Understanding Reimbursement Issues in New Jersey

A Guide for Health Care Providers and Practice Administration

New Jersey

Example EYLEA HD® (aflibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization

Issue: Plan delays prior authorization.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a request for prior authorization. Plan has not made a decision.

New Jersey Administrative Code Rule 11:24A-3.4 states...

(3) A Plan shall notify a provider and/or covered person of a determination concerning an urgent care claim and determined by the attending provider as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim by the Plan, of a determination concerning a nonurgent preservice claim (that is, prior authorization) no later than 15 days after receipt of the preservice claim by the Plan, and of a determination concerning postservice claims no later than 30 days after receipt of the postservice claim by the Plan.

(e) A Plan shall not reverse a utilization management decision where the provider relied upon the written or oral authorization of the Plan (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

(f) A Plan shall provide written notice within 2 business days of any determination to deny coverage or authorization of services or payment of benefits therefor otherwise covered under the contract or policy of the covered person, and shall include an explanation of the appeal process.

New Jersey Administrative Code Rule 11:22-8.3 states...

The following information shall appear on all Plan identification cards:

1. The name of the carrier issuing the Plan or the name of the third-party administrator administering the Plan

2. An indication of whether the Plan is insured or self-funded

NOTE: For self-funded Plans, refer to the ERISA Navigating Payer Challenges card.

New Jersey Assembly Bill A1255 states...

4. a. A Plan shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its Internet website to subscribers, health care providers, and the general public. Requirements shall be described in detail but also in easily understandable language.
   b. If a Plan intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the Plan shall ensure that the new or amended requirement is not implemented unless the Plan's Internet website has been updated to reflect the new or amended requirement or restriction.
   c. If a Plan intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the Plan shall provide contracted in-network health care providers with written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented.
   d. A Plan that uses prior authorization shall make statistics available regarding prior authorization approvals and denials on its Internet website in a readily accessible format. Plans shall include categories for:
      (1) physician specialty;
      (2) medication or diagnostic tests and procedures;
      (3) indication offered;
      (4) reason for denial;
      (5) whether prior authorization determinations were:
         (a) appealed; or
         (b) approved or denied on appeal; and
      (6) the time between submission of prior authorization requests and the determination.
5. A Plan shall ensure that all adverse determinations are made by a physician. The physician shall:
   a. possess a current and valid non-restricted license to practice medicine and surgery in the State of New Jersey;
   b. be of the same specialty as the physician who typically manages the medical condition or disease, or provides the health care service involved in the request;
   c. have experience treating patients with the medical condition or disease for which the health care services are being requested; and
   d. make the adverse determination under the clinical direction of a medical director of the Plan who is responsible for the provision of health care services provided to enrollees of the State of New Jersey. All medical directors of a Plan shall be physicians licensed in the State of New Jersey.

On the following pages:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prior Authorization (cont'd)

New Jersey Assembly Bill 540 states (cont'd)...

6. a. If a Plan is questioning the medical necessity of a health care service, the Plan shall notify the physician of the enrollee.
   b. Prior to issuing an adverse determination, the physician of the enrollee shall have the opportunity to discuss the medical necessity of the health care service by phone with the physician who will be responsible for determining authorization of the health care service under review.
7. A Plan shall ensure that all appeals are reviewed by a physician. The physician shall:
   a. possess a current and valid non-restricted license to practice medicine and surgery in the State of New Jersey;
   b. be currently in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least 5 consecutive years;
   c. be knowledgeable of, and have experience providing, the health care services under review;
   d. not be employed by or under contract with a Plan other than to participate in 1 or more of the Plan's health care provider networks or to perform reviews on appeal, or otherwise have any financial interest in the outcome of the appeal;
   e. not have been directly involved in making adverse determinations; and
   f. consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the utilization review entity by the health care provider of the enrollee, any relevant records provided to the Plan by a health care facility, and any medical literature provided to the Plan by the health care provider of the enrollee.
8. Notwithstanding the provisions of any other law to the contrary:
   a. If a Plan requires prior authorization of a covered service, the Plan shall make a prior authorization or adverse determination and notify the subscriber and the subscriber's health care provider of the prior authorization or adverse determination within 1 calendar day of obtaining all necessary information to make the prior authorization or adverse determination. For purposes of this section, "necessary information":
      (1) includes the results of any face-to-face clinical evaluation or second opinion that may be required; and
      (2) shall be considered transmitted to the Plan upon being sent by electronic portal, e-mail, facsimile, telephone or other means of communication.
   b. A Plan shall render a prior authorization or adverse determination concerning an urgent health care service, and notify the subscriber and the subscriber's health care provider of that prior authorization or adverse determination, not later than 24 hours after receiving all information needed to complete the review of the requested service.

10. A Plan shall not:
   a. require a health care provider offering services to a covered person to participate in a step therapy protocol if the provider deems that the step therapy protocol is not in the covered person's best interests;
   b. require that a health care provider first obtain a waiver, exception, or other override when deeming a step therapy protocol to not be in a covered person's best interests;
   c. sanction or otherwise penalize a health care provider for recommending or issuing a prescription, performing or recommending a procedure, or performing a test that may conflict with the step therapy protocol of the carrier;
   d. require prior authorization for:
      (1) generic medications that are not controlled substances;
      (2) dosage changes of medications previously prescribed and authorized; or
      (3) generic or brand name drugs after 6 months of adherence; or
   e. deny medications on the grounds of therapeutic duplication.

13. a. On receipt of information documenting a prior authorization from the enrollee or the health care provider of the enrollee, a Plan shall honor a prior authorization granted to an enrollee by a previous Plan for at least the initial 60 days of coverage under a new health plan of the enrollee.
   b. During the initial 60 days described in subsection a. of this section, a Plan may perform its own review to grant a prior authorization.
   c. If there is a change in coverage or approval criteria for a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.
   d. A Plan shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same carrier.
14. Any failure by a Plan to comply with a deadline or other requirement under the provisions of this act shall result in any health care services subject to review being automatically deemed authorized.
15. The Commissioner of Banking and Insurance shall promulgate rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), including any penalties or enforcement provisions, that the commissioner deems necessary to effectuate the purposes of this act.
16. This act shall take effect on the 90th day next following enactment.

New Jersey Insurance Code Section 17B:30-55.1 - [Effective 1/1/2025] states...

This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

On the following pages:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prior Authorization (cont'd)

New Jersey Insurance Code Section 17B:30-55.5 - [Effective 1/1/2025] states...

A Plan shall respond to a hospital or health care provider request for prior authorization of health care services by either approving or denying the request based on the covered person's health benefits plan upon submission of all necessary information.

New Jersey Insurance Code Section 17B:30-55.7 - [Effective 1/1/2025] states...

Except where shorter time frames are necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, if a Plan requires prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for **180 days** and the Plan shall not require the covered person to obtain a prior authorization again for the health care service within the 180-day period.

New Jersey Insurance Code Section 17B:30-55.8 - [Effective 1/1/2025] states...

Any denial of a request for prior authorization or limitation imposed by a Plan on a requested service on the basis of utilization management determination shall be made by a physician who shall: **a.** make the adverse determination under the clinical direction of a medical director of the Plan who shall: **(1)** be licensed in this State; and **(2)** strictly follow a medical policy that has been developed and made available in accordance with P.L. 2023, c. 296 (C.17B:30-55.1 et al.) and the "New Jersey Health Care Quality Act," P.L. 1997, c. 192 (C.26:2S-1 et seq.); **b.** not be compensated by a Plan based on the approval or denial rate of the reviewing physician; and **c.** not be provided preferential treatment by a Plan in the requests for prior authorization of the reviewing physician if that physician is also a network provider for the Plan.

New Jersey Insurance Code Section 17B:30-55.9 - [Effective 1/1/2025] states...

Except where shorter time frames are necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, prior authorization for a service which includes a defined number of discrete services within a set time frame shall be valid for purposes of authorizing the health care provider to provide care for a period of **180 days** from the date the provider receives the prior authorization and a Plan shall not revoke, limit, condition or restrict a prior authorization within that period if (1) the covered person continues to be eligible for coverage; (2) the clinical information provided at the time the prior authorization request was made has not been misrepresented by the treating physician or covered person; and (3) there has not been a material change in the clinical circumstances or condition of the covered person.

New Jersey Insurance Code Section 17B:30-55.10 - [Effective 1/1/2025] states...

On receipt of information documenting a prior authorization from the covered person or the health care provider of the covered person, a Plan shall honor a prior authorization granted to a covered person by a previous Plan for at least the initial **60 days** of coverage under a new health plan of the covered person, if that prior authorization was based on information provided in good faith by a provider.

New Jersey Insurance Code Section 17B:30-55.11 - [Effective 1/1/2025] states...

A denial of prior authorization shall be communicated to the hospital or health care provider by facsimile, e-mail, or any other means of written communication agreed to by the Plan and hospital or health care provider as follows: **[Note: Paragraphs (1) and (2) deal with inpatient prior authorization]**
(3) in the case of a request for prior authorization for a covered person who will be receiving health care services in an outpatient or other setting, including, but not limited to, a clinic, rehabilitation facility, or nursing home, the Plan shall communicate the denial of the request or the limitation imposed on the requested service to the hospital or health care provider within a time frame appropriate to the medical exigencies of the case but no later than **12 days** if the request is submitted in paper, or **9 days** if submitted through an electronic portal provided by the Plan, following the time the request was made; **(4)** in the case of a claim involving urgent care, the Plan shall notify the hospital or health care provider of the carrier's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the carrier, unless the hospital or health care provider fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the carrier shall notify the hospital or health care provider as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The hospital or health care provider shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the hospital or health care provider of the carrier's benefit determination as soon as possible, but in no case later than 48 hours after the carrier's receipt of the specified information; and
(5) if the Plan requires additional information to approve or make an adverse determination with regard to a request for prior authorization, the Plan shall so notify the hospital or health care provider by facsimile, e-mail, or any other means of written communication agreed to by the Plan and hospital or health care provider within the applicable time frame set forth in paragraph (1), (2), or (3) of this subsection and shall identify the specific information needed to approve or make the adverse determination with regard to the request for authorization. **b.** If the Plan is unable to approve or make an adverse determination with regard to a request for authorization within the applicable time frame set forth in paragraph (1), (2), (3), or (4) of this subsection because of the need for this additional information, the Plan shall have an additional period within which to approve or make an adverse determination with regard to the request, as follows: **[Note: Paragraphs (1) and (2) deal with inpatient prior authorization] (3)** in the case of a request for prior or concurrent authorization for a covered person who will be receiving health care services in another setting, within a time frame appropriate to the medical exigencies of the case but no more than **12 calendar days** beyond the time of receipt by the Plan from the hospital or health care provider of the additional information that the Plan has identified as needed to approve or make an adverse determination with regard to the request for authorization. For requests made through an electronic portal provided by the Plan, this time frame shall be **within 9 calendar days**. **c.** Plan and hospitals shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the time frames established pursuant to subsection a. of this section. **d.** If a Plan fails to respond to an authorization request within the time frames established pursuant to subsection a. or b. of this section, the hospital or health care provider's claim for the service shall not be denied on the basis of a failure to secure prior or concurrent authorization for the service. **e.** If a hospital or health care provider fails to respond to a Plan's request for additional information necessary to render an authorization decision within 72 hours, the hospital or health care provider's request for authorization shall be deemed withdrawn.

On the following page:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prior Authorization(cont'd)	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
New Jersey Insurance Code Section 17B:30-55.12 - [Effective 1/1/2025] states... A Plan shall ensure that any adverse determinations of any appeal are reviewed by a physician. The physician shall: **a.** be board-certified in a same or similar specialty that has experience treating the condition or service under review or has experience treating the condition within the last five years; **b.** not be paid by a Plan based on the reviewing physician's denial or approval rate; **c.** not have been directly involved in making an initial adverse determination for the same claim; **d.** consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the Plan by the health care provider of the covered person, any relevant records provided to the Plan by a health care facility, and any medical literature provided to the Plan by the health care service provider of the covered person; **e.** not be provided preferential treatment by the Plan in the reviewing physician's own requests for prior authorization if the reviewing physician is also a network provider; and **f.** when requested by the treating provider, engage in a telephonic conversation with the treating provider to discuss the need for the prescribed medication or service. **New Jersey Insurance Code Section 17B:30-55.13 - [Effective 1/1/2025] states...** **a.** When a hospital or health care provider complies with the provisions set forth in P.L. 2023, c. 296 (C.17B:30-55.1 et al.), no Plan shall deny reimbursement to a hospital or health care provider for covered services rendered to a covered person on grounds of failure to secure prior or concurrent authorization in the absence of fraud or misrepresentation if the hospital or health care provider: **(1)** requested authorization from the Plan and received approval for the health care services delivered prior to rendering the service; **(2)** requested authorization from the Plan for the health care services prior to rendering the services and the Plan failed to respond to the hospital or health care provider within the time frames established pursuant to P.L. 2023, c. 296 (C.17B:30-55.1 et al.); or **(3)** received authorization for the covered service for a patient who is no longer eligible to receive coverage from that Plan and it is determined that the patient is covered by another Plan, in which case the subsequent Plan, based on the subsequent Plan's benefits plan, shall accept the authorization and reimburse the hospital or health care provider. **b.** If the hospital is a network provider of the Plan, health care services shall be reimbursed at the contracted rate for the services provided. **c.** No Plan shall amend a claim by changing the diagnostic code assigned to the services rendered by a hospital or health care provider without providing written justification. **New Jersey Insurance Code Section 17B:30-55.15 - [Effective 1/1/2025] states...** In addition to the protections afforded to a health care provider or patient by the requirements of [this Act], any failure by a Plan to comply with a deadline shall result in any health care services subject to review being automatically deemed authorized	**Issue:** Plan delays timely payment pending medical necessity determination. **Example scenario:** Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination. **New Jersey Administrative Code Rule 11:22-1.5(a) states...** Plan must pay paper claims **no later than 40 days** and electronic claims **no later than 30 days**. Failure to pay in a timely manner may subject Plan to 12% interest on the claim. **New Jersey Administrative Code Rule 11:24A-3.4(e) states...** Plan cannot reverse a utilization management decision in which provider relied on the written or oral authorization of the Plan (or its agents) before providing the service to the covered person, except in cases of material misrepresentation or fraud. **New Jersey Assembly Bill 540 states...** 11. A Plan shall not revoke, limit, condition or restrict a prior authorization if care is provided within 45 business days from the date the health care provider received the prior authorization. Any language in a contract or a policy or any other attempt to disclaim payment for services that have been authorized within that 45-day period shall be null and void. 12. A prior authorization shall be valid for purposes of authorizing the health care provider to provide care for a period of 1 year from the date the health care provider receives the prior authorization.	**Issue:** Subsequent request for additional information. **Example scenario:** Provider submits a claim for EYLEA HD reimbursement, but 41 days later, Plan indicates payment of claim is pending receipt of additional information. **New Jersey Administrative Code Rule 11:22-1.5(a) states...** Plan must pay claims that are disputed or denied because of missing information or substantiating documentation **within 30 calendar days** for electronic claims and **within 40 calendar days** for nonelectronic claims of receipt of the missing information or substantiating documentation. **New Jersey Administrative Code Rule 11:22-1.4 states...** Plan may change the required information and documentation as long as provider is given notice **at least 30 days** prior to the change in the requirements.	**Issue:** Claim is past the filing deadline. **Example scenario:** Provider timely submits an EYLEA HD claim. Plan denies the claim for being past the filing deadline. **New Jersey Insurance Code Section 17B:27-41 states...** Written proof of such loss must be furnished to the insurer **within 90 days** after the date of such loss. Failure to furnish such proof within such time will not invalidate nor reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. **NOTE:** This provision sets forth minimum standards. Provider should check contract for specific requirements.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim. **New Jersey Administrative Code Rule 11:24A-3.5 states...** **Internal grievance:** Stage 1 standard appeals will be concluded in **10 calendar days**; stage 2 standard appeals, **20 calendar days**. **New Jersey Administrative Code Rule 11:24A-3.6 states...** **External review:** Provider must request an independent external review **within 120 days**. Plan may charge a $25 fee that will be refunded if provider wins the appeal. The review must be completed **within 45 days**. Forms for requesting an independent external review may be downloaded from the New Jersey Department of Insurance website.

Complaints regarding these and other payer issues can be made to the New Jersey Division of Insurance website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

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01/2025 US.EHD.24.11.0174

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Reference: Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg