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

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.

On the following page:

Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

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

Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.
New Jersey Administrative Code Rule 11:22-1.5(a) states...	**New Jersey Administrative Code Rule 11:22-1.5(a) states...**	**New Jersey Insurance Code Section 17B:27-41 states...**	**New Jersey Administrative Code Rule 11:24A-3.5 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.	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.	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.	**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-3.4(e) states...	**New Jersey Administrative Code Rule 11:22-1.4 states...**		**New Jersey Administrative Code Rule 11:24A-3.6 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.	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.		**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.
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.			

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

REGENERON®

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05/2024 US.EHD.24.02.0225

This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.

Reference: Data on file. Regeneron Pharmaceuticals, Inc.

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

EYLEA® HD (aflibercept) Injection 8 mg