[First Reprint]

SENATE, No. 3

STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

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SYNOPSIS

Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto.

CURRENT VERSION OF TEXT

As reported by the Senate Health, Human Services and Senior Citizens Committee on January 30, 2017, with amendments.

(Sponsorship Updated As Of: 2/16/2017)

AN ACT concerning substance use disorders and revising and supplementing various parts of the statutory law.

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

1. (New section) a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the hospital service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a hospital service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the contract.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted January 30, 2017.

submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No hospital service corporation shall initiate concurrent review more frequently than [1]**[**three-week**]** two-week[1] intervals. If a hospital service corporation determines that continued inpatient care in a facility is no longer medically necessary, the hospital service corporation shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The hospital service corporation shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the hospital service corporation's determination is upheld and it is determined continued inpatient care is not medically necessary, the hospital service corporation shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) The benefits for the first 28 days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the hospital service

corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. Medical necessity review shall utilize an evidence-based and peer reviewed clinical review tool to be designated through rulemaking by the Commissioner of Human Services in consultation with the Department of Health.

i. The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

j. The first 180 days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be deemed inpatient days for the purpose of the visit to day exchange provided in this subsection.

k. Except as stated above, the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the contract.

l. The benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section.

m. The provisions of this section shall apply to all hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

n. The Attorney General's Office shall be responsible for overseeing any violations of law that may result from P.L. , c. (C.) (pending before the Legislature as this bill), including fraud, abuse, waste, and mistreatment of covered persons. The Attorney General's Office is authorized to adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), rules and regulations to implement any of the provisions of P.L. , c. (C.) (pending before the Legislature as this bill).

o. The provisions of this section shall not apply to a hospital service corporation contract which, pursuant to a contract between the hospital service corporation and the Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other program administered by the Division of Medical Assistance and Health Services in the Department of Human Services.

p. As used in this section:

"Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and as appropriate, the discharge plans.

"Substance use disorder" is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and shall include substance use withdrawal.

2. (New section) a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the medical service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a medical service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the contract.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No medical service corporation shall initiate concurrent review more frequently than [1]**[**three-week**]** two-week[1] intervals. If a medical service corporation determines that continued inpatient [1]**[**confinement**]** care[1] in a facility is no longer medically necessary, the medical service corporation shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The medical service corporation shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the medical service corporation's determination is upheld and it is determined continued inpatient care is not medically necessary, the medical service corporation shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) The benefits for the first 28 days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the medical service

1 corporation and may be subject to prior authorization or,
2 retrospective review and other utilization management
3 requirements.
4 h. Medical necessity review shall utilize an evidence-based and
5 peer reviewed clinical review tool to be designated through
6 rulemaking by the Commissioner of Human Services in
7 consultation with the Department of Health.
8 i. The benefits for medication-assisted treatments for
9 substance use disorder shall be provided when determined
10 medically necessary by the covered person's physician,
11 psychologist or psychiatrist without the imposition of any prior
12 authorization or other prospective utilization management
13 requirements.
14 j. The first 180 days per plan year of benefits shall be
15 computed based on inpatient days. One or more unused inpatient
16 days may be exchanged for two outpatient visits. All extended
17 outpatient services such as partial hospitalization and intensive
18 outpatient, shall be deemed inpatient days for the purpose of the
19 visit to day exchange provided in this subsection.
20 k. Except as stated above, the benefits and cost-sharing shall be
21 provided to the same extent as for any other medical condition
22 covered under the contract.
23 l. The benefits required by this section are to be provided to all
24 covered persons with a diagnosis of substance use disorder. The
25 presence of additional related or unrelated diagnoses shall not be a
26 basis to reduce or deny the benefits required by this section.
27 m. The provisions of this section shall apply to all medical
28 service corporation contracts in which the medical service
29 corporation has reserved the right to change the premium.
30 n. The Attorney General's office shall be responsible for
31 overseeing any violations of law that may result from P.L. ,
32 c. (C.) (pending before the Legislature as this bill), including
33 fraud, abuse, waste, and mistreatment of covered persons. The
34 Attorney General's office is authorized to adopt, pursuant to the
35 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
36 eq.), rules and regulations to implement any of the provisions of
37 P.L. , c. (C.) (pending before the Legislature as this bill).
38 o. The provisions of this section shall not apply to a medical
39 service corporation contract which, pursuant to a contract between
40 the medical service corporation and the Department of Human
41 Services, provides benefits to persons who are eligible for medical
42 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
43 Health Care Coverage Act," P.L.2005, c.156 (C.30:2J-8 et seq.), or
44 any other program administered by the Division of Medical
45 Assistance and Health Services in the Department of Human
46 Services.
47 p. As used in this section:

"Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and as appropriate, the discharge plans.

"Substance use disorder" is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and shall include substance use withdrawal.

3. (New section) a. A health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the health service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a health service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the contract.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

1 submitted for concurrent review before the expiration of the initial
2 28 day period. A request for approval of inpatient care beyond any
3 period that is approved under concurrent review shall be submitted
4 within the period that was previously approved. No health service
5 corporation shall initiate concurrent review more frequently than
6 [1]**[**three-week**]** <u>two-week</u>[1] intervals. If a health service corporation
7 determines that continued inpatient care in a facility is no longer
8 medically necessary, the health service corporation shall within 24
9 hours provide written notice to the covered person and the covered
10 person's physician of its decision and the right to file an expedited
11 internal appeal of the determination pursuant to an expedited
12 process pursuant to sections 11 through 13 of P.L.1997, c.192
13 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
14 applicable. The health service corporation shall review and make a
15 determination with respect to the internal appeal within 24 hours
16 and communicate such determination to the covered person and the
17 covered person's physician. If the determination is to uphold the
18 denial, the covered person and the covered person's physician have
19 the right to file an expedited external appeal with the Independent
20 Health Care Appeals Program in the Department of Banking and
21 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
22 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
23 applicable. An independent utilization review organization shall
24 make a determination within 24 hours. If the health service
25 corporation's determination is upheld and it is determined
26 continued inpatient care is not medically necessary, the health
27 service corporation shall remain responsible to provide benefits for
28 the inpatient care through the day following the date the
29 determination is made and the covered person shall only be
30 responsible for any applicable co-payment, deductible and co-
31 insurance for the stay through that date as applicable under the
32 policy. The covered person shall not be discharged or released
33 from the inpatient facility until all internal appeals and independent
34 utilization review organization appeals are exhausted. For any costs
35 incurred after the day following the date of determination until the
36 day of discharge, the covered person shall only be responsible for
37 any applicable cost-sharing, and any additional charges shall be
38 paid by the facility or provider.
39 f. (1) The benefits for the first 28 days of intensive outpatient
40 or partial hospitalization services shall be provided without any
41 retrospective review of medical necessity and medical necessity
42 shall be as determined by the covered person's physician.
43 (2) The benefits for days 29 and thereafter of intensive
44 outpatient or partial hospitalization services shall be subject to a
45 retrospective review of the medical necessity of the services.
46 g. Benefits for inpatient and outpatient treatment of substance
47 use disorder after the first 180 days per plan year shall be subject to
48 the medical necessity determination of the health service

1 corporation and may be subject to prior authorization or,
2 retrospective review and other utilization management
3 requirements.
4 h. Medical necessity review shall utilize an evidence-based and
5 peer reviewed clinical review tool to be designated through
6 rulemaking by the Commissioner of Human Services in
7 consultation with the Department of Health.
8 i. The benefits for outpatient prescription drugs to treat
9 substance use disorder shall be provided when determined
10 medically necessary by the covered person's physician,
11 psychologist or psychiatrist without the imposition of any prior
12 authorization or other prospective utilization management
13 requirements.
14 j. The first 180 days per plan year of benefits shall be
15 computed based on inpatient days. One or more unused inpatient
16 days may be exchanged for two outpatient visits. All extended
17 outpatient services such as partial hospitalization and intensive
18 outpatient, shall be deemed inpatient days for the purpose of the
19 visit to day exchange provided in this subsection.
20 k. Except as stated above, the benefits and cost-sharing shall be
21 provided to the same extent as for any other medical condition
22 covered under the contract.
23 l. The benefits required by this section are to be provided to all
24 covered persons with a diagnosis of substance use disorder. The
25 presence of additional related or unrelated diagnoses shall not be a
26 basis to reduce or deny the benefits required by this section.
27 m. The provisions of this section shall apply to all health
28 service corporation contracts in which the health service
29 corporation has reserved the right to change the premium.
30 n. The Attorney General's Office shall be responsible for
31 overseeing any violations of law that may result from P.L . ,
32 c. (C.) (pending before the Legislature as this bill), including
33 fraud, abuse, waste, and mistreatment of covered persons. The
34 Attorney General's office is authorized to adopt, pursuant to the
35 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
36 seq.), rules and regulations to implement any of the provisions of
37 P.L. , c. (C.) (pending before the Legislature as this bill).
38 o. The provisions of this section shall not apply to a health
39 service corporation contract which, pursuant to a contract between
40 the health service corporation and the Department of Human
41 Services, provides benefits to persons who are eligible for medical
42 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
43 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.) or
44 any other program administered by the Division of Medical
45 Assistance and Health Services in the Department of Human
46 Services.
47 p. As used in this section:

"Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and as appropriate, the discharge plans.

"Substance use disorder" is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and shall include substance use withdrawal.

4. (New section) a. An individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, an insurer shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered policy shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial

28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No insurer shall initiate concurrent review more frequently than [1][three-week] two-week[1] intervals. If an insurer determines that continued inpatient care in a facility is no longer medically necessary, the insurer shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The insurer shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the insurer's determination is upheld and it is determined continued inpatient care is not medically necessary, the insurer shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the policy. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) The benefits for the first 28 days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the insurer and may be subject to prior authorization or, retrospective review and other utilization management requirements.

1 h. Medical necessity review shall utilize an evidence-based and
2 peer reviewed clinical review tool to be designated through
3 rulemaking by the Commissioner of Human Services in
4 consultation with the Department of Health.
5 i. The benefits for outpatient prescription drugs to treat
6 substance use disorder shall be provided when determined
7 medically necessary by the covered person's physician,
8 psychologist or psychiatrist without the imposition of any prior
9 authorization or other prospective utilization management
10 requirements.
11 j. The first 180 days per plan year of benefits shall be
12 computed based on inpatient days. One or more unused inpatient
13 days may be exchanged for two outpatient visits. All extended
14 outpatient services such as partial hospitalization and intensive
15 outpatient, shall be deemed inpatient days for the purpose of the
16 visit to day exchange provided in this subsection.
17 k. Except as stated above, the benefits and cost-sharing shall be
18 provided to the same extent as for any other medical condition
19 covered under the policy.
20 l. The benefits required by this section are to be provided to all
21 covered persons with a diagnosis of substance use disorder. The
22 presence of additional related or unrelated diagnoses shall not be a
23 basis to reduce or deny the benefits required by this section.
24 m. The provisions of this section shall apply to those policies in
25 which the insurer has reserved the right to change the premium.
26 n. The Attorney General's Office shall be responsible for
27 overseeing any violations of law that may result from P.L. ,
28 c. (C.) (pending before the Legislature as this bill), including
29 fraud, abuse, waste, and mistreatment of covered persons. The
30 Attorney General's Office is authorized to adopt, pursuant to the
31 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
32 seq.), rules and regulations to implement any of the provisions of
33 P.L. , c. (C.) (pending before the Legislature as this bill).
34 o. The provisions of this section shall not apply to an
35 individual health insurance policy which, pursuant to a contract
36 between the insurer and the Department of Human Services,
37 provides benefits to persons who are eligible for medical assistance
38 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
39 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
40 program administered by the Division of Medical Assistance and
41 Health Services in the Department of Human Services.
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43 "Concurrent review" means inpatient care is reviewed as it is
44 provided. Medically qualified reviewers monitor appropriateness of
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46 discharge plans.
47 "Substance use disorder" is as defined by the American
48 Psychiatric Association in the Diagnostic and Statistical Manual of

Mental Disorders, Fifth Edition and any subsequent editions and shall include substance use withdrawal.

5. (New section) a. A group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, an insurer shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered insurance policy shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No insurer shall initiate concurrent review more frequently than [1]**[**three-week**]** two-week[1] intervals. If an insurer determines that continued inpatient

1 care in a facility is no longer medically necessary, the insurer shall
2 within 24 hours provide written notice to the covered person and the
3 covered person's physician of its decision and the right to file an
4 expedited internal appeal of the determination pursuant to an
5 expedited process pursuant to sections 11 through 13 of P.L.1997,
6 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
7 applicable. The insurer shall review and make a determination with
8 respect to the internal appeal within 24 hours and communicate
9 such determination to the covered person and the covered person's
10 physician. If the determination is to uphold the denial, the covered
11 person and the covered person's physician have the right to file an
12 expedited external appeal with the Independent Health Care
13 Appeals Program in the Department of Banking and Insurance
14 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
15 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
16 independent utilization review organization shall make a
17 determination within 24 hours. If the insurer's determination is
18 upheld and it is determined continued inpatient care is not
19 medically necessary, the insurer shall remain responsible to provide
20 benefits for the inpatient care through the day following the date the
21 determination is made and the covered person shall only be
22 responsible for any applicable co-payment, deductible and co-
23 insurance for the stay through that date as applicable under the
24 policy. The covered person shall not be discharged or released
25 from the inpatient facility until all internal appeals and independent
26 utilization review organization appeals are exhausted. For any costs
27 incurred after the day following the date of determination until the
28 day of discharge, the covered person shall only be responsible for
29 any applicable cost-sharing, and any additional charges shall be
30 paid by the facility or provider.
31 f. (1) The benefits for the first 28 days of intensive outpatient
32 or partial hospitalization services shall be provided without any
33 retrospective review of medical necessity and medical necessity
34 shall be as determined by the covered person's physician.
35 (2) The benefits for days 29 and thereafter of intensive
36 outpatient or partial hospitalization services shall be subject to a
37 retrospective review of the medical necessity of the services.
38 g. Benefits for inpatient and outpatient treatment of substance
39 use disorder after the first 180 days per plan year shall be subject to
40 the medical necessity determination of the insurer and may be
41 subject to prior authorization or, retrospective review and other
42 utilization management requirements.
43 h. Medical necessity review shall utilize an evidence-based and
44 peer reviewed clinical review tool to be designated through
45 rulemaking by the Commissioner of Human Services in
46 consultation with the Department of Health.
47 i. The benefits for outpatient prescription drugs to treat
48 substance use disorder shall be provided when determined

1 medically necessary by the covered person's physician,
2 psychologist or psychiatrist without the imposition of any prior
3 authorization or other prospective utilization management
4 requirements.
5 j. The first 180 days per plan year of benefits shall be
6 computed based on inpatient days. One or more unused inpatient
7 days may be exchanged for two outpatient visits. All extended
8 outpatient services such as partial hospitalization and intensive
9 outpatient, shall be deemed inpatient days for the purpose of the
10 visit to day exchange provided in this subsection.
11 k. Except as stated above, the benefits and cost-sharing shall be
12 provided to the same extent as for any other medical condition
13 covered under the policy.
14 l. The benefits required by this section are to be provided to all
15 covered persons with a diagnosis of substance use disorder. The
16 presence of additional related or unrelated diagnoses shall not be a
17 basis to reduce or deny the benefits required by this section.
18 m. The provisions of this section shall apply to those policies in
19 which the insurer has reserved the right to change the premium.
20 n. The Attorney General's Office shall be responsible for
21 overseeing any violations of law that may result from P.L. ,
22 c. (C.) (pending before the Legislature as this bill), including
23 fraud, abuse, waste, and mistreatment of covered persons. The
24 Attorney General's Office is authorized to adopt, pursuant to the
25 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
26 seq.), rules and regulations to implement any of the provisions of
27 P.L. , c. (C.) (pending before the Legislature as this bill).
28 o. The provisions of this section shall not apply to a group
29 health insurance policy which, pursuant to a contract between the
30 insurer and the Department of Human Services, provides benefits to
31 persons who are eligible for medical assistance under P.L.1968,
32 c.413 (C.30:4D-1 et seq.), the "Family Health Care Coverage Act,"
33 P.L.2005, c.156 (C.30:4J-8 et seq.), or any other program
34 administered by the Division of Medical Assistance and Health
35 Services in the Department of Human Services.
36 p. As used in this section:
37 "Concurrent review" means inpatient care is reviewed as it is
38 provided. Medically qualified reviewers monitor appropriateness of
39 the care, the setting, and patient progress, and as appropriate, the
40 discharge plans.
41 "Substance use disorder" is as defined by the American
42 Psychiatric Association in the Diagnostic and Statistical Manual of
43 Mental Disorders, Fifth Edition and any subsequent editions and
44 shall include substance use withdrawal.
45
46 6. (New section) a. An individual health benefits plan that
47 provides hospital or medical expense benefits and is delivered,
48 issued, executed or renewed in this State, or approved for issuance

or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the carrier of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a carrier shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered health benefits plan shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the plan.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No carrier shall initiate concurrent review more frequently than [1]⟦three-week⟧ two-week[1] intervals. If a carrier determines that continued inpatient care in a facility is no longer medically necessary, the carrier shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The carrier shall review and make a determination with

1 respect to the internal appeal within 24 hours and communicate
2 such determination to the covered person and the covered person's
3 physician. If the determination is to uphold the denial, the covered
4 person and the covered person's physician have the right to file an
5 expedited external appeal with the Independent Health Care
6 Appeals Program in the Department of Banking and Insurance
7 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
8 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
9 independent utilization review organization shall make a
10 determination within 24 hours. If the carrier's determination is
11 upheld and it is determined continued inpatient care is not
12 medically necessary, the carrier shall remain responsible to provide
13 benefits for the inpatient care through the day following the date the
14 determination is made and the covered person shall only be
15 responsible for any applicable co-payment, deductible and co-
16 insurance for the stay through that date as applicable under the
17 policy. The covered person shall not be discharged or released
18 from the inpatient facility until all internal appeals and independent
19 utilization review organization appeals are exhausted. For any costs
20 incurred after the day following the date of determination until the
21 day of discharge, the covered person shall only be responsible for
22 any applicable cost-sharing, and any additional charges shall be
23 paid by the facility or provider.
24 f. (1) The benefits for the first 28 days of intensive outpatient
25 or partial hospitalization services shall be provided without any
26 retrospective review of medical necessity and medical necessity
27 shall be as determined by the covered person's physician.
28 (2) The benefits for days 29 and thereafter of intensive
29 outpatient or partial hospitalization services shall be subject to a
30 retrospective review of the medical necessity of the services.
31 g. Benefits for inpatient and outpatient treatment of substance
32 use disorder after the first 180 days per plan year shall be subject to
33 the medical necessity determination of the [1]**[**insurer**]** carrier[1] and
34 may be subject to prior authorization or, retrospective review and
35 other utilization management requirements.
36 h. Medical necessity review shall utilize an evidence-based and
37 peer reviewed clinical review tool to be designated through
38 rulemaking by the Commissioner of Human Services in
39 consultation with the Department of Health.
40 i. The benefits for outpatient prescription drugs to treat
41 substance use disorder shall be provided when determined
42 medically necessary by the covered person's physician,
43 psychologist or psychiatrist without the imposition of any prior
44 authorization or other prospective utilization management
45 requirements.
46 j. The first 180 days per plan year of benefits shall be
47 computed based on inpatient days. One or more unused inpatient
48 days may be exchanged for two outpatient visits. All extended

1 outpatient services such as partial hospitalization and intensive
2 outpatient, shall be deemed inpatient days for the purpose of the
3 visit to day exchange provided in this subsection.
4 k. Except as stated above, the benefits and cost-sharing shall be
5 provided to the same extent as for any other medical condition
6 covered under the health benefits plan.
7 l. The benefits required by this section are to be provided to all
8 covered persons with a diagnosis of substance use disorder. The
9 presence of additional related or unrelated diagnoses shall not be a
10 basis to reduce or deny the benefits required by this section.
11 m. The provisions of this section shall apply to all individual
12 health benefits plans in which the carrier has reserved the right to
13 change the premium.
14 n. The Attorney General's Office shall be responsible for
15 overseeing any violations of law that may result from P.L. ,
16 c. (C.) (pending before the Legislature as this bill), including
17 fraud, abuse, waste, and mistreatment of covered persons. The
18 Attorney General's Office is authorized to adopt, pursuant to the
19 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
20 seq.), rules and regulations to implement any of the provisions of
21 P.L. , c. (C.) (pending before the Legislature as this bill).
22 o. The provisions of this section shall not apply to an
23 individual health benefits plan which, pursuant to a contract
24 between the carrier and the Department of Human Services,
25 provides benefits to persons who are eligible for medical assistance
26 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
27 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
28 program administered by the Division of Medical Assistance and
29 Health Services in the Department of Human Services.
30 p. As used in this section:
31 "Concurrent review" means inpatient care is reviewed as it is
32 provided. Medically qualified reviewers monitor appropriateness of
33 the care, the setting, and patient progress, and as appropriate, the
34 discharge plans.
35 "Substance use disorder" is as defined by the American
36 Psychiatric Association in the Diagnostic and Statistical Manual of
37 Mental Disorders, Fifth Edition and any subsequent editions and
38 shall include substance use withdrawal.
39
40 7. (New section) a. A small employer health benefits plan that
41 provides hospital or medical expense benefits and is delivered,
42 issued, executed or renewed in this State, or approved for issuance
43 or renewal in this State by the Commissioner of Banking and
44 Insurance, on or after the effective date of this act, shall provide
45 unlimited benefits for inpatient and outpatient treatment of
46 substance use disorder at in-network facilities. The services for the
47 treatment of substance use disorder shall be prescribed by a licensed
48 physician, licensed psychologist, or licensed psychiatrist and

provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the carrier of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a carrier shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered health benefits plan shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the plan.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No carrier shall initiate concurrent review more frequently than [1]【three-week】 two-week[1] intervals. If a carrier determines that continued inpatient care in a facility is no longer medically necessary, the carrier shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The carrier shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance

1 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
2 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
3 independent utilization review organization shall make a
4 determination within 24 hours. If the carrier's determination is
5 upheld and it is determined continued inpatient care is not
6 medically necessary, the carrier shall remain responsible to provide
7 benefits for the inpatient care through the day following the date the
8 determination is made and the covered person shall only be
9 responsible for any applicable co-payment, deductible and co-
10 insurance for the stay through that date as applicable under the
11 policy. The covered person shall not be discharged or released
12 from the inpatient facility until all internal appeals and independent
13 utilization review organization appeals are exhausted. For any costs
14 incurred after the day following the date of determination until the
15 day of discharge, the covered person shall only be responsible for
16 any applicable cost-sharing, and any additional charges shall be
17 paid by the facility or provider.
18 f. (1) The benefits for the first 28 days of intensive outpatient
19 or partial hospitalization services shall be provided without any
20 retrospective review of medical necessity and medical necessity
21 shall be as determined by the covered person's physician.
22 (2) The benefits for days 29 and thereafter of intensive
23 outpatient or partial hospitalization services shall be subject to a
24 retrospective review of the medical necessity of the services.
25 g. Benefits for inpatient and outpatient treatment of substance
26 use disorder after the first 180 days per plan year shall be subject to
27 the medical necessity determination of the carrier and may be
28 subject to prior authorization or, retrospective review and other
29 utilization management requirements.
30 h. Medical necessity review shall utilize an evidence-based and
31 peer reviewed clinical review tool to be designated through
32 rulemaking by the Commissioner of Human Services in
33 consultation with the Department of Health.
34 i. The benefits for outpatient prescription drugs to treat
35 substance use disorder shall be provided when determined
36 medically necessary by the covered person's physician,
37 psychologist or psychiatrist without the imposition of any prior
38 authorization or other prospective utilization management
39 requirements.
40 j. The first 180 days per plan year of benefits shall be
41 computed based on inpatient days. One or more unused inpatient
42 days may be exchanged for two outpatient visits. All extended
43 outpatient services such as partial hospitalization and intensive
44 outpatient, shall be deemed inpatient days for the purpose of the
45 visit to day exchange provided in this subsection.
46 k. Except as stated above, the benefits and cost-sharing shall be
47 provided to the same extent as for any other medical condition
48 covered under the health benefits plan.

1 l. The benefits required by this section are to be provided to all
2 covered persons with a diagnosis of substance use disorder. The
3 presence of additional related or unrelated diagnoses shall not be a
4 basis to reduce or deny the benefits required by this section.
5 m. The provisions of this section shall apply to all small
6 employer health benefits plans in which the carrier has reserved the
7 right to change the premium.
8 n. The Attorney General's Office shall be responsible for
9 overseeing any violations of law that may result from P.L. ,
10 c. (C.) (pending before the Legislature as this bill), including
11 fraud, abuse, waste, and mistreatment of covered persons. The
12 Attorney General's Office is authorized to adopt, pursuant to the
13 Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
14 seq.), rules and regulations to implement any of the provisions of
15 P.L. , c. (C.) (pending before the Legislature as this bill).
16 o. As used in this section:
17 "Concurrent review" means inpatient care is reviewed as it is
18 provided. Medically qualified reviewers monitor appropriateness of
19 the care, the setting, and patient progress, and as appropriate, the
20 discharge plans.
21 "Substance use disorder" is as defined by the American
22 Psychiatric Association in the Diagnostic and Statistical Manual of
23 Mental Disorders, Fifth Edition and any subsequent editions and
24 shall include substance abuse withdrawal.
25
26 8. (New section) a. A health maintenance organization
27 contract that provides hospital or medical expense benefits and is
28 delivered, issued, executed or renewed in this State, or approved for
29 issuance or renewal in this State by the Commissioner of Banking
30 and Insurance, on or after the effective date of this act, shall provide
31 unlimited benefits for inpatient and outpatient treatment of
32 substance use disorder at in-network facilities. The services for the
33 treatment of substance use disorder shall be prescribed by a licensed
34 physician, licensed psychologist, or licensed psychiatrist and
35 provided by licensed health care professionals or licensed or
36 certified substance use disorder providers in licensed or otherwise
37 State-approved facilities, as required by the laws of the state in
38 which the services are rendered.
39 b. The benefits for the first 180 days per plan year of inpatient
40 and outpatient treatment of substance use disorder shall be provided
41 when determined medically necessary by the covered person's
42 physician, psychologist or psychiatrist without the imposition of
43 any prior authorization or other prospective utilization management
44 requirements. [1]The facility shall notify the health maintenance
45 organization of both the admission and the initial treatment plan
46 within 48 hours of the admission or initiation of treatment.[1] If there
47 is no in-network facility immediately available for a covered
48 person, a health maintenance organization shall provide necessary

exceptions to their network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No health maintenance organization shall initiate concurrent review more frequently than [1][three-week] two-week[1] intervals. If a health maintenance organization determines that continued inpatient [1][confinement] care[1] in a facility is no longer medically necessary, the health [1][insurance] maintenance[1] organization shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The health maintenance organization shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the health maintenance organization's determination is upheld and it is determined continued inpatient care is not medically necessary, the carrier shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the policy. The covered

1 person shall not be discharged or released from the inpatient facility
2 until all internal appeals and independent utilization review
3 organization appeals are exhausted. For any costs incurred after the
4 day following the date of determination until the day of discharge,
5 the covered person shall only be responsible for any applicable
6 cost-sharing, and any additional charges shall be paid by the facility
7 or provider.
8 f. (1) The benefits for the first 28 days of intensive outpatient
9 or partial hospitalization services shall be provided without any
10 retrospective review of medical necessity and medical necessity
11 shall be as determined by the covered person's physician.
12 (2) The benefits for days 29 and thereafter of intensive
13 outpatient or partial hospitalization services shall be subject to a
14 retrospective review of the medical necessity of the services.
15 g. Benefits for inpatient and outpatient treatment of substance
16 use disorder after the first 180 days per plan year shall be subject to
17 the medical necessity determination of the health maintenance
18 organization and may be subject to prior authorization or,
19 retrospective review and other utilization management
20 requirements.
21 h. Medical necessity review shall utilize an evidence-based and
22 peer reviewed clinical review tool to be designated through
23 rulemaking by the Commissioner of Human Services in
24 consultation with the Department of Health.
25 i. The benefits for outpatient prescription drugs to treat
26 substance use disorder shall be provided when determined
27 medically necessary by the covered person's physician,
28 psychologist or psychiatrist without the imposition of any prior
29 authorization or other prospective utilization management
30 requirements.
31 j. The first 180 days per plan year of benefits shall be
32 computed based on inpatient days. One or more unused inpatient
33 days may be exchanged for two outpatient visits. All extended
34 outpatient services such as partial hospitalization and intensive
35 outpatient, shall be deemed inpatient days for the purpose of the
36 visit to day exchange provided in this subsection.
37 k. Except as stated above, the benefits and cost-sharing shall be
38 provided to the same extent as for any other medical condition
39 covered under the contract.
40 l. The benefits required by this section are to be provided to all
41 covered persons with a diagnosis of substance use disorder. The
42 presence of additional related or unrelated diagnoses shall not be a
43 basis to reduce or deny the benefits required by this section.
44 m. The provisions of this section shall apply to those contracts
45 in which the health maintenance organization has reserved the right
46 to change the premium.
47 n. The Attorney General's Office shall be responsible for
48 overseeing any violations of law that may result from P.L. ,

1 c. (C.) (pending before the Legislature as this bill), including
2 fraud, abuse, waste, and mistreatment of covered persons. The
3 Attorney General's Office is authorized to adopt, pursuant to the
4 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
5 seq.), rules and regulations to implement any of the provisions of
6 P.L. , c. (C.) (pending before the Legislature as this bill).
7 o. The provisions of this section shall not apply to a health
8 maintenance organization contract which, pursuant to a contract
9 between the health maintenance organization and the Department of
10 Human Services, provides benefits to persons who are eligible for
11 medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the
12 "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et
13 seq.), or any other program administered by the Division of Medical
14 Assistance and Health Services in the Department of Human
15 Services.
16 p. As used in this section:
17 "Concurrent review" means inpatient care is reviewed as it is
18 provided. Medically qualified reviewers monitor appropriateness of
19 the care, the setting, and patient progress, and as appropriate, the
20 discharge plans.
21 "Substance use disorder" is as defined by the American
22 Psychiatric Association in the Diagnostic and Statistical Manual of
23 Mental Disorders, Fifth Edition and any subsequent editions and
24 shall include substance use withdrawal.
25
26 9. (New section) a. The State Health Benefits Commission
27 shall ensure that every contract purchased by the commission on or
28 after the effective date of this act provides unlimited benefits for
29 inpatient and outpatient treatment of substance use disorder at in-
30 network facilities. The services for the treatment of substance use
31 disorder shall be prescribed by a licensed physician, licensed
32 psychologist, or licensed psychiatrist and provided by licensed
33 health care professionals or licensed or certified substance use
34 disorder providers in licensed or otherwise State-approved facilities,
35 as required by the laws of the state in which the services are
36 rendered.
37 b. The benefits for the first 180 days per plan year of inpatient
38 and outpatient treatment of substance use disorder shall be provided
39 when determined medically necessary by the covered person's
40 physician, psychologist or psychiatrist without the imposition of
41 any prior authorization or other prospective utilization management
42 requirements. [1]The facility shall notify the benefit payer of both
43 the admission and the initial treatment plan within 48 hours of the
44 admission or initiation of treatment.[1] If there is no in-network
45 facility immediately available for a covered person, the contract
46 shall provide necessary exceptions to their network to ensure
47 admission in a treatment facility within 24 hours.

1 c. Providers of treatment for substance use disorder to persons
2 covered under a covered contract shall not require pre-payment of
3 medical expenses during this 180 days in excess of applicable co-
4 payment, deductible, or co-insurance under the policy.
5 d. The benefits for outpatient visits shall not be subject to
6 concurrent or retrospective review of medical necessity or any other
7 utilization management review.
8 e. (1) The benefits for the first 28 days of an inpatient stay
9 during each plan year shall be provided without any retrospective
10 review or concurrent review of medical necessity and medical
11 necessity shall be as determined by the covered person's physician.
12 (2) The benefits for days 29 and thereafter of inpatient care shall
13 be subject to concurrent review as defined in this section. A request
14 for approval of inpatient care beyond the first 28 days shall be
15 submitted for concurrent review before the expiration of the initial
16 28 day period. A request for approval of inpatient care beyond any
17 period that is approved under concurrent review shall be submitted
18 within the period that was previously approved. The contract shall
19 not initiate concurrent review more frequently than [1]**[**three-week**]**
20 <u>two-week</u>[1] intervals. If it is determined that continued inpatient
21 care in a facility is no longer medically necessary, the contract shall
22 provide that within 24 hours, written notice shall be provided to the
23 covered person and the covered person's physician of its decision
24 and the right to file an expedited internal appeal of the
25 determination pursuant to an expedited process pursuant to sections
26 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)
27 and N.J.A.C.11:24A-3.5, as applicable. A determination shall be
28 made with respect to the internal appeal within 24 hours and shall
29 be communicated to the covered person and the covered person's
30 physician. If the determination is to uphold the denial, the covered
31 person and the covered person's physician have the right to file an
32 expedited external appeal with the Independent Health Care
33 Appeals Program in the Department of Banking and Insurance
34 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
35 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
36 independent utilization review organization shall make a
37 determination within 24 hours. If the determination is upheld and it
38 is determined continued inpatient care is not medically necessary,
39 the contract shall state that benefits are provided for the inpatient
40 care through the day following the date the determination is made
41 and the covered person shall only be responsible for any applicable
42 co-payment, deductible and co-insurance for the stay through that
43 date as applicable under the contract. The covered person shall not
44 be discharged or released from the inpatient facility until all internal
45 appeals and independent utilization review organization appeals are
46 exhausted. For any costs incurred after the day following the date of
47 determination until the day of discharge, the covered person shall

1 only be responsible for any applicable cost-sharing, and any
2 additional charges shall be paid by the facility or provider.
3 f. (1) The benefits for the first 28 days of intensive outpatient
4 or partial hospitalization services shall be provided without any
5 retrospective review of medical necessity and medical necessity
6 shall be as determined by the covered person's physician.
7 (2) The benefits for days 29 and thereafter of intensive
8 outpatient or partial hospitalization services shall be subject to a
9 retrospective review of the medical necessity of the services.
10 g. Benefits for inpatient and outpatient treatment of substance
11 use disorder after the first 180 days per plan year shall be subject to
12 medical necessity determination and may be subject to prior
13 authorization or, retrospective review and other utilization
14 management requirements.
15 h. Medical necessity review shall utilize an evidence-based and
16 peer reviewed clinical review tool to be designated through
17 rulemaking by the Commissioner of Human Services in
18 consultation with the Department of Health.
19 i. The benefits for outpatient prescription drugs to treat
20 substance use disorder shall be provided when determined
21 medically necessary by the covered person's physician,
22 psychologist or psychiatrist without the imposition of any prior
23 authorization or other prospective utilization management
24 requirements.
25 j. The first 180 days per plan year of benefits shall be
26 computed based on inpatient days. One or more unused inpatient
27 days may be exchanged for two outpatient visits. All extended
28 outpatient services such as partial hospitalization and intensive
29 outpatient, shall be deemed inpatient days for the purpose of the
30 visit to day exchange provided in this subsection.
31 k. Except as stated above, the benefits and cost-sharing shall be
32 provided to the same extent as for any other medical condition
33 covered under the contract.
34 l. The benefits required by this section are to be provided to all
35 covered persons with a diagnosis of substance use disorder. The
36 presence of additional related or unrelated diagnoses shall not be a
37 basis to reduce or deny the benefits required by this section.
38 m. As used in this section:
39 "Concurrent review" means inpatient care is reviewed as it is
40 provided. Medically qualified reviewers monitor appropriateness of
41 the care, the setting, and patient progress, and as appropriate, the
42 discharge plans.
43 "Substance use disorder" is as defined by the American
44 Psychiatric Association in the Diagnostic and Statistical Manual of
45 Mental Disorders, Fifth Edition and any subsequent editions and
46 shall include substance use withdrawal.

10. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]The facility shall notify the benefit payer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

c. Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy.

d. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

e. (1) The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. The contract shall not initiate concurrent review more frequently than [1]**[**three-week**]** two-week[1] intervals. If it is determined that continued inpatient care in a facility is no longer medically necessary, the contract shall provide that within 24 hours, written notice shall be provided to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)

1 and N.J.A.C.11:24A-3.5, as applicable. A determination shall be
2 made with respect to the internal appeal within 24 hours and shall
3 be communicated to the covered person and the covered person's
4 physician. If the determination is to uphold the denial, the covered
5 person and the covered person's physician have the right to file an
6 expedited external appeal with the Independent Health Care
7 Appeals Program in the Department of Banking and Insurance
8 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
9 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
10 independent utilization review organization shall make a
11 determination within 24 hours. If the determination is upheld and it
12 is determined continued inpatient care is not medically necessary,
13 the contract shall state that benefits are provided for the inpatient
14 care through the day following the date the determination is made
15 and the covered person shall only be responsible for any applicable
16 co-payment, deductible and co-insurance for the stay through that
17 date as applicable under the contract. The covered person shall not
18 be discharged or released from the inpatient facility until all internal
19 appeals and independent utilization review organization appeals are
20 exhausted. For any costs incurred after the day following the date of
21 determination until the day of discharge, the covered person shall
22 only be responsible for any applicable cost-sharing, and any
23 additional charges shall be paid by the facility or provider.
24 f. (1) The benefits for the first 28 days of intensive outpatient
25 or partial hospitalization services shall be provided without any
26 retrospective review of medical necessity and medical necessity
27 shall be as determined by the covered person's physician.
28 (2) The benefits for days 29 and thereafter of intensive
29 outpatient or partial hospitalization services shall be subject to a
30 retrospective review of the medical necessity of the services.
31 g. Benefits for inpatient and outpatient treatment of substance
32 use disorder after the first 180 days per plan year shall be subject to
33 medical necessity determination and may be subject to prior
34 authorization or, retrospective review and other utilization
35 management requirements.
36 h. Medical necessity review shall utilize an evidence-based and
37 peer reviewed clinical review tool to be designated through
38 rulemaking by the Commissioner of Human Services in
39 consultation with the Department of Health.
40 i. The benefits for outpatient prescription drugs to treat
41 substance use disorder shall be provided when determined
42 medically necessary by the covered person's physician,
43 psychologist or psychiatrist without the imposition of any prior
44 authorization or other prospective utilization management
45 requirements.
46 j. The first 180 days per plan year of benefits shall be
47 computed based on inpatient days. One or more unused inpatient
48 days may be exchanged for two outpatient visits. All extended

outpatient services such as partial hospitalization and intensive outpatient, shall be deemed inpatient days for the purpose of the visit to day exchange provided in this subsection.

k. Except as stated above, the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the contract.

l. The benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section.

m. As used in this section:

"Concurrent review" means inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and as appropriate, the discharge plans.

"Substance use disorder" is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and shall include substance use withdrawal.

11. (New section) a. A practitioner shall not issue an initial prescription for an opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity exceeding a five-day supply for treatment of acute pain. [1]Any prescription for acute pain pursuant to this subsection shall be for the lowest effective dose of immediate-release opioid drug.[1]

b. Prior to issuing an initial prescription of a [1]**[**course of treatment that includes a**]**[1] Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) [1]in a course of treatment[1] for acute or chronic pain, a practitioner shall:

(1) take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;

(2) conduct, as appropriate, and document the results of a physical examination;

(3) develop a treatment plan, with particular attention focused on determining the cause of the patient's pain;

(4) access relevant prescription monitoring information under the Prescription Monitoring Program pursuant to section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

(5) limit the supply of any opioid drug prescribed for acute pain to a duration of no more than five days as determined by the directed dosage and frequency of dosage.

c. No less than four days after issuing the initial prescription [1]pursuant to subsection a. of this subsection[1], the practitioner, after

consultation with the patient, may issue a subsequent prescription for the drug to the patient in any quantity that complies with applicable State and federal laws, provided that:

(1) the subsequent prescription would not be deemed an initial prescription under this section;

(2) the practitioner determines the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and

(3) the practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

d. Prior to issuing the initial prescription of [1][a course of treatment that includes][1] a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) [1]in a course of treatment for acute or chronic pain[1] and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

(1) the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

The practitioner shall [1][obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs,] include a note in the patient's medical record[1] that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The Division of Consumer Affairs shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

e. At the time of the issuance of the third prescription for a prescription opioid drug, the practitioner shall enter into a pain management agreement with the patient.

f. When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for three months or more for chronic pain, the practitioner shall:

1 (1) review, at a minimum of every three months, the course of
2 treatment, any new information about the etiology of the pain, and
3 the patient's progress toward treatment objectives and document the
4 results of that review;
5 (2) assess the patient prior to every renewal to determine
6 whether the patient is experiencing problems associated with
7 physical and psychological dependence and document the results of
8 that assessment;
9 (3) periodically make reasonable efforts, unless clinically
10 contraindicated, to either stop the use of the controlled substance,
11 decrease the dosage, try other drugs or treatment modalities in an
12 effort to reduce the potential for abuse or the development of
13 physical or psychological dependence and document with
14 specificity the efforts undertaken;
15 (4) review the Prescription Drug Monitoring information in
16 accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and
17 (5) monitor compliance with the pain management agreement
18 and any recommendations that the patient seek a referral.
19 g. As used in this section:
20 "Acute pain" means pain, whether resulting from disease,
21 accidental or intentional trauma, or other cause, that the practitioner
22 reasonably expects to last only a short period of time. "Acute pain"
23 does not include chronic pain, pain being treated as part of cancer
24 care, hospice or other end of life care, or pain being treated as part
25 of palliative care.
26 "Initial prescription" means a prescription issued to a patient
27 who:
28 (1) has never previously been issued a prescription for the drug
29 or its pharmaceutical equivalent; or
30 (2) was previously issued a prescription for the drug or its
31 pharmaceutical equivalent, but the date on which the current
32 prescription is being issued is more than one year after the date the
33 patient last used or was administered the drug or its equivalent.
34 When determining whether a patient was previously issued a
35 prescription for a drug or its pharmaceutical equivalent, the
36 practitioner shall consult with the patient and review the patient's
37 medical record and prescription monitoring information.
38 "Pain management agreement" means a written contract or
39 agreement that is executed between a practitioner and a patient,
40 prior to the commencement of treatment for chronic pain using a
41 Schedule II controlled dangerous substance or any other opioid drug
42 which is a prescription drug as defined in section 2 of P.L. 2003, c.
43 280 (C.45:14-41), as a means to:
44 (1) prevent the possible development of physical or
45 psychological dependence in the patient;
46 (2) document the understanding of both the practitioner and the
47 patient regarding the patient's pain management plan;

1 (3) establish the patient's rights in association with treatment,
2 and the patient's obligations in relation to the responsible use,
3 discontinuation of use, and storage of Schedule II controlled
4 dangerous substances, including any restrictions on the refill of
5 prescriptions or the acceptance of Schedule II prescriptions from
6 practitioners;
7 (4) identify the specific medications and other modes of
8 treatment, including physical therapy or exercise, relaxation, or
9 psychological counseling, that are included [1]as[1] a part of the pain
10 management plan;
11 (5) specify the measures the practitioner may employ to monitor
12 the patient's compliance, including but not limited to random
13 specimen screens and pill counts; and
14 (6) delineate the process for terminating the agreement,
15 including the consequences if the practitioner has reason to believe
16 that the patient is not complying with the terms of the agreement.
17 "Practitioner" means a medical doctor, doctor of osteopathy,
18 dentist, optometrist, podiatrist, physician assistant, certified nurse
19 midwife, or advanced practice nurse [1], acting within the scope of
20 practice of their professional license pursuant to Title 45 of the
21 Revised Statutes[1].
22 h. This section shall not apply to a prescription for a patient
23 who is currently in active treatment for cancer, receiving hospice
24 care from a licensed hospice or palliative care, or is a resident of a
25 long term care facility, or to any medications that are being
26 prescribed for use in the treatment of substance abuse or opioid
27 dependence.
28 [1]i. Every policy, contract or plan delivered, issued, executed or
29 renewed in this State, or approved for issuance or renewal in this
30 State by the Commissioner of Banking and Insurance, and every
31 contract purchased by the School Employees' Health Benefits
32 Commission or State Health Benefits Commission, on or after the
33 effective date of this act, that provides coverage for prescription
34 drugs subject to a co-payment, coinsurance or deductible shall
35 charge a co-payment, coinsurance or deductible for an initial
36 prescription of an opioid drug prescribed pursuant to this section
37 that is either:
38 (1) proportional between the cost sharing for a 30-day supply
39 and the amount of drugs the patient was prescribed; or
40 (2) equivalent to the cost sharing for a full 30-day supply of the
41 opioid drug, provided that no additional cost sharing may be
42 charged for any additional prescriptions for the remainder of the 30-
43 day supply.[1]
44
45 12. Section 1 of P.L.1997, c.249 (C.45:9-22.19) is amended to
46 read as follows:

1 1. a. 【A】 Except in the case of an initial prescription issued
2 pursuant to section 11 of P.L. , c. (C.) (pending before the
3 Legislature as this bill), a physician licensed pursuant to chapter 9
4 of Title 45 of the Revised Statutes may prescribe a Schedule II
5 controlled dangerous substance for the use of a patient in any
6 quantity which does not exceed a 30-day supply, as defined by
7 regulations adopted by the State Board of Medical Examiners in
8 consultation with the Department of Health 【and Senior Services】.
9 The physician shall document the diagnosis and the medical need
10 for the prescription in the patient's medical record, in accordance
11 with guidelines established by the State Board of Medical
12 Examiners.
13 b. 【A】 Except in the case of an initial prescription issued
14 pursuant to section 11 of P.L. , c. (C.) (pending before the
15 Legislature as this bill), a physician may issue multiple
16 prescriptions authorizing the patient to receive a total of up to a 90-
17 day supply of a Schedule II controlled dangerous substance,
18 provided that the following conditions are met:
19 (1) each separate prescription is issued for a legitimate medical
20 purpose by the physician acting in the usual course of professional
21 practice;
22 (2) the physician provides written instructions on each
23 prescription, other than the first prescription if it is to be filled
24 immediately, indicating the earliest date on which a pharmacy may
25 fill each prescription;
26 (3) the physician determines that providing the patient with
27 multiple prescriptions in this manner does not create an undue risk
28 of diversion or abuse; and
29 (4) the physician complies with all other applicable State and
30 federal laws and regulations.
31 (cf: P.L.2009, c.165, s.1)
32
33 13. (New section) a. The Director of the Division of Consumer
34 Affairs, pursuant to the "Administrative Procedure Act," P.L.1968,
35 c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to
36 effectuate the purposes of sections 11 and 12 of P.L. , c. (C.)
37 (pending before the Legislature as this bill).
38 b. Notwithstanding the provision of the "Administrative
39 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the
40 contrary, the Director of the Division of Consumer Affairs may
41 adopt, immediately upon filing with the Office of Administrative
42 Law, and no later than the 90th day after the effective date of this
43 act, such regulations as the director deems necessary to implement
44 any of the provisions of P.L. , c. (C.) (pending before the
45 Legislature as this bill). Regulations adopted pursuant to this
46 subsection shall be effective until the adoption of rules and
47 regulations pursuant to subsection a. of this section, and may be

amended, adopted, or readopted by the director in accordance with the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

14. Section 3 of P.L.1991, c.97 (C.45:10-19) is amended to read as follows:

3. To qualify to prescribe drugs pursuant to section 2 of [this act] P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall have completed 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in pharmacology or a pharmacology course, acceptable to the board, in an accredited institution of higher education approved by the Department of Higher Education or the board. Such contact hours shall include one credit of educational programs or topics on issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

(cf: P.L.1991, c.97, s.3)

15. Section 10 of P.L.1991, c.377 (C.45:11-49) is amended to read as follows:

10. a. In addition to all other tasks which a registered professional nurse may, by law, perform, an advanced practice nurse may manage preventive care services and diagnose and manage deviations from wellness and long-term illnesses, consistent with the needs of the patient and within the scope of practice of the advanced practice nurse, by:

(1) initiating laboratory and other diagnostic tests;

(2) prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and

(3) prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

b. An advanced practice nurse may order medications and devices in the inpatient setting, subject to the following conditions:

(1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating physician is required to initiate an order for a controlled dangerous substance;

(2) the order is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;

(3) the advanced practice nurse authorizes the order by signing the nurse's own name, printing the name and certification number, and printing the collaborating physician's name;

(4) the physician is present or readily available through electronic communications;

(5) the charts and records of the patients treated by the advanced practice nurse are reviewed by the collaborating physician and the advanced practice nurse within the period of time specified by rule adopted by the Commissioner of Health pursuant to section 13 of P.L.1991, c.377 (C.45:11-52);

(6) the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated, and signed at least annually by both parties; and

(7) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]**, addiction prevention and management, and issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

c. An advanced practice nurse may prescribe medications and devices in all other medically appropriate settings, subject to the following conditions:

(1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating physician is required to initiate a prescription for a controlled dangerous substance;

(2) the prescription is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician;

(3) the advanced practice nurse writes the prescription on a New Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40 et seq.), signs the nurse's own name to the prescription and prints the nurse's name and certification number;

(4) the prescription is dated and includes the name of the patient and the name, address, and telephone number of the collaborating physician;

(5) the physician is present or readily available through electronic communications;

(6) the charts and records of the patients treated by the advanced practice nurse are periodically reviewed by the collaborating physician and the advanced practice nurse;

(7) the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated, and signed at least annually by both parties; and

(8) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy [and], addiction prevention and management, and issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

d. The joint protocols employed pursuant to subsections b. and c. of this section shall conform with standards adopted by the Director of the Division of Consumer Affairs pursuant to section 12 of P.L.1991, c.377 (C.45:11-51) or section 10 of P.L.1999, c.85 (C.45:11-49.2), as applicable.

e. (Deleted by amendment, P.L.2004, c.122.)

f. An attending advanced practice nurse may determine and certify the cause of death of the nurse's patient and execute the death certification pursuant to R.S.26:6-8 if no collaborating physician is available to do so and the nurse is the patient's primary caregiver.

(cf: P.L.2015, c.38, s.3)

16. R.S.45:12-1 is amended to read as follows:

45:12-1. Optometry is hereby declared to be a profession, and the practice of optometry is defined to be the employment of objective or subjective means, or both, for the examination of the human eye and adnexae for the purposes of ascertaining any departure from the normal, measuring its powers of vision and adapting lenses or prisms for the aid thereof, or the use and prescription of pharmaceutical agents, excluding injections, except for injections to counter anaphylactic reaction [,]; and excluding controlled dangerous substances as provided in sections 5 and 6 of P.L.1970, c.226 (C.24:21-5 and C.24:21-6), except as otherwise authorized by section 9 of P.L.1991, c.385 (C.45:12-9.11), for the purposes of treating deficiencies, deformities, diseases, or abnormalities of the human eye and adnexae, including the removal of superficial foreign bodies from the eye and adnexae.

An optometrist utilizing pharmaceutical agents for the purposes of treatment of ocular conditions and diseases shall be held to a standard of patient care in the use of such agents commensurate to that of a physician utilizing pharmaceutical agents for treatment purposes.

A person shall be deemed to be practicing optometry within the meaning of this chapter who in any way advertises himself as an

optometrist, or who shall employ any means for the measurement of the powers of vision or the adaptation of lenses or prisms for the aid thereof, practice, offer or attempt to practice optometry as herein defined, either on his own behalf or as an employee or student of another, whether under the personal supervision of his employer or perceptor or not, or to use testing appliances for the purposes of measurement of the powers of vision or diagnose any ocular deficiency or deformity, visual or muscular anomaly of the human eye and adnexae or prescribe lenses, prisms or ocular exercise for the correction or the relief thereof, or who uses or prescribes pharmaceutical agents for the purposes of diagnosing and treating deficiencies, deformities, diseases or abnormalities of the human eye and adnexae or who holds himself out as qualified to practice optometry.
(cf: P.L.2004, c.115, s.1)

17. Section 3 of P.L.1975, c.24 (C.45:12-9.3) is amended to read as follows:
3. Fifty credits of continuing professional optometric education shall be required biennially of each New Jersey optometrist holding an active license during the period preceding the established license renewal date. Each credit shall represent or be equivalent to one hour of actual course attendance or in the case of those electing an alternative method of satisfying the requirements of this act shall be approved by the board and certified to the board on forms to be provided for that purpose. Of the 50 credits biennially required under this section, at least one credit shall be for educational programs or topics that concern the prescription of hydrocodone, or the prescription of opioid drugs in general, including responsible prescribing practices, the alternatives to the use of opioids for the management and treatment of pain, and the risks and signs of opioid abuse, addiction, and diversion.
(cf: P.L.1975, c.24, s.3)

18. (New section) a. The New Jersey State Board of Dentistry shall require that the number of credits of continuing dental education required of each person licensed as a dentist, as a condition of biennial registration pursuant to R.S.45:6-10 and section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. The continuing dental education requirement in this subsection shall be subject to the provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

1 b. The New Jersey State Board of Dentistry, pursuant to the
2 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
3 seq.), shall adopt such rules and regulations as are necessary to
4 effectuate the purposes of this section.
5
6 19. (New section) a. The State Board of Medical Examiners
7 shall require that the number of credits of continuing medical
8 education required of each person licensed as a physician, as a
9 condition of biennial registration pursuant to section 1 of P.L.1971,
10 c.236 (C.45:9-6.1), include one credit of educational programs or
11 topics concerning prescription opioid drugs, including responsible
12 prescribing practices, alternatives to opioids for managing and
13 treating pain, and the risks and signs of opioid abuse, addiction, and
14 diversion. The continuing medical education requirement in this
15 subsection shall be subject to the provisions of section 10 of
16 P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the
17 authority of the board to waive the provisions of this section for a
18 specific individual if the board deems it is appropriate to do so.
19 b. The State Board of Medical Examiners, pursuant to the
20 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
21 seq.), shall adopt such rules and regulations as are necessary to
22 effectuate the purposes of this section.
23
24 20. (New section) a. The State Board of Medical Examiners
25 shall require that the number of credits of continuing medical
26 education required of each person licensed as a physician assistant,
27 as a condition of biennial renewal pursuant to section 4 of P.L.1991,
28 c.378 (C.45:9-27.13), include one credit of educational programs or
29 topics concerning prescription opioid drugs, including responsible
30 prescribing practices, alternatives to opioids for managing and
31 treating pain, and the risks and signs of opioid abuse, addiction, and
32 diversion. The continuing medical education requirement in this
33 subsection shall be subject to the provisions of section 16 of
34 P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the
35 authority of the board to waive the provisions of this section for a
36 specific individual if the board deems it is appropriate to do so.
37 b. The State Board of Medical Examiners, pursuant to the
38 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
39 seq.), shall adopt such rules and regulations as are necessary to
40 effectuate the purposes of this section.
41
42 21. (New section) a. The New Jersey Board of Nursing shall
43 require that the number of credits of continuing education required
44 of each person licensed as a professional nurse or a practical nurse,
45 as a condition of biennial license renewal, include one credit of
46 educational programs or topics concerning prescription opioid
47 drugs, including alternatives to opioids for managing and treating

1 pain and the risks and signs of opioid abuse, addiction, and
2 diversion.
3 b. The board may, in its discretion, waive the continuing
4 education requirement in subsection a. of this section on an
5 individual basis for reasons of hardship, such as illness or disability,
6 retirement of the license, or other good cause. A waiver shall apply
7 only to the current biennial renewal period at the time of board
8 issuance.
9 c. The New Jersey Board of Nursing, pursuant to the
10 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
11 seq.), shall adopt such rules and regulations as are necessary to
12 effectuate the purposes of this section.
13
14 22. (New section) a. The New Jersey State Board of Pharmacy
15 shall require that the number of credits of continuing pharmacy
16 education required of each person registered as a pharmacist, as a
17 condition of biennial renewal certification, include one credit of
18 educational programs or topics concerning prescription opioid
19 drugs, including alternatives to opioids for managing and treating
20 pain and the risks and signs of opioid abuse, addiction, and
21 diversion. The continuing pharmacy education requirement in this
22 subsection shall be subject to the provisions of section 15 of
23 P.L.2003, c.280 (C.45:14-54), including, but not limited to, the
24 authority of the board to waive the provisions of this section for a
25 specific individual if the board deems it is appropriate to do so.
26 b. The New Jersey State Board of Pharmacy, pursuant to the
27 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
28 seq.), shall adopt such rules and regulations as are necessary to
29 effectuate the purposes of this section.
30
31 23. (New section) The Commissioner of Health, in consultation
32 with the Commissioner of Banking and Insurance, shall submit
33 reports at two intervals to the Legislature, pursuant to section 2 of
34 P.L.1991, c.164 (C.52:14-19.1), and the Governor. The first report
35 shall be submitted six months, and the second report shall be
36 submitted 12 months, after the date of enactment of this act. The
37 reports shall evaluate the implementation and impact of the act's
38 provisions and make recommendations regarding revisions to the
39 statutes that may be appropriate. The report shall include, but not
40 be limited to, an evaluation of the following:
41 a. The effects of the five-day supply limitation on
42 prescriptions, and other requirements concerning the prescribing of
43 opioids and other drugs pursuant to section 11 of the act, including
44 the impact of these provisions on patients with chronic pain and the
45 impact on patient cost sharing; and
46 b. The effects of the provisions of the bill providing that if
47 there is no in-network facility immediately available for a covered
48 person to receive treatment, a carrier shall provide necessary

1 exceptions to their network to ensure admission in a treatment
2 facility within 24 hours, including the impact of these provisions on
3 the availability of treatment beds for patients, the impact on
4 facilities in the State, and the costs associated with these provisions.
5
6 24. The following sections are repealed:
7 P.L.1977, c.115 (C.17:48-6a);
8 P.L.1977, c.116 (C.17B:27-46.1);
9 P.L.1977, c.117 (C.17:48A-7a);
10 P.L.1977, c.118 (C.17B:26-2.1); and
11 Section 34 of P.L.1985, c.236 (C.17:48E-34).
12
13 25. This bill shall take effect on the 90th day next after
14 enactment.