Understanding Reimbursement Issues in Alabama

A Guide for Health Care Providers and Practice Administration

Alabama

Example EYLEA HD® (aflibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization

Issue: Plan delays prior authorization.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a request for prior authorization. Plan has not made a decision.

Alabama Insurance Code Section 27-3A-5 states...

Notification of a determination by the utilization review agent shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual **within 2 business days** of the receipt of the request for determination and the receipt of all information necessary to complete the review.

Prompt Payment

Issue: Plan delays timely payment pending medical necessity determination.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination.

Alabama Insurance Code Section 27-1-17 states...

Plan will pay a paper-based clean claim **within 45 calendar days** upon receipt and an electronic clean claim **within 30 calendar days** upon receipt. See explanation of a clean claim in the Request for Additional Information column.

Any undisputed portion of the claim will be paid within these time periods. If Plan fails to provide notice to provider of the reason for denying or pending the claim, then that claim (if and when determined to be payable) will accrue interest at the rate as provided. If Plan fails to deny or pay a clean claim within these time periods, the amount of the overdue claim must include an interest payment of 1.5% per month, prorated daily, that accrues from the date the payment was overdue and is payable at the time the claim is paid. Provider will not be required to give further notice to Plan.

A Plan domiciled outside Alabama is deemed to be subject to these provisions if it receives, processes, adjudicates, pays, or denies claims for services submitted by or on behalf of patients, insureds, or beneficiaries who reside in or receive services in Alabama.

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA HD reimbursement, but 46 days later, Plan indicates payment of claim is pending receipt of additional information.

Alabama Insurance Code Section 27-1-17 states...

Plan must notify provider **within 45 calendar days** for a paper-based claim and **within 30 calendar days** for an electronic claim of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. Plan must pay, deny, or otherwise adjudicate the claim **within 21 calendar days** of receiving the requested information.

A claim is considered a clean claim if it contains substantially all required data elements necessary for accurate adjudication without obtaining additional information from the provider or a third party. In no event will Plan require that the provider submit information or data elements in excess of those required on the standard health insurance claim form as a condition to the acceptance and processing of an initial claim as a clean claim.

Filing Deadlines

Issue: Claim is past the filing deadline.

Example scenario: Provider timely submits an EYLEA HD claim. Plan denies the claim for being past the filing deadline.

Alabama Insurance Code Section 27-1-17 states...

No Plan will be in violation of this section for any claim submitted **more than 180 days** in advance.

NOTE: This provision sets forth minimum standards. Providers should check contract for specific requirements.

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

Alabama Insurance Code Section 27-3A-5 states...

Internal appeal

- **Standard internal appeal:** Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures **no later than 30 days** from the date the appeal is filed and the receipt of all information necessary to complete the appeal
- **Expedited internal appeal:** Utilization review agents shall complete the adjudication of expedited appeals **within 48 hours** of the date the appeal is filed and the receipt of all information necessary to complete the appeal. Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard appeal process

On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate shall be made by **a physician in the same or a similar general specialty** as typically manages the medical condition, procedure, or treatment under discussion as mutually deemed appropriate.

Title 45 Code of Federal Regulations Section 147.136 states...

External appeal

- Request must be filed **within 120 days** of notice of final adverse determination
- **Standard external appeal: Within 45 days** after the date of receipt of the request for an external review by the health carrier, the independent review organization (IRO) shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or their authorized representative and the health carrier
- **Urgent external appeal:** As expeditiously as possible but within **no more than 72 hours** after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the IRO for conducting the external review.

Complaints regarding these and other payer issues can be made to the Alabama Department of Insurance website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

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This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.

Reference: Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg