Understanding Reimbursement Issues in Virginia

A Guide for Health Care Providers and Practice Administration

Virginia

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.

Code of Virginia Section 32.1-137.13 states...

The treating provider will be notified in writing of any adverse determination **within 2 working days** of the determination. At any time before the entity renders its determination, the provider will be entitled to review the issue of medical necessity with a physician-adviser or peer of the treating health care provider who represents the entity.

Optional reconsideration: A treating provider **may request reconsideration** of an adverse determination pursuant to this section **or may appeal** an adverse determination. Any reconsideration will be rendered and the determination provided to the treating provider and the covered person in writing **within 10 working days** of receipt of the request for reconsideration.

In addition, the utilization review process **shall:**

- Allow for **flexibility**, taking into account **individual cases** when appropriate
- Evaluate uniform application of guidelines to determine the necessity for **case-by-case decision-making**

Code of Virginia Section 38.2-3407.9:5 states...

The carrier or utilization review organization shall respond to a step therapy exception request **within 72 hours** of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, a carrier or utilization review organization shall respond **within 24 hours** of receipt, including hours on weekends, that the request is approved, denied, or requires supplementation. A patient may appeal any step therapy exception request denial made pursuant to this section under the Plan's existing appeal procedures.

Code of Virginia Section 38.2-3407.15:2 states...

9. Require a carrier to honor a prior authorization issued by the carrier for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with US Food and Drug Administration-labeled dosages;

15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other provision of this section, to establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a) impose a fee or charge on any person for accessing the online process as required by this subdivision or (b) access, absent provider consent, provider data via the online process other than for the enrollee. No later than July 1, 2024, a carrier shall provide contact information of any third-party vendor or other entity the carrier will use to meet the requirements of this subdivision or the requirements of §38.2-3407.15:7 to any provider that requests such information. A carrier that posts such contact information on its website shall be considered to have met this requirement; and

16. Require a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access, at the point of prescribing, the electronic prior authorization process established by a carrier as required by subdivision 15 and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to §38.2-3407.15:7. A provider may request a waiver of compliance under this subdivision for undue hardship for a period specified by the appropriate regulatory authority with the Health and Human Resources Secretariat.

Code of Virginia Section 38.2-3407.15:7 states...

Beginning July 1, 2025, any carrier or its pharmacy benefits manager shall provide real-time cost information data to enrollees and contracted providers for a covered prescription drug, including any cost-sharing requirement or prior authorization requirements, and shall ensure that the data is accurate.

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

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

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 41 days later, claim is still pending medical necessity determination.

Code of Virginia Section 38.2-3407.15 states...

Plan shall pay any claim **within 40 days** of receipt of the claim except where the obligation of the Plan to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

(a.) The claim is determined by the Plan not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another Plan for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or (b.) The claim was submitted fraudulently.

Interest will be paid on a delinquent claim at the legal rate, without necessity of demand, when the claim is paid or **within 60 days** thereafter.

Plan will, **within 30 days** after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the Plan from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, the Plan will make the payment of the claim in compliance with this section. No Plan may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the Plan fails to timely notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such Plan from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Beginning **no later than January 1, 2026**, all notifications and information required under this subdivision shall be delivered electronically.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, will, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or **within 60 days** thereafter.

With certain exceptions, Plan will pay a claim if Plan has issued a prior authorization or has advised provider or enrollee in advance of the provision of health care services that the services are medically necessary and a covered benefit.

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.

Code of Virginia Section 38.2-3407.15 states...

Plan will, **within 30 days** of receiving a claim, request the information and documentation that Plan reasonably believes will be required to process and pay the claim or to determine whether the claim is a clean claim.

Upon receipt of the additional information required to make the original claim a clean claim, Plan will make timely payment of the claim. **Plan cannot refuse to pay a claim for health care services rendered that are covered benefits if Plan does not, in a timely manner, notify or attempt to notify provider of the matters noted in this section unless such failure was caused in material part by the person who submitted the claim.**

Code of Virginia Section 38.2-3407.15:2 states...

If Plan requires a prescriber to provide supplemental information that is in the covered individual's health record or electronic health record, Plan must identify the specific information required.

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.

Code of Virginia Section 38.2-3536 states...

Every group accident and sickness insurance policy will contain a provision that written proof of the loss will be furnished to the Plan **within 90 days** after the commencement of the period for which the Plan is liable. Failure to furnish such proof within the prescribed time will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof within that time and the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, will such proof be furnished **later than 1 year** from the time proof is otherwise required.

NOTE: This provision sets forth minimum contractual standards. Provider should check contract for specific requirements.

Code of Virginia Section 38.2-3407.15 states...

No carrier may impose any retroactive denial of a previously paid claim unless the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) **12 months** or (b) **the number of days within which the carrier requires under its provider contract** that a claim be submitted by the provider following the date on which a health care service is provided. **Effective July 1, 2000**, a carrier shall notify a provider **at least 30 days** in advance of any retroactive denial of a claim.

Code of Virginia Section 8.01-27.5 states...

An in-network provider that provides health care services to a covered patient shall submit its claim to the Plan for the health care services in accordance with the terms of the applicable provider agreement or as permitted under applicable federal or state laws or regulations, provided that the covered patient provides the in-network provider with information required by the terms of the covered patient's Plan documents, including the information that is required to verify the individual's coverage under the health care policy, within **no fewer than 21 business days** before the deadline for the in-network provider to submit its claim to the Plan as required by the terms of the provider agreement.

Provider Appeals

Issue: Provider appeals.

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

Virginia Administrative Code Rule 5-216-40(E) states...

Internal appeal: Plan must make its decision **within 30 days** of receiving a preservice claim review request and **within 60 days** of receiving a postservice claim review request. Plan may provide a second level of internal appeal if **up to 15 days** (preservice claim review request) and **up to 30 days** (postservice claim review request) are allowed for a benefit determination and notification from each level of the appeal.

Code of Virginia Section 38.2-3560 states...

Covered person may request an external review if a written decision is not received **within 30 days** following the date the appeal was filed.

Code of Virginia Section 38.2-3561 states...

External review: A request for external review must be filed **within 120 days**. The form to request the review may be downloaded from the Virginia Law Portal.

The independent review organization must make its determination **within 45 days** after receiving the external review request. Plan must pay the cost incurred by the independent review organization in conducting the review.

Complaints regarding these and other payer issues can be made to the Virginia State Corporation Commission 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