Understanding Reimbursement Issues in Washington

A Guide for Health Care Providers and Practice Administration

Washington

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.

Washington Administrative Code Rule 284-43-2020 states...

For a nonurgent care review request, Plan must either:
- Approve the request **within 5 calendar days** and include the authorization number in the approval if the information is sufficient to approve the claim, or
- Deny the request **within 5 calendar days** if the requested service is not medically necessary and the information provided is sufficient to deny the claim

If the information provided is not sufficient to approve or deny the claim, Plan must:
- **Within 5 calendar days**, request that the provider submit additional information to make the prior authorization determination
  - Give the provider **5 calendar days** to submit the requested additional information
  - Approve or deny the request within **4 calendar days** of receiving the additional information and include the authorization number in the approval

Revised Code of Washington Section 48.43.420 states...

Once information is sufficient to determine the claim is received by the Plan, exception requests for step therapy override must be decided **within 3 business days** for nonurgent care claims and **within 1 business day** for urgent care claims once information sufficient to determine the claim is received by Plan. If a response by Plan is not received within the time frames established under this section, the exception request will be deemed granted.

Revised Code of Washington Section 48.43.016 states...

A health care provider with whom a Plan consults regarding a decision to deny, limit, or terminate a person's covered health care services must hold a license, certification, or registration in good standing and must be in the same or related health field as the health care provider being reviewed or of a specialty whose practice entails the same or similar covered health care service.

Revised Code of Washington Section 48.43.0161 (amended by House Bill 1357) states...

Each carrier offering a health plan issued or renewed on or after January 1, 2024, shall comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The Plan shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic prior authorization process, as designated by each Plan:
  (i) For electronic standard prior authorization requests, the Plan shall make a decision and notify the provider or facility of the results of the decision within 3 calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the Plan to make a decision, the Plan shall request any additional information from the provider or facility within 1 calendar day of submission of the electronic prior authorization request.
  (ii) For electronic expedited prior authorization requests, the Plan shall make a decision and notify the provider or facility of the results of the decision within 1 calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the Plan to make a decision, the Plan shall request any additional information from the provider or facility within 1 calendar day of submission of the electronic prior authorization request.

(b) The Plan shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process:
  (i) For nonelectronic standard prior authorization requests, the Plan shall make a decision and notify the provider or facility of the results of the decision within 5 calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the Plan to make a decision, the Plan shall request any additional information from the provider or facility within 5 calendar days of submission of the nonelectronic prior authorization request.
  (ii) For nonelectronic expedited prior authorization requests, the Plan shall make a decision and notify the provider or facility of the results of the decision within 2 calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the Plan to make a decision, the Plan shall request any additional information from the provider or facility within 1 calendar day of submission of the nonelectronic prior authorization request.

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	Request for Additional Information	Filing Deadlines	Provider Appeals
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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.
Washington Administrative Code Rule 284-170-431 states...	**Washington Administrative Code Rule 284-170-431 states...**	**Group Health Insurance Standards Act Section 8 states...**	**Revised Code of Washington Section 48.43.530 states...**
For health services provided to covered persons, Plan will pay providers as soon as practical but is subject to the following minimum standards: • 95% of the monthly volume of clean claims will be paid **within 30 days** of receipt, and • 95% of the monthly volume of all claims will be paid or denied **within 60 days** of receipt, except as agreed to in writing by the parties on a claim-by-claim basis Interest will be assessed at the rate of 1% per month and calculated monthly as simple interest prorated for any portion of a month. Plan will add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim.	**Within 30 days** of receipt of a claim, the decision to deny a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based on medical necessity or similar grounds, then Plan, on request of the provider or facility, must also promptly disclose the supporting basis for the decision (eg, a description of how the claim failed to meet the medical necessity guidelines).	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.	**Internal appeal:** Plan must: • Make its decision regarding the appeal **within 30 days** of the date the appeal is received • If the carrier has exceeded the time lines for grievances without good cause and without reaching a decision, claimant may proceed to Independent Review
Washington Administrative Code Rule 284-43-2050 states...			**Revised Code of Washington Section 48.43.535 states...**
Prior authorization determinations will expire **no sooner than 45 days** from the date of approval.			An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service or of any adverse determination made by a carrier after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the time lines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision.
			Washington Administrative Code Rule 284-43A-070 states...
			An independent external review request must be filed **within 120 days** of notice of final adverse determination. An independent review organization (IRO) shall make its determination within the following time limits: • If the review is not expedited, **within 15 days** after receiving necessary information, or **within 20 days** after receiving the referral, whichever is earlier • In exceptional circumstances where information is incomplete, the determination may be delayed until **no later than 25 days** after receiving the referral The carrier shall pay the cost of the IRO for conducting the independent review.

Complaints regarding these and other payer issues can be made to the Washington Office of the Insurance Commissioner website.

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

REGENERON®

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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