



## Vascular Society of New Jersey

November, 2010

### Good news for the New Jersey physician community!

### “Assignment of Benefits” Law Takes Effect January 16, 2011

#### *How does it work?*

After years of lobbying to advance an assignment of benefits law, Gov. Jon Corzine signed the law on January 16, 2010, in his final days in office. The law permits out of network physicians to have patients sign an “assignment of benefits” form, which will direct reimbursement to the physician, not the patient.

The law takes effect January 16, 2011, meaning that all care delivered on January 16, 2011, and forward, would qualify for the assignment of benefits provisions.

Most physicians already have an assignment of benefits form in use in their offices, but we have attached a sample form, should you need a form.

A copy of the entire law is below. The law permits an insurance company to require two signatures on the check (the physician and the patient), but we have learned that insurance companies think this requirement is too onerous to enforce and will not be requiring the dual signatures.

**Questions? Call your attorney, Mark Manigan from Brach Eichler (973-228-5700) or VSNJ, at 609-392-7553.**

#### CHAPTER 209

AN ACT concerning assignment of health benefits under managed care plans and amending P.L.2001, c.367.

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

1. Section 2 of P.L.2001, c.367 (C.26:2S-6.1) is amended to read as follows:

C.26:2S-6.1 Managed care plan to pay full contractual rate to out-of-network provider, direct payments, certain circumstances.

2. a. With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that:

(1) a covered person is admitted by an out-of-network health care provider to an in-network health care facility for covered, medically necessary health care services; or

(2) the covered person receives covered, medically necessary health care services from an out-of-network health care provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider, the carrier shall reimburse the health care facility for the services provided by the facility at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network provider, in accordance with the in-network policies and in-network copayment, coinsurance or deductible requirements of the managed care plan.

b. The provisions of subsection a. of this section shall apply only if the covered person complies with the preauthorization or review requirements of the health benefits plan regarding the determination of medical necessity to access in-network inpatient benefits, as set forth in writing pursuant to section 5 of P.L.1997, c.192 (C.26:2S-5).

c. With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as joint payees, with a signature line for each of the payees. Payment shall be made in accordance with the provisions of this section and P.L.1999, c.154 (C.17B:30-23 et al.). Any payment made only to the covered person rather than the health care provider under these circumstances shall be considered unpaid, and unless remitted to the health care provider within the time frames established by P.L.1999, c.154 (C.17B:30-23 et al.), shall be considered overdue and subject to an interest charge as provided in that act.

2. This act shall take effect on the 365th day next following enactment and shall apply to any health benefits plan in which the carrier has reserved the right to change the premium and which is in effect on or after the effective date.

Approved January 16, 2010.

**SAMPLE Assignment of Benefits form for your use in the office:**

**ASSIGNMENT OF BENEFITS**

I AUTHORIZE AND DIRECT MY INSURER OR PAYOR TO PAY DIRECTLY TO THE ABOVE [CENTER/PRACTICE], AND THE PHYSICIANS, ANY OR ALL BENEFITS, THAT WOULD OTHERWISE BE PAYABLE TO ME (OR THE PATIENT, IF SIGNED BY A RESPONSIBLE PARTY), UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT AT THE [CENTER/PRACTICE].

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDIGAP OR OTHER HEALTH INSURANCE POLICY BENEFITS FOR SERVICES FURNISHED TO ME BY THE [CENTER/PRACTICE] BE MADE ON MY BEHALF TO THE [CENTER/PRACTICE]. IN THE EVENT THAT PAYMENTS ARE MADE TO THE [CENTER/PRACTICE] AND ME AS JOINT PAYEES, I AGREE TO COOPERATE WITH THE [CENTER/PRACTICE] TO ENSURE THAT THE CENTER/PRACTICE RECEIVES ALL AMOUNTS DUE TO THE [CENTER/PRACTICE].

I HEREBY AUTHORIZE THE [CENTER/PRACTICE] TO PURSUE ANY MEANS NECESSARY TO COLLECT ALL CHARGES ON MY ACCOUNT INCLUDING FOLLOW UP CALLS, APPEALS, ARBITRATION, AND CIVIL SUIT, IF ALLOWABLE UNDER LAW. IN THE EVENT THAT THE [CENTER/PRACTICE] OR PHYSICIAN ELECTS TO BRING AN APPEAL, LAWSUIT OR PETITION FOR ARBITRATION AGAINST THE INSURANCE CARRIER, I HEREBY ASSIGN TO THEM MY RIGHTS, TITLE, AND INTEREST UNDER ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS, IF ALLOWABLE UNDER LAW. THIS ASSIGNMENT SHALL ALLOW AN ATTORNEY OF THEIR CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION THEIR CLAIM OF ANY UNPAID OR UNDERPAID BILLS FOR TREATMENT RENDERED AT THE [CENTER/PRACTICE].