Understanding Reimbursement Issues in Colorado

A Guide for Health Care Providers and Practice Administration

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

Prior Authorization	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
Issue: Plan delays prior authorization. **Example scenario:** Patient is diagnosed and meets medical necessity criteria for EYLEA injections. Provider submits a request for prior authorization. Plan has not made a decision. **Colorado Revised Statute Section 10-16-124.5 states...** Except as provided, a prior authorization request **is deemed granted** if a carrier or pharmacy benefit management firm fails to: **For prior authorization requests submitted electronically:** A. Notify the prescribing provider, within 2 business days after receipt of the request, that the request is approved, denied, or incomplete, and if incomplete, indicate the specific additional information; or B. Notify the prescribing provider, within 2 business days after receiving the additional information required by the carrier or pharmacy benefit management firm pursuant to sub-subparagraph (A) of this subparagraph (II), that the request is approved or denied **For nonurgent prior authorization requests** submitted orally or by facsimile or electronic mail, notify the prescribing provider, **within 3 business days** after receipt of the request, that the request is approved or denied. **Colorado Revised Statute Section 10-16-122.9 states...** Upon request of a covered person's provider, a carrier shall furnish the cost, benefit, and coverage data to the covered person's provider, and shall ensure that the data is: I. Current and updated no later than 1 business day after any change is made; II. Provided in **real time**; and III. Provided in the same format that the request was made by the covered person's provider **Colorado Revised Statute Section 10-16-145 states...** A carrier shall not require a covered person to undergo step therapy, and shall provide coverage for the drug prescribed by the covered person's health care provider as long as the prescribed drug is on the carrier's prescription drug formulary, when the patient has tried the step therapy–required prescription drugs while under their current or previous health insurance or health benefit plan, and such prescription drugs were discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event. Pharmacy drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy–required prescription drug. A carrier shall grant or deny a step therapy exception request or an appeal of a denial of a request within: A. 3 business days after receipt of the request; or B. In cases where exigent circumstances exist, within 24 hours after receipt of the request A carrier must request additional or clinically relevant information within the same time frames. If a carrier does not make a determination regarding the step therapy exception request or the appeal of a denial of the requestor does not make a request for additional or clinically relevant information within the required time, the step therapy exception request or the appeal of a denial of the request is deemed granted. **Colorado Revised Statute Section 10-16-112.5 states...** "Medical necessity" means a determination by the carrier that a prudent provider would provide a particular covered health care service to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is in accordance with generally accepted standards of medical practice and approved by the US Food and Drug Administration or other required agency.	**Issue:** Plan delays timely payment pending medical necessity determination. **Example scenario:** Patient is diagnosed and meets medical necessity criteria for EYLEA injections. Provider submits a claim for EYLEA reimbursement, but 31 days later, claim is still pending medical necessity determination. **Colorado Revised Statute Section 10-16-106.5 states...** Plan will pay, deny, or settle a clean claim **within 30 calendar days** after receipt if submitted electronically and **within 45 calendar days** after receipt if submitted by any other means. If Plan intends to prospectively conduct a charge audit, Plan will, **within 45 days** of receiving the claim: • Pay charges from a participating institutional provider at the rate of at least 85% of the contracted rate on the claim (less deductibles, coinsurance, and copayments) • Pay a nonparticipating institutional provider at least 60% of the amount due on the claim (less deductibles, coinsurance, and copayments) Plan will complete the charge audit and make any additional payments **within 90 days** of receiving the claim. Penalties for failure to pay timely are as follows: • Days 31 to 90: 10% per annum • Day 91 and beyond: 20% of the total amount	**Issue:** Subsequent request for additional information. **Example scenario:** Provider submits a claim for EYLEA reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information. **Colorado Revised Statute Section 10-16-106.5 states...** If the resolution of a claim requires additional information, Plan will, **within 30 calendar days** of receiving the claim, give the provider a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving the request for additional information will submit all additional information **within 30 calendar days** of receiving the request. If this person has provided all such additional information necessary to resolve the claim, Plan will pay, deny, or settle the claim **within 90 calendar days** of receiving the claim.	**Issue:** Claim is past the filing deadline. **Example scenario:** Provider timely submits an EYLEA claim. Plan denies the claim for being past the filing deadline. **Colorado Revised Statute Section 10-16-202 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. **Colorado Revised Statute Section 12-3-113 states...** An out-of-network health care provider must send a claim for a covered service to the carrier within 180 days after the receipt of insurance information. **Colorado Revised Statute Section 10-16-106.5 states...** Plan will make a mechanism available to enable a provider to confirm the receipt of a claim that is filed with Plan in a manner other than electronically. **Within 10 business days** of submission of the claim as determined by the provider, Plan will list such claim on the notification mechanism as received. The claim will be deemed received on the date it is listed on the notification mechanism by Plan. If the claim is not listed on the notification mechanism, the provider may contact Plan to resubmit the claim. Plan will have a separate facsimile process to receive the resubmission of the paper claims. The resubmitted claim will be deemed received on the date of the facsimile transmission acknowledgment. If such mechanism is accessible only by electronic means, on request of the provider, the information must be made available in hard-copy form **within 3 business days**. If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by Plan or Plan's clearinghouse. Plan or Plan's clearinghouse will provide a confirmation **within 1 business day** after submission by the provider.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA claim. **3 Code of Colorado Regulations 702-4, Series 4-2, Regulation 4-2-17, Section 6 states...** **Internal appeal:** A prospective review determination must be decided **no later than 15 days**; a retrospective review determination, **no later than 30 days**. **Colorado Revised Statute Section 10-16-113.5 states...** A request for an **independent external review** must be filed **within 120 days** of notice of final adverse determination. **Within 45 days** of receiving the request for an external review, the independent review organization will provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or covered person's authorized representative and to Plan. Plan will pay the cost of the independent review organization for conducting the review.

Complaints regarding these and other payer issues can be made to the Colorado Department of Regulatory Agencies website.

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

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.

REGENERON

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03/2023 EYL.23.02.0067