Understanding Reimbursement Issues in Illinois

A Guide for Health Care Providers and Practice Administration

Illinois

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.

Illinois Insurance Code Section 134/45.1 states...

Plan's established medical exceptions procedures must require, at a minimum, the following:

- Any request for approval of coverage made verbally or in writing (regardless of whether done via paper or electronically or some other writing) may be reviewed anytime by appropriate health care professionals
- The health insurance carrier must, within 72 hours after receipt of a request made under subsection (a) of this section, either approve or deny the request

Illinois Insurance Code Section 200/25 (Prior Authorization Reform Act) states...

If a health insurance issuer requires prior authorization, the health insurance issuer must make an approval or adverse determination and notify the enrollee's provider no later than 5 calendar days after obtaining all necessary information to complete the review of the requested health care services.

Illinois Insurance Code Section 200/75 (Prior Authorization Reform Act) states...

A failure by a health insurance issuer or its contracted utilization review organization to comply with the deadlines and other requirements specified in this Act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted utilization review organization.

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.

Illinois Insurance Code Section 5/368a states...

All insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, and third-party administrators shall ensure that all claims and indemnities concerning health care services other than for any periodic payment shall be paid **within 30 days** after receipt of due written proof of such loss. Failure to pay within this time period entitles the payee to 9% interest per year from the 30th day after receipt of such proof of loss to the date of late payment. Interest of less than $1.00 will not be paid. Any required interest payments will be made **within 30 days** after the payment.

Illinois Insurance Code Section 200/55 (Prior Authorization Reform Act) states...

The health insurer or its contracted utilization review organization may not revoke or further limit, condition, or restrict a previously issued prior authorization approval while it remains valid under this Act.

A health insurer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service of the claim.

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.

Illinois Insurance Code Section 5/368a states...

Plan must notify the insured person or insured person's assignee, health care professional, or health care facility of any known failure to provide sufficient documentation for due proof of loss **within 30 days** after receipt of the claim. Failure to pay within this time period entitles the payee to 9% interest per year from the 30th day after receipt of such proof of loss to the date of late payment. Interest of less than $1.00 will not be paid. Any required interest payments will be made **within 30 days** after the payment.

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.

Illinois Insurance Code Section 5/357.8 states...

Written proof of loss must be furnished **within 90 days** after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, **later than 1 year** from the time proof is otherwise required.

NOTE: This provision sets forth minimum standards. Provider should check contract for specific requirements.

Provider Appeals

Issue: Provider appeals.

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

Illinois Insurance Code Section 134/45 states...

Internal appeal:

Standard internal grievance: Upon submission of an appeal under this subsection, a Plan must notify the party filing an appeal, **within 3 business days**, of all information that the Plan requires to evaluate the appeal. The Plan shall render a decision on the appeal **within 15 business days** after receipt of the required information.

Expedited internal grievance: When an appeal concerns a decision or action by a Plan, that relates to a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the Plan must allow for the filing of an appeal **either orally or in writing**. Upon submission of the appeal, a Plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the Plan requires to evaluate the appeal. The Plan shall render a decision on the appeal within **24 hours** after receipt of the required information.

Even if a Plan or other utilization review program uses an algorithmic automated process in the course of utilization review for medical necessity, the Plan or other utilization review program shall ensure that only a clinical peer makes any adverse determination based on medical necessity and that any subsequent appeal is processed as required by this Section, including the restriction that only a clinical peer may review an appeal. A Plan or other utilization review program using an automated process shall have the accreditation and the policies and procedures required by subsection (b-10) of Section 85 of this Act.

Illinois Insurance Code Section 180/35 states...

External appeal: Must be filed **within 120 days**.

Standard external appeal: Within 5 days after the date of receipt of all necessary information, but in no event **more than 45 days** after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination.

Illinois Insurance Code Section 180/40 states...

Expedited external appeal: As expeditiously as the covered person's medical condition or circumstances require, but in no event **more than 72 hours** after the date of receipt of the request for an expedited external review, the assigned independent review organization shall make a decision to uphold or reverse the final adverse determination.

Form for requesting the external review may be downloaded from the Illinois Department of Insurance website.

Illinois Insurance Code Section 180/70 states...

Plan must pay for the cost of the review.

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

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

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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