Understanding Reimbursement Issues in New York

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 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
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.	**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.	**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	**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**.	**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

777 Old Saw Mill River Road, Tarrytown, NY 10591
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This information is provided to you by Regeneron, the maker of

EYLEA® (aflibercept) Injection