Understanding Medicare Advantage Plan/HMO

A Guide for Health Care Providers and Practice Administration

Example EYLEA® (aflibercept) Injection Claim Issues and Applicable Medicare Advantage Plan/HMO Provisions

Prior Authorization	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
Issue: Delay pending medical necessity determination. **Example scenario:** Patient is diagnosed and meets medical necessity criteria for EYLEA injections. Provider submits a request for preservice authorization, but 15 days later, Medicare Advantage (MA) Plan has not made a decision. **Title 42 Code of Federal Regulations Section 422.101(b) states...** MA Plan must comply with: 1. Centers for Medicare and Medicaid Services (CMS) national coverage determinations 2. General coverage guidelines included in Original Medicare manuals and instructions, unless superseded by Part C regulations 3. Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under MA Plan Provider may request an Organization Determination from MA Plan. MA Plan must issue the determination as expeditiously as the health condition requires and **no later than 14 days**. MA Organization may extend the time frame by **up to 14 calendar days** if requested by patient or in patient's best interest. **Title 42 Code of Federal Regulations Section 422.136 states...** **Important note: This Medicare Part C regulation requires Medicare Advantage Plans to follow Medicare Part D time frames for Medicare Part B drug coverage.** **Time frame for requests for drug benefits:** When a party makes a request for a drug benefit, the Part D Plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but **no later than 72 hours** after receipt of the request. For an exceptions request, the Part D Plan sponsor must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but **no later than 72 hours** after receipt of the physician's or other prescriber's supporting statement. **Effect of failure to meet the adjudicatory time frames:** If the Part D Plan fails to notify the enrollee of its determination in the appropriate time frame, the failure constitutes an adverse coverage determination, and the Plan must forward the enrollee's request to the independent review entity (IRE) **within 24 hours** of the expiration of the adjudication time frame. **Time frame for requests for payment:** When a party makes a request for payment, the Part D Plan sponsor must notify the enrollee of its determination and make payment (when applicable) **no later than 14 calendar days** after receipt of the request. **42 Code of Federal Regulations Section 422.568 states...** **Requests for a Part B drug:** An MA Plan must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but **no later than 72 hours** after receipt of the request. This 72-hour period may not be extended under the provisions of this section.	**Issue:** MA Plan delays timely payment pending medical necessity determination. **Example scenario:** Patient is diagnosed and 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. **Title 42 Code of Federal Regulations Section 422.520 states...** Deadline to pay a Medicare Part C claim is **30 days** from receipt of a clean claim* by MA Plan. MA Plan must pay interest for the period beginning on the day after the required payment date and ending on the date the payment is made. *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.	**Issue:** Subsequent request for additional information. **Example scenario:** Provider submits a claim for EYLEA reimbursement, but 31 days later, MA Plan indicates payment of claim is pending receipt of additional information. **Medicare Managed Care Manual, Chapter 16A, Section 110 states...** A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. MA Plan must clearly identify the records, information, and documents it needs when requesting information from provider. If MA Plan does not obtain the requested information, it must make a decision **within the applicable time frame** based on the available clinical information. Provider's MA Plan contract may also address requests for additional information and related time frames.	**Issue:** Claim is past the filing deadline. **Example scenario:** Provider timely submits an EYLEA claim. MA Plan denies the claim for being past the filing deadline. **Title 42 Code of Federal Regulations Section 424.30 states...** Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by an MA Organization. Claim filing deadlines may vary among MA Organizations. Provider should check the MA Organization contract for specific billing requirements.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge MA Plan's denial or reduction of an EYLEA claim. **Title 42 Code of Federal Regulations Section 422.582 states...** If a Medicare Part C claim is denied as "noncovered" or "not medically necessary," provider should request a reconsideration† **within 60 calendar days** from the date the notice of denial or reduction is received. Once MA Plan receives the request, it must make a decision and notify provider **within:** • **30 days** for a standard request • **60 days** for a payment request A reconsideration resulting in a denial or reduction will automatically be advanced to an independent review **within:** • **30 days** for a standard review • **60 days** for a payment request Provider may appeal beyond reconsideration to an Administrative Law Judge and Medicare Appeals Council if the "amount in controversy" threshold is met. †Reconsideration is the second level of the appeals process under Medicare Part B; however, it is the first level of appeal under Medicare Part C. No specific CMS form is available. **Title 42 Code of Federal Regulations Section 422.590 states...** **Internal appeal:** **For a standard request for Part B drugs:** If the MA Plan makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the IRE contracted with CMS no later than **7 calendar days** from the date it receives the request for a standard reconsideration. **For an expedited request for Part B drugs:** An MA Plan that approves a request for expedited reconsideration must complete its reconsideration and give the enrollee (and the physician or other prescriber involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires but **no later than 72 hours** after receiving the request. This 72-hour period may not be extended under the provisions of this section. **Medicare Managed Care Manual, Chapter 13, Section 60.3 states...** **External appeal:** The IRE must conduct the reconsideration as expeditiously as the enrollee's health condition requires, but not exceed the required time frames outlined below: • **Standard:** Preservice: **30 days**; postservice: **60 days**; Part B drugs: **7 days** • **Expedited:** Part B drug requests cannot be expedited **Failure to meet time frame for expedited reconsideration.** If the MA Plan fails to provide the enrollee with the results of its reconsideration within the time frames described, this failure constitutes an adverse reconsidered determination, and the **MA Plan must submit the file to the IRE within 24 hours**. **Medicare Managed Care Manual, Chapter 13, Section 50.12.1 states...** If CMS determines that the Plan has a pattern of not making appropriate efforts to forward information to the IRE, **the Plan will be considered to be out of compliance with the terms of its Medicare contract and/or subject to intermediate sanctions** in accordance with subpart O of 42 Code of Federal Regulations Part 422 or Part 423. **Title 42 Code of Federal Regulations Section 422.582 states...** The MA Plan may dismiss a reconsideration request, either entirely or as to any stated issue, under certain circumstances. The MA Plan's dismissal is binding **unless the enrollee or other party requests review** by the IRE. **Title 42 Code of Federal Regulations Section 422.590 states...** **Requests for review of a dismissal by the independent entity.** If the MA Plan dismisses a request for a reconsideration, the enrollee or other proper party has the right to request review of the dismissal by an IRE. A request for review of a dismissal must be filed in writing with the IRE **within 60 calendar days** from the date of the MA Plan's dismissal notice. **Title 42 Code of Federal Regulations Section 422.590 states...** If **good cause** is established, the MA Plan may vacate its dismissal of a request for an organization determination **within 6 months** from the date of the notice of dismissal.

- **Find information about MA Plan payment requirements in the Medicare Managed Care Manual at http://go.cms.gov/2FPvxOO**
- **Access in-depth information about appeals and grievances, billing, coding, contracting, payments, and more by visiting CMS.gov and clicking on the Medicare tab**
- **To access an Appointment of Representative form, visit the CMS website at https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf**

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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777 Old Saw Mill River Road, Tarrytown, NY 10591
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This information is provided to you by Regeneron, the maker of

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