SENATE, No. 227

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:
Senator SAMUEL D. THOMPSON
District 12 (Burlington, Middlesex, Monmouth and Ocean)

SYNOPSIS

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

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

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

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

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

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

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

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

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

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

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

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

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

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

(e) any other information required by the department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. This act shall take effect immediately.

STATEMENT

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

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

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

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

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