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BULLETIN NO. 24-17

TO: **ALL HOSPITAL, MEDICAL AND HEALTH SERVICE CORPORATIONS, PREPAID PRESCRIPTION SERVICE ORGANIZATION, INSURANCE COMPANIES AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS IN NEW JERSEY**

FROM: **JUSTIN ZIMMERMAN, COMMISSIONER**

RE: **ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT (P.L. 2023, C. 296)**

The purpose of this Bulletin is to advise carriers[1] that on January 16, 2024, Governor Murphy signed into law P.L. 2023, c. 296, the Ensuring Transparency in Prior Authorization Act ("ETPAA"[2]) which repeals and replaces the Health Claims Authorization, Processing and Payment Act ("HCAPPA"). HCAPPA was originally promulgated on January 12, 2006, to establish uniform procedures and guidelines for providers, health insurance carriers and health maintenance organizations ("HMOs") to administer utilization management and claims payment processes. The ETPAA now replaces HCAPPA and updates these procedures and guidelines. Carriers are advised that the ETPAA takes effect on January 1, 2025. The Department of Banking and Insurance ("Department") is in the process of promulgating regulations to effectuate the purposes of the ETPAA. Prior to the promulgation of regulations, carriers must still comply with the Act.

The ETPAA updates the uniform procedures and guidelines for hospitals, physicians, and carriers to follow in communicating and following utilization management decisions and determinations on patients' behalf. N.J.S.A. 17B:30-55.2(g). The ETPAA aims to reduce inefficiencies in the health care delivery system, which can harm patients, by modernizing the prior authorization process. N.J.S.A. 17B:30-55.2. The ETPAA emphasizes the need for enhanced transparency of

[1] "Carrier" refers to hospital, medical and health service corporations, prepaid prescription service organization, insurance companies and health maintenance organizations authorized to transaction business in this State. N.J.S.A. 17B:30-55.3.

[2] As referenced herein, the ETPAA includes sections 2 through 15 of P.L. 2023, c. 296 (N.J.S.A. 17B:30-55.1 et al.) and sections 2, 3, 4, 5, 6, 7 and 10 of P.L. 1999, c. 154 (N.J.S.A. 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2, 26:2J-8.1 and 17:48F-13.1) as amended by P.L.2023, c.296.

the prior authorization process by requiring certain information be posted on the carrier's website. N.J.S.A. 17B:30-55.16.

The ETPAA also includes provisions regarding the prompt payment of claims, overdue claims, the accrual of interest on overdue claims, reimbursement of overpaid claims, reimbursement for underpaid claims, the process for a provider or carrier to appeal or dispute a claim internally, and the arbitration process, which is final and binding upon all parties.[3]

Prior Authorization

The ETPAA defines "prior authorization" as the process by which a carrier determines the medical necessity of an otherwise covered service prior to the rendering of the service including, but not limited to, preadmission review, pretreatment review, utilization review, and case management. N.J.S.A. 17B:30-55.3. As summarized below, the ETPAA sets forth specific requirements related to prior authorizations, including: timeframes for a carrier to respond to a request and for a provider to respond to a carrier request for additional information; the consequences if those timeframes are not met; parameters related to a carrier's denial or limitation of a prior authorization request; timeframes for the validity of a prior authorization; an appeals process for denials or limitations of a prior authorization request; and reimbursement for covered services including requirements related to medically necessary emergency and urgent care services.

Timeframes for Response to Request for Prior Authorization[4]

The ETPAA sets forth the following timeframes for a carrier to respond to a request for prior authorization.

- **Prescription Medication.** The carrier must respond to a prior authorization request for medication submitted via National Council for Prescription Drug Programs ("NCPDP") Script Standard within 24 hours for urgent requests, 72 hours for non-urgent requests.
- **Inpatient Services.** The carrier shall communicate the denial/limitation of the request to the provider within a time frame appropriate to the medical exigencies of the case but no later than 12 days (submitted by paper) or 9 days (submitted by an electronic portal provided by the carrier) after receipt of the claim.
- **Inpatient Services Rendered in the Emergency Department.[5]** The carrier shall communicate the denial/limitation of the request to the provider within a time frame appropriate to the medical exigencies of the case, but no later than 24 hours.

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[3] These provisions are variously codified at N.J.S.A. 17:48-8.4, N.J.S.A. 17:48A-7.12, N.J.S.A. 17:48E-10.1, N.J.S.A. 17:48F-13.1, N.J.S.A. 17B:26-9.1, N.J.S.A. 17B:27-44.2, N.J.S.A. 26:2J-8.1.

[4] See, N.J.S.A. 17B:30-55.6 and N.J.S.A. 17B:30-55.11.

[5] The ETPAA makes a distinction between "emergency health care services" and "urgent care claims". "Emergency health care services" refers to services provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the health of the patient in jeopardy; (2) serious impairment to bodily

- **Care Requiring Immediate Post-Evaluation or Post-Stabilization Services**. The carrier has 150 minutes to make authorization determinations for emergency health care services that require immediate post-evaluation or post-stabilization services. If the authorization determination is not made within 150 minutes, those services shall be deemed approved.

- **Outpatient Services.** For services rendered in an outpatient setting, including, but not limited to, a clinic, rehabilitation facility, or nursing home, the carrier shall communicate the denial/limitation of the request to the provider within a timeframe appropriate to the medical exigencies of the case but no later than 12 days (submitted by paper) or 9 days (submitted by electronic portal provided by the carrier) after receipt of the claim.
- **Urgent Care Services.** The carrier shall notify the 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.
  - If the provider fails to provide sufficient information for the carrier to determine whether, or to what extent, benefits are covered under the plan, the carrier shall notify the provider as soon as possible, but not less than 24 hours after receipt of the claim, of the specific information necessary to complete the request.
  - The provider shall be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. The carrier shall notify the provider of the carrier's benefit determination as soon as possible, but not later than 48 hours after the carrier's receipt of the specified information.
- **If/When Additional Information Needed.** If a carrier requires additional information to respond to a request for prior authorization, the carrier shall notify the provider in writing within the timeframes specified above and shall identify the specific information needed to approve or make the adverse determination with regard to the request for authorization.
  - **Prior or concurrent authorization for a covered person who will be receiving inpatient hospital services or health care in another setting.** The carrier shall respond within a time frame appropriate to the medical exigencies of the case but no later than 12 calendar days (submitted by paper) or 9 calendar days (submitted by electronic portal provided by the carrier) beyond the time of receipt by the carrier from the provider of the additional information that the carrier has identified as needed to respond to the request.
  - **Prior or concurrent authorization for a covered person who is currently receiving inpatient hospital services or care rendered in the emergency department.** The carrier shall respond no more than 24 hours beyond the time of receipt by the carrier from the provider of the additional information that the carrier has identified as needed to respond to the request.

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function; or (3) serious dysfunction of any bodily organ or part. "Urgent care" refers to any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination may seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or, in the opinion of a physician with knowledge of the medical condition of the covered person, subjects the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In determining if a claim involves urgent care, a carrier shall apply the judgement of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the medical condition of the covered person determines that a claim involves urgent care, the claim shall be treated as an urgent care claim. N.J.S.A. 17B:30-55.3

Failure of a Carrier or Provider to Meet Timeframes Related to a Prior Authorization Request

The ETPAA states that if a carrier fails to respond to an authorization request within the time frames established pursuant to N.J.S.A. 17B:30-55.11, the provider's claim for the service shall not be denied based on a failure to secure prior or concurrent authorization for the service. Further, pursuant to N.J.S.A. 17B:30-55.15, failure by the carrier to meet timeframes automatically deems services authorized. However, if a provider fails to respond to a carrier's request for additional information necessary to render a decision within 72 hours, the provider's request shall be deemed withdrawn. N.J.S.A. 17B:30-55.11(e). A denial or limitation of prior authorization request shall be communicated to the provider by facsimile, e-mail, or any other means of written communication agreed to by the carrier and the provider. N.J.S.A. 17B:30-55.11(a).

Denial or Limitation of a Prior Authorization Request

A denial or limitation of a prior authorization request imposed by a carrier must be made under the clinical direction of a medical director of the carrier who must be licensed in this State, not be compensated by a carrier based on the approval or denial rate of the reviewing physician, and not be provided preferential treatment by a carrier in the requests for prior authorization of the reviewing physician if that physician is also a network provider for the carrier. N.J.S.A. 17B:30-55.8.

Timeframes for Validity of Prior Authorization

The ETPAA establishes timeframes for how long a prior authorization is effective in the following circumstances:

- **Chronic or Long-Term Conditions.** Except where shorter time frames are necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, a prior authorization for a chronic or long-term condition shall remain in effect for 180 days. N.J.S.A. 17B:30-55.7.
- **Defined Number of Discrete Services**. Except where shorter time frames are necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, a prior authorization for a service which includes a defined number of discrete services shall remain valid for 180 days from the date the provider receives the prior authorization and a carrier 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 of the request 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. N.J.S.A. 17B:30-55.9.
- **Previously Authorized Requests.** The carrier must honor a prior authorization granted to covered persons by a previous carrier for 60 days while the new carrier undertakes its own review. N.J.S.A. 17B:30-55.10.

Appeals of a Denial or Limitation of a Prior Authorization Request

Upon the denial or limitation of a prior authorization request, the determination may be subject to appeal. The appeals process includes an internal informal appeal (Stage 1), an internal formal appeal (Stage 2), and an external formal review.

The ETPAA requires that an internal appeal of a denial or limitation of a prior authorization request must be reviewed by a physician who is Board-certified in a same or similar specialty who has experience treating the condition or service under review within the last five years; not be paid by a carrier based on the reviewing physician's denial or approval rate; not have been directly involved in making an initial adverse determination for the same request; consider all known clinical aspects of the service under review, including, but not limited to, a review of all pertinent medical records provided to the carrier by the provider of the covered person, any relevant records provided to the carrier by a facility, and any medical literature provided to the carrier by the provider of the covered person; not be provided preferential treatment by the carrier in the reviewing physician's own requests for prior authorization if the reviewing physician is also a network provider; and when requested by the treating provider, must engage in a telephonic conversation with the treating provider to discuss the need for the prescribed medication or service. N.J.S.A. 17B:30-55.12.

Reimbursement for Covered Services

The ETPAA requires that a carrier provide reimbursement to a provider for covered services if the provider requested authorization and received approval prior to rendering services or the provider requested authorization and the carrier failed to respond within the established timeframes. N.J.S.A. 17B:30-55.13. If the provider received authorization for a covered service for a patient that is no longer eligible for coverage from that carrier and it is determined that the patient has coverage under another carrier, the subsequent carrier must provide reimbursement to the provider. N.J.S.A. 17B:30-55.13.

The ETPAA also imposes specific reimbursement requirements for medically necessary emergency and urgent care services under N.J.S.A. 17B:30-55.14:

- A carrier must provide reimbursement for medically necessary emergency and urgent care services covered by the health benefits plan; a covered person has 24 hours to notify a carrier of their admission.
- Coverage for screening and stabilizing services must be provided without requiring prior authorization.

Payment of Claims - Generally

The ETPAA contains provisions with the same or substantially the same requirements as the repealed HCAPPA related to the payment of claims generally (codified at N.J.S.A. 17:48-8.4, N.J.S.A. 17:48A-7.12, N.J.S.A. 17:48E-10.1, N.J.S.A. 17:48F-13.1, N.J.S.A. 17B:26-9.1, N.J.S.A. 17B:27-44.2, N.J.S.A. 26:2J-8.1). These provisions address the following:

- **Electronic transmission of claims.** A carrier shall adopt and implement the standards to receive and transmit health care transactions electronically using a standard health care claim form. A carrier shall acknowledge receipt of claim submitted by electronic means within two working days following transmission of claim.
- **Payment of claims.** A carrier must remit payment for a claim within 30 days if submitted electronically, 40 days if submitted other than electronically.
- **Denial of a claim.** A carrier may deny a claim if it is incomplete due to outstanding substantiating documentation, is incorrectly coded, if the amount is disputed, or if there is strong evidence of fraud.

- **The carrier must notify the provider with the reason the claim is unpaid.** The carrier must notify the provider within 30 days if filed electronically, 40 days if submitted other than electronically.
- **Circumstances where the carrier cannot deny payment of a claim.** A carrier that has reserved the right to change the premium cannot deny payment because the carrier has requested documentation or information that is not specific to the service provided to the covered person or while seeking coordination of benefits information.
- **When a claim becomes overdue.** Claims are considered overdue if payment is not remitted on or before the 30th calendar day if submitted electronically, 40th calendar day if submitted other than electronically, or the time limit established by Medicare, whichever is earlier.
- **Overdue claims are subject to interest.** Overdue claims will bear simple interest at a rate of 12% per annum, with interest payable at time of overdue claim payment.
- **Reimbursement for the overpayment of claims.** A carrier cannot seek reimbursement for overpayment of a claim previously paid later than 18 months after the date of the first payment made on the claim. A carrier cannot seek more than one reimbursement for overpayment of a particular claim. If a reimbursement request is made, the carrier must provide written documentation that identifies the error made by the carrier in the processing or payment of the claim that justifies a reimbursement request.
- **Circumstances where a carrier cannot request reimbursement for overpayment.** A carrier may not collect or attempt to collect: the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request; the funds for reimbursement if the provider disputes the request and initiates an appeal on or before the 45th day following the submission of the request until the providers right to appeal is exhausted; or, penalties against the reimbursement request including an interest charge or a late fee.
- **Reimbursement assessed against future claims.** After the 45th calendar day following the submission of the request for reimbursement or after the provider's right to appeal have been exhausted, a carrier may collect a reimbursement request by assessing it against the payment of any future claims submitted by the carrier, if the carrier submits an explanation in writing to the provider so that the provider can reconcile each covered person's bill.
- **Underpayment of claims.** A provider cannot seek reimbursement from a carrier or covered person for underpayment of a claim more than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal or the claim is subject to continual claims submission. No provider shall seek more than one reimbursement for underpayment of a particular claim.

Appeal and Arbitration of Disputed Claims

The ETPAA requires an internal appeal mechanism and an arbitration process if a claim is disputed, summarized below:

- **Internal appeal mechanism to resolve disputed claims.** A provider may initiate an appeal on or before the 90th calendar day following the receipt by the provider of the carrier's claims determination. A carrier shall conduct a review of the appeal and notify the provider of its determination on or before the 30th day following the receipt of the appeal form. If a provider is not notified within this timeframe, the provider may refer the dispute to arbitration.
    - **Appealed claims in favor of the provider.** Appealed claims in favor of the provider are subject to an accrued interest rate of 12%, which begins to accrue on the day the

appeal was received by the carrier and must be paid on or before the 30th calendar day following the notification of the carrier's determination on the appeal.
    - **Appealed claims against the provider.** The carrier must notify the provider on or before the 30th calendar day following the receipt of the appeal form and include written instructions to refer the dispute for arbitration.
- **Arbitration.** A provider who has exhausted a carrier's internal appeal process may seek arbitration under the Program for Independent Claims Payment Arbitration ("PICPA"). Additional information and frequently asked questions related to the PICPA process is available at https://dispute.maximus.com/nj/indexNJ.
- **Threshold for arbitration.** Any party may initiate arbitration on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal if the payment amount in dispute is more than $1,000.
- **Determination.** The determination must be signed by the arbitrator, issued in writing on or before the 30th calendar day following the receipt of the required documentation. The determination is not appealable and is binding on all parties.
- **Determination that the carrier has withheld payment.** Payment of a claim with accrued interest must be made on or before the 10th business day following the issuance of the determination. If the carrier withheld or denied payment based on information submitted by the provider that the carrier requested but did not receive, the carrier shall not be required to pay any accrued interest.
- **Pattern and practice of improper billing.** The arbitrator may award the carrier a refund, including interest accrued.

Transparency: Data Available on Carrier's Website

Pursuant to N.J.S.A. 17B:30-55.4, the ETPAA requires the following information appear in a clear and conspicuous manner on the carrier's website:

- A description of the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the carrier or its agent to determine the medical necessity of health care services;
- A list of the material, documents, or other information required to be submitted to the carrier with a claim for payment for health care services;
- A description of the type of claims for which the submission of additional documentation or information is required for the adjudication of a claim fitting that description;
- The carrier's policy or procedure for reducing the payment for a duplicate or subsequent service provided by a provider on the same date of service; and
- Prescription drug formularies.

Any changes to the information required to be posted shall be clearly noted. In addition, notice of any materially adverse amended requirements must be posted on a carrier's website 90 days prior to taking effect in addition to notice provided in writing to impacted network providers. N.J.S.A. 17B:30-55.4.

Pursuant to N.J.S.A. 17B:30-55.16, carriers must also make statistics regarding prior authorization approvals and denials available and readily accessible on their website. The carrier shall include:

- health care provider specialty;
- medication or diagnostic tests and procedures;

- indication offered;
- reason for denial;
- whether prior authorization determinations were appealed, and whether the determination was approved or denied on appeal;
- the time between submission of prior authorization requests and the determination;
- the average median time elapsed between a request for clinical records from the requesting health care provider and receipt of adequate clinical records to complete the prior authorization; and
- the number of appeals generated for cases denied in which there was inadequate or no prior clinical information.

Moreover, carriers are reminded of certain other information required to be posted on their website, including:

- **Addition or Termination of a Provider.** A carrier must update their website within 20 days of the addition or termination of a provider from the carrier's network or a change in a physician's affiliation with a facility, provided that in the case of a change in affiliation the carrier has had notice of such change. N.J.S.A. 26:2SSS-6(a).
- **Out-of-network services.** A carrier must provide access to a website that reasonably permits a covered person or prospective covered person to calculate the anticipated out-of-pocket cost for out-of-network services in a geographical region or zip code based upon the difference between the amount the carrier will reimburse for out-of-network services and the usual and customary cost of out-of-network services. N.J.S.A. 26:2SSS-6(b)4.

In addition, the Department advises that carriers are required to include in their annual public regulatory filing, the number of claims submitted by providers to the carrier which are denied or down coded by the carrier and the reason for the denial or down coding determination. N.J.S.A. 26:2SS-6(f).

Penalties

A carrier found in violation of the ETPAA shall be liable for a civil penalty of not more than $10,000 for each day that the carrier is in violation. N.J.S.A. 17B:30-55.15.

Questions related to this Bulletin should be directed to the Department's Office of Life and Health at lifehealth@dobi.nj.gov.

December 31, 2024
Date

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Commissioner

Bulletins/AR ETPAA Bulletin