Understanding Reimbursement Issues in Nevada

A Guide for Health Care Providers and Practice Administration

Example EYLEA® (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 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 injections. Provider submits a claim for EYLEA 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 reimbursement, but 31 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 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 claim.
Nevada Revised Statutes Title 57, Section 687B.225 states...	**Nevada Revised Statutes Title 57, Section 689B.255 states...**	**Nevada Revised Statutes Title 57, Section 689B.255 states...**	**Group Health Insurance Standards Act Section 8 states...**	**Nevada Revised Statutes Title 57, Section 695G.210 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	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%.	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.	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.	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

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.

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

EYLEA® (aflibercept) Injection