# Understanding Reimbursement Issues in Texas

A Guide for Health Care Providers and Practice Administration

Texas

## 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.

**Texas Insurance Code Section 4201.034 states...**

If the patient is not hospitalized at the time of the adverse determination, both the patient and the provider will be notified in writing **within 3 working days** or within a time frame that is appropriate to the patient's condition and delivery of services.

A Plan that uses a preauthorization process may not require a physician to obtain preauthorization for a particular health care service, if in the most recent 6-month evaluation period, the Plan has approved or would have approved not less than 90% of the preauthorization requests submitted by the physician.

**Texas Insurance Code Section 1301.135 states...**

On receipt of a request from a preferred provider for preauthorization, the Plan shall review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination must be issued and transmitted no later than the third calendar day after the date the request is received by the Plan.

**Texas Insurance Code Section 1301.1351 states...**

Plan that uses a preauthorization process for medical care or health care services will make the requirements and information about the preauthorization process readily accessible to insureds, physicians, providers, and the general public by posting the requirements and information on the Plan's website.

**Texas Insurance Code Section 1301.1353 states...**

(a) In addition to any other penalty or remedy provided by law, a Plan that violates this subchapter must provide an expedited appeal under Section 4201.357.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

**Texas Insurance Code Section 1369.0546 states...**

Except as provided by Subsection (e), if a Plan does not deny an exception request described by Subsection (c) before 72 hours after the Plan receives the request, the request is considered granted.

(e) If an exception request described by Subsection (c) also states that the prescribing provider reasonably believes that denial of the request makes the death of or serious harm to the patient probable, the request is considered granted if the Plan does not deny the request before 24 hours after the Plan receives the request.

(f) The denial of an exception request under this section is an adverse determination for purposes of Section 4201.002 and is subject to appeal under Subchapters H and I, Chapter 4201.

### 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.

**Texas Insurance Code Section 1301.103 states...**

No later than the 45th day after the date a Plan receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date a Plan receives a clean claim from a preferred provider that is electronically submitted, the Plan shall make a determination of whether the claim is payable and pay the total amount of the claim in accordance with the contract, or pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid, or notify the preferred provider in writing why the claim will not be paid.

**Texas Insurance Code Section 1301.135 states...**

If a Plan has preauthorized medical care or health care services, the Plan may not deny or reduce payment to the physician or health care provider for those services based on medical necessity or appropriateness of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

The provisions of this section may not be waived, voided, or nullified by contract.

**Texas Insurance Code Section 1301.137 states...**

A. Except as provided by this section, if a clean claim submitted to a Plan is payable and the Plan does not determine under Subchapter C that the claim is payable and pays the claim on or before the date the Plan is required to make a determination or adjudication of the claim, the Plan shall pay the preferred provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:
   **(1)** 50% of the difference between the billed charges, as submitted on the claim, and the contracted rate; or
   **(2)** $100,000.

B. If the claim is paid on or after the 46th day and before the 91st day after the date the Plan is required to make a determination or adjudication of the claim, the Plan shall pay a penalty in the amount of the lesser of:
   **(1)** 100% of the difference between the billed charges, as submitted on the claim, and the contracted rate; or
   **(2)** $200,000.

C. If the claim is paid on or after the 91st day after the date the Plan is required to make a determination or adjudication of the claim, the Plan shall pay a penalty computed under Subsection (b) plus 18% annual interest on that amount. Interest under this subsection accrues beginning on the date the Plan was required to pay the claim and ending on the date the claim and the penalty are paid in full.

A Plan is not liable for penalty under this section:

(1) If the failure to pay the claim in accordance with Subchapter C is a result of a catastrophic event and:

  (a) The commissioner published a notice allowing an extension of the applicable prompt payment deadlines due to the catastrophic event; or

  (b) The department approved the Plan's request for an extension due to the substantial interference of the catastrophic event with the normal business operations of the Plan

On the following page: Request for Additional Information | Filing Deadlines | Provider Appeals

EYLEA® HD (aflibercept) Injection 8 mg

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

### 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.

**Texas Insurance Code Section 1301.1054 states...**

If a Plan needs additional information from a treating preferred provider to determine payment, the Plan, **no later than the 30th calendar day** after the date the Plan receives a clean claim, **shall request in writing** that the preferred provider provide an attachment to the claim that is relevant and necessary for clarification of the claim. The request must describe with **specificity the clinical information requested** and **relate only to information the Plan can demonstrate is specific to the claim** or the claim's related episode of care. The preferred provider is **not required to provide an attachment that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by a preferred provider**.

A Plan that requests an attachment shall determine whether the claim is payable **on or before the later of the 15th day** after the date the Plan receives the requested attachment or the latest date for determining whether the claim is payable.

A Plan may **not make more than 1 request**.

If a Plan requests an attachment or other information from a person other than the preferred provider who submitted the claim, the Plan shall provide notice containing the name of the physician or health care provider from whom the Plan is requesting information to the preferred provider who submitted the claim. **The Plan may not withhold payment pending receipt of an attachment or information requested**.

The provisions of this section may not be waived, voided, or nullified by contract.

### 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.

**Texas Insurance Code Section 1301.102 states...**

A physician or provider must submit a claim to Plan **no later than the 95th day** after the date the physician or provider provides the medical or health care services for which the claim is made. A physician or provider may, as appropriate, do any of the following:

- Mail a claim by US first-class mail or by overnight delivery
- Submit the claim electronically
- Fax the claim
- Hand-deliver the claim

Plan will accept as proof of timely filing a claim filed in compliance with the above requirements or information from another Plan or health maintenance organization showing that the physician or provider submitted the claim in compliance with these requirements.

**Texas Insurance Code Section 1301.1021 states...**

A claim for medical health care services provided to a patient is presumed to have been received by Plan:

- If mailed, on the fifth day after the date the claim was mailed or, if mailed using overnight service or return receipt requested, on the date the delivery receipt was signed
- If submitted electronically, on the date of electronic verification of receipt by Plan or Plan's clearinghouse or within 24 hours of submission by the physician's clearinghouse
- If faxed, on the date of the transmission acknowledgment
- If hand-delivered, on the **date the delivery receipt was signed**

The provisions of this section may not be waived, voided, or nullified by contract, **except for the 95-day filing deadline**.

The period for submitting a claim under this section may be extended by:

(1) Contract;

(2) Notice published by the commissioner allowing an extension of prompt payment deadlines to a later date chosen by the commissioner due to a catastrophic event; or

(3) The department's approval of a physician's or health care provider's request for an extension due to a catastrophic event that substantially interferes with the normal business operations of the physician or provider.

### Provider Appeals

**Issue:** Provider appeals.

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

**Texas Insurance Code Section 4201.359 states...**

**Internal review:** The procedures for appealing an adverse determination must require written notice to the appealing party of the determination of the appeal as soon as practicable but **no later than the 30th calendar day** after the date the utilization review agent receives the appeal.

A specialty review may be requested **no later than the 10th working day** after the date an appeal is denied. The provider reviewing the denial must be of the same or similar specialty as the provider who would typically manage the medical condition, procedure, or treatment under consideration for review. The specialty review must be completed **within 15 working days** of the date when the provider's request for specialty review is received.

**Texas Insurance Code Section 4201.152 states...**

A utilization review agent will conduct a utilization review under the direction of a physician licensed to practice medicine in Texas.

**Texas Insurance Code Section 4201.402 states...**

No later than the third business day after the date a utilization review agent receives a request for independent review, the agent shall provide to the appropriate independent review organization all relevant documentation and medical records.

**Texas Insurance Code Section 4202.003 states...**

A request for an independent external review must be submitted **no later than 120 days** after adverse determination. The decision must be made **no later than the earlier of the:**

- **15th day** after the date the organization receives the information necessary to make the determination, or
- **20th day** after the date the organization receives the request that the determination be made

A utilization review agent will pay for the review.

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

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

REGENERON®

© 2024, Regeneron Pharmaceuticals, Inc. All rights reserved.

777 Old Saw Mill River Road, Tarrytown, NY 10591

05/2024 US.EHD.24.03.0043

***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