Understanding Reimbursement Issues in Louisiana

A Guide for Health Care Providers and Practice Administration

Louisiana

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.

Louisiana Revised Statute 22:1821 states...

A **period in excess of 2 working days** from the time of the duly licensed health care provider's request to the insurer, for preutilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's certification, approval, or denial of the contemplated medical services **may be considered unreasonable** depending on the circumstances of each individual case.

Louisiana Revised Statute 22:1053 states...

The step therapy override process shall be made easily accessible on the Plan's website. A Plan shall approve or deny an override request **within 72 hours of receipt**. In cases where exigent circumstances exist, a Plan shall approve or deny an override request **within 24 hours of receipt**. If the Plan fails to comply with the timelines, **the override request shall be considered approved**.

Louisiana Revised Statute 22:1020.53 states...

A health insurance issuer shall not refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs and related services to covered persons. A health insurance issuer shall not condition, deny, restrict, refuse to authorize or approve, or reduce payment to a participating provider for a physician-administered drug when all criteria for medical necessity are met.

Louisiana Revised Statute 22:1020.62 states...

(1) A health insurance issuer shall annually publish on its publicly available website a list of all items and services that are subject to a prior authorization request according to each health coverage plan. This list shall be published on the website prior to open enrollment. If a health insurance issuer changes the list of items and services that are subject to prior authorization, a health insurance issuer shall, in a timely manner, update its website to reflect the changes. (2) A health insurance issuer shall include a current web address on any application or enrollment materials that are distributed by each health coverage plan.

Louisiana Revised Statute 22:1260.44 states...

B. (1) For any request requiring authorization by the requesting provider as being medically necessary for the treatment or management of an urgent condition a Plan or utilization review entity shall offer an expedited review by electronic means to the provider requesting prior authorization. When such a request is made by the provider, the Plan shall electronically communicate its decision to the provider as soon as possible, but not more than 2 business days from receipt of the request. If additional information is needed and requested for the Plan or utilization review entity to make its determination, the Plan or entity shall electronically communicate its decision to the provider as soon as possible, but not more than 48 hours from receipt of the required additional information.

(2) For any requests from a provider for health care services requiring prior authorization for which the Plan does not receive a request for expedited review, the Plan shall communicate its decision on the prior authorization request no more than 5 business days from the receipt of the request. If additional information is needed and requested for the Plan to make its determination, the Plan shall communicate its decision to the provider no more than 5 business days from receipt of the additional information.

(3) The Plan shall provide an initial notification of its determination to the provider rendering the service either by telephone or electronically within 24 hours of making the determination.

E. (1) In the case of an adverse determination, the Plan shall provide an initial notification to the provider rendering the service either by telephone or electronically within 24 hours of making the adverse determination and shall provide written or electronic notification to the enrollee and the provider within 3 business days of making the adverse determination.

G. If a Plan fails to make a determination within the timeframes set forth in Subsection B of this Section, the Plan shall not deny a claim based upon a lack of prior authorization.

On the following page: Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.
Louisiana Department of Insurance Regulation 74 states...	**Louisiana Department of Insurance Regulation 74 states...**	**Louisiana Revised Statute 22:1832 states...**	**Louisiana Revised Statute 22:2435 states...**
Any claim submitted by a **contracted provider** shall be paid to the claimant not more than 45 days from the date upon which a clean claim is received by a health insurance issuer. Any claim submitted for payment by the provider rendering covered medical services that are **not under a medical service contract** with the health insurance issuer shall be paid not more than 30 days from the date upon which a clean claim is received by a health insurance issuer. Any clean claim for a covered benefit payable to or on behalf of a covered person submitted by a contracted provider as an electronic claim shall be paid to the claimant **not more than 25 days** from the date upon which a clean claim form is received by the health insurance issuer. Any claimant who is not paid within the time frames specified in this regulation receives a late payment adjustment equal to 1 percent of the amount due at the time the claim is paid. For any period greater than 25 days following the time frames specified in this regulation, the health insurance issuer shall pay to the claimant an additional late payment adjustment equal to 1 percent of the unpaid balance due for each month **or partial month** that such claim or any portion of the claim remains unpaid.	For any claim that is found to be incomplete or otherwise not payable, Plan will provide specific written notice to claimant **within 2 days** of all known reasons that the claim cannot be processed for payment within a reasonable period of time from the date of reviewing such claim for completeness.	Any nonelectronic claim by a provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider more than 45 days after the date of service, or resubmitted because the original claim was not an accepted claim or not a clean claim, will be paid, denied, or pended **not more than 60 days** from the date upon which a nonelectronic clean claim is received by the issuer, unless it is not payable under the terms of the applicable contract of insurance. Health insurance issuers will have appropriate procedures approved by the department to ensure compliance. Such procedures will include a process for documenting the date of actual receipt of nonelectronic claims.	**An internal appeal** must be completed within 30 days or claimant may advance to external review. **An external review:** • Must be requested **within 120 days** • Must be decided **within 45 days** • Decision is binding on the health carriers • Must be paid by health carriers
Louisiana Revised Statute 22:1828 states...		**Louisiana Revised Statute 22:1833 states...**	**Louisiana Revised Statute 22:2436 states...**
Within the time period prescribed by a health insurance issuer in which the health insurance issuer can review or audit a claim, if a provider submits a request orally or in writing to a health insurance issuer, the health insurance issuer shall provide a copy of all documentation that is associated with a claim for payment for services. The health insurance issuer shall provide the requested documentation (at no cost) within 2 business days of the request submitted by the provider.		**Within 5 working days** of receipt of an electronic claim, a health insurance issuer will review the entire claim and, if the issuer determines that the claim is not an accepted claim, issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not an accepted claim. A provider who submits a claim that is not an accepted claim will be deemed to have timely submitted a claim for the payment of covered health care services if the health insurance issuer or its agent fails to notify the provider, or the provider clearinghouse from which the claim was received, of all defects or reasons known at the time that the claim is not an accepted claim.	If a health insurance issuer or its utilization review organization fails to provide the documents and information within the time frame **(5 business days)** specified in paragraph 1 of this subsection, the assigned independent review organization may terminate the external review process and make a decision to reverse the adverse determination or the final adverse determination.
Louisiana Revised Statute 22:1260.44 states...			**Louisiana Revised Statute 22:2439 states...**
For retrospective review determinations, a Plan shall make the determination within 30 business days of receiving all necessary information. A Plan shall provide notice of the determination in writing to the enrollee and provider within 3 business days of making the retrospective review determination.			The decision from the external review is binding on Plan.
			Louisiana Revised Statute 22:2444 states...
			Plan must pay for the costs of the review.

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