Understanding Reimbursement Issues in Oklahoma

A Guide for Health Care Providers and Practice Administration

Oklahoma

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.

Title 45 Code of Federal Regulations Section 147.136 states...

In the case of a preservice claim, Plan will notify the claimant of Plan's benefit determination (whether adverse or not) **no later than 15 days** after receipt of the claim by Plan. Plan may extend this period **1 time for up to 15 days**, provided that such an extension is necessary due to matters beyond Plan's control **and** Plan notifies the claimant, prior to the expiration of the **initial 15-day period**, of the extension and the date by which Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded **at least 45 days** from receipt of the notice within which to provide the specified information.

Oklahoma Statutes Title 36, Section 1250.5 states...

Denying payment to a claimant on the grounds that services provided by a treating physician were not medically necessary unless the Plan first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures, or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician, or hospital, the opinion shall be set forth in a written report, prepared and signed by the reviewing physician.

A copy of each report of a reviewing physician shall be mailed by the Plan or administrator, postage prepaid, to the claimant, treating physician, or hospital requesting the report **within 15 days** after receipt of the written request.

Oklahoma Statutes Title 63, Section 7330 states...

Step Therapy

1. Subject to paragraph 2 of this subsection, not later than 72 hours after receiving an initial exception request, the Plan shall respond to the requesting prescriber with either a determination of exception eligibility or a request for additional required information, strictly necessary to make a determination of whether the conditions specified in subsection D of this section are met. The Plan shall respond to the requesting provider with a determination of exception eligibility no later than 72 hours after receipt of the additional required information; or
2. In the case of a request under circumstances in which the applicable equipment step therapy protocol may seriously jeopardize the life or health of the participant or beneficiary, the Plan shall conduct a review of the request and respond to the requesting prescriber with either a determination or exception eligibility or a request for additional required information strictly necessary to make a determination of whether the conditions specified in subsection D of this section are met, in accordance with the following:
   a. if the Plan can make a determination of exception eligibility without additional information, such determination shall be made on an expedited basis and no later than 1 business day after receipt of such request; or
   b. if the Plan requires additional information before making a determination of exception eligibility, the Plan shall respond to the requesting provider with a request for such information within 1 business day of the request for a determination, and shall respond with a determination of exception eligibility as quickly as the condition or disease requires and no later than 1 business day after receipt of the additional required information.

Oklahoma Title 36 Section 6570.6 - [Effective 1/1/2025] states...

A. If a utilization review entity requires prior authorization of a health care service, the utilization review entity must make a prior authorization or adverse determination and notify the enrollee and the enrollee's Plan of the prior authorization or adverse determination in accordance with the time frames set forth below: **1.** For purposes of approving prior authorization for urgent health care services, **within 72 hours** of obtaining all necessary information to make the prior authorization or adverse determination; or **2.** For purposes of approving prior authorization for non-urgent health care services, **within 7 days** of obtaining all necessary information to make the prior authorization or adverse determination. For purposes of this section, "necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

B. For those health care providers that submit all necessary information through the utilization review entity's authorized prior authorization system, health care services are deemed authorized if a utilization review entity fails to comply with the deadlines set forth in this section.

Oklahoma Title 36 Section 6570.8 - [Effective 1/1/2025] states...

A. A Plan may not revoke, limit, condition, or restrict a prior authorization if care is provided **within 45 business days** from the date the health care provider received the prior authorization unless the enrollee was no longer eligible for care on the day care was provided.

On the following page:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

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Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

Prior Authorization(cont'd)	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
Oklahoma Title 63 Section 2550.4 states... **A.** A Plan that has a closed formulary or that requires prior authorization to obtain certain drugs shall approve or disapprove a provider's or a covered person's request for a nonformulary drug or a drug that requires prior authorization **within 24 hours** of receipt of such request. **B.** If the managed care plan does not render a decision **within 24 hours**, the provider or covered person shall be entitled to a **72-hour supply** of the drug. The Plan shall then approve or disapprove the request for a nonformulary drug or prior authorized drug within the additional **72-hour period**. **C.** Failure of the Plan to respond within the subsequently allowed **72-hour period** shall be deemed as approval of the request for the nonformulary drug or prior authorized drug; provided, however, the approval shall be subject to the terms of the Plan's drug formulary; provided further, the purchase of the approved drug shall be at no additional cost to the covered person beyond what the covered person would otherwise pay for a prescription pursuant to the Plan. **D.** All providers and covered persons in a Plan shall be provided with a copy of the plan's drug prior authorization process upon initial contracting or enrollment and at the time of enactment of any subsequent changes to the process. **Oklahoma Title 63 Section 7310 states...** A Plan provider shall respond to a request for a step therapy exception, or any appeal therefore, **within 72 hours** of receipt of the request or appeal. If a patient's prescribing health care provider indicates that exigent circumstances exist, the Plan provider shall respond to such a request or appeal **within 24 hours** of receipt of the request or appeal. If the Plan provider fails to respond within the required time, the step therapy exception or appeal shall be deemed granted. Upon granting a step therapy exception, the Plan provider shall authorize coverage for and dispensation of the prescription drug prescribed by the patient's health care provider.	**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. **Oklahoma Statutes Title 36, Section 1219 states...** In the administration, servicing, or processing of any accident and health insurance policy, Plan will reimburse a clean claim from an insured person, an assignee of the insured person, or a provider **within 45 calendar days** after receipt of the claim. An overdue payment will bear simple interest at the rate of 10% per year. If a clean claim or any portion of a clean claim is denied for any reason, a provider shall be notified in writing **within 30 calendar days** after receipt of the claim by the Plan. The written notice shall specify in detail the reason for the denial, including instructions on where a person who received notification may respond through dedicated facsimile or electronic mail message or the address or electronic mail message address of the department of appeals of the Plan. Upon receiving written notice of denial, a recipient may submit a detailed appeal in writing explaining why the claim should be approved. If the Plan denies the appeal, the Plan shall address in writing the specific details included in the written appeal and provide the phone number of a Plan representative at the department of appeals of the Plan. **Access the Oklahoma Prompt Payment Form.**	**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. **Oklahoma Statutes Title 36, Section 1219 states...** If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of the insured, and health care provider shall be notified in writing **within 30 calendar days** after receipt of the claim by the Plan. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of the Plan to provide the insured, enrollee or subscriber, assignee of the insured, and health care provider with the notice **shall constitute *prima facie* evidence that the claim will be paid in accordance with the terms of the policy.** **Oklahoma Statutes Title 36, Section 1250.5 states...** It is an unfair claim settlement practice for the Plan to request a refund of all or a portion of a payment of a claim made to a claimant **more than 12 months** or a health care provider **more than 18 months** after the payment is made.	**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. **Group Health Insurance Standards Act Section 8 states...** Written proof of loss must be furnished to the Plan **within 90 days** after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, **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 HD claim. **Title 29 Code of Federal Regulations Section 2560.503-1 states...** **Standard internal appeal:** Preservice initial appeal decided **within 30 days**; postservice initial appeal decided **within 60 days**. **Urgent internal appeal:** A Plan shall notify an individual of a benefit determination, whether adverse or not, with respect to a request involving urgent care as soon as possible, taking into account the medical exigencies, **but no later than 72 hours** after the receipt of the request by the Plan, unless the individual fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the coverage. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but **no later than 24 hours** after receipt of the claim by the plan, of the specific information necessary to complete the claim. **NOTE:** An expedited external appeal request may be filed at the same time as the expedited internal appeal. **Oklahoma Statutes Title 36, Section 6475.1 et seq states...** **External appeal:** If the Plan has not issued a written decision to the covered person or the covered person's authorized representative **within 30 days** following the date the covered person or the covered person's authorized representative files the grievance (internal appeal) with the Plan and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review. **Filing deadline: Within 120 days** of notice of final adverse determination. **Standard external appeal: Within 45 days** after the date of receipt of the request for an external review by the Plan, the independent review organization (IRO) shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or his authorized representative and the Plan. **Urgent external appeal:** As expeditiously as possible but **within no more than 72 hours** after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the Plan.

Complaints regarding these and other payer issues can be made to the Oklahoma 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.

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Reference: Data on file. Regeneron Pharmaceuticals, Inc.

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

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