Understanding Reimbursement Issues in New Jersey

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 41 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 Jersey Administrative Code Rule 11:24A-3.4 states... (3) A Plan shall notify a provider and/or covered person of a determination concerning an urgent care claim and determined by the attending provider as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim by the Plan, of a determination concerning a nonurgent preservice claim (that is, prior authorization) no later than 15 days after receipt of the preservice claim by the Plan, and of a determination concerning postservice claims no later than 30 days after receipt of the postservice claim by the Plan. **(e)** A Plan shall not reverse a utilization management decision where the provider relied upon the written or oral authorization of the Plan (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud. **(f)** A Plan shall provide written notice within 2 business days of any determination to deny coverage or authorization of services or payment of benefits therefor otherwise covered under the contract or policy of the covered person, and shall include an explanation of the appeal process.	**New Jersey Administrative Code Rule 11:22-1.5(a) states...** Plan must pay paper claims **no later than 40 days** and electronic claims **no later than 30 days**. Failure to pay in a timely manner may subject Plan to 12% interest on the claim. **New Jersey Administrative Code Rule 11:24A-3.4(e) states...** Plan cannot reverse a utilization management decision in which provider relied on the written or oral authorization of the Plan (or its agents) before providing the service to the covered person, except in cases of material misrepresentation or fraud.	**New Jersey Administrative Code Rule 11:22-1.5(a) states...** Plan must pay claims that are disputed or denied because of missing information or substantiating documentation **within 30 calendar days** for electronic claims and **within 40 calendar days** for nonelectronic claims of receipt of the missing information or substantiating documentation. **New Jersey Administrative Code Rule 11:22-1.4 states...** Plan may change the required information and documentation as long as provider is given notice **at least 30 days** prior to the change in the requirements.	**New Jersey Insurance Code Section 17B:27-41 states...** Written proof of such loss must be furnished to the insurer **within 90 days** after the date of such loss. Failure to furnish such proof within such time will not invalidate nor reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. **NOTE:** This provision sets forth minimum standards. Provider should check contract for specific requirements.	**New Jersey Administrative Code Rule 11:24A-3.5 states...** **Internal grievance:** Stage 1 standard appeals will be concluded in **10 calendar days**; stage 2 standard appeals, **20 calendar days**. **New Jersey Administrative Code Rule 11:24A-3.6 states...** **External review:** Provider must request an independent external review **within 120 days**. Plan may charge a $25 fee that will be refunded if provider wins the appeal. The review must be completed **within 45 days**. Forms for requesting an independent external review may be downloaded from the New Jersey Department of Insurance website.
New Jersey Administrative Code Rule 11:22-8.3 states... The following information shall appear on all Plan identification cards: **1.** The name of the carrier issuing the Plan or the name of the third-party administrator administering the Plan **2.** An indication of whether the Plan is insured or self-funded **NOTE:** For self-funded Plans, refer to the ERISA Navigating Payer Challenges card.				

Complaints regarding these and other payer issues can be made to the New Jersey 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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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