Understanding Reimbursement Issues in Delaware

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. **Delaware Insurance Code Section 3371 states…** If a utilization review entity requires preauthorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health care provider **within 2 business days**. If a utilization review entity requires preauthorization of a health care service, the utilization review entity must grant a preauthorization or issue an adverse determination and notify the covered person's health care provider of the determination **within 8 business days** for nonelectronic requests and **within 5 business days** for electronic requests. Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this subchapter will result in any health care services subject to review to be automatically deemed preauthorized. **Delaware Insurance Code Section 3381 states…** **Effective March 18, 2020:** A step therapy exception request must be granted or denied within **2 business days**. Failure to respond to the exception request within 2 business days will deem the exception granted. These provisions cannot be waived by contract issued or renewed after January 1, 2017. Any contractual arrangement in conflict with the provisions of this subchapter or that purports to waive any requirements of this subchapter is null and void.	**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. **Delaware Administrative Code Rule 1310, Section 6.0 states…** Plan must do one of the following **within 30 days** of receiving a clean claim*: • If the entire claim is deemed payable, pay the total allowed amount of the claim • If a portion of the claim is deemed payable, pay the allowable portion that is deemed payable and specifically notify provider or policyholder in writing why the remaining portion of the claim will not be paid • If the entire claim is deemed not payable, specifically notify provider or policyholder in writing why the claim will not be paid • If Plan needs additional information to determine the propriety of payment of a claim, Plan must request in writing that provider or policyholder provide documentation relevant and necessary to clarify the claim **Delaware Insurance Code Section 3375 states…** If prior authorization has been obtained, Plan cannot revoke, limit, condition, or restrict the prior authorization on grounds of medical necessity after the date the provider received the prior authorization. Any language attempting to disclaim payment for services on the basis of changes to medical necessity that have been preauthorized and delivered while under coverage will be null and void. *Claim with no defect or impropriety (eg, lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment from being made on the claim.	**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. **Delaware Administrative Code Rule 1310, Section 6.2 states…** Plan may make only 1 request for additional information. Plan must take action **within 15 days** of receiving the requested information. The request for additional information must describe specifically the clinical information needed and relate only to information the Plan can demonstrate is specific to the claim or the claim's related episode of care. Provider is not required to provide information that is not contained in or not being incorporated into the patient's medical or billing record.	**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. **Delaware Insurance Code Section 3311 states…** Written proof of loss must be furnished to the insurer **within 90 days** after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, **later than 1 year** from the time proof is otherwise required. **NOTE:** This provision sets forth minimum contractual standards. Provider should check contract for specific requirements. **Delaware Insurance Code 3370C states…** Regardless of network status, Plan shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between the Plan and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section. **Delaware Insurance Code 3571W states…** Any electronic claim shall be acknowledged by the Plan electronically no later than 2 business days following receipt of the claim to the entity submitting the claim.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA claim. **Delaware Insurance Code Section 332(c) states…** **Internal grievance:** Must be completed after receipt of all necessary information: • **Within 30 days** for requests for referrals or determinations on whether a requested benefit is covered • **Within 45 days** in all other instances **Delaware Insurance Code Sections 6416(c) and 6417(c) state…** **External review:** Covered person or covered person's authorized representative must file a request for an external review **within 4 months** of the date the Plan issued the final decision. An independent review organization will complete its review and make its written determination **within 45 days** of receipt of a completed application for an appeal review.

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

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

EYLEA® (aflibercept) Injection