Understanding Reimbursement Issues in Ohio

A Guide for Health Care Providers and Practice Administration

Ohio

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.

Ohio Revised Code Section 1751.81 states…

Plan will make a prospective review determination **within 2 business days** of receiving all necessary information on a proposed admission, procedure, or service.

When conducting a prospective or concurrent review, Plan will collect only the information necessary to certify the procedure or treatment, frequency, and duration of services.

Failure of Plan to make a determination and notify provider within the required time frame will be deemed an adverse determination by Plan for the purpose of initiating an internal review.

Ohio Revised Code Section 1751.72(B) states…

For policies issued on or after January 1, 2018, if provider submits the request for prior authorization, Plan must respond to the request **within 48 hours** for an urgent care service and **within 10 calendar days** for a nonurgent care service.

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.

Ohio Revised Code Section 3901.381 states…

Plan will pay or deny the claim **within 30 days** of receiving the claim. If claim is denied, Plan must notify both provider and beneficiary. Notification must state, with specificity, why Plan has denied the claim.

Ohio Revised Code Section 3901.389 states…

Interest shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with section 3901.381 of the Revised Code or the contractual payment arrangement entered into under section 3901.383 of the Revised Code, and the date payment is made. The interest rate for determining the amount of interest due shall be equal to an annual percentage rate of 18%.

Ohio Revised Code Section 3923.041 states…

Within certain conditions, for policies issued on or after January 1, 2017, except in cases of fraudulent or materially incorrect information, **Plan cannot retroactively deny a prior authorization** for a health care service, drug, or device when all of the following are met:

- Provider submits a prior authorization request to the Plan for a health care service, drug, or device
- Plan approves the prior authorization request after determining the patient is eligible under the Plan, the health care service, drug, or device is covered under Plan and meets Plan's standards for medical necessity and prior authorization
- Provider renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the provider's contract with the Plan
- On the date the provider renders the prior approved health care service, drug, or device, all of the following are true: The patient is eligible under the Plan, the patient's condition or circumstances related to the patient's care have not changed, and the provider submits an accurate claim that matches the information submitted by the provider in the approved prior authorization request
- If the provider submits a claim that includes an unintentional error, and the error results in a claim that does not match the information originally submitted by the provider in the approved prior authorization request, upon receiving a denial of services from Plan, the provider may resubmit the claim pursuant to division (C) of this section with the information that matches the information included in the approved prior authorization
- Any provision of a contractual arrangement entered into between a Plan and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable

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.

Ohio Revised Code Section 3901.381 states…

Payer will notify all relevant external sources **within 30 days** of receiving the claim that supporting documentation is needed. If payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer will pay or deny the claim **within 45 days** of receiving the claim.

The number of days that elapse between the payer's last request for supporting documentation within the 30-day period and the payer's receipt of all the supporting documentation requested will not be counted toward determining the payer's compliance with the 45-day period for payment or denial of claim.

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.

Ohio Revised Code Section 3901.384 states…

A third-party payer requiring timely submission of claims for payment for services will process a claim not submitted in a timely manner if:

- A claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits, and
- Payer or program has determined that it is not responsible for the cost of the services

When a claim is submitted later than 1 year after the last date of service for which reimbursement is sought, the third-party payer will pay or deny the claim **within 90 days** of receiving the claim. Notification must state, with specificity, why the third-party payer denied the claim.

The third-party payer may refuse to process a claim submitted by a provider if:

- Claim is submitted later than 45 days after receiving notice from the different third-party payer or a state or federal program that the payer or program is not responsible for the cost of the services, or
- Provider does not submit the notice of denial from the different third-party payer or program with the claim. Failure of a provider to submit a notice of denial in accordance with this division will not affect the terms of a benefits contract

Ohio Revised Code Section 3901.381(C) states…

If a dispute exists between a provider and a third-party payer about the day when a claim form was received by the third-party payer, both of the following apply:

- If the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there will be a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise
- If the provider submits a claim directly to a third-party payer electronically, there will be a rebuttable presumption that the claim was received by the third-party payer 24 hours after the claim was submitted, unless it can be proven otherwise

Provider Appeals

Issue: Provider appeals.

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

Ohio Revised Code Section 56-1751.83 states…

Internal appeal: Plan will consider and provide a written response to the request for an internal review **within 30 days** of receiving the request, except that if the seriousness of the enrollee's medical condition requires an expedited review, Plan will provide the written response **within 7 days** of receiving the request or in accordance with applicable preemptive federal laws or regulations. Failure of Plan to provide a written response within these time frames will be deemed a denial for purposes of requesting an external review.

Ohio Revised Code Section 3922.10 states…

External review: An independent review organization may reverse an adverse benefit determination if the required information is not provided in the allotted time.

The assigned independent review organization will provide written notice of its decision to uphold or reverse the adverse benefit determination to the covered person, the Plan, and the superintendent of insurance **within 30 days** after Plan receives a request for a standard external review and **within 72 hours** after Plan receives a request for an expedited external review. Plan will pay for the cost of the review.

Complaints regarding these and other payer issues can be made to the Ohio Department 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®

777 Old Saw Mill River Road, Tarrytown, NY 10591
05/2024 US.EHD.24.03.0011

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

EYLEA® HD (aflibercept) Injection 8 mg