

Understanding Reimbursement Issues in Tennessee

A Guide for Health Care Providers and Practice Administration

Example EYLEA® (afibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
<p>Issue: Plan delays prior authorization.</p> <p>Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA injections. Provider submits a request for prior authorization. Plan has not made a decision.</p>	<p>Issue: Plan delays timely payment pending medical necessity determination.</p> <p>Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA injections. Provider submits a claim for EYLEA reimbursement, but 31 days later, claim is still pending medical necessity determination.</p>	<p>Issue: Subsequent request for additional information.</p> <p>Example scenario: Provider submits a claim for EYLEA reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.</p>	<p>Issue: Claim is past the filing deadline.</p> <p>Example scenario: Provider timely submits an EYLEA claim. Plan denies the claim for being past the filing deadline.</p>	<p>Issue: Provider appeals.</p> <p>Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA claim.</p>
<p>Tennessee Insurance Code Section 56-6-705 states...</p> <p>All utilization review agents shall meet the following minimum standards:</p> <ul style="list-style-type: none"> 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 	<p>Tennessee Insurance Code Section 56-7-109(b) states...</p> <p>Within 30 calendar days of receiving a paper claim and within 21 calendar days of receiving an electronic claim, Plan will pay:</p> <ul style="list-style-type: none"> 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 <p>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.</p> <p>*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.</p>	<p>Tennessee Insurance Code Section 56-7-109(b) states...</p> <p>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.</p> <p>No paper claim may be denied upon resubmission for lack of substantiating documentation or information that had been previously provided.</p>	<p>Tennessee Insurance Code Section 56-7-109 states...</p> <p>A clean claim does not include any claim submitted more than 90 days after the date of service.</p> <p>NOTE: This provision sets forth minimum standards. Provider should check contract for specific requirements.</p>	<p>Tennessee Insurance Code Section 56-61-107 states...</p> <p>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.</p> <p>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.</p> <p>Failure to comply with the time frames for internal review will allow claimant to proceed directly to external review.</p> <p>Tennessee Insurance Code Section 56-61-115 states...</p> <p>Claimant may proceed directly to an external review if Plan fails to comply with these deadlines.</p> <p>Tennessee Insurance Code Sections 56-61-116 and 56-61-117 state...</p> <p>Standard external appeal: Claimant must file a request for an external review within 6 months of final adverse determination.</p> <p>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.</p> <p>If the Plan fails to provide the documents and information within the time specified, the external review organization may reverse the final adverse determination.</p>
<p>Tennessee Insurance Code Section 56-7-3502 states...</p> <p>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.</p> <p>A step therapy exception is eligible for appeal by an insured.</p>				

Complaints regarding these and other payer issues can be made to the [Tennessee Department of Commerce and Insurance website](https://www.tn.gov/commerce).



Visit [NavigatingPayerChallenges.com](https://www.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

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 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.

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

Complaints regarding these and other payer issues can be made to the [Tennessee Department of Commerce and Insurance website](#).



Visit [NavigatingPayerChallenges.com](https://www.navigatingpayerchallenges.com) for state-specific and federal legislation or contact your [Reimbursement Business Manager \(RBM\)](#) for more information

REGENERON

© 2023, Regeneron Pharmaceuticals, Inc. All rights reserved.
777 Old Saw Mill River Road, Tarrytown, NY 10591
04/2023 EYL.23.02.0184

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**[®]
(aflibercept) Injection