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BULLETIN NO: 06-16

TO: CARRIERS SUBJECT TO P.L. 2005, C. 352 AND OTHER INTERESTED PARTIES

FROM: STEVEN M. GOLDMAN, COMMISSIONER

RE: P.L. 2005, C. 352 – HEALTH CLAIMS AUTHORIZATION, PROCESSING AND PAYMENT ACT – FORMS, EFFECTIVE DATE, AND AN UPDATE ON ARBITRATION

- **CONSENT AND AUTHORIZATION (FOR UM APPEALS AND ARBITRATION);**
- **NOTICE OF REVOCATION OF CONSENT (FOR UM APPEALS);**
- **APPLICATION TO APPEAL A CLAIMS DETERMINATION**

The Health Claims Authorization, Processing and Payment Act (HCAPPA or Act), P.L. 2005, c. 352, was enacted on January 12, 2006, and will become effective on July 11, 2006. Although the Department of Banking and Insurance (Department) intends to promulgate rules to implement the provisions of the HCAPPA, the Department will not have any rules in place prior to the effective date of the HCAPPA. Pursuant to the HCAPPA, carriers and health care providers have an obligation to meet certain requirements of the law as of July 11, 2006, regardless of whether the Department has rules in place at that time. In addition, certain rights of health care providers become effective as of July 11, 2006. Accordingly, the Department will be issuing bulletins to provide guidance and certain tools to carriers, health care providers and other interested parties to help carriers and other interested parties meet their obligations or exercise their rights under HCAPPA pending adoption of rules. This bulletin addresses the forms referenced above, the effective date applicability of HCAPPA, and provides a brief update on the arbitration process.

FORMS

Consent to Representation and Authorization of Release of Medical Records for UM Appeals
Consent to Authorization of Release of Medical Records for Arbitration of Claims
Revocation of Consent and Authorization with respect to UM Appeals

Among other things, the HCAPPA amends the Health Care Quality Act, N.J.S.A. 26:2S-1 et seq., with respect to the Independent Health Care Appeals Program (IHCAP). The HCAPPA establishes a statutory right of a covered person to consent to representation by a health care

provider in an appeal of an adverse utilization management (UM) determination[1] presented to the IHCAP. Furthermore, the HCAPPA specifies that the covered person may consent to such representation and to the disclosure of personal health information *prior* to receiving health care services, and that, when given, such consent is valid for all stages of a UM appeal. In addition, the HCAPPA requires that a health care provider that obtains consent must provide written notice to the covered person prior to appealing at each stage of the UM appeal process, and the Act specifies that the covered person retains the right to revoke consent at any time.[2]

The HCAPPA also amends the Health Information Electronic Interchange Technology law (P.L. 1999, c. 154), with respect to both claims payment and the establishment of an independent claims arbitration program to be administered through the Department. Health care providers are permitted to request arbitration of one or more claims if the health care provider remains dissatisfied after having pursued an appeal of the carrier's handling of the claim(s) through the carrier's internal claims appeal mechanism. The health care provider is assumed to be appealing in his or her own right and, thus, consent from a covered person to representation of his or her interests is not required. However, arbitration of the claim may result in release of personal health information of covered persons by the health care provider. Accordingly, the Department believes the health care provider must obtain consent from the covered person for release of his or her personal health information to third parties. The Department believes it is reasonable to permit health care providers to obtain consent from covered persons for the release of personal health information for arbitration purposes prior to services being rendered, along with the consent for the UM appeal process.

Attached is a **single** form that the Department has developed for use by health care providers in obtaining: (1) consent to representation in a UM appeal; (2) authorization for release of personal health information for purposes of an IHCAP appeal; and, (3) authorization for release of personal health information for purposes of requesting an independent arbitration of one or more claims. In addition, the form provides a vehicle and process for covered persons to revoke their consent to representation in, and release of personal health information for, a UM appeal. The Department considered it important to include the consent and authorizations in one document if at all possible in order to minimize the number of new documents the patient would be expected to complete prior to receiving services. Health care providers are urged to use this form until further notice. Similarly, until further notice, when the form is presented to carriers for purposes of the internal UM appeal process, carriers are advised to accept the form as reasonable evidence of the covered person's consent if the covered person has appropriately completed the form and consented to representation by the health care provider.

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[1] An adverse UM determination involves a denial, reduction, termination or other limitation of a covered health care service, or benefits for such service, resulting from the application of a UM review in which the carrier determines that a service otherwise covered under the terms of the health benefits plan is not medically necessary or appropriate, is cosmetic instead of medically necessary, is dental instead of medical, or is experimental or investigational in the particular circumstance.

[2] By virtue of state and federal regulations, health care providers heretofore had been permitted to appeal to a carrier on behalf of a covered person with the covered person's consent, as well as to the IHCAP. However, the Department's rules – which the Act supercedes -- had *not* accepted consents for IHCAP appeals when consent was given *prior* to the date that a UM determination was made, but also did not require any further notice from the health care provider to the covered person as to when an appeal would be filed.

The Department and its contracted Independent Utilization Review Organizations will accept the consent and authorization form for purposes of representation and release of personal health information when appropriately completed and presented for IHCAP appeals. Likewise, the Department and its contracted independent arbitration organization will accept the form for purposes of release of personal health information when appropriately completed and presented for arbitration.

Note that the consent and authorization form should be used only for services rendered on or after July 11, 2006, or for which a prior authorization request was submitted on or after July 11, 2006 when prior authorization is required**.** The Department and its contractors will not accept the form for purposes of either an IHCAP appeal or independent arbitration related to services provided prior to July 11, 2006. The form will be posted to the Department's website. The Department urges health care providers to maintain copies modified to include the health care provider's name. Note: the electronic form can *only* be modified for the health care provider's name, and is not intended for completion online. The form should always be printed and presented in its entirety (as a double-sided page, or two single-sided pages).

With respect to presentation of the form to the IHCAP and the Program for Independent Claims Payment Arbitration (PICPA), the form should be attached to the respective application forms for each of these programs. The Department is in the process of revising the IHCAP application form, and developing the PICPA form. When revised, the Department intends to forward the IHCAP form by bulletin to carriers and add the form to the Department's website on or about July 11, 2006. (Carriers are reminded that, notwithstanding the IHCAP application being available on the Internet at the Department's website, carriers continue to have an obligation to distribute the IHCAP application form with instructions when issuing determinations for Stage 2 UM appeals.) In addition, the Department will provide general notice by bulletin to carriers and trade associations for health care providers when the PICPA application form becomes available, and will also post it to the Department's website.

Health Care Provider Application to Appeal a Claims Determination

As indicated above, the HCAPPA requires carriers to have an internal claims appeal mechanism specifically for the use of the health care provider,[3] and sets forth some standards for such appeals. Specifically, the HCAPPA requires the Department to develop a form for use by health care providers in making appeals of claims determinations. Attached is the form the Department has developed. The Department has tried to assure that the information sought in the form is adequate for the claims appeal process while not unduly burdensome or restrictive for health care providers. The Department is cognizant that the appeal process will now be a prelude to the statutorily-mandated arbitration mechanism in many instances, and thus, tried to design a form that would gather a relatively comprehensive set of information useful for purposes of both the internal claims appeal process and potential subsequent arbitration through the PICPA.

[3] The HCAPPA claims appeal mechanism is intended for use by health care providers separate and apart from any right of claims appeal that may exist for covered persons pursuant to federal law. New Jersey law had previously required that carriers have an internal mechanism in place for network providers to dispute compensation matters, but the law did not provide formal standards or procedures for these mechanisms.

The Department has developed two versions of the claims appeal application form – one which carriers may make carrier-specific, and one which is generic. The Department intends that the version attached to this bulletin will be modified by carriers to provide the carrier's name and instructions on where and how to submit the application. Carriers may add their logo/brand if they desire. Other modifications are not permitted. (An electronic version will be available on the Department's website shortly after distribution of this bulletin.) The Department expects carriers to provide notice to network health care providers of the existence of the *Health Care Provider Application to Appeal a Claims Determination* form and to add the carrier-modified *Health Care Provider Application to Appeal a Claims Determination* to their website for ease of access by health care providers. The Department will be posting the generic version of the *Health Care Provider Application to Appeal a Claims Determination* form to the Department's website for use by any health care providers. Although a carrier is encouraged to use a permissibly-modified form and to urge network health care providers to use the carrier's permissibly-modified form, carriers should accept both versions of the *Health Care Provider Application to Appeal a Claims Determination* form.

As with the UM appeal process, the Department has determined that **carriers should only accept claims appeals on *Health Care Provider Application to Appeal a Claims Determination* forms for claims arising from services rendered on or after July 11, 2006**. Accordingly, carriers should instruct health care providers that appeals of claims determinations for services rendered on or after July 11, 2006 should be submitted with the *Health Care Provider Application to Appeal a Claims Determination* form if the health care provider wants to avail itself of the statutory process and have the claim potentially eligible for the PICPA. The Department does not intend that claims for services rendered prior to July 11, 2006 will be eligible for the PICPA, and consequently, is not requiring carriers to accept appeals of such claims for purposes of compliance with Chapter 352. This should not be interpreted to mean that carriers should not entertain appeals on claims for services rendered prior to July 11, 2006, only that such claims need not be treated in accordance with Chapter 352. Prompt pay statutes and the rules at N.J.A.C. 11:22-1 et seq. still apply.

Even if the claim is related to services rendered on or after July 11, 2006, carriers are not required to apply the Chapter 352 process[4] if the claim appeal is not accompanied by the *Health Care Provider Application to Appeal a Claims Determination* form. The Department urges carriers to send the form to a health care provider that the carrier believes is attempting to file an appeal but does not understand the process, and/or is having difficulty getting the appeal to the proper location. In addition, while carriers and health care providers are permitted to "discuss" claims issues informally if they so desire, health care providers are cautioned that the 90-day statutory timeframe for filing an appeal will continue to run from the date of receipt of a claim determination.

[4] The statutory process establishes timeframes for a determination to be rendered on the appeal application (30 days following receipt), after which the health care provider may apply for arbitration (90 days following the appeal determination). Pursuant to the Act, a health care provider is not eligible to present a claim to the arbitrator if the health care provider has not first availed itself of the statutory appeal process with respect to the claim.

EFFECTIVE DATE AND APPLICABILITY OF CHAPTER 352

As noted, the effective date of Chapter 352 is July 11, 2006. The Department's determination on the application of the effective date to the various provisions of the law is as follows[5]:

1. Carriers must provide Internet-based disclosures as required by the HCAPPA (regarding clinical criteria, claims submissions requirements, and policies for certain claims adjudications) as of July 11, 2006. To the extent that any of the Internet-posted disclosures are different from information previously provided in writing to in-network health care providers, the information shall not be effective for at least 30 days following the date of the posting (August 10, 2006). In addition, as the carrier makes changes to the information, such changes shall not be effective until at least 30 days following the date of the posted changes. Accordingly, the Department urges carriers to include with the disclosures the dates that the disclosures and any subsequent changes are posted. *N.J.S.A. 17B:30-51*

2. Carriers and health care providers are required to comply with the provisions of *N.J.S.A. 17B:30-52* with respect to prior authorization requests made on or after July 11, 2006 for health care services to be rendered on or after July 11, 2006. Prior authorization requests submitted before July 11, 2006 are not subject to Chapter 352. Similarly, Chapter 352 does not apply to services rendered prior to July 11, 2006. Accordingly, carriers are not required to comply with the provisions of *N.J.S.A. 17B:30-53 and 54* except with respect to health care services with a date of service on or after July 11, 2006, and, where health care services did not involve emergency or urgent care, for which a prior authorization request was made on or after July 11, 2006.

3. The amendments to *N.J.S.A. 26:2S-11 and 12* apply to appeals made on UM determinations related to health care services that were rendered on or after July 11, 2006, or for which a prior authorization request was made on or after July 11, 2006 when prior authorization is required. As stated previously, consent and authorization forms should be used only for services rendered on or after July 11, 2006; the Department and Independent Utilization Review Organizations will not accept the new form for purposes of an IHCAP appeal related to the provision of services prior to July 11, 2006.

4. The amendments to paragraphs *d* of *N.J.S.A. 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17:48F-13.1, 17B:26-9.1, 17B:27-44.2, and N.J.S.A. 26:2J-8.1*, apply to all claim payments made on or after July 11, 2006. Thus, a carrier paying any overdue claim on or after July 11, 2006 should include 12% interest with the payment of the claim, and interest should be calculated as of the date that the claim became overdue, even if the date precedes July 11, 2006. Provisions of the respective paragraphs *d* relating to coordination of benefits, recoupment and offsets apply as of July 11, 2006.

[5] In all instances, appeals and claims that fall outside of Chapter 352 are subject to the laws in place on the date that the appeal or claim arose, and alternate legal forums remain available.

5. New paragraphs *e* of *N.J.S.A. 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17:48F-13.1, 17B:26-9.1, 17B:27-44.2, and N.J.S.A. 26:2J-8.1*, apply only to claims related to health care services rendered on or after July 11, 2006. As previously noted, the Department and its contractors will not accept the authorization for arbitration form for purposes of a PICPA request related to the provision of services rendered prior to July 11, 2006. Furthermore, carriers are not required to accept claims appeals on *Health Care Provider Application to Appeal a Claims Determination* forms for claims arising from services rendered before July 11, 2006.

With respect to the applicability of the Act, in some instances the language of the law suggests that it applies across health care providers, and in some instances the language suggests that the law applies more narrowly (sometimes only to hospital services, sometimes to hospital and physician services as these terms are defined by HCAPPA or other existing New Jersey statutes). The Department believes the intent of the Legislature was for the law to apply broadly across health care providers and health care services, and intends to issue proposed rules accordingly.

The language of the HCAPPA is also inconsistent with respect to the applicability of various provisions to carriers and other entities. The provisions of *N.J.S.A. 17B:48 through 54* suggest that the law as a whole applies to: insurers offering health benefits plans, hospital service corporations, medical service corporations, health service corporations, and HMOs (to the extent that the carriers incorporate UM with one or more health benefits plans), as well as carriers' subcontractors (including affiliates) that perform UM activities or claims handling functions, whether or not the subcontractor is required to be certified or licensed as an Organized Delivery System (ODS) or registered as a Third Party Administrator. With respect to claims handling issues, claims appeals, and arbitration, Chapter 352 specifically amends the statutes applicable to: insurers authorized to engage in health insurance business, hospital service corporations, medical service corporations, health service corporations, HMOs and prepaid prescription service organizations. Chapter 352 also amends the language of *N.J.S.A. 26:2S-11 and 12*, which apply specifically to carriers as defined at *N.J.S.A. 26:2S-2* (that is, health insurers, hospital service corporations, medical service corporations, health service corporations and HMOs). However, *N.J.S.A. 26:2S-1 et seq.* also applies to certain additional entities via P.L. 2001, c. 187 (sometimes referred to as the "Right to Sue" law) specifically with respect to *N.J.S.A. 26:2S-11 and 12*, and P.L. 1999, c. 409 (Organized Delivery System Act) to the extent that an ODS is performing a function on behalf of a carrier.

In order to harmonize the provisions of Chapter 352, the Department believes that, **but for** the amendments to *N.J.S.A. 26:2S-11 and 12*, **all** of the provisions of Chapter 352 apply to: insurers, hospital service corporations, medical service corporations, health service corporations, HMOs and prepaid prescription service organizations, and the subcontractors to which any of these listed carriers may delegate any function regulated by the provisions of Chapter 352. The amendments to *N.J.S.A. 26:2S-11 and 12* also apply to dental service corporations and dental plan organizations as well as the aforementioned carriers **except** prepaid prescription service organizations. To the extent that an ODS may be performing some aspect of an internal UM appeal process on behalf of a carrier, the ODS would also be required to comply with the amendments of *N.J.S.A. 26:2S-11 and 12* (for instance, the ODS would be required to accept the

consent and authorization form for an internal UM appeal performed on behalf of a carrier). As always, the Department's position is that the ultimate responsibility for assuring compliance rests with the carrier, and the Department will look first to carriers in the event that compliance is lacking.

Provision (brief description)	Entities That Must Comply or are Directly Affected
N.J.S.A. 17B:51 (disclosure of criteria and claims handling information)	insurers, hospital service corporations, medical service corporations, health service corporations, HMOs, and prepaid prescription service corporations (including subcontractors that may be performing a function relevant to the information disclosed)
N.J.S.A. 17B:52 (prior authorization process)	insurers, hospital service corporations, medical service corporations, health service corporations, HMOs, and prepaid prescription service corporations (including subcontractors that may be performing a function relevant to the UM process); all health care providers
N.J.S.A. 17B:53 (payment based on UM activity)	insurers, hospital service corporations, medical service corporations, health service corporations, HMOs, and prepaid prescription service corporations (including subcontractors that may be performing a function relevant to the regulated activities); all health care providers
N.J.S.A. 17B:54 (payment for emergency and urgent service)	insurers, hospital service corporations, medical service corporations, health service corporations, HMOs, and prepaid prescription service corporations (including subcontractors that may be performing a function relevant to the regulated activities); all health care providers (but limited by type and setting of health care services)
Amendments to N.J.S.A. 26:2S-11 and 12 (access to the IHCAP, consent and authorization in UM appeals)	insurers, hospital service corporations, medical service corporations, health service corporations, HMOs, dental service corporations, and dental plan organizations (including subcontractors that may be performing a function relevant to the regulated activities); all health care providers
Amendments to N.J.S.A. 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17:48F-13.1, 17B:26-9.1, 17B:27-44.2, and N.J.S.A. 26:2J-8.1 (claims handling, recoupment, offset, internal claims appeals, arbitration)	respectively: hospital service corporations, medical service corporations, health service corporations, prepaid prescription service corporations, insurers, HMOs (including subcontractors that may be performing a function relevant to the regulated activities) But note: claims appeals and arbitration are always against the carrier

UPDATE ON THE ARBITRATION MECHANISM AND PROCESS

In accordance with the HCAPPA, the Department is required to contract with an arbitration organization (AO) to perform the independent arbitration function. Accordingly, the Department is working with the New Jersey Department of Treasury to issue a Request for Proposal and award a contract to an AO. The Department is unable to predict when the AO contract may be awarded. (No award will be made on or before July 11, 2006.) In order to avoid prejudicing the interests of any party, the Department believes that **the time for filing an application for arbitration cannot begin to run until the AO contract is awarded and the PICPA is operational**.

Thus, a payment dispute arising with respect to services rendered on or after July 11, 2006, but prior to the start of PICPA operations, shall continue to be eligible for consideration for arbitration until 60 days after the date that the PICPA is available to begin accepting applications for independent claims arbitration **or** 90 days following receipt by the health care

provider of the carrier's determination on the internal claim(s) appeal(s),[6] **whichever occurs later in time**. The Department will issue a general notice by bulletin announcing the date that the PICPA will be available to begin accepting applications for independent claims arbitration, along with instructions on how applications may be filed and a copy of relevant form(s), if any. Notice also will be posted on the Department's website at www.state.nj.us/dobi.

Questions regarding this bulletin may be directed to Consumer Protection Services, Office of Managed Care, by phone at (609) 292-5316 ext. 50998, or by fax at (609) 633-0807. Please specify that the question concerns the HCAPPA Consent Bulletin for speediest reply.

The Department intends to propose rules in the near future to implement the provisions of HCAPPA. Notice of the proposed rulemaking and directions for public comment will appear on the Department's website at www.state.nj.us/dobi/legsregs.htm. A copy of this bulletin and related bulletins will also be posted to the webpage.

7/10/06
Date

/s/ Steven M. Goldman
Steven M. Goldman
Commissioner

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[6] Time will be calculated based on the earliest receipt of a determination among claims that are aggregated.