Understanding Reimbursement Issues in New York

A Guide for Health Care Providers and Practice Administration

New York

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.

New York Insurance Code Section 4903 states...

Utilization review agent will make a determination on a prior authorization and notify (by phone and in writing) the insured and the provider of the determination **within 3 business days** of receipt of the necessary information.

If utilization review agent renders an adverse determination without discussing the matter with the provider who recommended the service, procedure, or treatment under review, provider may request a reconsideration of the adverse determination. Reconsideration will occur **within 1 business day** of receipt of the request.

If Plan requires step therapy, utilization review agent must make a determination **within 72 hours** of receiving the required information from provider. Failure of utilization review agent to meet this time period will be deemed an override of the step therapy protocol.

(E-1) Notice of an adverse determination made by a Plan in relation to a step therapy protocol override determination request shall be made in writing to the insured or the insured's authorized representative and the insured's prescribing health care professional as defined in subsection (f) of section 4900 of this chapter, and shall include:

(i) the reasons for the determination, including the clinical rationale, if any;

(ii) instructions on how to initiate standard and expedited appeals pursuant to section 4904 of this article and an external appeal pursuant to section 4914 of this article;

(iii) information that includes: any applicable alternative covered medications; the clinical review criteria relied upon to make such determination; and any additional necessary information that must be provided to, or obtained by, the Plan in order to render a decision on the appeal;

(iv) the provisions of this section shall be satisfied by making such information available electronically on a formulary website, on the member portal and/or provider portal of the insurer, the Plan's website, or the website of an organization subject to article 43 of this chapter, provided that the member consents to receiving the information electronically.

Prompt Payment

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.

New York Insurance Code Section 3224a states...

Plan must pay paper claims **within 45 days** and electronic claims **within 30 days**. Failure to comply with these time frames may subject Plan to interest at a minimum 12% rate.

New York Insurance Code Section 4905 states...

If prior authorization has been received for a health care service, a utilization review agent will not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used in the utilization review for procedures, treatment, and services delivered to the insured during the same course of treatment.

Request for Additional Information

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.

New York Insurance Code Section 3224a states...

Plan must notify the policyholder, covered person, or health care provider in writing, and through the internet or other electronic means for claims submitted in that manner, **within 30 calendar days** of the receipt of the claim:

- Whether the claim or bill has been denied or partially approved;
- Which claim or medical payment that it is not obligated to pay, stating the specific reasons why it is not liable; and
- To request all additional information needed to determine liability to pay the claim or make the health care payment

Filing Deadlines

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.

New York Insurance Code Section 3224a states...

Provider must submit claim **within 120 days** after date of service for claim to be valid and enforceable against Plan. Provider and Plan may agree contractually to a different time period that is **not less than 90 days**.

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

New York Insurance Code Section 4903 states...

Internal grievance:

- Prospective review request must be filed **no later than 45 days**
- Plan must acknowledge **within 15 days** of filing
- Determination **within 30 days** of receipt of all necessary information

(e) Notice of an adverse determination made by a Plan shall be in writing and must include:

(I) the reasons for the determination, including the clinical rationale, if any;

(II) instructions on how to initiate standard appeals and expedited appeals pursuant to section 4904 and an external appeal pursuant to 4914 of this article; and

(III) notice of the availability, upon request of the insured, or the insured's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the Plan in order to render a decision on the appeal; and

(IV) for an adverse determination related to a step therapy protocol override request, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the Plan.

New York Insurance Code Section 4904 states...

Internal grievance:

- Retrospective review request must be filed **no later than 45 days**
- Plan must acknowledge **within 15 days** of filing
- Determination **within 30 days** of receipt of all necessary information
- Failure by the utilization review agent to make a determination within the applicable time periods in this section **shall be deemed to be a reversal** of the utilization review agent's adverse determination

New York Insurance Code Section 4914 states...

External review:

- Insured has 120 days to request an external review of final adverse determination, but provider has only 60 days
- The external appeal agent will have 30 days to make a determination
- A $50 fee may be charged to the provider by the Plan. The fee is to be refunded if the provider wins the appeal
- If an insured's provider was acting as the insured's designee, payment for the external appeal shall be made by the Plan. The external appeal and any **designation shall be submitted on a standard form** developed by the superintendent in consultation with the Commissioner of Health

Download designated form from the New York State Department of Financial Services website.

Complaints regarding these and other payer issues can be made to the New York State Department of Financial Services 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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05/2024 US.EHD.24.02.0227

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

EYLEA® HD (aflibercept) Injection 8 mg