Understanding Reimbursement Issues in South Carolina

A Guide for Health Care Providers and Practice Administration

South Carolina

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.

South Carolina Insurance Code Section 38-70-20 states...

Plan must notify insured or party designated by insured **within 5 business days** of an adverse decision.

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.

South Carolina Insurance Code Section 38-59-230 states...

Plan will pay a paper-based clean claim* **within 40 business days** and an electronic clean claim **within 20 business days** following the later of Plan's receipt of the claim or the date when Plan receives:

- All the information needed, and in a format required, for claim to constitute a clean claim
- All documentation that may be requested and is reasonably needed by Plan to determine that the claim contains no material defect, error, or impropriety or to make a payment determination

*See explanation of a clean claim in the Request for Additional Information column.

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.

South Carolina Insurance Code Section 38-59-210 states...

A clean claim is an eligible electronic or paper claim for reimbursement that **includes all required substantiating documentation or coding** and:

- Is received by Plan **within 120 business days** of the date the health care services at issue were performed
- When submitted via paper, has all the elements of the standardized CMS 1500 or UB-04 claim form (or successors of each)
- When submitted electronically, uses only permitted standard code sets and has all the elements of standard electronic formats (as required by HIPAA† and other regulatory authorities)
- Is for health care services covered by Plan and rendered to an insured person by a provider eligible for reimbursement under Plan
- Has any corresponding referral that may be required for the applicable claim
- Is a claim for which Plan is the primary payer or for which Plan's responsibility as a secondary payer has been clearly established
- Has no material defect, error, or impropriety that would affect adjudicating the claim
- Is not subject to any particular circumstance the insurer reasonably believes would prevent accurate or timely payment on the claim under the terms of Plan, participating provider agreement, or Plan's published filing requirements
- Is under a Plan that has timely paid all applicable premiums

†Health Insurance Portability and Accountability Act of 1996.

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.

South Carolina Insurance Code Section 38-59-210 states...

A clean claim is an eligible electronic or paper claim for reimbursement that is received by Plan **within 120 business days** of the date the health care services at issue were performed.

NOTE: This provision sets forth minimum contractual standards. Provider should check contract for specific requirements.

Provider Appeals

Issue: Provider appeals.

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

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

Provider must request an **internal review within 180 days**. A prospective review must be completed **within 30 days**; a retrospective review **within 60 days**.

Whenever a Plan fails to adhere to the time requirements of this Act with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Act and may request external review.

South Carolina Insurance Code Section 38-71-1970 states...

External appeal:

Request must be filed **within 120 days** of notice of adverse determination.

Within 5 business days from the date the Plan receives a request for an external review, the Plan or its designee shall assign an independent review organization.

Within 45 days after the date of receipt of the request for an external review by the Plan, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or their authorized representative and the Plan.

The Plan shall pay for the external review.

Complaints regarding these and other payer issues can be made to the South Carolina Department of Insurance website.

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

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777 Old Saw Mill River Road, Tarrytown, NY 10591
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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