeals Program and the independent utilization review
12 organization and the findings and recommendations of the
13 organization made pursuant to this act are confidential and shall be
14 used only by the department, the organization and the affected
15 carrier for the purposes of this act. The Carrier Appeals Program
16 and the independent utilization review organization shall not
17 divulge or otherwise make public the medical records and findings
18 and recommendations so as to disclose the identity of any person to
19 whom they relate, nor shall the medical records and findings and
20 recommendations be included under materials available to public
21 inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

22 (10) The commissioner shall establish a reasonable, per case
23 reimbursement schedule for the independent utilization review
24 organization.

25 (11) An employee of the department who participates in the
26 Carrier Appeals Program shall not be liable in any action for
27 damages to any person for any action taken within the scope of his
28 function in this program. The Attorney General shall defend the
29 person in any civil suit, and the State shall provide indemnification
30 for any damages awarded.

31 (12) The carrier that is the subject of a review shall not be liable
32 in any action for damages to any person for any action taken to
33 implement a recommendation of the independent utilization review
34 organization pursuant to this subsection.

35 (13) The commissioner shall report every six months to the
36 Senate and General Assembly standing reference committees on
37 health and insurance and to the Governor on the status of the
38 Carrier Appeals Program. The report shall include a summary of
39 the number of reviews conducted and medical specialties affected, a
40 summary of the findings and recommendations made by the
41 independent utilization review organization, any penalties or
42 sanctions imposed upon a carrier by the commissioner pursuant to
43 paragraph (7) of this subsection and any other information and
44 recommendations deemed appropriate by the commissioner.

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46 2. Sections 11 through 14 of P.L.1997, c.192 (C.26:2S-11
47 through 26:2S-14) are repealed.

1 3. This act shall take effect immediately.

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4 STATEMENT

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6 This bill supplements the "Health Care Quality Act,"
7 N.J.S.A.26:2S-1 et seq., to provide that when a physician or other
8 health care provider, in the course of providing health care services
9 to a covered person, determines that a particular form of care or
10 treatment is medically necessary or appropriate and can furnish
11 reasonable evidence that the care or treatment is based upon
12 generally accepted standards of health care practice, the covered
13 person's health insurance carrier shall cover any health care service
14 provided to the covered person as part of that care or treatment and
15 shall not deny, reduce or terminate a health care benefit or deny
16 payment for a health care service associated with that care or
17 treatment; except that:

- 18 • The provisions of this bill shall not be construed to require a
19 carrier to provide a benefit that is not covered by a covered
20 person's health benefits plan; and
21 • A carrier may appeal a provider's order of a health care
22 service for a covered person to a new Carrier Appeals
23 Program established in the Department of Health and Senior
24 Services (DHSS) under this bill.

25 The purpose of the new Carrier Appeals Program is to provide an
26 independent review of any appeal by a carrier of a provider's order
27 of a health care service for a covered person which the carrier
28 contends is not medically necessary or appropriate. The decision
29 rendered on a carrier's appeal of a provider's order by an
30 independent utilization review organization selected by DHSS
31 under this bill shall be binding on the carrier and provider with
32 respect to payment for the health care service. In making its
33 determination regarding the appropriate, medically necessary health
34 care services that the covered person should receive, the
35 independent utilization review organization shall place the burden
36 of proof on the carrier to demonstrate that any service ordered by
37 the covered person's provider is not medically necessary or
38 appropriate.

39 The bill repeals N.J.S.A.26:2S-11 through 14, which established
40 the Independent Health Care Appeals Program to consider appeals
41 by patients (and health care providers acting on their behalf) of a
42 carrier's final decision to deny, reduce or terminate health care
43 benefits provided to that person. The provisions of this bill obviate
44 the need for the Independent Health Care Appeals Program, since
45 carriers will now be required to cover any care or treatment ordered
46 by a provider which the provider determines is medically necessary
47 or appropriate and is based upon generally accepted standards of
48 health care practice.

1 The premise of this bill is that decisions about the medical care
2 and treatment of a patient should be based primarily on
3 considerations of medical necessity or appropriateness, rather than a
4 health insurer's "bottom line." The purpose of this bill is to provide
5 explicit statutory authority for putting the locus of decision-making
6 with regard to medical care and treatment that is provided to a
7 patient firmly in the hands of the patient's physician or other health
8 care provider, who is best qualified to determine which health care
9 services are medically necessary for that patient in accordance with
10 generally accepted standards of health care practice.