Understanding Reimbursement Issues in Arizona

A Guide for Health Care Providers and Practice Administration

Arizona

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.

Arizona Revised Statutes Section 20-3404 states...

For prior authorization requests concerning urgent health care services, the Plan or its utilization review agent shall notify the provider of the prior authorization or adverse determination no later than 5 days after the receipt of all necessary information to support the prior authorization request.

For prior authorization requests concerning health care services that are not urgent health care services, the Plan or its utilization review agent shall notify the provider of the prior authorization or adverse determination not later than 14 days after receipt of all necessary information to support the prior authorization request.

A prior authorization request is deemed granted if a Plan or its utilization review agent fails to comply with the deadlines and notification requirements of this section.

Arizona Revised Statutes Section 20-3406 states...

Notwithstanding any other law, on or before January 1, 2022, the Department [of Insurance] shall approve a uniform Prior Authorization Request Form. All providers shall use the approved Prior Authorization Form.

Arizona Revised Statutes Section 20-3654 states...

The Plan or utilization review agent shall grant or deny a step therapy exception request within 72 hours after receiving the request. In a case where exigent circumstances exist, the Plan or utilization review agent shall grant or deny the step therapy request within 24 hours after receiving the request.

If the prescribing provider does not receive a determination or request for additional or clinically relevant information from the Plan or utilization review agent within the time period prescribed, the exception is deemed granted.

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.

Arizona Revised Statutes Section 20-3102 states...

Plan will adjudicate any clean claim from a contracted or noncontracted provider relating to health care insurance coverage **within 30 days** after Plan receives the clean claim or within the time period specified by contract. Unless there is an express written contract between Plan and provider that specifies the period in which approved claims will be paid, Plan will pay the approved portion of any clean claim **within 30 days** after the claim is adjudicated. If the claim is not paid within the 30-day period or within the time period specified in the contract, Plan will pay interest on the claim at a rate that is equal to the legal rate. Interest will be calculated beginning on the date that the payment to the provider was due.

NOTE: The above time frame may be altered by contract between the health care insurer and health care provider.

Arizona Revised Statutes Section 20-2803 states...

If prior authorization is obtained, Plan that gives prior authorization for specific care by a provider **will not rescind or modify the authorization** after the provider renders the authorized care in good faith and pursuant to the authorization.

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.

Arizona Revised Statutes Section 20-3102 states...

If the claim is not a clean claim and Plan requires additional information to adjudicate the claim, Plan will:

- Send a written request for additional information to the provider **within 30 days** of receiving the claim
- Notify the provider of all the specific reasons for the delay in adjudicating the claim
- Record the date it receives the additional information
- Adjudicate the claim **within 30 days** of receiving all the additional information

Plan will not request information from the provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim. In addition, Plan will not request that the provider resubmit claim information that the provider can document it has already provided to Plan, unless Plan provides a reasonable justification for the request and the purpose of the request is not to delay the payment of the 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.

Group Health Insurance Standards Act Section 8 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. Forms required to be furnished may be electronic or paper in accordance with the communications preferences of the person making the claim.

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.

Arizona Revised Statutes Section 20-2534 (A) states...

Any member who is denied a request for a covered service may pursue an expedited medical review of that denial if the member's treating provider certifies in writing and provides supporting documentation to the utilization review agent that the time period for the informal reconsideration process and formal appeal process is likely to cause a significant negative change in the member's medical condition at issue that is subject to the appeal. **The treating provider's certification is not challengeable by the health care insurer**.

Within 3 business days after receiving the request for an expedited appeal, the utilization review agent shall provide notice of the expedited appeal decision as prescribed in this subsection.

Arizona Revised Statutes Section 20-2536 states...

Internal appeal: For adverse decisions relating to services that have not been provided, member must be notified in writing **up to 30 days** after receipt of the written appeal of the utilization review agent's decision and the clinical reasons for that decision. For denials relating to claims that have already been provided, member must be notified in writing **up to 60 days** after receipt of the written appeal of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

Arizona Revised Statutes Section 20-2537 states...

A request for an **independent external review** must be filed **within 120 days** of notice of final adverse determination. For cases involving an issue of medical necessity under the coverage document, the independent review organization will, **within 21 days** of receiving a case for independent review from the director, render a decision on whether the service or claim for the service is medically necessary and send the decision to the director. **Within 5 business days** of receiving a notice of decision from the independent review organization, the director will mail the notice to the treating provider.

Arizona Revised Statutes Section 20-2540 states...

The director will charge an appealing member's health care insurer for all amounts owed to the independent review organization.

Complaints regarding these and other payer issues can be made to the Arizona 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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777 Old Saw Mill River Road, Tarrytown, NY 10591
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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