Understanding Reimbursement Issues in Iowa

A Guide for Health Care Providers and Practice Administration

Iowa

Example EYLEA HD® (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 HD injections. Provider submits a request for prior authorization. Plan has not made a decision. **Iowa Administrative Code Rule 191-79.3 states...** Prior authorization requests for nonurgent claims will be approved or denied as soon as possible but **no later than 5 calendar days** after receiving the request. If Plan or pharmacy benefits manager does not approve or deny a completed prior authorization request or requests additional information from provider within that time, the prior authorization request will be deemed as granted.	**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. **Iowa Administrative Code Rule 191-15.32(2) states...** Plan will either accept and pay or deny a clean claim **within 30 days** after receiving the receipt of such claim. A clean claim is paid on the date when a check, draft, or other valid negotiable instrument is written. Plan will implement procedures to ensure that these payments are promptly delivered. If Plan fails to pay a clean claim within 30 days of receiving a properly completed billing instrument, Plan will pay interest at the rate of 10% per annum, commencing on the 31st day after Plan's receipt of all information necessary to establish a clean claim. Interest will be paid to claimant or provider based on who is entitled to the payment. See explanation of a clean claim in the Request for Additional Information column.	**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. **Iowa Administrative Code Rule 191-15.32 states...** Plan will have **30 days** from receiving a claim to request additional information to establish a clean claim.* Plan will provide written or electronic notice to claimant or provider if additional information is needed to establish a clean claim. The notice will include a full explanation of the information necessary to establish a clean claim. *Clean claim means a properly completed paper or electronic billing instrument containing all reasonably necessary information; that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation; and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.	**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. **Iowa Administrative Code Rule 191-35.4(4) states...** Written proof of loss must be furnished to the insurer **within 90 days** after the date of such loss. Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was shown to not have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible. **NOTE:** This provision sets forth minimum standards. Provider should check contract for specific requirements.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim. **Iowa Insurance Code Section 514J.106 states...** **Internal review:** A covered person or covered person's authorized representative will be considered to have exhausted Plan's internal grievance process if the covered person or covered person's authorized representative has led a grievance involving an adverse determination and, except to the extent the covered person or covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from Plan **within 30 days** following the date the covered person or covered person's authorized representative filed the grievance with Plan. **Iowa Insurance Code Section 514J.107 states...** **External review:** A request for an external review must be filed **within 120 days**. If Plan fails to provide the documents and information within that time, the independent review organization may terminate the external review and make a decision to reverse the adverse determination. The external review will be made as soon as practical but **no later than 45 days** after receiving the review request. Form for requesting an external review may be downloaded from the Iowa Insurance Division website.

Complaints regarding these and other payer issues can be made to the Iowa Insurance Division website.

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

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777 Old Saw Mill River Road, Tarrytown, NY 10591
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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.