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BULLETIN NO. 17-05

TO: **ALL HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, ORGANIZED DELIVERY SYSTEMS, AND OTHER INTERESTED PARTIES**

FROM: **RICHARD J. BADOLATO, COMMISSIONER**

RE: **IMPLEMENTATION OF P.L. 2017, c. 28, WHICH REQUIRES CERTAIN COVERAGE FOR TREATMENT OF SUBSTANCE USE DISORDERS AND WHICH PLACES CERTAIN RESTRICTIONS ON OPIOID AND OTHER PRESCRIPTION DRUGS**

P.L. 2017, c. 28 ("Chapter 28") was enacted February 15, 2017, and is effective May 16, 2017. The New Jersey Department of Banking and Insurance ("Department") issued Bulletin No. 17-01 on March 6, 2017, to provide initial guidance. The Department issues this Bulletin to provide further guidance regarding Chapter 28. Chapter 28 adds new, substantively identical statutes to multiple areas of our insurance laws.[1]

Application of the Law

The law applies to plans[2] issued or renewed on or after May 16, 2017.

Individual plans

Since the majority of individual plans are issued January 1 and all individual plans renew January 1, Chapter 28 will first apply to most persons covered under individual plans on January 1, 2018. However, persons who qualify for a special enrollment period may purchase an individual plan that will be effective prior to January 1, 2018. A person covered under an

[1] See N.J.S.A. 17:48-6nn, N.J.S.A. 17:48A-7kk, N.J.S.A. 17:48E-35.38, N.J.S.A. 17B:26-2.1hh, N.J.S.A. 17B:27-46.1nn, N.J.S.A. 17B:27A-7.21, N.J.S.A. 17B:27A-19.25, N.J.S.A. 26:2J-4.39, N.J.S.A. 52:14-17.29u, and N.J.S.A. 52:14-17.46.6f

[2] The law applies to all fully-insured health benefits plans issued in New Jersey, the State Health Benefits Plan and the School Employees Health Benefits Plan. Coverage provided under self-funded plans, Medicare, Medicaid, Tricare, and out-of-state plans is not subject to the requirements of Chapter 28. ID cards issued in New Jersey are required to state whether the coverage is fully-insured or self-funded.

individual policy effective May 16, 2017, or later will be entitled to the protections of Chapter 28 as of the policy effective date.

Group plans

Group plans are issued year-round. All coverage under a group plan issued or renewed on or after May 16, 2017, will be subject to the requirements of Chapter 28 as of the effective date or renewal date of the group plan. The requirements of Chapter 28 are not triggered by the addition of new employees or dependents to a group plan prior to renewal.

Check whether the law applies

Covered persons who are unsure whether the law applies to them as well as providers treating such persons may call the member services number on the covered person's ID card to confirm whether Chapter 28 applies to the covered person's coverage. If a carrier mistakenly advises a covered person or provider that the law applies to a covered person's coverage, then the carrier will be required to honor the information provided to the covered person or provider during the call. The Department encourages carriers to provide covered persons and providers with a call reference number to facilitate validation of the contents of the discussion in the event of a dispute. Where carriers are unable to demonstrate that they provided correct information to a caller in the event of a dispute about that call, the Department will require the carrier to provide coverage pursuant to the terms of Chapter 28.

Note that the first step in any validation of coverage must be to confirm whether the person is covered under a fully-insured plan issued in New Jersey, the State Health Benefits Plan or the School Employees Health Benefits Plan.

Substance Use Disorder

The law requires carriers to administer benefits for the treatment of substance use disorder in a specific way and relies on the definition of substance use disorder of the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and subsequent editions. As stated in the law, substance use disorder includes substance use withdrawal.

The DSM-5 states that the diagnosis of substance use disorder can be applied to the following classes:

- Alcohol
- Cannabis
- Hallucinogens
    - Phencyclidine
    - Other hallucinogens
- Inhalants
- Opioids
- Sedatives, hypnotics, or anxiolytics
- Stimulants
- Tobacco
- Other (or unknown)

Section 24 of Chapter 28 repeals the various state laws mandating coverage of alcoholism. Since substance use disorder includes the alcohol class, the benefits of Chapter 28 replace the prior benefits required for the treatment of alcoholism.

Network Benefits

As stated in paragraph a of Chapter 28, sections 1-10, carriers are required to provide unlimited inpatient and outpatient benefits for the treatment of substance use disorder at network facilities. Since outpatient benefits are not always provided by facilities, the Department reads network facilities to mean network providers, thus encompassing both facilities and physicians and other practitioners that render inpatient and outpatient care.

Except in the case of an in-plan exception, a person covered under a PPO or POS plan who voluntarily uses an out-of-network provider will not be entitled to the protections of Chapter 28 with respect to those out-of-network services.

180 Days per Plan Year and 28 Days during a Plan Year

As stated in paragraph b of Chapter 28, sections 1-10, carriers are required to provide benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder without prior authorization or other prospective utilization management requirements when determined medically necessary by the covered person's physician, psychologist or psychiatrist. Thus, a new 180-day period commences at the beginning of each new plan year.

As stated in paragraph e of Chapter 28, sections 1-10, carriers are required to provide benefits for the first 28 days of an inpatient stay during each plan year without retrospective or concurrent review, where medical necessity has been determined by the covered person's physician, psychologist or psychiatrist. A new 28-day period commences at the beginning of each new plan year.

Recognizing that inpatient stays and outpatient services may cross plan years, and the potential for a covered person to be in the midst of care when the law first applies to the person, the Department offers the following examples.

Example 1: A person is covered under an individual plan. The person receives authorization for an inpatient stay that commences December 28, 2017. The individual plan renews and the new plan year begins January 1, 2018. Chapter 28 first applies to the plan as of January 1, 2018. The person is still confined as of January 1, 2018. The person is entitled to 28 days of inpatient care beginning January 1, 2018. During those 28 days, the carrier may not perform prior authorization, concurrent review or retrospective review. Days prior to the start of the plan year on January 1, 2018, do not reduce the 28 days available during the plan year that begins January 1, 2018.

Example 2: A person is covered under a group plan with a group plan effective date of June 1, 2017. Thus, the plan year runs from June 1, 2017, through May 31, 2018. The person begins outpatient services four times per week on February 1, 2018. As provided under Chapter 28, the person is entitled to 180 days per plan year of outpatient treatment as determined medically necessary by the physician, psychologist or psychiatrist and without prior authorization, concurrent review or retrospective review. The person is still receiving outpatient services on June 1, 2018, when the new plan year begins. A new 180-day period with medical necessity as

determined by the physician, psychologist or psychiatrist and without retrospective review begins June 1, 2018.

Medical Necessity
During the first 180 days of inpatient or outpatient network services for the treatment of substance use disorder per plan year, the determination of medical necessity is made by the covered person's physician, psychologist or psychiatrist. Carriers are not permitted to engage in any prior authorization or utilization management even if a provider might request it.

Providers that might be concerned that services will be denied upon the concurrent review which may occur as of day 29 with respect to inpatient services, or upon a retrospective review with respect to intensive outpatient and partial hospitalization services, may want to contact the carrier or review the clinical policy guidelines to be adopted by the Commissioner of Human Services. Carriers are permitted to respond to provider requests for clarification with respect to the types of services covered.

Inpatient Care - Concurrent Review
As stated in paragraph e(2) of Chapter 28, sections 1-10, carriers are permitted to begin concurrent review as of day 29 of an inpatient stay. With respect to services during days 1 – 28, carriers shall not request any information from the facility or the covered person's treating providers for any purpose, except that, upon notice by the provider of plans for continuing care beyond day 28, carriers may initiate discussions with the provider to facilitate *concurrent review of days 29 and beyond*.

If the concurrent review after day 28 results in a determination that continued stay is not medically necessary, the carrier must provide the required notice within 24 hours of the determination with appeal rights and the covered person's stay in the facility is covered until the day after all appeals are exhausted even where the carrier's determination is upheld.

If the facility or the physician initiates a discussion with the carrier during the first 28 days of inpatient care because they believe the covered person might be ready for discharge, the carrier may participate in that provider-initiated discussion.

Note that inpatient care is not limited to hospitals and may be in any facility that carries out its stated purpose under all relevant state and local laws, and is:

- accredited for its stated purpose by the Joint Commission; or
- approved for its stated purpose by Medicare.

Carriers may also elect to recognize facilities:

- accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or
- credentialed by the carrier.

Summary for inpatient care by in-network providers, or providers used pursuant to an in-plan exception:

- Days 1 – 28: No prospective, concurrent or retrospective review are permitted
- Days 29 – 180: Concurrent review permitted; no prospective or retrospective reviews are permitted
- Days 181 – 365: Prospective, concurrent and retrospective reviews are permitted

Inpatient Care – In-Plan Exception
As stated in paragraph b of Chapter 28, sections 1-10, if no network facility is immediately available, carriers are required to make an in-plan exception such that the covered person could be admitted within 24 hours.

In order for carriers to determine whether a network facility is available and suitable to treat the covered person, carriers may require the admitting physician, psychologist or psychiatrist to supply the covered person's diagnosis and the recommended treatment plan specifying the services the covered person requires. The carrier must not request any additional documentation such as medical records. The Department notes that it is incumbent upon the physician, psychologist or psychiatrist and covered person to select a network facility to receive the benefits of Chapter 28. If a network facility is not available the physician, psychologist or psychiatrist and/or covered person should immediately request an in-plan exception. If the carrier disagrees and determines that a network facility is available and suitable to treat the covered person, then the in-plan exception may be denied and internal and external appeal rights afforded.

If a covered person elects to use an out-of-network facility even though network facilities are available, then the admission will not be subject to the requirements of Chapter 28.

While the in-plan exception is expressly required under Chapter 28, an in-plan exception is not unique to benefits for the treatment of substance use disorder. The shopping guide posted at http://www.state.nj.us/dobi/division_insurance/ihcseh/whichindividualplanbest/whichplan.html provides an explanation of the in-plan exception process which is applicable to individual and group plans alike.

Emergency Admission to an Out-of-Network Hospital
In case of an emergency admission to an out-of-network hospital, the covered person must comply with the emergency admission requirements stated in his or her plan. A common requirement is that the covered person must notify the carrier of the admission within 48 hours, or as soon as reasonably possible. Since the hospital is not a network provider, the provisions of Chapter 28 do not apply to the emergency admission to an out-of-network hospital. The carrier may review whether the admission qualifies as an emergency admission and the medical necessity of the admission and continued stay. If the carrier determines that inpatient care is medically necessary but that the covered person could safely be transferred to a network facility, the carrier may require that continued inpatient care be provided in a network facility.

Note that while New Jersey law, (N.J.A.C. 11:4-37.3, 11:24-5.3 and 9.1(d), and 11:24A-2.5 and 2.6), requires carriers to limit the cost sharing liability of covered persons to the network level cost sharing in the event of an emergency admission, the facility is an out-of-network facility and is treated as such for the purposes of Chapter 28.

Notice of Admission
As stated in paragraph b of Chapter 28, sections 1-10, the network facility is required to notify the carrier of the admission and the initial treatment plan within 48 hours.

Carriers that find a facility failed to provide the required notice may refer the facility to the Attorney General's Office for review and handling of the violation of the requirements of Chapter 28.

Note that a carrier may not deny the facility claim for failure to provide the required notice. As required by Chapter 28, a carrier may not engage in concurrent review prior to day 29 even if the facility failed to provide the required notice of admission.

Intensive Outpatient or Partial Hospitalization – Retrospective Review
As stated in paragraph f(2) of Chapter 28, sections 1-10, carriers are permitted to begin retrospective review as of day 29 for intensive outpatient or partial hospitalization services.

Since a provider claim may be the first notice the carrier receives that a covered person has received intensive outpatient or partial hospitalization services, the Department recognizes the importance of timely claim submission. The Department expects that network providers will bill within the timeframes set forth in provider contracts. Providers may choose to submit bills promptly to receive early feedback with retrospective review. Note that N.J.S.A. 45:1-10.1 and 26:2H-12.12 require that facilities and health care professionals file claims within 60 or 180 days (in case of an assignment) of the last date of service for a course of treatment.

Since services provided by out-of-network providers are not subject to the provisions of Chapter 28 carriers may employ existing processes to review such out-of-network provider services. Services rendered by out-of-network providers with an in-plan exception should submit bills within the timeframes that may be established in any single case agreements.

Summary for intensive outpatient or partial hospitalization by in-network providers, or providers used pursuant to an in-plan exception:

- Days 1 – 28: No prospective, concurrent or retrospective review are permitted
- Days 29 – 180: Retrospective review permitted; no prospective or concurrent reviews are permitted
- Days 181 – 365: Prospective, concurrent and retrospective reviews are permitted

Combination of Types of Care
Under Chapter 28, covered persons are entitled to 28 days of inpatient care during a plan year and a *separate* 28 days of intensive outpatient and partial hospitalization care per plan year. During those separate 28-day periods carrier must rely on the medical necessity determinations of the physician, psychologist or psychiatrist and may not engage in prior authorization, concurrent review or retrospective review.

For example, if a covered person is confined as an inpatient for 28 days and then commences treatment on an intensive outpatient or on a partial hospitalization basis, a separate 28 day period for those subsequent services would commence. Note that if the covered person later requires further inpatient care *during the same plan year*, the initial 28-days for inpatient care would have been exhausted and the carrier may review that subsequent admission using concurrent review. Similarly, if the covered person again requires intensive outpatient or partial hospitalization services, the initial 28 days would have been exhausted and the carrier may use retrospective review for the subsequent services. Note that once the covered person has exhausted the 180

days of treatment per plan year with any combination of inpatient and outpatient services, any further services during the plan year may be subject to the carrier's full review processes.

Combination of Network and Out-of-Network Care

Under Chapter 28, a covered person is entitled to 180 days per plan year of inpatient and outpatient treatment of substance use disorder by network providers. Any days of treatment a covered person may receive from out-of-network providers without an in-plan exception shall not reduce the 180 days available to the covered person from network providers. However, as noted above, the carrier may subject such out-of-network treatment to the carrier's full review processes. Note that any services a covered person receives from an out-of-network provider through an in-plan exception are counted as if rendered by a network provider.

Outpatient Care

As stated in paragraph d of Chapter 28, sections 1-10, outpatient visits during the first 180 days of treatment may not be subject to concurrent or retrospective review or any other utilization management review.

Summary for outpatient care by in-network providers, or providers used pursuant to an in-plan exception:

- Days 1 – 180: No prospective, concurrent or retrospective review are permitted
- Days 181 – 365: Prospective, concurrent and retrospective reviews are permitted

Multiple Diagnoses

As stated in paragraph l of Chapter 28, sections 1-10 "[t]he benefits required by this section are to be provided to all covered persons with a diagnosis of substance use disorder. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this section."

This provision addresses the care of multiple conditions, where one of the conditions being treated is substance use disorder. Chapter 28 does not apply to the care provided for other conditions or medical diagnoses, even if the patient is being separately treated for substance use disorder. Thus, if the treatment is entirely unrelated to the treatment of substance use disorder, carriers may apply normal utilization management. However, if any part of the treatment to be provided is to treat substance use disorder, then Chapter 28 applies to the treatment of the substance use disorder.

Example 1: If a covered person has a heart attack and is admitted through the emergency room to a network acute care facility to treat the heart attack, the carrier can apply the regular utilization management strategies with respect to the treatment of the heart attack even if the carrier learns that the covered person also has a diagnosis of substance use disorder. The admission is to treat a heart attack, not to treat the substance use disorder.

Example 2: A covered person falls and hits his or her head and suffers a brain blead. The family member who brings the person to the emergency room of a network hospital explains that the person suffers from alcohol dependence and fell while under the influence of alcohol. The covered person is admitted to treat both the brain bleed and the substance use disorder. Since substance use disorder is one of the conditions being treated, the provisions of Chapter 28 apply

to the treatment for alcohol use. Chapter 28 does not apply to the treatment of the brain bleed and therefore carriers may apply regular utilization management strategies to that treatment.

Coverage of Prescription Drugs under Chapter 28

As stated in paragraph i of Chapter 28, sections 1 - 10, benefits for outpatient prescription drugs for the first 180 days may not be subject to any prior authorization or prospective utilization management. As stated in paragraph b of Chapter 28, sections 1-10, benefits for the first 180 days of treatment shall be provided when determined necessary by the covered person's physician, psychologist or psychiatrist.

Summary for prescription drugs:

- Days 1 – 180: No prospective, concurrent or retrospective review are permitted
- Days 181 – 365: Prospective, concurrent and retrospective reviews are permitted

Except as stated in paragraph i of Chapter 28, section 11 (new N.J.S.A. 24:21-15.2), the cost sharing for covered prescription drugs is the applicable cost sharing required by the covered person's plan. Covered persons must be guided by the prescription drug provisions of their plans when selecting a pharmacy.

As also stated in paragraph i of Chapter 28, section 11, the cost sharing applied to the initial maximum five-day supply of an opioid drug may be determined in two ways. The first method permits cost sharing proportional to the amount prescribed. The second method allows the cost sharing for the full 30-day supply to be charged but prohibits cost sharing if/when the balance of the same drug is prescribed.

Example 1: A physician writes a five-day prescription for opioid X. Assume the covered person's plan requires a $50 copay for a 30-day supply. Since the covered person receives a five-day supply (which is 1/6 of the 30-day supply), the copay is reduced to 1/6 to $8.33.

Example 2: A physician writes a five-day prescription for opioid X; and the covered person pays the cost sharing for the full 30-day supply. Assume the copay is $50 for the 30-day supply. The physician sees the covered person does well with opioid X and now writes a prescription for a 25-day supply of opioid X to complete the 30-day supply. Since the covered person already paid for the 30-day supply when getting the five-day supply, there is no charge for the balance. If the physician never gives the balance of the prescription, then the covered person would have paid for a 30-day supply but gotten only a five-day supply.

The Department assumes any "balance" prescription is to enable the covered person to continue treatment with the particular opioid drug and it is reasonable to expect that the additional 25-day supply will be dispensed and picked-up soon after the initial five-day supply has been exhausted. The Department suggests allowing up to a seven-day timeframe for the covered person to pick up the 25-day balance. However, if the covered person can demonstrate it was not reasonably possible to pick up the balance within the seven-day period the carrier should consider the circumstances and make an allowance, as appropriate.

Example 3: A physician writes a five-day prescription for opioid X; and the covered person pays the cost sharing for the full 30-day supply. Assume the copay is $50 for the 30-day supply. The

physician sees the covered person does well with opioid X and now writes a prescription for a 30-day supply of opioid. Once dispensed, the covered person has received a total supply of the opioid under the two separate prescriptions that covers 35 days, but they have only paid the copay for a 30-day supply. Since the covered person already paid for a 30-day supply when getting the 5-day supply, there is no charge for 25 days of the newly written 30-day supply. However, there is a charge for the five-day supply. The covered person should pay proportional cost sharing for the additional five-day supply as in example 1, or $8.33.

Summary Chart

P.L. 2017, c.28

Service/Supply	Time Period (Days)	Prohibited Utilization Management	Permitted Utilization Management
Inpatient	First 1-28 days of benefit period	No prior authorization No retrospective review No concurrent review Medical necessity is determined by covered person's physician	Facility to provide 48 hour notice of admission and submission of initial treatment plan
Inpatient	Days 29-180 of benefit period	No prior authorization	Concurrent review allowed at 2 week intervals, 24 hour prior notice of denial, 24 hour internal and external appeal period, benefits provided through day after notification of denial; medical necessity using tool designated by DHS
Intensive Outpatient/Partial Hospitalization	First 1-28 days of benefit period	No prior authorization No retrospective review Medical necessity is determined by covered person's physician	NONE
Intensive Outpatient/Partial Hospitalization	Days 29-180 of benefit period	No prior authorization or concurrent review	Retrospective review; medical necessity using tool designated by DHS
Outpatient Visits	First 1-180 days of benefit period	No prior authorization or other prospective UM No concurrent review No retrospective review No UM	
Outpatient RX	First 1-180 days of benefit period	No prior authorization or other prospective UM Medical necessity as determined by covered person's physician	NONE

5/8/17
Date

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