Understanding Reimbursement Issues in Idaho

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.
Idaho Statutes Section 41-3930 states...	**Idaho Statutes Section 41-5602 states...**	**Idaho Statutes Section 41-5602 states...**	**Idaho Statutes Section 41-5602 states...**	**Idaho Statutes Section 41-5907 states...**
A managed care organization will respond to a member or provider request for prior authorization of a nonemergency service **within 2 business days** after complete member medical information is provided to the managed care organization unless exceptional circumstances warrant a longer period to evaluate a request.	Plan will pay or deny: • An electronic claim **within 30 days** of receipt if submitted within 30 days of the date on which service was delivered • A paper claim **within 45 days** of receipt if submitted within 45 days of the date on which service was delivered **Idaho Statutes Section 41-3930 states...** When prior approval for a covered service is required of and obtained by or on behalf of a member, the approval will be final and may not be rescinded by the managed care organization after the covered service has been provided, except in cases of fraud, misrepresentation, nonpayment of premium, or exhaustion of benefits or if the member for whom the prior approval was granted was not enrolled at the time the covered service was provided.	If Plan needs additional information to process the claim, Plan will notify the practitioner in writing **within 30 days** of receiving an electronic claim and **within 45 days** of receiving a paper claim. The notice will state why Plan denied the claim. If the claim was denied because more information was required to process the claim, the notice will specifically describe all information and supporting documentation needed to evaluate the claim for processing. If the practitioner submits the information and documentation identified by Plan **within 30 days** of receipt of the written notice, Plan will process and pay the claim **within 30 days** of receiving the additional information or, if appropriate, deny the claim.	Plan will pay or deny: • An electronic claim **within 30 days** of receipt if submitted within 30 days of the date on which service was delivered • A paper claim **within 45 days** of receipt if submitted within 45 days of the date on which service was delivered **NOTE:** To expect prompt payment of claims, the provider must meet the minimum standards for timely submission of claims.	**Internal appeal:** Plan must make a written decision on the grievance **within 35 days** of the date the covered person filed the grievance with Plan. If Plan has failed to strictly follow its duties in affording a timely, full, and fair opportunity for the covered person to take advantage of the internal grievance procedures, then the covered person may proceed to an external review. **Idaho Statutes Section 41-5908 states...** A request for an **independent external review** must be filed **within 120 days** of notice of final adverse determination. The assigned independent review organization will, **within 42 days** of receiving the request for an independent external review, provide written notice of its decision to uphold or reverse the final adverse benefit determination to the covered person. **Idaho Statutes Section 41-5915 states...** Plan will pay the cost of the independent review.

Complaints regarding these and other payer issues can be made to the Idaho Department of Insurance website.

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

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