Understanding Reimbursement Issues in Kentucky

A Guide for Health Care Providers and Practice Administration

Kentucky

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.

Kentucky Insurance Code Section 304.17A-607 states...

Effective January 1, 2020: After obtaining all necessary information, prior authorization must be decided **no later than 24 hours** for urgent care and **within 5 days** for nonurgent care.

Kentucky Insurance Code Section 304.17A-167 states...

If a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, the prior authorization will be valid for the lesser of 1 year from the date the provider receives the prior authorization or until the last day of coverage under the covered person's Plan during a single Plan year.

Kentucky Insurance Code Section 304.17A-603 states...

Prior authorization involving **urgent care** must be decided **no later than 24 hours** after obtaining all necessary information. Prior authorization involving **nonurgent care** must be decided **within 5 days** after obtaining all necessary information. The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be **deemed to be an adverse determination** by the insurer for the purpose of initiating an internal appeal.

Kentucky Insurance Code Section 304.17A-163 states...

The duration of any step therapy or fail-first protocol **shall not be longer than a period of 30 days** if the treatment is deemed and documented as clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require **more than 30 days** to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended **up to 7 additional days**.

A step therapy exception request, or an internal appeal under Section 7 of this Act of a step therapy exception request denial, shall be granted by the insurer, Plan, private review agent, or the pharmacy benefit manager within **48 hours**.

If a step therapy exception request determination, notification under subsection (4)(b) of this section, or internal appeal determination under Section 7 of this Act of a step therapy exception request denial by an insurer, Plan, pharmacy benefit manager, or private review agent is not received by the prescribing provider within the time period specified in subsection (4) of this section, the step therapy exception request or internal appeal **shall be deemed granted**.

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.

Kentucky Insurance Code Section 304.17A-702 states...

Plan will reimburse provider for a clean claim or send (in writing or electronically) notice denying or contesting the claim **within 30 calendar days** of receiving the claim. Within the applicable claims payment time frame, Plan will:

- Pay the total amount of the claim in accordance with Plan-provider contract; or
- Pay the portion of the claim that is not in dispute and notify provider of the reasons why the remaining portion of the claim will not be paid; or
- Notify the provider of the reasons why no part of the claim will be paid

Failing to pay, deny, or settle a clean claim in a timely manner will subject Plan to the following interest on the unpaid amount of the claim:

- 12% per annum for claims paid 1 to 30 days from due date
- 18% per annum for claims paid 31 to 60 days from due date
- 21% per annum for claims paid 61 or more days from due date

Kentucky Insurance Code Section 304.17A-611 states...

A utilization review decision will not retrospectively deny coverage for health care services provided when prior authorization has been obtained from the Plan unless the prior authorization was based on fraudulent, materially inaccurate, or misrepresented information.

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.

Kentucky Insurance Code Section 304.17A-704 states...

Plan must request additional information **within 48 hours** of receiving an original or corrected claim submitted electronically and **within 20 calendar days** of an original or corrected claim submitted nonelectronically. Plan will notify provider of the date claim is received and whether the claim contains errors or lacks necessary information.

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.

Kentucky Insurance Code Section 304.17-110 states...

For loss of time to file a claim, provider must furnish Plan with written proof of such loss **within 90 days**. Failure to furnish such proof within that time will neither invalidate nor reduce any claim if:

- Furnishing the proof was not reasonably possible within that time, and
- Proof is furnished as soon as reasonably possible **no later than 1 year** from the time proof is required

NOTE: This provision sets forth minimum contractual 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.

Kentucky Insurance Code Section 304.17A-617 states...

Plan will provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials **within 30 days** of receiving the appeal request.

Kentucky Insurance Code Section 304.17A-623 states...

An independent review entity will conduct a nonexpedited external review and make a determination **within 21 calendar days** of receiving all required information from Plan. An extension of **up to 14 calendar days** may be allowed if Plan and the covered person are in agreement.

The covered person must pay a once-only $25 filing fee to the independent review entity. Fee may be waived if the independent review entity determines that fee creates a financial hardship on the covered person. Fee will be refunded if the independent review entity rules in favor of the covered person.

Complaints regarding these and other payer issues can be made to the Kentucky 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.

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

EYLEA HD® (aflibercept) Injection 8 mg