Understanding Reimbursement Issues in Michigan

A Guide for Health Care Providers and Practice Administration

Example EYLEA® (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 injections. Provider submits a request for prior authorization. Plan has not made a decision.

Michigan Insurance Code Section 500.2212c states…

Beginning January 1, 2016, a prior authorization request that has not been certified for expedited review by the prescriber **is considered to have been granted** by the insurer **if the insurer fails to grant the request, deny the request, or require additional information** of the prescriber **within 15 days** after the date and time of submission of a standard prior authorization request under this section.

If additional information is requested by an insurer, a prior authorization request under this subsection is considered void if the prescriber fails to submit the additional information **within 21 days** after the date and time of the original submission of a properly completed standard prior authorization request under this section.

Michigan Insurance Code Section 500.2212e states…

Standard: Beginning June 1, 2023, through May 31, 2024, a prior authorization request by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 9 calendar days after the date and time of submission of the prior authorization. After May 31, 2024, a prior authorization request by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 7 calendar days after the date and time of submission of the prior authorization.

Urgent: Beginning June 1, 2023, a prior authorization request under this section that has been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request.

Prompt Payment

Issue: 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.

Michigan Insurance Code Section 500.2006(8) states…

Plan must pay a clean claim **within 45 days** of receipt. A clean claim not paid within that time will bear simple interest at a rate of 12% per annum.

A clean claim means a claim that does all of the following:

- Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers
- Sufficiently identifies the patient and Plan subscriber
- Lists the date and place of service
- Is a claim for covered services for an eligible individual
- If necessary, substantiates the medical necessity and appropriateness of the service provided
- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained
- Identifies the service rendered using a generally accepted system of procedure or service coding
- Includes additional documentation based upon services rendered as reasonably required by Plan

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.

Michigan Insurance Code Section 500.2006(8) states…

Plan will notify provider **within 30 days** of receiving the claim of all known reasons preventing the claim from being a clean claim. Provider has **45 days** to correct all known defects. This time period is tolled from the date of provider's receipt of a notice from Plan to date of Plan's receipt of response from provider. If provider's response makes the claim a clean claim, Plan will pay provider **within the 45-day time period**, excluding any time period tolled.

Filing Deadlines

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.

Michigan Insurance Code Section 500.2006 states…

Provider must bill Plan **within 1 year** of the date of service or the date of discharge from health care facility for a claim to be a clean claim.

NOTE: This provision sets forth minimum standards. Provider should check contract for specific requirements.

Provider or Plan alleging that a timely processing or payment procedure has been violated may file a complaint with the director on a director-approved form and has the right to a determination of the matter by the director or his or her designee. Provider or Plan may also seek court action.

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA claim.

Michigan Insurance Code Section 500.2213 states…

Internal grievance: Plan will make its final determination in writing **no later than 30 calendar days** after a formal preservice grievance is submitted or **within 60 calendar days** after a formal postservice grievance is submitted in writing by the insured or enrollee. These time periods, as applicable, may be tolled for a time period **not exceeding 10 business days** if Plan has not received requested information from provider or facility.

Michigan Insurance Code Section 550.1911 states…

An **external appeal** must be filed **within 120 days**. If Plan fails to provide the documents and information **within 7 business days**, the director may terminate the external review and make a decision to reverse the adverse determination.

The assigned independent review organization will provide its recommendation to the director **within 14 days** after the assignment and will provide written notice of the decision to uphold or reverse the adverse determination or the final adverse determination **within 7 business days** of receipt of the independent review organization's recommendation.

Form for requesting an external review may be downloaded from the Michigan Department of Insurance and Financial Services website.

Complaints regarding these and other payer issues can be made to the Michigan Department of Insurance and Financial Services 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.

REGENERON

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

EYLEA® (aflibercept) Injection