Understanding Reimbursement Issues in Oregon

A Guide for Health Care Providers and Practice Administration

Oregon

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.

Oregon Revised Statutes Section 743B.423 states...

A provider request for prior authorization of nonemergency service must be answered **within 2 business days**, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

If a change in a drug formulary or other change in coverage impacts the coverage of any enrollee's treatment plan and the enrollee has been stabilized on the treatment plan for at least 90 days, the insurer must continue to provide coverage of the treatment until utilization review and all internal appeals and external reviews are completed.

The insurer may not alter utilization review requirements, or initiate or implement new utilization review requirements, without giving a 60-day advance notice to all participating providers.

Oregon Revised Statutes Section 743B.602 states...

Grant or deny a request for an exception to step therapy or an appeal of a denial of coverage no later than 72 hours or 2 business days, whichever is later, after receipt of the request unless exigent circumstances exist. If exigent circumstances exist, the entity shall grant or deny the request for an exception no later than 1 business day after receipt of the request. A request for an exception to step therapy or an appeal of a denial of coverage shall be deemed granted if the entity fails to act within the time frames specified in this paragraph.

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.

Oregon Revised Statutes Section 743B.450 states...

When a provider submits a claim to Plan on behalf of an enrollee, **Plan will pay a clean claim or deny the claim** no later than 30 days after the date on which the Plan receives the claim.

An insurer that fails to pay a claim to a provider within the time lines established shall pay simple interest of **12% per annum** on the unpaid amount of the claim that is due and owing.

Oregon Revised Statutes Section 743B.420 states...

Prior authorization determinations relating to benefit coverage and medical necessity **will be binding on Plan** if obtained no more than 60 days prior to the date when the service is provided.

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.

Oregon Revised Statutes Section 743B.450 states...

If Plan requires additional information before payment of a claim, **no later than 30 days** after the date on which Plan receives the claim, Plan will provide both enrollee and provider with written notification explaining the additional information needed to process the claim.

Plan will pay a clean claim or deny the claim **no later than 30 days** after the date on which Plan receives the additional information.

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.

Oregon Revised Statutes Section 743.429 states...

Written proof of loss must be furnished to the insurer **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.

Oregon Revised Statutes Section 743B.453 states...

A health insurer may not consider a provider's claim untimely if the claim is made **no later than 12 months** after a different insurer:

- Denied the claim in whole or in part, or
- Requested a refund of an erroneous payment made on the claim

Provider Appeals

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 carrier 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 carrier, 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.

Failure of a Plan to follow appeal procedures will result in claimant exhausting internal appeals and allow claimant to seek additional remedies.

Oregon Revised Statutes Section 743B.255 states...

A request for an **independent external review** must be filed **within 180 days** of notice of final adverse determination.

Oregon Revised Statutes Section 743B.256 states...

External appeal filing deadline: Request must be filed **within 120 days**.

Expedited: When review is expedited, the independent review organization (IRO) shall issue a decision no later than the **third day** after the date on which the enrollee applies to the insurer for an expedited review or the Director of the Department of Consumer and Business Services orders an expedited review.

Standard: When a review is not expedited, the IRO shall issue a decision no later than the **30th day** after the enrollee applies to the insurer for a review or the director orders a review.

The carrier shall pay the cost of the IRO for conducting the independent review.

Complaints regarding these and other payer issues can be made to the Oregon Division of Financial Regulation website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

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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.

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

EYLEA HD® (aflibercept) Injection 8 mg