Understanding Reimbursement Issues in Maine

A Guide for Health Care Providers and Practice Administration

Maine

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, but 10 days later, Plan has not made a decision.

Maine Insurance Code Section 4304(2) states...

Requests for prior authorization of a nonemergency service must be determined within 2 business days. Both the provider and the enrollee must be notified of the determination. If the information submitted is insufficient to make a decision, the Plan shall notify the provider within 2 business days of the additional information necessary to render a decision. If the Plan determines that outside consultation is necessary, the Plan shall notify the provider and the enrollee for whom the service was requested within 2 business days. The Plan shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

Maine Insurance Code Section 4303(4) states...

Grievance procedure for enrollees. A carrier offering or renewing a Plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials, prior authorization denials, or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following: **(1)** Notice to the enrollee and the enrollee's provider promptly of any claim denial, prior authorization denial, or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so, and the time period in which the grievance must be filed; **(2)** Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within **30 calendar days** if the insured has not requested the opportunity to appear in person before authorized representatives of the Plan; **(3)** Procedures for the submission of relevant information and enrollee or provider participation; **(4)** Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; **(5)** Decision-making by one or more individuals not previously involved in making the decision subject to the grievance; and **(6)** Procedures for a provider actively treating an enrollee to act as an authorized representative of the enrollee within the meaning of section 4301-A subsection 2, paragraph D and file a grievance on the enrollee's behalf as long as the provider notifies the enrollee in writing **at least 14 days** prior to filing a grievance and within **7 days** after filing a grievance or withdrawing a grievance. The enrollee has the right to affirmatively object to a provider that has filed a grievance at any time, and the enrollee has the right to notify the Plan at any time that the enrollee intends to take the place of the provider as a party to the grievance.

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the Plan, of a provider of the same specialty participating in the Plan. If a provider of the same specialty does not participate in the Plan, then the second opinion must be given by a nonparticipating provider.

Maine Insurance Code Section 4304(2) states...

No later than January 1, 2022, unless a waiver is granted by the superintendent, a Plan or entity under contract to a Plan shall make available to a provider in real time at the point of prescribing one or more electronic benefit tools that are capable of integrating with at least one electronic prescribing system or electronic medical record system to provide complete, accurate, timely, clinically appropriate formulary and benefit information specific to an enrollee, including, but not limited to, the estimated cost-sharing amount to be paid by the enrollee, information on any available formulary alternatives that are clinically appropriate, and information about the formulary status and the utilization review and prior authorization requirements of each drug presented.

Maine Insurance Code Section 4320(M) states...

Requests for step therapy override or exception must be determined within **72 hours or 2 business days**, whichever is less.

If the Plan does not grant or deny the step therapy override or exception within the time required, the prior authorization will **be deemed granted**.

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. **Maine Insurance Code Section 2436 states...** A claim that is neither disputed nor paid **within 30 days** is overdue. If Plan fails to pay, the amount of the overdue claim will bear 1.5% interest per month after the due date. **Maine Insurance Code Section 4304(4) states...** If Plan has granted prior approval for a service or other covered item, **Plan cannot retrospectively deny coverage or payment for the originally approved service** unless fraudulent or materially incorrect information was provided at the time Plan granted the prior approval. **Maine Administrative Code Rule 02-031 Chapter 850, Section 8 States...** A **Request for Reconsideration** may be made by telephone, fax, or electronically, and the decision must be rendered within **1 working day**. Reconsideration is **NOT** a prerequisite to appeal. **Maine Insurance Code Section 4304 States...** **E.** If a covered, medically necessary service cannot be delivered on the approved date of an approved prior authorization request, a Plan may not deny the claim if the covered medically necessary service is provided within **14 days** before or after the approved date. **F.** For nonemergency services provided without a required prior authorization approval, a Plan may not deny a claim for nonemergency services that were within the scope of the enrollee's coverage pending medical necessity review and may not impose a penalty on the provider for failing to obtain a prior authorization of **greater than 15%** of the contractually allowed amount for the services that required prior authorization approval. If a Plan does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted.	**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. **Maine Insurance Code Section 2436 states...** Plan may dispute a claim **within 30 days** by notifying enrollee or beneficiary, or representative of enrollee or beneficiary, that the claim is disputed. Statement must be made in writing and include the grounds on which the claim is disputed. Within the 30 days, if Plan notifies enrollee or beneficiary in writing that reasonable additional information is required, the undisputed claim will not be considered overdue **until 30 days** following receipt by Plan of the additional required 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. **Maine Insurance Code Section 2824 states...** Written proof of loss must be furnished to the insurer **within 90 days** after the date of the loss. Failure to furnish the proof within that time will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided the proof is furnished as soon as 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. **Maine Administrative Code Rule 02-031, Chapter 850, Section 8 states...** Provider may initiate a standard first-level appeal for **internal review**. Appeal must be reviewed by a clinical peer not involved in the initial determination of denial or reduction. Review must be completed **within 30 calendar days**. If dissatisfied with the standard first-level appeal, provider may initiate a standard second-level appeal for internal review. Review must be completed **within 45 calendar days** of the request. Plan must appoint a panel that includes one or more disinterested clinical peers. The majority of panelists must agree on an appeal decision that is adverse to the enrollee. **Maine Insurance Code Section 4312 states...** Provider may request an **independent external review within 12 months** of exhausting both levels of internal review. Request must be made in writing to the Maine Bureau of Insurance. Provider may advance the appeal to an independent external review if Plan fails to follow the timeline for internal review. An independent review organization must issue its decision **within 30 days** of receiving the request for external review. Plan must pay for the cost of the review and must abide by the organization's decision.

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

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

REGENERON®

777 Old Saw Mill River Road, Tarrytown, NY 10591
01/2025 US.EHD.24.11.0179

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