

# 26:2S-12

## LEGISLATIVE HISTORY CHECKLIST

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**LAWS OF:** 2001                    **CHAPTER:** 1  
**NJSA:** 26:2S-12            (Independent Healthcare Appeals Program)  
**BILL NO:** A322                (Substituted for S640)

**SPONSORS:** Vandervalk and Talarico

**DATE INTRODUCED:** Pre-filed

**COMMITTEE:**                **ASSEMBLY:** Banking and Insurance; Health

**SENATE:** ----

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:**            **ASSEMBLY:** May 11, 2000

**SENATE:** December 4, 2000

**DATE OF APPROVAL:** January 16, 2001

### FOLLOWING ARE ATTACHED IF AVAILABLE:

**FINAL TEXT OF BILL** (1<sup>st</sup> reprint enacted)

(Amendments during passage denoted by superscript numbers)

**A322**

**SPONSORS STATEMENT:** (Begins on page 3 of original bill)                    Yes

**COMMITTEE STATEMENT:**                    **ASSEMBLY:** Yes    1/27/00

(Health)

2/10/00 (Banking &

Ins)

**SENATE:** No

**FLOOR AMENDMENT STATEMENTS:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**S640**

**SPONSORS STATEMENT:** (Begins on page 3 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY:** No

**SENATE:** Yes

**FLOOR AMENDMENT STATEMENTS:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**VETO MESSAGE:** No

**GOVERNOR'S PRESS RELEASE ON SIGNING:** Yes

**FOLLOWING WERE PRINTED:**

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**REPORTS:** No

**HEARINGS:** No

**NEWSPAPER ARTICLES:** Yes

"New law requires HMOs to accept appeal rulings," 1-17-2001 Star Ledger, p19

# ASSEMBLY, No. 322

## STATE OF NEW JERSEY 209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

**Sponsored by:**

**Assemblywoman CHARLOTTE VANDERVALK**

**District 39 (Bergen)**

**Assemblyman GUY F. TALARICO**

**District 38 (Bergen)**

**SYNOPSIS**

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

**CURRENT VERSION OF TEXT**

Introduced Pending Technical Review by Legislative Counsel.



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

3  
4 **BE IT ENACTED** by the Senate and General Assembly of the State  
5 of New Jersey:

6  
7 1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read  
8 as follows:

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

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

20 c. The independent utilization review organization shall promptly  
21 review the pertinent medical records of the covered person to  
22 determine the appropriate, medically necessary health care services the  
23 person should receive, based on applicable, generally accepted practice  
24 guidelines developed by the federal government, national or  
25 professional medical societies, boards or associations and any  
26 applicable clinical protocols or practice guidelines developed by the  
27 carrier. The organization shall complete its review and make its  
28 determination within 90 days of receipt of a completed application for  
29 an appeal review or within less time, as prescribed by the  
30 commissioner.

31 Upon completion of the review, the organization shall state its  
32 findings in writing and make a determination of whether the carrier's  
33 denial, reduction or termination of benefits deprived the covered  
34 person of medically necessary services covered by the person's health  
35 benefits plan. If the organization determines that the denial, reduction  
36 or termination of benefits deprived the person of medically necessary  
37 covered services, it shall [make a recommendation] convey to the  
38 covered person and carrier its decision regarding the appropriate,  
39 medically necessary health care services that the person should  
40 receive[. Upon receiving the organization's recommendation], which  
41 shall be binding on the carrier [shall promptly notify the covered  
42 person and the commissioner about what action the carrier will take  
43 with respect to the recommendation]. If the covered person is not in

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**

1 agreement with the organization's [findings and recommendation or  
2 the carrier's action on the recommendation] decision, the person may  
3 seek the desired health care services outside of his health benefits plan,  
4 at his own expense.

5 d. If the commissioner determines that a carrier [exhibits a pattern  
6 of noncompliance] has failed to comply with the [findings and  
7 recommendations] decision of an independent utilization review  
8 organization[, the commissioner shall review the carrier's utilization  
9 management program to ensure that the carrier is in compliance with  
10 all relevant State laws and regulations, including utilization  
11 management standards. If the commissioner determines that the  
12 carrier] or is otherwise in violation of patient rights and other  
13 applicable regulations, the commissioner may impose such penalties  
14 and sanctions on the carrier, as provided by regulation, as the  
15 commissioner deems appropriate.

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

21 f. The covered person's medical records provided to the  
22 Independent Health Care Appeals Program and the independent  
23 utilization review organization and the findings and recommendations  
24 of the organization made pursuant to this act are confidential and shall  
25 be used only by the department, the organization and the affected  
26 carrier for the purposes of this act. The medical records and findings  
27 and recommendations shall not otherwise be divulged or made public  
28 so as to disclose the identity of any person to whom they relate, and  
29 shall not be included under materials available to public inspection  
30 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

34 h. The cost of the appeal review shall be borne by the carrier  
35 pursuant to a schedule of fees established by the commissioner.  
36 (cf: P.L.1997, c.192, s.12)

37  
38 2. This act shall take effect immediately.

#### 39 STATEMENT

40  
41  
42 This bill makes the decisions rendered by independent utilization  
43 review organizations under the Independent Health Care Appeals  
44 Program established pursuant to the "Health Care Quality Act,"  
45 P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance  
46 carriers against whom a covered person files an appeal under the  
47 program.

# ASSEMBLY HEALTH COMMITTEE

## STATEMENT TO

### **ASSEMBLY, No. 322**

with committee amendments

# **STATE OF NEW JERSEY**

DATED: JANUARY 27, 2000

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 322.

As amended by the committee, this bill makes the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against which a covered person files an appeal under the program.

The committee amendments specify that if all or part of the independent utilization review 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.

As reported by the committee, this bill is identical to Senate Bill No. 2123 (1R) of 1999 (Matheussen/Sinagra) which was reported by the Senate Health Committee during the prior session, and is similar to Assembly Bill No. 3319 of 1999 (Vandervalk/Talarico).

This bill was prefiled for introduction in the 2000-2001 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

# ASSEMBLY BANKING AND INSURANCE COMMITTEE

## STATEMENT TO

[First Reprint]

## **ASSEMBLY, No. 322**

# **STATE OF NEW JERSEY**

DATED: FEBRUARY 10, 2000

The Assembly Banking and Insurance Committee reports favorably Assembly Bill No. 322 (1R).

This bill makes the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program. The bill further provides that if all or part of the independent utilization review 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.

[First Reprint]

**ASSEMBLY, No. 322**

**STATE OF NEW JERSEY**  
**209th LEGISLATURE**

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

**Sponsored by:**

**Assemblywoman CHARLOTTE VANDERVALK**

**District 39 (Bergen)**

**Assemblyman GUY F. TALARICO**

**District 38 (Bergen)**

**Co-Sponsored by:**

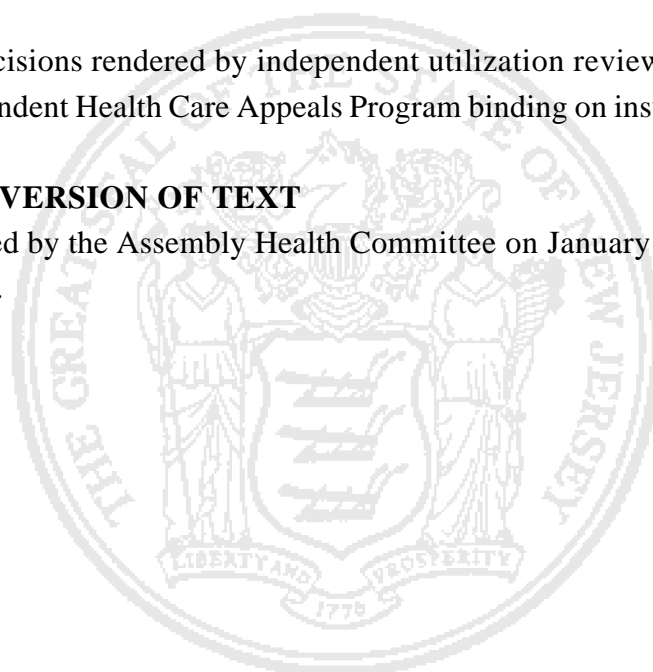
**Assemblywoman Crecco, Assemblymen LeFevre, Conaway, Gusciora, Garrett, Assemblywoman Greenstein, Assemblyman Thompson, Senators Matheussen, Sinagra, Gormley, Cafiero, Bennett, Bark, Robertson, Palaia, Kavanaugh, Bassano, McNamara, Allen, Inverso, Bucco, Singer, Kosco and Martin**

**SYNOPSIS**

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

**CURRENT VERSION OF TEXT**

As reported by the Assembly Health Committee on January 27, 2000, with amendments.



**(Sponsorship Updated As Of: 12/5/2000)**



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

3

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

6

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

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

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

20 c. The independent utilization review organization shall promptly  
21 review the pertinent medical records of the covered person to  
22 determine the appropriate, medically necessary health care services the  
23 person should receive, based on applicable, generally accepted practice  
24 guidelines developed by the federal government, national or  
25 professional medical societies, boards or associations and any  
26 applicable clinical protocols or practice guidelines developed by the  
27 carrier. The organization shall complete its review and make its  
28 determination within 90 days of receipt of a completed application for  
29 an appeal review or within less time, as prescribed by the  
30 commissioner.

31 Upon completion of the review, the organization shall state its  
32 findings in writing and make a determination of whether the carrier's  
33 denial, reduction or termination of benefits deprived the covered  
34 person of medically necessary services covered by the person's health  
35 benefits plan. If the organization determines that the denial, reduction  
36 or termination of benefits deprived the person of medically necessary  
37 covered services, it shall [make a recommendation] convey to the  
38 covered person and carrier its decision regarding the appropriate,  
39 medically necessary health care services that the person should  
40 receive[. Upon receiving the organization's recommendation], which  
41 shall be binding on the carrier [shall promptly notify the covered

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**

**Matter enclosed in superscript numerals has been adopted as follows:**

**<sup>1</sup> Assembly AHL committee amendments adopted January 27, 2000.**

1 person and the commissioner about what action the carrier will take  
2 with respect to the recommendation]. <sup>1</sup>If all or part of the  
3 organization's decision is in favor of the covered person, the carrier  
4 shall promptly provide coverage for the health care services found by  
5 the organization to be medically necessary covered services.<sup>1</sup> If the  
6 covered person is not in agreement with the organization's [findings  
7 and recommendation or the carrier's action on the recommendation]  
8 decision, the person may seek the desired health care services outside  
9 of his health benefits plan, at his own expense.

10 d. If the commissioner determines that a carrier [exhibits a pattern  
11 of noncompliance] has failed to comply with the [findings and  
12 recommendations] decision of an independent utilization review  
13 organization[, the commissioner shall review the carrier's utilization  
14 management program to ensure that the carrier is in compliance with  
15 all relevant State laws and regulations, including utilization  
16 management standards. If the commissioner determines that the  
17 carrier] or is otherwise in violation of patient rights and other  
18 applicable regulations, the commissioner may impose such penalties  
19 and sanctions on the carrier, as provided by regulation, as the  
20 commissioner deems appropriate.

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

26 f. The covered person's medical records provided to the  
27 Independent Health Care Appeals Program and the independent  
28 utilization review organization and the findings and recommendations  
29 of the organization made pursuant to this act are confidential and shall  
30 be used only by the department, the organization and the affected  
31 carrier for the purposes of this act. The medical records and findings  
32 and recommendations shall not otherwise be divulged or made public  
33 so as to disclose the identity of any person to whom they relate, and  
34 shall not be included under materials available to public inspection  
35 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

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

41 (cf: P.L.1997, c.192, s.12)

42

43 2. This act shall take effect immediately.

**SENATE, No. 640**

**STATE OF NEW JERSEY**  
**209th LEGISLATURE**

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

**Sponsored by:**

**Senator JOHN J. MATHEUSSEN**

**District 4 (Camden and Gloucester)**

**Senator JACK SINAGRA**

**District 18 (Middlesex)**

**SYNOPSIS**

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

**CURRENT VERSION OF TEXT**

Introduced Pending Technical Review by Legislative Counsel.



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2 shall promptly provide coverage for the health care services found by  
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5 and recommendation or the carrier's action on the recommendation]  
6 decision, the person may seek the desired health care services outside  
7 of his health benefits plan, at his own expense.

8 d. If the commissioner determines that a carrier [exhibits a pattern  
9 of noncompliance] has failed to comply with the [findings and  
10 recommendations] decision of an independent utilization review  
11 organization[, the commissioner shall review the carrier's utilization  
12 management program to ensure that the carrier is in compliance with  
13 all relevant State laws and regulations, including utilization  
14 management standards. If the commissioner determines that the  
15 carrier] or is otherwise in violation of patient rights and other  
16 applicable regulations, the commissioner may impose such penalties  
17 and sanctions on the carrier, as provided by regulation, as the  
18 commissioner deems appropriate.

19 e. The commissioner shall require the independent utilization  
20 review organization to establish procedures to provide for an  
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24 f. The covered person's medical records provided to the  
25 Independent Health Care Appeals Program and the independent  
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28 be used only by the department, the organization and the affected  
29 carrier for the purposes of this act. The medical records and findings  
30 and recommendations shall not otherwise be divulged or made public  
31 so as to disclose the identity of any person to whom they relate, and  
32 shall not be included under materials available to public inspection  
33 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

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

39 (cf: P.L.1997, c.192, s.12)

40

41 2. This act shall take effect immediately.

42

43

44

#### STATEMENT

45

46 This bill would make the decisions rendered by independent

**S640 MATHEUSSEN, SINAGRA**

4

1 utilization review organizations under the Independent Health Care  
2 Appeals Program established pursuant to the "Health Care Quality  
3 Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those  
4 insurance carriers against whom a covered person files an appeal under  
5 the program.

6 The bill would specify that if all or part of the independent  
7 utilization review organization's decision is in favor of the covered  
8 person, the carrier shall promptly provide coverage for the health care  
9 services found by the organization to be medically necessary covered  
10 services.

# SENATE HEALTH COMMITTEE

## STATEMENT TO

### **SENATE, No. 640**

# **STATE OF NEW JERSEY**

DATED: MARCH 20, 2000

The Senate Health Committee reports favorably Senate Bill No. 640.

This bill would make the decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program established pursuant to the "Health Care Quality Act," P.L.1997, c.192 (N.J.S.A.26:2S-1 et seq.) binding on those insurance carriers against whom a covered person files an appeal under the program.

The bill would specify that if all or part of the independent utilization review 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.

In the 1998-1999 session, the committee reported favorably with amendments Senate Bill No. 2123, which is identical to this bill. This bill is also identical to Assembly Bill No. 322(1R) (Vandervalk/Talerico) which is pending before the General Assembly.

This bill was prefiled for introduction in the 2000-2001 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

# SENATE, No. 640

## STATE OF NEW JERSEY 209th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2000 SESSION

**Sponsored by:**

**Senator JOHN J. MATHEUSSEN**

**District 4 (Camden and Gloucester)**

**Senator JACK SINAGRA**

**District 18 (Middlesex)**

**Co-Sponsored by:**

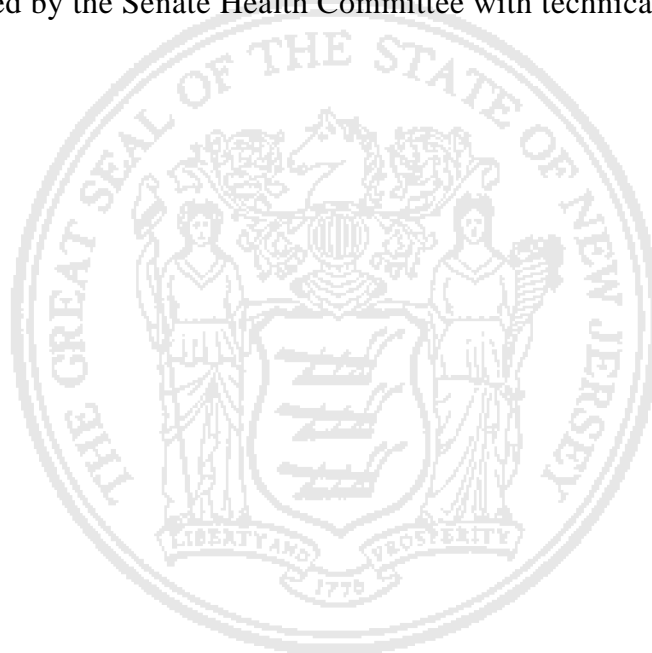
**Senators Gormley, Cafiero, Bennett, Bark, Robertson, Palaia, Kavanaugh,  
Bassano, McNamara, Allen, Inverso, Bucco, Singer, Kosco and Martin**

**SYNOPSIS**

Makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.

**CURRENT VERSION OF TEXT**

As reported by the Senate Health Committee with technical review.



**(Sponsorship Updated As Of: 11/14/2000)**



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

3

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

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7 1. Section 12 of P.L.1997, c.192 (C.26:2S-12) is amended to read  
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33 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

37 h. The cost of the appeal review shall be borne by the carrier  
38 pursuant to a schedule of fees established by the commissioner.  
39 (cf: P.L.1997, c.192, s.12)

40

41 2. This act shall take effect immediately.

P.L. 2001, CHAPTER 1, *approved January 16, 2001*  
Assembly, No. 322 (*First Reprint*)

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

3

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35 benefits plan. If the organization determines that the denial, reduction  
36 or termination of benefits deprived the person of medically necessary  
37 covered services, it shall **[make a recommendation]** convey to the  
38 covered person and carrier its decision regarding the appropriate,  
39 medically necessary health care services that the person should  
40 receive<sup>1</sup>. Upon receiving the organization's recommendation<sup>1</sup>, which  
41 shall be binding on the carrier **[shall promptly notify the covered**  
42 **person and the commissioner about what action the carrier will take**

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**

**Matter enclosed in superscript numerals has been adopted as follows:**

<sup>1</sup> Assembly AHL committee amendments adopted January 27, 2000.

1 with respect to the recommendation]. <sup>1</sup>If all or part of the  
2 organization's decision is in favor of the covered person, the carrier  
3 shall promptly provide coverage for the health care services found by  
4 the organization to be medically necessary covered services.<sup>1</sup> If the  
5 covered person is not in agreement with the organization's [findings  
6 and recommendation or the carrier's action on the recommendation]  
7 decision, the person may seek the desired health care services outside  
8 of his health benefits plan, at his own expense.

9 d. If the commissioner determines that a carrier [exhibits a pattern  
10 of noncompliance] has failed to comply with the [findings and  
11 recommendations] decision of an independent utilization review  
12 organization[, the commissioner shall review the carrier's utilization  
13 management program to ensure that the carrier is in compliance with  
14 all relevant State laws and regulations, including utilization  
15 management standards. If the commissioner determines that the  
16 carrier] or is otherwise in violation of patient rights and other  
17 applicable regulations, the commissioner may impose such penalties  
18 and sanctions on the carrier, as provided by regulation, as the  
19 commissioner deems appropriate.

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

25 f. The covered person's medical records provided to the  
26 Independent Health Care Appeals Program and the independent  
27 utilization review organization and the findings and recommendations  
28 of the organization made pursuant to this act are confidential and shall  
29 be used only by the department, the organization and the affected  
30 carrier for the purposes of this act. The medical records and findings  
31 and recommendations shall not otherwise be divulged or made public  
32 so as to disclose the identity of any person to whom they relate, and  
33 shall not be included under materials available to public inspection  
34 pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

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

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

40 (cf: P.L.1997, c.192, s.12)

41  
42 2. This act shall take effect immediately.

43  
44 \_\_\_\_\_  
45  
46 Makes decisions rendered by independent utilization review  
47 organizations under Independent Health Care Appeals Program  
48 binding on insurance carriers.

## 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.

PL. 2001, CHAPTER 1  
2

Approved January 16, 2001.

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*Office of the Governor*  
**NEWS RELEASE**

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RELEASE: January 16, 2001

**Whitman Signs HMO Patient Protection Into Law**

Governor Christie Whitman today signed legislation that protects patients who appeal decisions made by health insurance companies. The bill makes decisions in appeals binding on insurance carriers.

"This bill helps ensure that patients always come first," said Whitman. "For too long the needs of consumers were not the priority. This bill makes sure that if any or all of a decision is in favor of the patient the insurance carrier must provide coverage for services found to be medically necessary. Throughout this administration, we have been committed to enacting strong HMO consumer protection measures, such as the HMO patient's bill of rights and the HMO report card. This measure extends our commitment and further places patient needs at the top of the list."

**A-322**, sponsored by Assembly Members Vandervalk (R-Bergen) and Talarico (R-Bergen) and Senators Matheussen (R-Camden/Gloucester) and Sinagra (R-Middlesex), makes decisions rendered by independent utilization review organizations under Independent Health Care Appeals Program binding on insurance carriers.