Understanding Reimbursement Issues in the District of Columbia

A Guide for Health Care Providers and Practice Administration

District of Columbia

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.

Code of District of Columbia Section 44-301.04 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.

District of Columbia Law 25-100 "Prior Authorization Reform Amendment Act of 2023" states...

Title I Prior Authorizations Section 103. Prior authorization in non-urgent, urgent, and emergency circumstances.

(a) If a Plan requires prior authorization of a health care service, the Plan shall, after receiving all required information to make its decision, make an approval or adverse determination and notify the enrollee, representative, and the enrollee's health care provider of its decision within:
(1) For an urgent health care service, 24 hours;
(2) For long-term services and supports, 30 days; provided, that the enrollee has been determined to be otherwise eligible for such benefits under Medicaid; and
(3) For all other health care services, 3 business days of receiving the request via electronic portal or 5 business days of receiving the request via mail, telephone, or facsimile.

(b) A health care service described under subsection (a) of this section shall be deemed approved if the utilization review entity does not provide notice within the time frames provided by that subsection.

(c) The notice required under subsection (a) of this section shall include:

(1) The qualifications of the individual making the determination, including:
- States in which the individual is licensed;
- Status of their medical licenses; and
- Their medical specialty; and

(2) For an adverse determination, an explanation of:
- The Plan's reasons for making an adverse determination based on its prior authorization requirements;
- The enrollee's right to appeal;
- The process to file an appeal; and
- All information necessary to support a successful appeal of the adverse 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.

Code of District of Columbia Section 31-3132 states...

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

District of Columbia Law 25-100 "Prior Authorization Reform Amendment Act of 2023" states...

Title I Prior Authorizations Section 104. Length of prior authorization.

(c) A Plan may not revoke, limit, condition, or restrict approval if care is provided within 45 business days from the date the enrollee receives notice of the approval; provided, that approval may be revoked or otherwise restricted in cases of fraud.

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.

Code of District of Columbia Section 31-3132 states...

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.

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.

Code of District of Columbia Section 31-3132 states...

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

On the following page: Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

District of Columbia Law 25-100 "Prior Authorization Reform Amendment Act of 2023" states...

Title I Prior Authorizations Section 105. Appeals.

(a) A Plan shall provide an enrollee with at least 15 calendar days from the date the enrollee receives notice of an adverse determination to appeal the decision via the Plan's website, facsimile, or mail; provided, that an appeal submitted by mail shall be considered timely if postmarked within 15 calendar days of the enrollee receiving notice.

(b) In reviewing an appeal, the Plan shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records, other relevant records, and any medical literature provided by the enrollee, representative, or the enrollee's health care provider.

(c) The enrollee, representative, and the enrollee's health care provider shall be notified within 24 hours of the Plan making a decision on the appeal, which shall include the following information:

(1) The qualifications of the physician reviewing the appeal, including:
- States in which the physician is licensed;
- Status of their medical licenses;
- Their medical specialty; and
- Years of practice in that specialty; and

(2) The grounds for the physician's decision under the Plan's prior authorization requirements.

Code of District of Columbia Section 44-301.06 states...

Internal Review:

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.

External Review:
- Must be requested by letter within 120 days (see address below)
- External grievance must be completed within 45 days
- Insurers shall pay all costs associated with the external review
- To file an external appeal, submit a letter of request to: Office of Health Care Ombudsman and Bill of Rights – 441 4th Street, N.W. – Suite 900S – Washington, DC 20001

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 HD® (aflibercept) Injection 8 mg