Understanding Reimbursement Issues in Minnesota

A Guide for Health Care Providers and Practice Administration

Minnesota

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.

Minnesota Insurance Code Section 62M.05 states...

Standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision **within 5 business days** after receiving the request if the request is received electronically, or **within 6 business days** if received through nonelectronic means, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

Minnesota Insurance Code Section 62M.07 states...

If prior authorization for a health care service is required, the utilization review organization, Plan, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, 7 days a week.

Minnesota Insurance Code Section 62Q.184 states...

A Plan shall respond to a step therapy override request or an appeal within 5 days of receipt of a complete request. In cases where exigent circumstances exist, a Plan shall respond within 72 hours of receipt of a complete request. If a Plan does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the Plan.

Minnesota Insurance Code Section 62M.04 states...

For a routine prospective utilization review, Plan must collect only the information necessary to certify the admission, procedure or treatment, and length of stay. Plan must not routinely request copies of medical records for all patients reviewed.

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.

Minnesota Insurance Code Section 62Q.75 states...

Plan or third-party administrator must pay or deny a claim that is a clean claim **within 30 calendar days** after receiving the claim. (See explanation of a clean claim in the Request for Additional Information column).

The rate of interest paid by Plan or third-party administrator will be 1.5% per month or any part of a month.

Minnesota Insurance Code Section 62M.07 states...

No utilization review organization, Plan, or claims administrator may **revoke, limit, condition, or restrict** a prior authorization that has been authorized unless there is evidence that the prior authorization was authorized based on fraud or misinformation or a previously approved prior authorization conflicts with state or federal law.

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.

Minnesota Insurance Code Section 62Q.75 states...

Plan or third-party administrator must pay or deny a claim that is a clean claim **within 30 calendar days** after receiving the claim.

A clean claim means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including (but not limited to) coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this insurance code section. A special circumstance includes (but is not limited to) a claim held pending payment of an overdue premium for the time period during which the expense was incurred as allowed by the Affordable Care Act. Nothing in this insurance code section alters an enrollee's obligation to disclose information as required by law.

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.

Minnesota Insurance Code Section 62Q.75 states...

Unless otherwise provided by contract, provider must submit charges to Plan or third-party administrator **within 6 months** from the date of service or the date when provider knew or was informed of the correct name and address of Plan or third-party administrator, whichever is later.

Provider or facility that does not make an initial submission of charges within the 6-month time period will not be reimbursed for the charges and may not collect the charges from the recipient of the service or any other payer. The 6-month submission requirement may be extended to **12 months** if provider has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by provider for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by Plan within the same time frame as the contractually agreed-upon claims filing timeline.

NOTE: This provision sets forth minimum 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.

Minnesota Insurance Code Section 62M.06 states...

Internal appeal: A utilization review organization shall notify in writing the attending health care professional of its determination on the appeal within 15 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 4 additional days to notify the attending health care professional of its determination. If the utilization review organization takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

Minnesota Insurance Code Section 62Q.73 states...

External review: A request for an external review must be filed **within 180 days**. The external review will be made as soon as practical but **no later than 45 days** after receiving the review request.

A $25 filing fee will be refunded if an adverse determination is reversed. Plan will pay for the cost of the review in excess of filing fee.

Complaints regarding these and other payer issues can be made to the Minnesota Commerce Department 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.

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Reference: Data on file. Regeneron Pharmaceuticals, Inc.