Understanding Reimbursement Issues in Vermont

A Guide for Health Care Providers and Practice Administration

Vermont

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

Prior Authorization	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
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. **Vermont Statutes Annotated Title 18, Section 9418b states...** The Vermont Department of Financial Regulation has developed a clear, uniform, and readily accessible form for prior authorization requests for medical procedures and medical tests. Form may be downloaded from the Vermont Agency of Human Services website. Plan will respond to a completed prior authorization request from a prescribing health care provider: • **Within 48 hours** for urgent requests • **Within 2 business days** for nonurgent requests Plan will notify the provider of or make available to the provider a receipt for the request for prior authorization and any needed missing information **within 24 hours** of receipt. If Plan does not respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information within the required time limits, **the prior authorization request will be deemed as granted**. Plan shall review the list of medical procedures and medical tests for which it requires prior authorization at least annually and shall eliminate the prior authorization requirements for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree sufficient to justify the administrative costs to the Plan.	**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. **Vermont Statutes Annotated Title 18, Section 9418 states...** Plan, contracting entity, or payer will, **no later than 30 days** following receipt of a claim, pay or reimburse the claim or notify the claimant in writing that the claim is contested or denied. The notice will include the specific reasons supporting the contest or denial, as well as a description of any additional information required for Plan, contracting entity, or payer to determine liability for the claim. Interest will accrue on a claim at the rate of 12% per annum. **Vermont Department of Financial Regulation Rule H-2009-03, Part 3 states...** Regarding utilization management determinations, the managed care organization will ensure that individual clinical case assessments and clinical data reported by the treating provider are given equal or greater weight than utilization review guidelines in making decisions to approve or deny care, with the former taking precedence over the latter when there is a conflict between them. If prior authorization has been received, except in cases of material misrepresentation or fraud, the managed care organization will not retroactively deny or limit reimbursement for any covered service provided to an eligible member by a provider (or referral) who relied on the written or oral authorization of the managed care organization or its agents prior to providing the service to the member.	**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. **Vermont Statutes Annotated Title 18, Section 9418 states...** If a claim is contested because Plan, contracting entity, or payer was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by this section, then Plan, contracting entity, or payer will have **30 days** after receipt of the additional information to complete consideration of the claim. **NOTE:** The request for additional information must be sent to the provider prior to the expiration of the initial 30 days. See the Prompt Payment column.	**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. **Vermont Statutes Annotated Title 8, Section 4065 states...** Written proof of loss must be furnished to the Plan **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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim. **Vermont Department of Financial Regulation Rule H-2009-03, Part 3 states...** A member must explicitly and in writing authorize a provider to submit a grievance on the member's behalf in nonurgent preservice and postservice situations. An **internal grievance** must be filed **within 180 days** of claim denial. A nonurgent preservice grievance must be resolved **within 30 days**; a nonurgent postservice claim, **within 60 days**. A second-level internal grievance is voluntary. **Vermont Department of Financial Regulation, Rule H-2011-02, Section 5 states...** Provider has the right to request an **independent external review** if an internal grievance decision was not rendered timely. The request for an independent external review must be filed **within 120 days** of the final internal grievance decision. A $25 ($75 annual max) filing fee must accompany the request. **Vermont Department of Financial Regulation, Rule H-2011-02, Section 6 states...** The selected independent review organization will render its decision to uphold or reverse the determination of Plan and notify the covered person or the covered person's authorized representative and Plan in writing **within 30 days** of receiving all necessary information. **Vermont Department of Financial Regulation, Rule H-2011-02, Section 6 states...** Plan will pay for the cost of the independent external review.

Complaints regarding these and other payer issues can be made to the Vermont Department 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