Understanding Reimbursement Issues in Maryland

A Guide for Health Care Providers and Practice Administration

Maryland

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.

Maryland Insurance Code Section 15-10b-06 states...

A Plan must make all initial determinations on whether to authorize a nonemergency course of treatment for a patient **within 2 working days** after receipt of the information necessary to make the determination.

Maryland Insurance Code Section 15-10b-07 states...

(1) Except as provided in paragraphs (2) [mental or substance abuse] and (3) [dental] of this subsection, all adverse decisions shall be made by a licensed physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel, who is: (I) board certified or eligible in the same specialty as the treatment under review (II) knowledgeable about the requested health care service or treatment through actual clinical experience.

Maryland Insurance Code Section 15-854 states...

Effective January 1, 2020: If a provider indicates that a prescription drug is needed to treat a chronic condition, a payer may not request a reauthorization for a period of 1 year or for the standard course of treatment for the chronic condition.

Maryland Insurance Code Section 15-142 states...

A Plan subject to this section may not impose a step therapy or fail-first protocol on an insured or an enrollee if:
(1) the step therapy drug **has not been approved** by the US Food and Drug Administration for the medical condition being treated; or
(2) a prescriber provides supporting medical information to the Plan that a prescription drug covered by the Plan:
(i) was ordered by a prescriber for the insured or enrollee within the past 180 days and
(ii) based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.

A Plan subject to this section may not impose a step therapy or fail-first protocol on an insured or an enrollee for a prescription drug approved by the US Food and Drug Administration if:
(1) the prescription drug is used to treat the insured's or enrollee's **stage four advanced metastatic cancer**; and
(2) use of the prescription drug is:
(i) consistent with the US Food and Drug Administration-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
(ii) supported by peer-reviewed medical literature.

For a step therapy exception request submitted electronically in accordance with a process established under Section 15-142 (F) of this title or a prior authorization request submitted electronically for pharmaceutical services, a private review agent shall make a determination: (1) in real time, if: 1. No additional information is needed by the private review agent to process the request, and 2. The request meets the private review agent's criteria for approval; or (2) If a request is not approved under item (1) of this paragraph, within 1 business day after the private review agent receives all the information necessary to make the determination.

This Act shall apply to all policies, contracts and health benefit plans issued, delivered, or renewed in the state on or after January 1, 2024.

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.

Maryland Insurance Code Section 15-1005 states...

Plan must do any of the following **within 30 days** of receiving a claim for reimbursement:
- Pay the claim
- Deny the claim and provide reasons for the denial
- Notify provider of additional information necessary to determine whether all or part of the claim will be reimbursed

If Plan fails to pay a clean claim* for reimbursement or otherwise violates the provisions for requesting additional information, Plan will pay interest on the unpaid amount of the claim **beginning 31 days** after receipt of the initial clean claim for reimbursement at the monthly rates of 1.5% from day 31 through day 60, 2% from day 61 through day 120, and 2.5% after day 120. Interest paid will be included in any late reimbursement without the necessity of the provider to make an additional claim for that interest.

*See explanation in the Request for Additional Information column.

Maryland Insurance Code Section 15-1009(b) states...

Subject to exceptions, if prior authorization has been obtained, Plan cannot deny reimbursement to provider for the preauthorized or approved service.

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.

Maryland Insurance Code Section 15-1005 states...

Plan must send notice that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.†

†Claim with no defect or impropriety (eg, lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment from being made on the claim.

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.

Maryland Insurance Code Section 15-1005 states...

Plan must allow provider **a minimum of 180 days** from the date a covered service is rendered to submit a claim for reimbursement for the service.

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.

Maryland Administrative Code Chapter 31.10.18 states...

Internal grievance: Plan must render a final decision:
- **Within 30 working days** after the filing date on a grievance involving a prospective denial in a nonemergency case
- **Within 45 working days** after the filing date on a grievance involving a retrospective denial

Maryland Administrative Code Chapter 31.10.19 states...

External review: With certain exceptions, an independent external review must be completed **within 45 days**.

Complaints regarding these and other payer issues can be made to the Maryland Insurance Administration 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