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LEGAL ALERT

April 11, 2017

The Substance Use Disorders Law, P. L. 2017, c. 28, Imposes New Requirements on Certain Health Insurance Plans, Related to the Coverage for Treatment of Substance Use Disorders.

By Brian M. Foley, Esq. and Meghan V. Hoppe, Esq.

- Health benefits plans issued in New Jersey must provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services must be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed (or otherwise State-approved) facilities.

- The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder must be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

- The facility shall notify the health benefits plan of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.

- Providers of treatment for substance use disorder to persons covered under a covered contract shall not require pre-payment of medical expenses during this 180 days in excess of applicable co-payment, deductible, or co-insurance under the contract.

- If there is no in-network facility immediately available for a covered person, the health benefits plan must provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

- The benefits for **outpatient visits** cannot be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

Florham Park
220 Park Avenue
Florham Park, NJ 07932
(973) 539-1000

Paramus
115 West Century Road
Suite 100
Paramus, NJ 07652
(201) 262-1600

Sparta
351 Sparta Avenue
Sparta, NJ 07871
(973) 295-3670

New York
116 West 23rd Street
Suite 500
New York, NY 10011
(212) 386-7628

- The benefits for the first 28 days of an **inpatient stay** during each plan year must be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician.

- The benefits for days 29 and thereafter of **inpatient care** are subject to the following concurrent review process. A request for approval of inpatient care beyond the first 28 days must be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved.

- Health benefits plans shall not initiate concurrent review more frequently than two-week intervals.

- If a health benefits plan determines that continued **inpatient care** in a facility is no longer medically necessary, it must, within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination.

    - A health benefits plan shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program. An independent utilization review organization shall make a determination within 24 hours. If the health benefits plan's determination is upheld and it is determined continued inpatient care is not medically necessary, the health benefits plan shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made, and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

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- The benefits for the first 28 days of **intensive outpatient** or **partial hospitalization** services must be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician. The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

- Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the health benefits plan and may be subject to prior authorization or retrospective review and other utilization management requirements.

- Medical necessity review shall utilize an evidence-based and peer reviewed clinical review tool to be designated through rules by the Commissioner of Human Services in consultation with the Department of Health.

- The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

- The first 180 days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be deemed inpatient days for the purpose of the visit to day exchange.

- The benefits required by this law 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 law.

- The benefits required by this law shall apply to the following types of health benefits plans:

  Hospital Service Corporation
  Medical Service Corporation
  Health Services Corporation
  Individual Health Insurance Policies
  Group Health Insurance Policies
  Individual Health Benefits Plans
  Small Employer Health Benefits Plans

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Health Maintenance Organizations
State Health Benefits Plans
School Employees' Health Benefits Plans

- The benefits required by this law shall not apply to the following types of health benefits plans:

  Medicaid
  Any other program administered by the New Jersey Division of Medical Assistance and Health Services in the Department of Human Services

DISCLAIMER: This Alert is designed to keep you aware of recent developments in the law. It is not intended to be legal advice, which can only be given after the attorney understands the facts of a particular matter and the goals of the client.

Florham Park (973) 539-1000
Paramus (201) 262-1600
Sparta (973) 295-3670
New York (212) 386-7628