Understanding Reimbursement Issues in New Hampshire

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.
New Hampshire Revised Statutes Section 420-J:6 states...	**New Hampshire Revised Statutes Section 420-J:8-a states...**	**New Hampshire Revised Statutes Section 420-J:8-a states...**	**New Hampshire Revised Statutes Section 415:6-h states...**	**New Hampshire Revised Statutes Section 420-J:5 states...**
Plan must make its determination of nonurgent preservice benefits **no later than 15 days**. Plan may take an **additional 15 days** to make its determination if a determination cannot be made for reasons beyond its control. For a one-time extension, Plan must notify provider of the delay **within the initial 15 days**, explain the reason for the delay, and request any additional information needed. Plan must also indicate the date it expects to render a decision. If Plan requests additional information, it will allow claimant **at least 45 days** to supply it. Plan must make its determination and notify claimant of the determination **no later than 15 days** after Plan receives the additional information or the end of the period afforded the claimant to provide the additional information (whichever is earlier).	Plan must pay claims for services rendered in New Hampshire **within 30 calendar days** for a nonelectronic clean claim or **within 15 calendar days** for an electronic clean claim. If delayed, Plan must pay the amount of the overdue claim plus 1.5% interest per month beginning from the due date of the payment. **New Hampshire Revised Statutes Section 420-J:6 states...** Plan must decide a postservice claim **within 30 days** of the date of filing. If Plan requests additional information, it will allow claimant **at least 45 days** to supply it and must notify claimant **within 15 days** of the additional information required. The 30-day period for claim determination will be tolled until claimant submits the required information.	For a denied or pending claim, Plan must notify claimant **within 30 days** for a nonelectronic claim or **within 15 days** for an electronic claim of the reason for denying or pending the claim and request any additional information required. Upon receiving the additional information, Plan must decide the claim **within 45 calendar days**. If Plan does not provide claimant with the required notice for additional information, it must treat the claim as clean and adjudicate the claim.	No insurer will be in violation of this section (Prompt Payment) for any claim submitted more than 90 days after the service was rendered.	Provider may initiate an appeal for an **internal review within 180 days** of claim denial or reduction. Reviewer of the appeal must be of the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. Nonurgent claims must be decided **within 30 days**. If Plan provides for 2 levels of mandatory appeal, both levels must be completed **within 30 days**. **New Hampshire Revised Statutes Section J:5-a states...** The covered person or covered person's authorized representative must submit a request for an **external review** in writing to the commissioner **within 180 days** of the date of Plan's denial decision. **New Hampshire Revised Statutes Section J:5-b states...** The selected independent review organization will render its decision upholding or reversing Plan's determination and notify the covered person or covered person's authorized representative and Plan in writing **within 20 days** of the date that all information was submitted.

Complaints regarding these and other payer issues can be made to the New Hampshire 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® (aflibercept) Injection