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

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.

For urgent prior authorization requests, a Plan shall approve, deny, or inform the insured or health care provider if any information is missing from a prior authorization request from an insured or a prescribing health care provider within **24 hours** following receipt. **(ii)** If a Plan informs an insured or a health care provider that more information is necessary for the Plan to make a determination on the request, the Plan shall have **24 hours** to approve or deny the request upon receipt of the necessary information. **(B)** For nonurgent prior authorization requests: **(i)** A Plan shall approve or deny a completed prior authorization request from an insured or a prescribing health care provider within **2 business days** following receipt. **(ii)** A Plan shall acknowledge receipt of the prior authorization request within **24 hours** following receipt and shall inform the insured or health care provider at that time if any information is missing that is necessary for the health plan to make a determination on the request. **(iii)** If a Plan notifies an insured or a health care provider that more information is necessary pursuant to subdivision **(ii)** of this subdivision **(4)(B)**, the Plan shall have **24 hours** to approve or deny the request upon receipt of the necessary information. **(C)** If a Plan does not, within the time limits set forth in this section.

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.

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.

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.

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.

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.

Vermont Statutes Annotated Title 8, Section 4065 states...

PROOFS OF LOSS: Written proof of loss must be furnished to the Plan at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Plan is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, **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.

Provider Appeals

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