Understanding Reimbursement Issues in New Mexico

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. **New Mexico Statutes Section 59A-47-47.1 states…** A Plan shall respond with its decision on a subscriber's exception request within 72 hours of receipt. In the event the Plan does not respond to an exception request within the time frames required pursuant to this subsection, the exception request shall be granted. A Plan's denial of a request for an exception for step therapy protocols shall be subject to review and appeal pursuant to the Patient Protection Act. **New Mexico Insurance Code Section 59A-22-52 states…** By January 1, 2021, for auto-adjudication of prior authorization requests: Provide an electronic receipt to the provider and assign a tracking number to the provider for the provider's use in tracking the status of the prior authorization request, regardless of whether or not the request is tracked electronically, through a call center, or by facsimile. If a Plan fails to use or accept the uniform Prior Authorization Form or fails to respond **within 3 business days** upon receipt of a uniform Prior Authorization Form, the prior authorization request **shall be deemed to have been granted**. **New Mexico Administrative Code Section 13.10.31.8 states…** Retrospective Authorization Requests: A Plan shall establish written policies and guidance for the process and circumstances under which it will consider a retrospective authorization. A Plan's policies shall not unreasonably limit the ability of a provider to request or obtain a retrospective authorization. Expiration of prior authorization: A Plan's prior authorization shall expire no sooner than 60 days from the date of approval, unless an earlier expiration is warranted by the clinical criteria. A Plan shall allow a request for the extension of an authorization as supported by the clinical criteria. Reasonable prior authorization requirements: A Plan shall not impose a prior authorization requirement that deters or unreasonably delays the delivery of medically necessary and covered benefits warranted by prevailing standards of care. A Plan shall only require prior authorization for a benefit to the extent reasonably necessary to contain inappropriate or unnecessary costs or implement demonstrably effective medical management services.	**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. **New Mexico Statutes Section 59A-16-21.1 states…** Plan will pay interest on its liability at the rate of 1.5% per month on the amount of a clean claim submitted electronically by the eligible provider and not paid **within 30 days** of the date of receipt or submitted manually by the eligible provider and not paid **within 45 days** of the date of receipt. **New Mexico Administrative Code 13.10.22.9 states…** If prior authorization was obtained, Plan may not retroactively deny reimbursement for a covered service provided to a covered person by a provider who relied on the verbal or written authorization before providing the service to the covered person, except in cases of material misrepresentation or fraud.	**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. **New Mexico Statutes Section 59A-16-21.1 states…** If Plan is unable to determine liability for or refuses to pay a claim of an eligible provider within the required time, Plan will make a good-faith effort to notify the eligible provider by fax, electronic, or other written communication **within 30 days** of receiving a claim submitted electronically or **within 45 days** of receiving a claim submitted manually of all specific reasons why Plan is not liable for the claim or that specific information is required to determine liability for the claim.	**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. **New Mexico Statutes Section 59A-22-10 states…** Written proof of loss must be furnished to the Plan **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 claim. **New Mexico Administrative Code 13.10.17.14 states…** **Internal appeal:** In all cases not requiring expedited review, both the standard first-level internal review and the internal panel's review will be completed **within 30 days** of receiving a request for internal review prior to service and **within 60 days** of receiving a request involving a postservice claim. If Plan fails to comply with the deadline for completion of an internal review, unless such deadline is postponed by the grievant, the requested health care service will be deemed as approved provided that the requested health care service reasonably appears to be a covered benefit under the applicable Plan. **New Mexico Administrative Code 13.10.17.21 states…** A request for an **independent external review** must be filed **within 120 days** of notice of final adverse determination. **New Mexico Administrative Code 13.10.17.22 states…** The independent review organization will complete a standard external review and provide written notice of its decision to the grievant, the provider, the Plan, and the superintendent **within 20 days** after appointment by the superintendent. **New Mexico Administrative Code 13.10.17.19 states…** The Plan against which the request for an external review is filed will pay for the costs of the independent review organization's external review.

Complaints regarding these and other payer issues can be made to the New Mexico Office of Superintendent 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.

REGENERON

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