Understanding Reimbursement Issues in West Virginia

A Guide for Health Care Providers and Practice Administration

West 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.

West Virginia Administrative Code Rules Sections 95-7.1.c and 95-6.3.a state...

Prospective Review should be made within a reasonable period of time appropriate to the covered person's medical condition but in **no event later than 15 days** after receiving the request for determination.

Whenever a Plan fails to adhere to the time requirements for making a benefit determination, the covered person may file a request for external review.

Code of West Virginia Section 33-15-4s states...

If a provider submits the request for prior authorization electronically, Plan will respond to the prior authorization request **within 7 days** from the time on the electronic receipt of the prior authorization request, except that Plan will respond to the prior authorization request **within 2 days** if the request is for a medical care or other service for a condition where application of the time frame for making routine or non–life-threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state, or
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request

If information submitted is considered incomplete, provider will provide the additional information requested **within 72 hours** from the time the request is received by provider, or the prior authorization is deemed denied and a new request must be submitted.

Code of West Virginia Section 33-15-4s states...

(5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the provider.

(d) After the provider submits the request for prior authorization electronically, and all of the information as required is provided, the Plan shall respond to the prior authorization request within 5 business days from the day on the electronic receipt of the prior authorization request, except that the Plan shall respond to the prior authorization request within 2 business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a provider with knowledge of the patient's medical condition would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the Plan shall identify all deficiencies, and within 2 business days from the day on the electronic receipt of the prior authorization request return the prior authorization to the provider. The provider shall provide the additional information requested within 3 business days from the time the return request is received by the provider. The Plan shall render a decision within 2 business days after receipt of the additional information submitted by the provider. If the provider fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the Plan wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within 2 business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by a Plan is carried over to all other managed care organizations, health insurers, and the Public Employees Insurance Agency for 3 months if the services are provided within the state.

(h) The Plan shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Plan and the provider who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The Plan's medical director has the ultimate decision regarding the appeal determination and the provider has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than 5 business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(k) If a provider has performed an average of 30 procedures per year and in a 6-month time period during that year has received a 90% final prior approval rating, the Plan may not require the provider to submit a prior authorization for at least the next 6 months, or longer if the insurer allows:

Provided, that at the end of the 6-month time frame, or longer if the Plan allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Plan allows. This exemption is subject to internal auditing, at any time, by the Plan and may be rescinded if the Plan determines the provider is not performing services or procedures in conformity with the Plan's benefit plan, it identifies substantial variances in historical utilization, or identifies other anomalies based upon the results of the Plan's internal audit. The Plan shall provide a provider with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit a Plan from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

On the following page:

Prior Authorization (cont'd) | Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

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

Prior Authorization (cont'd)	Prompt Payment	Request for Additional Information	Filing Deadlines	Provider Appeals
Code of West Virginia Section 33-24-7p states... A step therapy override determination request shall be expeditiously granted if: • Contraindicated or will likely cause an adverse reaction • The required prescription drug is expected to be ineffective based on the known relevant physical or mental characteristics of the patient and the known characteristics of the prescription drug regimen • The patient has tried the required prescription drug while under their current or a previous health insurance or Plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event • The required prescription drug is not in the best interest of the patient, based upon medical appropriateness • The patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration This section shall not be construed to prevent a health care provider from prescribing a prescription drug that is determined to be medically appropriate.	**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. **West Virginia Insurance Code Section 33-45-2 states...** Plan must pay claims submitted electronically **within 30 days** and claims submitted by other means **within 40 days**. Interest at the rate of 10% will be paid on delinquent claims without necessity of demand.	**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. **West Virginia Insurance Code Section 33-45-2(3) states...** Plan must request additional information **within 30 days** of receiving the claim. Plan must pay the claim in a timely manner after receiving the additional information necessary to process the claim or determine whether the claim is a clean claim.* Plan cannot refuse to pay the claim for health care services rendered pursuant to a provider contract that are covered benefits if Plan fails to notify (or attempt to notify) provider of the additional information needed unless such failure was caused in material part by the person who submitted the claim. *Claim with no defect or impropriety (eg, lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment from being made on the claim.	**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. **West Virginia Insurance Code Section 33-15-4 states...** For loss of time to file a claim, provider must furnish Plan with written proof of such loss **within 90 days**. Failure to furnish such proof within that time will neither invalidate nor reduce any claim if: • Furnishing the proof was not reasonably possible within that time, and • Proof is furnished as soon as reasonably possible **no later than 1 year** from the time proof is required **NOTE:** This provision sets forth minimum contractual standards. Provider should check contract for specific requirements. **West Virginia Insurance Code Section 33-45-2 states...** If Plan fails to maintain a record of the date a claim is received, the claim will be considered received **3 business days** after the claim was submitted based on the record of the date of submittal by the person who submitted the claim.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's adverse determination (denial or reduction) of an EYLEA HD claim. **Code of West Virginia Section 33-16-3dd states...** **Effective January 1, 2020:** If a prior authorization is rejected by Plan, and health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review will be with a health care practitioner similar in specialty, education, and background. Plan's medical director has the ultimate decision regarding the appeal determination, and the health care practitioner has the option to consult with the medical director after the peer-to-peer consultation. Time frames regarding this appeal process will take **no longer than 30 days**. **West Virginia Administrative Code Rule 114-96-5 states...** An internal appeal must be filed **within 180 days**. A **prospective review** should be made within a reasonable period of time appropriate to the covered person's medical condition but in **no event later than 30 days** after receiving the request for determination. A **retrospective review** should be made within a reasonable period of time but in **no event later than 60 days** after receiving the request for determination. **West Virginia Administrative Code Rule 114-96-7 states...** **An expedited review** decision shall be made and the covered person shall be notified of the decision as expeditiously as the covered person's medical condition requires, but in **no event more than 72 hours** after the receipt of the request for the expedited review. Whenever a Plan fails to adhere to the time requirements for making a benefit determination, the covered person may file a request for external review. **West Virginia Administrative Code Rule 114-58-4 et seq state...** **Requests for external review** shall be made **within 60 calendar days** after the Plan has exceeded the time periods for grievances without reaching a decision, or **within 60 calendar days** after receiving written notice of an adverse determination by the Plan. **A standard review shall be made within 45 days** after the date of receipt of the request for an external review, the independent review organization shall make its determination. **An expedited review shall be made** as soon as possible, but **no more than 7 calendar days** after the date the request for expedited external review is received by the commissioner, the assigned external review organization shall notify the enrollee, the Plan, and the commissioner of its decision to uphold or reverse the Plan's adverse determination. The Plan shall pay the cost incurred by the independent review organization in conducting the external review.

Complaints regarding these and other payer issues can be made to the West Virginia Offices 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