Understanding Reimbursement Issues in Alaska

A Guide for Health Care Providers and Practice Administration

Alaska

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.

Title 3 Alaska Administrative Code Rule 28.910 states…

For a prospective review determination, Plan will make the determination and notify the covered person or the covered person's authorized representative of the determination (regardless of whether Plan certifies the provision of the benefit) within a reasonable time period appropriate to the covered person's medical condition but **no later than 5 working days** after the date Plan receives the request. The time period for making a determination may be extended 1 time by Plan for **no later than 5 working days** if Plan:

- Determines that an extension is necessary because of matters beyond its control, and
- Notifies the covered person or the covered person's authorized representative before the expiration of the initial 5-working-day time period of the circumstances requiring the extension of time and the date by which Plan expects to make a determination

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.

Alaska Statutes Section 21.36.495 states…

Plan will pay or deny indemnities under a health care insurance policy (regardless of whether services were provided by a participating provider) **within 30 calendar days** of receiving a clean claim.

If Plan does not pay a claim or denies a claim, it will, **within 30 calendar days** of receiving the claim, notify the provider of the basis for denial or the specific information needed to adjudicate the claim.

If Plan does not provide the notice as required, the claim will be presumed a clean claim, and interest will accrue at the rate of 15% annually, beginning on the day following the day when the notice was due and continuing until the date the claim is paid.

Alaska Statutes Section 21.07.020 states…

Plan must contain a provision that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider.

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA HD reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.

Alaska Statutes Section 21.36.495 states…

If Plan provides the required notice (see the Prompt Payment column) and requests specific information needed to adjudicate the claim, it will pay the claim **no later than 15 calendar days** after receipt of the information specified in the notice or **within 30 days** of receiving the claim. If Plan does not pay the claim within the required time period, the claim will be presumed a clean claim, and interest at the rate of 15% will accrue and continue accruing until the date the claim is paid.

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.

Alaska Statutes Section 21.51.100 states…

Written proof of loss must be furnished to the insurer **within 90 days** after the date of loss. Failure to furnish the proof within that time will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, **later than 1 year** from the time proof is otherwise required.

NOTE: This provision sets forth minimum standards. Provider 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.

Title 3 Alaska Administrative Code Rule 28.936 states…

Standard internal review: For a prospective or retrospective review, Plan will make a decision and notify the covered person **no later than 30 days** after the date Plan received the grievance.

Title 3 Alaska Administrative Code Rule 28.938 states…

Expedited internal appeal: Plan shall make an expedited review decision and shall notify a covered person or the covered person's authorized representative of the decision tinder (h) of this section as expeditiously as the covered person's medical condition requires, but not later than **72 hours** after the receipt of the request for the expedited review.

Title 3 Alaska Administrative Code Rule 28.956 states…

A covered person or the covered person's authorized representative will be considered to have exhausted a Plan's grievance process if the covered person or the covered person's authorized representative:

- has filed a grievance involving an adverse determination; and
- except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the Plan **no later than 30 days** after the covered person or the covered person's authorized representative filed the grievance with the Plan

Title 3 Alaska Administrative Code Rule 28.958 states…

If Plan has not issued a written decision **within 30 days**, the covered person may, upon request, proceed directly to an **independent external review**.

A request for an independent external review must be submitted **no later than 180 days** after notice of the adverse determination.

No later than 45 days after receipt of the request for an external review, an assigned independent review organization will provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination of Plan.

Title 45 Code of Federal Regulations Section 147.136 states…

External review 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 Plan, 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 his 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 Plan.

The Plan 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 Alaska Division 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