Understanding Reimbursement Issues in Guam

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.
45 Code of Federal Regulations Section 147.136 states...	**Title 10 Guam Statutes Section 9902 states...**	**Title 10 Guam Statutes Section 9902 states...**	**Title 10 Guam Statutes Section 9903 states...**	**Title 29 Code of Federal Regulations Section 2560.503-1 states...**
In the case of a preservice claim, the Plan administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) **not later than 15 days** after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that such an extension is necessary due to matters beyond the control of the Plan **and** the Plan notifies the claimant prior to the expiration of the initial 15-day period and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.	A Plan administrator shall reimburse a clean claim, or any portion thereof, submitted by a provider who is eligible for payment and not contested or denied not more than 45 days after receiving the clean claim. Notwithstanding any provision to the contrary, interest shall be allowed to accrue at a rate of 12% per annum as damages for money owed by a Plan administrator for payment of a clean claim or portion thereof that exceeds the applicable reimbursement time limitation.	If the claim is contested or denied, the Plan administrator shall notify the provider in writing not more than 30 calendar days after receiving the claim for payment. The notice shall identify the contested or denied portions of the claim and the specific reasons for contesting or denying the claim, and may request additional information. In no event may a claim be contested or denied for the lack of information that has no factual impact upon the Plan administrator's ability to adjudicate the claim.	With the exception of those claims that involve the coordination of benefits, all claims for payment must be submitted by the provider within 90 days from the date that the health care services were rendered. Any claim not submitted by the provider within 90 days from the date the health care services were rendered shall not be the financial responsibility of either the Plan administrator or the patient.	**Internal appeal:** Preservice initial appeal decided within 30 days. Postservice initial appeal decided within 60 days. 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...** **Independent external review:** Request must be filed within 120 days of notice of final adverse determination. Within 45 days after the date of receipt of the request for an external review by the health carrier, 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 his authorized representative and the health carrier. The health carrier 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.

Information about complaints regarding these and other payer issues can be found at https://www.guamtax.com or emailed to pinadmin@revtax.guam.gov

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.

REGENERON

777 Old Saw Mill River Road, Tarrytown, NY 10591
03/2023 EYL.23.02.0073

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

EYLEA® (aflibercept) Injection