Understanding Reimbursement Issues in Nevada

A Guide for Health Care Providers and Practice Administration

Nevada

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.

Nevada Revised Statutes Title 57, Section 687B.225 states...

Any contract for group, blanket, or individual health insurance may require the insured or member to obtain prior authorization for care from Plan. Plan will:
- File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner
- Respond to any request for approval by the insured or member pursuant to this section **within 20 days** of receiving the request

Nevada Revised Statutes 695G.150 states...

Authorization of recommended and covered health care services required. Each managed care organization shall authorize coverage of a health care service that has been recommended for the insured by a provider of health care acting within the scope of his or her practice if that service is covered by the Plan of the insured, unless:
1. The decision not to authorize coverage is made by a physician who:
(a) Is licensed to practice medicine in the State of Nevada pursuant to chapter 630 or 633 of NRS;
(b) Possesses the education, training and expertise to evaluate the medical condition of the insured; and
(c) Has reviewed the available medical documentation, notes of the attending physician, test results and other relevant medical records of the insured.

The physician may consult with other providers of health care in determining whether to authorize coverage.

2. The decision not to authorize coverage and the reason for the decision have been transmitted in writing in a timely manner to the insured, the provider of health care who recommended the service and the primary care physician of the insured, if any.

29 Code of Federal Regulations 2560.503-1 states...

Urgent care claims. In the case of a claim involving urgent care, the Plan shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.
Pre-service claims (prior authorization) must be decided within a reasonable period of time appropriate to the medical circumstances, but **no later than 15 days** after the Plan has received the claim. The Plan may extend the time period up to an **additional 15 days** if, for reasons beyond the Plan's control, the decision cannot be made within the first 15 days.
If the Plan fails to follow pre-service procedures (prior authorization) then the claimant is deemed to have exhausted all remedies and may proceed to external review.

Nevada Revised Statutes Chapter 689A states...

1. When developing a step therapy protocol, a Plan shall use guidelines based on medical or scientific evidence, if such guidelines are available.
2. A Plan that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:
(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:
(1) Request an exemption for the insured from the step therapy protocol; and
(2) Appeal a decision made by the Plan concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);
(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the Plan; and
(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the Plan shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.
3. A Plan shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the Plan a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The Plan shall determine whether such justification exists if the statement and documentation demonstrate that:

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
Nevada Revised Statutes Chapter 689A states (cont'd)... (a) Each prescription drug that is required to be used earlier in the step therapy protocol: (1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured; (2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug; (3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or (4) Is not in the best interest of the insured, based on medical necessity; or (b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug. 4. If a Plan does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted. 5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the Plan shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured. 6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage by this section, and any provisions of the policy that conflict with the provisions of this section is void. 7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689A.04041 apply. 8. As used in this section: (a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed. (b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.	**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. **Nevada Revised Statutes Title 57, Section 689B.255 states...** Plan will approve or deny a claim relating to a policy of group health insurance or blanket insurance **within 30 days** of receiving the claim. If the claim is approved, Plan will pay the claim **within 30 days** of approval. If Plan does not pay the approved claim within that time, it will pay interest on the claim at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6%.	**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. **Nevada Revised Statutes Title 57, Section 689B.255 states...** If Plan requires additional information to determine whether to approve or deny the claim, it will notify the claimant of its request for the additional information **within 20 days** of receiving the claim. Notification will include all the specific reasons for the delay in approving or denying the claim. Plan will approve or deny the claim **within 30 days** of receiving the additional information. If the claim is approved, Plan will pay the claim **within 30 days** of receiving the additional information. If the approved claim is not paid within that time, Plan will pay interest on the claim. Plan will not request the claimant to resubmit information that the claimant has already provided unless Plan provides a legitimate reason for the request, and the purpose of the request is not to delay the payment of the claim, harass the claimant, or discourage the filing of claims.	**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. **Group Health Insurance Standards Act Section 8 states...** Written proof of loss must be furnished to the insurer **within 90 days** after the date of loss. Failure to furnish the proof within that time will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, **later than 1 year** from the time proof is otherwise required. **NOTE:** This provision sets forth minimum standards. Provider should check contract for specific requirements.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim. **Nevada Revised Statutes Title 57, Section 695G.210 states...** A review board will complete its review regarding a complaint or appeal and notify the insured of its determination **no later than 30 days** after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period. **Nevada Revised Statutes Title 57, Section 695G.251 states...** A request for an **independent external review** must be filed **within 120 days** of notice of final adverse determination. **Nevada Revised Statutes Title 57, Section 695G.275 states...** **Within 45 days** of receiving the request for an external review, the independent review organization will provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or covered person's authorized representative and to Plan. **Nevada Revised Statutes Title 57, Section 695G.290 states...** Plan will pay for the cost of the independent external review.

Complaints regarding these and other payer issues can be made to the Nevada Division 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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Reference: Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg