## **Understanding Reimbursement Issues in Massachusetts**

## A Guide for Health Care Providers and Practice Administration

## Example EYLEA® (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	Issue: Plan delays timely payment pending medical necessity determination.  Example scenario: Patient is diagnosed and	EYLEA reimbursement, but 46 days later, Plan	Issue: Claim is past the filing deadline.  Example scenario: Provider timely submits an EYLEA 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 claim.
injections. Provider submits a request for prior authorization. Plan has not made a decision.	meets medical necessity criteria for EYLEA injections. Provider submits a claim for EYLEA reimbursement, but 31 days later, claim is still pending medical necessity determination.			Massachusetts Insurance Code Chapter 1760, Sections 13 and 14 state
Massachusetts Insurance Code Chapter 1760, Section 25 states				Internal grievance: Plan must give provider written acknowledgment of receipt of the grievance within 15 days and a written resolution of the grievance within 30 days from receipt thereof. Plan must have a procedure to accept grievances by telephone, in person, by mail, or by electronic means. Plan will put an oral grievance into writing and forward a copy to provider within 48 hours of receipt. The time limits established by this paragraph may be waived or extended by mutual agreement of provider and Plan.  A grievance not properly acted on by Plan within the required time limits will be deemed resolved in favor of the provider. In addition, a grievance that is an adverse determination (denial or reduction) will be immediately eligible for external review if (notwithstanding the exhaustion of formal internal grievance process remedies) Plan fails to act properly on the grievance within the
When requiring prior authorization for a health care service or benefit, Plan must use and	Massachusetts Insurance Code 176I, Section 2 states	Massachusetts Insurance Code Chapter 176I, Section 2 states	Group Health Insurance Standards Act, Section 8 states	
accept only the Prior Authorization Forms designated for the specific types of services and benefits. Provider may access the available forms from the Commonwealth of Massachusetts Government website.  With form: A prior authorization request will be considered granted if Plan fails to use or accept the required Prior Authorization Form or fails to respond within 2 business days after receiving the completed request.  Massachusetts Insurance Code Chapter 1760, Section 12 states  Without form: Upon request by the insured	organization must contain a provision requiring that, within 45 days after receipt of completed forms, organization must:  • Make payments for such services provided, • Notify provider in writing of the reason(s) for nonpayment, or  • Notify provider in writing of what additional information or documentation is necessary to complete the forms for such reimbursement If organization fails to comply, organization will pay—in addition to any reimbursement for health care services provided—interest on the benefits at 1.5% per month (not to exceed 18% per year) beginning 45 days after organization's receipt of request for reimbursement.	forms, organization must:  • Make payments for such services provided,  • Notify provider in writing of the reason(s) for nonpayment, or  • Notify the provider in writing of what additional information or documentation is necessary to complete the forms for such reimbursement If organization fails to comply, organization will pay—in addition to any reimbursement for health care services provided—interest on the benefits at 1.5% per month (not to exceed 18% per year)	Written proof of loss must be furnished to the insurer within 90 days after the date of loss. Failure to furnish proof within that time shall not 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.	
or insured's provider, Plan, or utilization review organization will determine whether a proposed admission, procedure, or service is medically necessary within 7 working days of obtaining all necessary information. Plan or utilization review organization may choose not to perform such a review if it determines that the admission, procedure, or service will be covered.				required time limits.  External review: A filing fee of \$25 (\$75 annual maximum) must accompany the request for an independent external review. The selected external review panel will render a decision in writing within 45 days of receipt of the request for review.  Forms for requesting an independent external review may be downloaded from the Commonwealth of Massachusetts Government website.

Complaints regarding these and other payer issues can be made to the Commonwealth of Massachusetts Government 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.



This information is provided to you

Massachusetts Government website.