Understanding ERISA*

A Guide for Health Care Providers and Practice Administration

ERISA Plans Can Be Either			
	Fully insured	OR	**State provisions apply** subject to **state** insurance regulations
	Self-funded		**State provisions preempted** subject to **ERISA** insurance regulations

Example EYLEA® (aflibercept) Injection Claim Issues and Applicable ERISA 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 claim for prior authorization. Plan has not made a decision. **29 Code of Federal Regulations 2560.503-1 states...** **Urgent care claims**. In the case of a claim involving urgent care, the Plan administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but **no later than 72 hours** after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan administrator shall notify the claimant as soon as possible, but **no later than 24 hours** after receipt of the claim by the Plan, of the specific information necessary to complete the claim. **Preservice claims**. Prior authorization must be decided within a reasonable period of time appropriate to the medical circumstances, but **no later than 15 days** after the Plan has received the claim. The Plan may extend the time period up to an **additional 15 days** if, for reasons beyond the Plan's control, the decision cannot be made within the first 15 days. If the Plan fails to follow preservice procedures (prior authorization), the claimant is deemed to have exhausted all remedies and may proceed to external review.	**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 reimbursement, but 31 days later, claim is still pending medical necessity determination. **ERISA Regulations Section 2560.503-1(f)(iii)(B) states...** Postservice claims must be decided **no later than 30 days**. Plan may take an **additional 15 days** to decide the claim if a determination cannot be made for reasons beyond its control. For a one-time extension, Plan must notify provider of the delay **within the initial 30 days**, explain the reason for the delay, and request any additional information needed. Plan must also indicate the date it expects to render a decision. If Plan requests additional information, Plan will allow provider **at least 45 days** to supply it. Note that ERISA regulations establish time frames within which claims must be decided. The regulations do not address the periods within which payments must be made, though Plans are expected to pay authorized benefits within a reasonable time.	**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. **ERISA Regulations Section 2560.503-1(f)(iii)(B) states...** For a postservice claim, Plan may **make only 1 request** for additional information. Plan must make the request **within 30 days** of receiving the claim and allow provider **at least 45 days** to supply the 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. **ERISA Regulations Section 2560.503-1(b) states...** Every employee benefit Plan will establish and maintain reasonable procedures governing the filing of benefit claims. The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. Note that this provision sets forth minimum contractual standards. Check your provider contract or Summary Plan Description for specific requirements.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA claim. **Title 29 Code of Federal Regulations Section 2560.503-1 states...** **Internal appeal:** **Standard:** A preservice initial appeal is decided **within 30 days**. A postservice initial appeal is decided **within 60 days**. **Urgent:** A carrier shall notify an individual of a benefit determination, whether adverse or not, with respect to a request involving urgent care as soon as possible, taking into account the medical exigencies, but **no later than 72 hours** after the receipt of the request by the carrier, unless the individual fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the coverage. In the case of such a failure, the Plan administrator shall notify the claimant as soon as possible, but **no later than 24 hours** after receipt of the claim by the Plan, of the specific information needed to complete the claim. Failure of a Plan to follow appeal procedures will result in claimant exhausting internal appeals and allow claimant to seek additional remedies. **Title 45 Code of Federal Regulations Section 147.136 states...** **External appeal:** **Filing deadline:** Request must be filed **within 120 days** of notice of final adverse determination. **Standard external appeal: Within 45 days** after the date of receipt of the request for an external review by the health carrier, the independent review organization (IRO) shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or his authorized representative and the health carrier. **Urgent external appeal:** As expeditiously as possible but **within no more than 72 hours** after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer.

For the full ERISA regulations on claims procedures (29 Code of Federal Regulations 2560.503-1), go to http://bit.ly/2DuDaLK.

*Employee Retirement Income Security Act of 1974.

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