Understanding Reimbursement Issues in the District of Columbia

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.	**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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA claim.
Code of District of Columbia Section 44-301.04 states...	**Code of District of Columbia Section 31-3132 states...**	**Code of District of Columbia Section 31-3132 states...**	**Code of District of Columbia Section 31-3132 states...**	**Code of District of Columbia Section 44-301.06 states...**
Plan must follow claims procedures established by the Employee Retirement Income Security Act of 1974. Prior authorizations must be decided **no later than 15 days** after receipt of claim. Plan may take an additional 15 days to decide the claim if a determination cannot be made for reasons beyond its control. If Plan fails to follow the procedures for prior authorizations, then claimant is deemed to have exhausted all internal appeals and may proceed to an external review.	Plan must reimburse for covered services **within 30 days** after receipt of a clean claim. If Plan fails to comply with the requirements of reimbursement, Plan will pay interest on the unpaid amount of the claim **beginning 31 days** after receipt of the claim. A formal claim by the person filing the original claim will not be required. Interest will be paid at the monthly rates of: • 1.5% from day 31 through day 60 • 2% from day 61 through day 120 • 2.5% after day 120	**Within 30 days** of receiving the claim, Plan must: • Notify the person who submitted the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute • Notify, in writing, the person who submitted the claim of the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute • Pay any undisputed portion of the claim Plan will process the disputed portion of the claim **within 30 days** of receiving all reasonable and necessary documentation.	Plan must allow provider **a minimum of 180 days** from the date a covered service is rendered to submit a claim for reimbursement for the service. There will be a rebuttable presumption that Plan has received the claim: • **Within 5 business days** from the postmarked date provider or claimant mailed the claim • **Within 24 hours** if provider or provider's agent submitted claim electronically and claim was not returned to provider by a claims clearinghouse or returned by Plan if submitted directly to Plan • **On the date recorded by the courier** if claim was delivered by courier	Provider must request an **internal review within 180 days**. A prospective review must be completed **within 30 days**; a retrospective review must be completed **within 60 days**. Claimant may proceed directly to **external review** if Plan fails to comply with these deadlines. **Code of District of Columbia Section 44-301.07 states...** Claimant must request an external review by letter **within 120 days** to the Office of Health Care Ombudsman at the following address: One Judiciary Square 441 4th Street, NW, 900 South Washington, DC 20001 The external review must be completed **within 180 days**. Plan must pay for all costs associated with the review.

Complaints regarding these and other payer issues can be made to the District of Columbia Department of Insurance, Securities, and Banking website.

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

REGENERON

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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® (aflibercept) Injection