ASSEMBLY, No. 1890

STATE OF NEW JERSEY

210th LEGISLATURE

INTRODUCED FEBRUARY 21, 2002

Sponsored by:
Assemblyman NEIL M. COHEN
District 20 (Union)

Co-Sponsored by:
Assemblyman Eagler

SYNOPSIS

"Health and Dental Claims Authorization, Processing and Payment Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/15/2003)

AN ACT concerning health and dental claims authorization, processing and payment and supplementing Title 17B of the New Jersey Statutes.

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 "Health and Dental Claims Authorization, Processing and Payment Act."

2. The Legislature finds and declares that:

a. Health care services available under health benefits plans must be promptly provided to covered persons under all circumstances, along with timely reimbursement to health care providers for their services rendered.

b. However, confusion still exists among consumers, health care providers and carriers with respect to time frames for communication of determinations by carriers to deny, reduce or terminate benefits under the provisions of a health benefits plan based upon utilization management decisions, which determinations must be communicated as quickly and efficiently as possible.

c. Because both consumers and health care providers have experienced repeated denials or failure by carriers to respond to them in a timely manner with respect to utilization management determinations, many health care providers have found themselves financially uncompensated when carriers have failed to respond to certain requests for authorization of health care services.

d. Because these occurrences reflect negatively on health insurance carriers and because it is fair and reasonable for health care providers to receive reimbursement for health care services delivered to covered persons under their health benefits plans, it is appropriate for the Legislature now to establish uniform procedures and guidelines for health care providers and health insurance carriers to follow in communicating and following utilization management decisions and determinations on behalf of consumers.

3. As used in this act:

"Authorization" means a determination by a carrier that an admission, availability of health care services, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

"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.

1 "Commissioner" means the Commissioner of Banking and
2 Insurance.
3 "Covered person" means a person on whose behalf a carrier offering
4 the plan is obligated to pay benefits or provide services pursuant to the
5 health benefits plan.
6 "Covered service" means a health care service provided to a
7 covered person under a health benefits plan for which the carrier is
8 obligated to pay benefits or provide services.
9 "Health benefits plan" means a benefits plan which pays or provides
10 hospital and medical expense benefits for covered services, and is
11 delivered or issued for delivery in this State by or through a carrier.
12 Health benefits plan includes, but is not limited to, Medicare
13 supplement coverage and Medicare+Choice contracts to the extent not
14 otherwise prohibited by federal law. For the purposes of this act,
15 health benefits plan shall not include the following plans, policies or
16 contracts: accident only, credit, disability, long-term care, CHAMPUS
17 supplement coverage, coverage arising out of a workers' compensation
18 or similar law, automobile medical payment insurance, personal injury
19 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et
20 seq.) or hospital confinement indemnity coverage.
21 "Health care provider" means an individual or entity which, acting
22 within the scope of its licensure or certification, provides a covered
23 service defined by the health benefits plan. Health care provider
24 includes, but is not limited to, a physician and other health care
25 professionals licensed pursuant to Title 45 of the Revised Statutes, and
26 a hospital and other health care facilities licensed pursuant to Title 26
27 of the Revised Statutes.
28 "Network provider" means a participating health care provider
29 under contract or other agreement with a carrier to furnish health care
30 services to covered persons.
31 "Payer" means a carrier which requires that utilization management
32 be performed to authorize the approval of a health care service and
33 includes an organized delivery system that is certified by the
34 Commissioner of Health and Senior Services or licensed by the
35 commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).
36 "Payer's agent" or "agent" means an intermediary contracted or
37 affiliated with the payer to perform administrative functions including,
38 but not limited to, the payment of claims or the receipt, processing or
39 transfer of claims or claim information.
40 "Utilization management" means a system for reviewing the
41 appropriate and efficient allocation of health care services under a
42 health benefits plan according to specified guidelines, in order to
43 recommend or determine whether, or to what extent, a health care
44 service given or proposed to be given to a covered person should or
45 will be reimbursed, covered, paid for, or otherwise provided under the
46 health benefits plan. The system may include: preadmission

1 certification, the application of practice guidelines, continued stay
2 review, discharge planning, preauthorization of ambulatory care
3 procedures and retrospective review.
4
5 4. a. A payer shall respond to a health care provider's request for
6 authorization of health care services by either approving or denying
7 the request based on a utilization management decision. Any denial of
8 a request or limitation imposed by a payer on a requested service shall
9 be made by a physician licensed in this State and communicated to the
10 provider by facsimile or E-mail, as follows:
11 (1) In the case of a request for authorization for a covered person
12 who is receiving inpatient hospital services or care rendered in the
13 emergency department of a hospital, the payer shall communicate the
14 denial of the request or the limitation imposed on the requested service
15 to the provider within a time frame appropriate to the medical
16 exigencies of the case but no later than 24 hours following the time the
17 request was made;
18 (2) In the case of a request for authorization for a covered person
19 who is currently receiving health care services in an outpatient or other
20 setting, including but not limited to, a clinic, rehabilitation facility or
21 nursing home, the payer shall communicate the denial of the request
22 or the limitation imposed on the requested service to the provider
23 within a time frame appropriate to the medical exigencies of the case
24 but no later than three business days following the time the request
25 was made; and
26 (3) If the payer requires additional information to approve or deny
27 a request for authorization, the payer shall so notify the provider by
28 facsimile or E-mail within the applicable time frame set forth in
29 paragraph (1) or (2) of this subsection and shall identify the specific
30 information needed to approve or deny the request for authorization.
31 If the payer is unable to approve or deny a request for authorization
32 within the applicable time frame set forth in paragraph (1) or (2) of
33 this subsection because of the need for this additional information, the
34 payer shall have an additional period within which to approve or deny
35 the request, as follows:
36 (a) in the case of a request for authorization for a covered person
37 who is receiving inpatient hospital services or care rendered in the
38 emergency department of a hospital, no more than 12 hours beyond
39 the time of receipt by the payer from the provider of the additional
40 information that the payer has identified as needed to approve or deny
41 the request for authorization; and
42 (b) in the case of a request for authorization for a covered person
43 who is currently receiving health care services in another setting, no
44 more than two business days beyond the time of receipt by the payer
45 from the provider of the additional information that the payer has
46 identified as needed to approve or deny the request for authorization.

b. Payers and providers 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 health care provider's request shall be deemed approved and the payer shall be responsible to the health care provider for the payment of the requested services at the full contractual rate.

5. a. A payer, or its agent, shall reimburse a hospital if:

(1) the hospital requested authorization from the payer and received approval for the health care services delivered prior to rendering the service; or

(2) the hospital requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the hospital within the time frames established pursuant to subsection a. of section 4 of this act.

b. If the hospital or other health care provider is a network provider of the payer, health care services shall be reimbursed at the provider's contracted rate for the services provided and based on the setting in which the services are delivered.

c. 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 care to that same covered person at the hospital.

d. A payer, or its agent, shall not amend a claim by changing the diagnostic code assigned to the services rendered by the health care provider without providing written justification.

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 rate until an appropriate placement can be made.

6. a. A payer, or its agent, shall reimburse a health care provider for all medically necessary services rendered to a covered person that are covered under the health benefits plan, including emergency and urgent care health care services and all tests necessary, according to nationally recognized treatment protocols as developed by the federal government, to determine the nature of an illness or injury.

b. A payer shall provide each network health care provider with a copy of all clinical criteria guidelines used by the payer or agent to determine the medical necessity of health care services. These guidelines may be used by the payer only as a screening tool and may not be applied without considering the covered person's individual health care circumstances. The payer or agent shall notify each network provider in writing of any proposed change in the guidelines at least 60 days prior to implementing the change.

7. a. Upon admission to a hospital or prior to receiving health care services, a covered person or a person designated by the covered person may sign a consent form authorizing a health care provider, on the covered person's behalf, to appeal a determination by a payer to deny, reduce or terminate a health care benefit or deny payment for a health care service based upon the payer's determination that the health care benefit or service is not medically necessary, and which consent would be valid for all stages of the payer's informal and formal appeals process and the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11).

b. The health care provider shall provide notice to the covered person whenever the health care provider institutes an appeal of a payer's determination to deny, reduce or terminate a health care benefit or deny payment for a health care service and shall provide additional notice to the covered person each time the health care provider continues that appeal to the next stage of the payer's appeal process, including any appeal to an independent utilization review organization pursuant to section 12 of P.L.1997, c.192(C26:2s-12).

c. The covered person shall retain the right to revoke at any time his consent granted pursuant to subsection a. of this section.

8. a. A contract between a payer and any health care provider other than a dentist shall contain a provision, approved by the commissioner, that provides that any dispute regarding the recovery of payments due under the terms of this act, shall, on the initiative of any party to the dispute, be referred to arbitration as provided in this section.

b. Arbitration proceedings shall be conducted by an independent third-party. A party shall initiate an arbitration proceeding within 90 days of receipt of a written determination, on a form prescribed by the commissioner, which is the basis for the arbitration. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that disputed payment amounts may be aggregated for the purposes of meeting the threshold requirements of this section.

c. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program

established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) shall be the subject of arbitration pursuant to this section.

d. An arbitrator may review any records in connection with the payment dispute, including the claims file of the payer, or of the health care provider or the covered person to whom payment is due, subject to confidentiality requirements established by State or federal law.

e. (1) An arbitrator*s determination shall be in writing, in a form prescribed by the commissioner, and shall state the issues in dispute and the findings and conclusions on which the determination is based. The determination shall be signed by the arbitrator and shall be binding on all parties to the dispute.

(2) If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this act, the arbitrator shall order the payer to make payment of the claim within 10 business days.

(3) In accordance with regulations adopted by the commissioner, the cost of the arbitration proceedings, including the payment of reasonable attorney's fees, shall be awarded to the prevailing party.

9. a. For the purposes of this section:

"Dental care provider" means a dentist or other health care provider licensed pursuant to Title 45 of the Revised Statutes to perform dental care services in this State.

Dental care service" means a service provided to a covered person under a dental plan.

"Dental carrier" means a dental service corporation established pursuant to the "Dental Service Corporation Act of 1968," P.L.1968, c.305 (C.17:48C-1 et seq.), a dental plan organization established pursuant to the "Dental Plan Organization Act," P.L.1979, c.478 (C.17:48D-1 et seq.) or a carrier authorized to issue dental plans in this State.

"Dental claim" means a request to a third party for payment of a covered dental care service.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Predetermination request" means a request transmitted to a dental carrier in connection with a dental plan to issue an advance determination of coverage, which may include the amount of benefits then available for a dental care service prior to rendering the dental service or services.

b. A dental carrier shall respond to a dental care provider's predetermination request or request for authorization of dental care services by either approving or denying the request based on a utilization management decision. Any denial of a request or limitation imposed on a requested service shall be made by a dentist licensed in

1 this State, and communicated to the provider by facsimile or E-mail,
2 as follows:
3 (1) In the case of a predetermination request or request for
4 authorization for a covered person who is receiving care rendered in
5 the emergency department of a hospital, the dental carrier shall
6 communicate the denial of the request or the limitation imposed on the
7 requested service to the provider within a time frame appropriate to
8 the medical exigencies of the case but no later than 24 hours following
9 the time the request was made;
10 (2) In the case of a predetermination request or request for
11 authorization for a covered person who is currently receiving dental
12 care services in an outpatient setting, the dental carrier shall
13 communicate the denial of the request or the limitation imposed on the
14 requested service to the provider within a time frame appropriate to
15 the medical exigencies of the case but no later than five business days
16 following the time the request was made; and
17 (3) If the dental carrier requires additional information to approve
18 or deny a request for authorization, the dental carrier shall so notify
19 the provider by facsimile or E-mail within the applicable time frame set
20 forth in paragraph (1) or (2) of this subsection and shall identify the
21 specific information needed to approve or deny the request for
22 predetermination or authorization. If the dental carrier is unable to
23 approve or deny a request for predetermination or authorization within
24 the applicable time frame set forth in paragraph (1) or (2) of this
25 subsection because of the need for this additional information, the
26 dental carrier shall have an additional period within which to approve
27 or deny the request, as follows:
28 (a) in the case of a request for a predetermination request or
29 authorization for a covered person who is receiving care rendered in
30 the emergency department of a hospital, no more than 12 hours
31 beyond the time of receipt by the dental carrier from the provider of
32 the additional information that the dental carrier has identified as
33 needed to approve or deny the request for predetermination or
34 authorization; and
35 (b) in the case of a request for predetermination or authorization
36 for a covered person who is currently receiving health care services in
37 another setting, no more than two business days beyond the time of
38 receipt by the dental carrier from the provider of the additional
39 information that the dental carrier has identified as needed to approve
40 or deny the request for authorization.
41 c. Dental carriers and dental care providers shall have appropriate
42 staff available between the hours of 9 a.m. and 5 p.m., five days a
43 week, to respond to predetermination or authorization requests within
44 the time frames established pursuant to subsection a. of this section.
45 d. If a dental carrier fails to respond to a predetermination or
46 authorization request within the time frames established pursuant to

subsection a. of this section, the dental care provider's request shall be deemed approved and the dental carrier shall be responsible to the dental care provider for the payment of the requested services at the full contractual rate.

10. The commissioner shall enforce the provisions of this act. A payer or dental carrier found in violation of the provisions of this act shall be liable to a civil penalty of not less than $250 and not greater than $10,000 for each day that the payer or dental carrier is in violation of the act if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the payer or dental carrier has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

11. The commissioner shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) as are necessary to carry out the purposes of this act.

12. This act shall take effect on the 120th day after enactment, but the commissioner may take such anticipatory administrative action in advance as shall be necessary for the implementation of this act.

STATEMENT

This bill, the "Health and Dental Claims Authorization, Processing and Payment Act," is intended to ensure that health care providers, including, but not limited to physicians, dentists and other licensed health care professionals, hospitals and other health care facilities, receive reimbursement to which they are entitled from payers for health care services delivered to covered persons under health maintenance organization (HMO) contracts, health, hospital and medical service corporation contracts, health insurance policies and dental plans.

The bill defines "payer" as a carrier (HMO, health, hospital, medical service corporation or commercial insurer) 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 Health and Senior Services or licensed by the Commissioner of Banking and Insurance.

The bill provides that a payer shall respond to a health care provider's request for authorization of services by either approving or denying the request based on a utilization management decision. Any denial of a request or limitation imposed on a requested service shall be made by a State licensed physician and shall be communicated to the provider by facsimile or E-mail within a time frame appropriate to the medical exigencies of the case, but no later than 24 hours in the case of a request for authorization for a covered person who is receiving inpatient hospital or emergency room care, and no later than three business days for a covered person who is receiving health care services in another setting. If the payer requires additional information to approve or deny a request for authorization, the payer shall notify the provider by facsimile or E-mail within the applicable time frame 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 those time frames because of the need for this additional information, the bill provides that the payer shall have an additional time period within which to approve or deny the request.

If a payer fails to respond to an authorization request within the required time frames, the health care provider's request shall be deemed approved and the payer shall be responsible to the health care provider for the payment of the requested services.

The bill provides that a payer:

- shall reimburse a hospital if the hospital requested authorization from the payer and received approval for the health care services delivered prior to rendering the service or the hospital requested authorization from the payer for the health care services prior to rendering the services and the payer failed to respond to the hospital within the time frames established under the bill;
- 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 care to that same covered person at the hospital;
- shall not amend a claim by changing the diagnostic code assigned to the services rendered by the health care provider without providing written justification; and
- shall reimburse a health care provider for all medically necessary services rendered to a covered person that are covered under the health benefits plan, including emergency and urgent care health care services and all tests necessary, in accordance with nationally recognized treatment protocols, to determine the nature of an illness or injury.

The bill also specifies that if a payer has determined that a covered person who is an inpatient in a hospital requires medically necessary

1 health care services that are not available or provided at the hospital
2 or are less than the acute level of care provided at the hospital, the
3 payer shall be responsible for identifying an available contracted health
4 care provider that offers the required covered services and that will
5 accept the covered person. The payer shall pay the hospital in
6 accordance with the contracted rate until an appropriate placement can
7 be made.
8 The bill provides that upon admission to a hospital or prior to
9 receiving health care services, a covered person or a person designated
10 by the covered person may sign a consent form authorizing a health
11 care provider, on the covered person's behalf, to appeal a
12 determination by a payer to deny, reduce or terminate a health care
13 benefit or deny payment for a health care service based upon the
14 payer's determination that the health care benefit or service is not
15 medically necessary and which consent would be valid for all stages of
16 the payer's appeals process and the Independent Health Care Appeals
17 Program. The health care provider shall provide notice to the covered
18 person whenever an appeal is initiated and provide additional notice
19 each time the health care provider continues that appeal to the next
20 stage of the payer's appeals process. A covered person retains his
21 right to revoke his consent at any time.
22 The bill further provides that a contract between a payer and a
23 health care provider other than a dentist shall contain a provision that
24 any dispute regarding the recovery of payments, shall, on the initiative
25 of any party to the dispute, be referred to binding arbitration. The
26 cost of the arbitration proceedings, including the payment of
27 reasonable attorney's fees, shall be awarded to the prevailing party.
28 In recognition that dental predetermination requests and requests
29 for authorization for dental services between dentists and dental plans
30 are different from similar requests between other health care providers
31 and insurance carriers, the bill provides for certain procedures with
32 respect to dental claims.
33 Finally, the bill provides for the imposition of civil monetary
34 penalties for violations of the bill's provisions.