Understanding Reimbursement Issues in Mississippi

A Guide for Health Care Providers and Practice Administration

Mississippi

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.

Mississippi Administrative Code Rule 82.7.5 states...

Private review agent must make certification determinations **within 2 working days** of receiving the necessary information on a proposed admission or service requiring a review determination.

Mississippi Administrative Code Rule 82.7.2 states...

Private review agent will not routinely request copies of medical records on all patients reviewed. During prospective and concurrent reviews, copies of medical records should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

Mississippi Insurance Code Section 41-145-NEW-001 states...

This act shall be known and may be cited as the "Mississippi Prior Authorization Reform Act."

Mississippi Insurance Code Section 41-145-NEW-006 states...

(1) If any Plan requires prior authorization of a health care service, the Plan or its designee utilization review organization shall, by January 1, 2025, make available a standardized electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system. (2) Not later than January 1, 2027, all health care professionals and health care providers shall be required to use the standardized electronic prior authorization request transaction process made available as required by subsection (1) of this section.

Mississippi Insurance Code Section 41-145-NEW-007 states...

If a Plan requires prior authorization of a health care service, the Plan must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as expeditiously as the enrollee's condition requires but no later than **7 calendar days** after obtaining all necessary information to make the approval or adverse determination, unless a longer minimum time frame is required under federal law for the Plan and the health care service at issue. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required. Notwithstanding the foregoing provisions of this section, the Plan must comply with the requirements of Section 83-9-6.3 to respond by **2 business days** for prior authorization requests for pharmaceutical services and products.

Mississippi Insurance Code Section 41-145-NEW-008 states...

If requested by a treating health care provider or health care professional for an enrollee, a Plan must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as expeditiously as the enrollee's condition requires but no later than **48 hours** after receiving all information needed to complete the review of the requested health care services, unless a longer minimum time frame is required under federal law for the Plan and the urgent health care service at issue.

Mississippi Insurance Code Section 41-145-NEW-012 states...

(1) A Plan may not revoke or further limit, condition or restrict a previously issued prior authorization approval while it remains valid under this act. (2) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a Plan, the Plan shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one (1) of the following occurs: (a) It is timely determined that the enrollee's health care professional or health care provider knowingly and without exercising prudent clinical judgment provided health care services that required prior authorization from the health insurance issuer or its contracted private review agent without first obtaining prior authorization for those health care services; (b) It is timely determined that the health care services claimed were not performed; (c) It is timely determined that the health care services rendered were contrary to the instructions of the Plan or its contracted private review agent or delegated reviewer if contact was made between those parties before the service being rendered; (d) It is timely determined that the enrollee receiving such health care services was not an enrollee of the Plan; or (e) The approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation. (3) Nothing in this section shall preclude a private review agent or a Plan from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

On the following page:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prior Authorization (cont'd)	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
Mississippi Insurance Code Section 83.9.36 states... When medications for the treatment of any medical condition are restricted for use by a Plan by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to expeditiously request an override of that restriction from the Plan. An override of that restriction shall be expeditiously granted by the Plan under the following circumstances: a.The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or b. Based on sound clinical evidence or medical and scientific evidence: i. The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or ii. The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured. The duration of any step therapy or fail-first protocol shall not be longer than a period of **30 days** when the treatment is deemed clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than **30 days** to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to **7 additional days**.	**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. **Mississippi Insurance Code Section 83-9-5 states...** Plan must pay all benefits **within 25 days** of receiving a clean electronic claim and **within 35 days** of receiving a clean paper claim.* If claim is not denied for valid and proper reasons by the end of the applicable time period, Plan must pay the provider interest on accrued benefits at the rate of 3% per month. Interest will accrue from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. *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. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance. The Commissioner of Insurance shall adopt any rules and regulations necessary to enforce these provisions regarding assignment of benefits and billing.	**Issue:** Subsequent request for additional information. **Example scenario:** Provider submits a claim for EYLEA HD reimbursement, but 46 days later, Plan indicates payment of claim is pending receipt of additional information. **Mississippi Insurance Code Section 83-9-5 states...** Plan must notify provider of the reasons why the claim (or portion thereof) is not clean and will not be paid, as well as what substantiating documentation and information are required to adjudicate the claim as clean, **no later than 25 days** after actually receiving an electronic claim and **no later than 35 days** after actually receiving a paper claim. Plan must pay any claim (or portion thereof) resubmitted with the supporting documentation and information **within 20 days** of receipt.	**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. **Mississippi Insurance Code Section 83-9-5 states...** Claims submitted by a provider **more than 30 days** after the date of service are not considered clean claims. If provider does not submit the claim on behalf of the insured, then claim is not clean when submitted **more than 30 days** after the date of billing by the provider to the insured.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim. **Mississippi Administrative Code Rule 82.10.2 states...** **Internal appeal:** Private review agent must notify the patient, provider, and claims administrator in writing of its determination on the appeal **no later than 60 days** after receiving the required documentation on the appeal. The required documentation may include copies of part or all of the medical record and/or a written statement from the attending physician. **Mississippi Administrative Code Rule 15.07 states...** **External review:** Request for an external review must be filed **within 120 days** of notice of adverse determination. If Plan or utilization review organization fails to provide the documents and information **within 5 business days**, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Independent review organization must make its determination and provide written notice of the decision **within 45 days** after receiving the request. Plan must pay for the cost of the review. Forms for requesting an external review may be downloaded from the Mississippi Department of Insurance website.

Complaints regarding these and other payer issues can be made to the Mississippi Department of Insurance website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

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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 by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg