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	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 HD injections. Provider submits a request for prior authorization. Plan has not made a decision.	**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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.
Mississippi Administrative Code Rule 82.7.5 states...	**Mississippi Insurance Code Section 83-9-5 states...**	**Mississippi Insurance Code Section 83-9-5 states...**	**Mississippi Insurance Code Section 83-9-5 states...**	**Mississippi Administrative Code Rule 82.10.2 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.	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 1.5% 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.	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.	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.	**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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777 Old Saw Mill River Road, Tarrytown, NY 10591
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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