Understanding Reimbursement Issues in Florida

A Guide for Health Care Providers and Practice Administration

Florida

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.

Florida Insurance Codes Section 627.42392 states...

A health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the Prior Authorization Form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed 2 pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full name, and health plan ID number; (2) provider name, address, and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed.

Florida Insurance Codes Section 627.42393 states...

A denial of a [step] protocol exemption request must include a written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure for appealing the health insurer's denial.

A health insurer shall publish on its website and provide to an insured in writing a procedure for the insured and his or her health care provider to request a protocol exemption or an appeal of the health insurer's denial of a protocol exemption request. The procedure must include, at a minimum:

1. The manner in which the insured or health care provider may request a protocol exemption, including a form to request the protocol exemption.
2. The manner and time frame in which the health insurer authorizes or denies a protocol exemption request, which must occur within a reasonable time.
3. The manner and time frame in which the insured or health care provider may appeal the health insurer's denial of a protocol exemption request.

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 not 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 not 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), then the claimant is deemed to have exhausted all remedies and may proceed to external review.

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 21 days later, claim is still pending medical necessity determination.

Florida Insurance Code Section 627.6131 states...

Plan must pay the claim or notify provider that claim is denied or contested **within 20 days** of receiving an electronic claim and **within 40 days** of receiving a nonelectronic claim. Plan's payment on the claim or notice of action on the claim is considered to be made on the date the payment or notice was mailed or electronically transferred.

If Plan requests and provider submits additional information, Plan must pay or deny an electronic claim **within 90 days** after initial receipt of claim and a nonelectronic claim **within 120 days** after initial receipt of claim. Failure to pay or deny an electronic claim **within 120 days** and a nonelectronic claim **within 140 days** creates an uncontestable obligation to pay the claim.

Plan's payment of the claim is considered to be made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears interest at 12% per year.

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA HD reimbursement, but 21 days later, Plan indicates payment of claim is pending receipt of additional information.

Florida Insurance Code Section 627.6131 states...

Plan must notify provider or designee that a claim is denied or contested with an itemized list of additional information or documents that Plan reasonably determines are necessary to process the claim. Plan must give this notification **within 20 days** of receiving an electronic claim and **within 40 days** of receiving a nonelectronic claim.

Provider must submit the additional information or documents, as specified on the itemized list, **within 35 days** after receiving the notification. Additional information is considered to be submitted on the date it was mailed or electronically transferred. Plan may not request duplicate documents.

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.

Florida Insurance Code Section 627.6131 states...

Provider must mail or electronically transfer all claims for payment or overpayment to the primary insurer **within 6 months** after the following have occurred:

- Discharge for inpatient services or the date of service for outpatient services, and
- Provider was furnished with the correct name and address of the patient's health insurer

Provider must mail or electronically transfer all claims for payment to the secondary insurer **within 90 days** after final determination by the primary insurer. Provider's claim is considered to be submitted on the date it was mailed or electronically transferred.

After receiving an electronic claim, insurer shall, **within 24 hours** after the beginning of the next business day, provide the clearinghouse with electronic acknowledgment of receipt of the claim. After receiving a nonelectronic claim, insurer shall, **within 15 days**, give the provider acknowledgment of receipt of the claim or electronic access to the status of a submitted claim.

Provider Appeals

Issue: Provider appeals.

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

Florida Insurance Code Section 641.511 states...

Internal appeal: The organization will resolve a grievance **within 60 days** of receiving the grievance or **within a maximum of 90 days** if the grievance involves the collection of information outside the service area.

These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided.

Florida Insurance Code Section 627.6141 states...

Internal appeal:

Denial of claims: Each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the Plan or is a member of the Plan's peer review group. The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

External appeal:

Important note: Florida follows a federally administered external review process.

29 Code of Federal Regulations 2590.715-2719 states...

Request must be filed **within 120 days** of notice of adverse determination.

Within 45 days after the date of receipt of the request for an external review by the Plan, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or their authorized representative and the Plan.

The Plan against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Complaints regarding these and other payer issues can be made to the Florida Department of Financial Services, Division of Consumer Services website.

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

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04/2025 US.EHD.25.03.0202

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.