Understanding Reimbursement Issues in Tennessee

A Guide for Health Care Providers and Practice Administration

Tennessee

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.

Tennessee Insurance Code Section 56-6-705 states...

All utilization review agents shall meet the following minimum standards:

- Notification of a determination by the utilization review agent shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual **within 2 business days** of the receipt of the request for determination and the receipt of all information necessary to complete the review

Tennessee Insurance Code Section 56-7-3502 states...

The health carrier, Plan, or utilization review organization shall grant or deny a step therapy exception request or an appeal within the turnaround times established pursuant to Section 56-6-705. If a response by a health carrier, Plan, or utilization review organization is not received within that time period, then the exception is granted.

A step therapy exception is eligible for appeal by an insured.

Effective January 1, 2025
Tennessee Insurance Code Section 56-7-3604 states...

(1) For prior authorization adverse determination appeals submitted electronically, a utilization review organization shall ensure that such appeals are reviewed or made by a licensed physician or health care professional with the same or a similar specialty as the health care professional who requested the initial prior authorization. The reviewing health care professional shall:
(A) Possess a current and valid non-restricted license to practice in this state or another state or territory of the United States;
(8) Be knowledgeable of, and have experience providing, the health care services under appeal;
(C) Not have been directly involved in making the adverse determination; and
(D) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided by the enrollee's health care provider, and any medical literature provided.
(2) Utilization review organizations shall perform:
(A) A non-urgent prior authorization review within 7 calendar days; and
(8) An urgent care prior authorization review within 72 hours, plus, if applicable, 1 additional business day.

Tennessee Insurance Code Section 56-7-3605 states...

(a) A prior authorization request under this section that has not been submitted as an urgent care request by the health care provider is deemed approved within 7 calendar days, or after the date and time of submission if the health carrier or utilization review organization, or its designee:
(1) Fails to approve or deny the request;
(2) Fails to request from the health care provider all additional information needed to make a decision; or
(3) Except for a prior authorization for a prescription drug, fails to notify the health care provider that prior authorization is being questioned for medical necessity.

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.

Tennessee Insurance Code Section 56-7-109(b) states...

Within 30 calendar days of receiving a paper claim and **within 21 calendar days** of receiving an electronic claim, Plan will pay:

- Total covered amount of claim if clean,* or
- Portion of claim that is clean and not in dispute and notify provider in writing why the remaining portion of the claim will not be paid

Failure to comply with these requirements will subject Plan to interest at 1% per month, accruing from the day after the payment was due, on the unpaid amount of claim.

*Claim with no defect or impropriety (eg, lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment from being made on the claim.

(d) Notwithstanding subsection (c) [fraud], if a Plan or an agent that contracted to provide eligibility verification verifies that an individual is a covered person, and if the health care provider provides services to the individual in reliance on the verification, then the Plan shall not thereafter recoup a claim on the basis that the individual is not a covered person unless the recoupment occurs within 6 months of the date that the Plan paid the claim; otherwise, the Plan is barred from making the recoupment unless there was fraud by the health care provider.

(f) If a health care provider initiates an appeal within 30 days of the date of a notice of recoupment pursuant to subsection (e), then payment must not be withheld from the health care provider until all appeals are exhausted.

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.

Tennessee Insurance Code Section 56-7-109(b) states...

Within 30 calendar days of receiving a paper claim and **within 21 calendar days** of receiving an electronic claim, Plan must notify provider of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Notification must be in writing for a paper claim.

No paper claim may be denied upon resubmission for lack of substantiating documentation or information that had been previously provided.

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.

Tennessee Insurance Code Section 56-7-109 states...

A clean claim does not include any claim submitted **more than 90 days** after the date of service.

NOTE: This provision sets forth minimum 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.

Tennessee Insurance Code Section 56-61-107 states...

Internal appeal: Plan must issue decision and notify claimant, in writing or electronically, **within 30 days** for a prospective review and **within 60 days** for a retrospective review.

Expedited review decision shall be rendered and the aggrieved person shall be notified of the decision as expeditiously as the covered person's medical condition requires, but in **no event more than 72 hours** after the receipt of the request.

Failure to comply with the time frames for internal review will allow claimant to proceed directly to external review.

Tennessee Insurance Code Section 56-61-115 states...

Claimant may proceed directly to an external review if Plan fails to comply with these deadlines.

Tennessee Insurance Code Sections 56-61-116 and 56-61-117 state...

Standard external appeal: Claimant must file a request for an external review **within 6 months** of final adverse determination.

Expedited external appeal: As expeditiously as the covered person's medical condition or circumstances require, but in **no event more than 72 hours** after the date of receipt of the request for an expedited external review that meets the reviewability requirements, the external review organization shall make a decision to uphold or reverse the adverse determination or final adverse determination.

If the Plan fails to provide the documents and information within the time specified, the external review organization may reverse the final adverse determination.

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

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

Understanding Step Therapy Exceptions in Tennessee

A Guide for Health Care Providers and Practice Administration

Tennessee Step Therapy Exception

Example of Issues Related to Step Therapy Requirements

Step Therapy Exception

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.

Tennessee Insurance Code Section 56-6-705 states...

All utilization review agents shall meet the following minimum standards: (1) Notification of a determination by the utilization review agent shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual **within 2 business days** of the receipt of the request for determination and the receipt of all information necessary to complete the review.

Tennessee Insurance Code Section 56-7-3502 states...

The health carrier, Plan, or utilization review organization shall grant a step therapy exception if 1 of the following applies:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction to, or physical or mental harm to, the patient due to a documented adverse event with a previous use of the required prescription drug or a documented medical condition, including a comorbid condition;

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(3) The required prescription drug is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to:
(A) Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
(B) Worsen a comorbid condition of the patient; or
(C) Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities

(4) The patient is currently receiving a positive therapeutic outcome on a prescription drug selected by the patient's health care provider for the medical condition under consideration while on a current or previous health insurance or Plan, and the patient's health care provider gives documentation to the health insurance, Plan, or utilization review organization that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug

The health carrier, Plan, or utilization review organization shall grant or deny a step therapy exception request or an appeal within the turnaround times established pursuant to Section 56-6-705. If a response by a health carrier, Plan, or utilization review organization is not received within that time period, then the exception is granted.

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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