

Understanding Reimbursement Issues in Virginia

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>Code of Virginia Section 32.1-13713 states...</p> <p>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.</p> <p>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.</p> <p>In addition, the utilization review process shall:</p> <ul style="list-style-type: none"> • 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 <p>Code of Virginia Section 38.2-34079:5 states...</p> <p>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.</p> <p>Code of Virginia Section 38.2-340715:2 states...</p> <p>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.</p> <p>Code of Virginia Section 38.2-340715:7 states...</p> <p>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.</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 41 days later, claim is still pending medical necessity determination.</p> <p>Code of Virginia Section 38.2-340715 states...</p> <p>Plan will pay any claim within 40 days of receiving the claim except where the obligation of the Plan to pay a claim is not reasonably clear. 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.</p> <p>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.</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>Code of Virginia Section 38.2-340715 states...</p> <p>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.</p> <p>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.</p> <p>Code of Virginia Section 38.2-340715:2 states...</p> <p>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.</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>Code of Virginia Section 38.2-3536 states...</p> <p>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.</p> <p>NOTE: This provision sets forth minimum contractual standards. Provider should check contract for specific requirements.</p> <p>Code of Virginia Section 38.2-340715 states...</p> <p>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.</p> <p>Code of Virginia Section 8.01-27.5 states...</p> <p>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.</p>	<p>Issue: Provider appeals.</p> <p>Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA claim.</p> <p>Virginia Administrative Code Rule 5-216-40(E) states...</p> <p>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.</p> <p>Code of Virginia Section 38.2-3560 states...</p> <p>Covered person may request an external review if a written decision is not received within 30 days following the date the appeal was filed.</p> <p>Code of Virginia Section 38.2-3561 states...</p> <p>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.</p> <p>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.</p>

Complaints regarding these and other payer issues can be made to the [Virginia State Corporation Commission website](#).



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



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