CHAPTER 1

AN ACT concerning the Independent Health Care Appeals Program and amending P.L.1997, c.192.

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

1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read as follows:

C.26:2S-12 Contract to conduct appeal reviews; procedures.

12. a. The commissioner shall contract with one or more independent utilization review organizations in the State that meet the requirements of this act to conduct the appeal reviews. The independent utilization review organization shall be independent of any carrier. The commissioner may establish additional requirements, including conflict of interest standards, consistent with the purposes of this act that an organization shall meet in order to qualify for participation in the Independent Health Care Appeals Program.

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

c. 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 the 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 90 days of receipt of a completed application for an appeal review or within less time, as prescribed by the commissioner.

Upon completion of the review, the organization shall state its findings in writing and make a determination of whether the carrier's denial, reduction or termination of benefits deprived the covered person of medically necessary services covered by the person's health benefits plan. If the organization determines that the denial, reduction or termination of benefits deprived the person of medically necessary covered services, it shall convey to the covered person and carrier its decision regarding the appropriate, medically necessary health care services that the person should receive, which shall be binding on the carrier. If all or part of the organization's decision is in favor of the covered person, the carrier shall promptly provide coverage for the health care services found by the organization to be medically necessary covered services. If the covered person is not in agreement with the organization's decision, the person may seek the desired health care services outside of his health benefits plan, at his own expense.

d. 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 patient rights and other applicable regulations, the commissioner may impose such penalties and sanctions on the carrier, as provided by regulation, as the commissioner deems appropriate.

e. The commissioner shall require the independent utilization review organization to establish procedures to provide for an expedited review of a carrier's denial, reduction or termination of a benefit decision when a delay in receipt of the service could seriously jeopardize the health or well-being of the covered person.

f. The covered person's medical records provided to the Independent Health Care 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 medical records and findings and recommendations shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate, and shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

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

2. This act shall take effect immediately.

Approved January 16, 2001.