Understanding Reimbursement Issues in Wisconsin

A Guide for Health Care Providers and Practice Administration

Wisconsin

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.

Wisconsin Administrative Code Rule Ins 6.11 states...

Plan must, upon the request of claimant, promptly provide a reasonable explanation of the basis in the policy contract or applicable law for denial of a claim. The terms *prompt* and *promptly* mean responsive action **within 10 consecutive days** from receipt of a communication concerning a claim.

29 Code of Federal Regulations 2560.503-1 states...

Urgent care claims: The Plan administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but **no later than 72 hours** after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan administrator shall notify the claimant as soon as possible, but **no later than 24 hours** after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

Preservice claims: Prior authorization must be decided within a reasonable period, appropriate to the medical circumstances, but **no later than 15 days** after the Plan has received the claim. The Plan may extend the time period up to an **additional 15 days** if, for reasons beyond the Plan's control, the decision cannot be made within the first 15 days.

If the Plan fails to follow preservice procedures (prior authorization), then the claimant is deemed to have exhausted all remedies and may proceed to external review.

Wisconsin Insurance Code Section 632.866 states...

A Plan, pharmacy benefit manager, or utilization review organization will grant or deny a request for any exception to the step therapy protocol **within 72 hours** of receipt of the request or the request to appeal the previous decision.

In exigent circumstances, a Plan, pharmacy benefit manager, or utilization review organization will grant or deny a request for an exception to the step therapy protocol **within 24 hours** of receipt of the request. If the Plan, pharmacy benefit manager, or utilization review organization does not grant or deny a request or an appeal under the time specified under this paragraph, the exception will be considered granted.

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.

Wisconsin Insurance Code Section 628.46 states...

Unless otherwise provided by law, Plan will promptly pay every insurance claim. A claim will be overdue if not paid **within 30 days** after Plan is furnished written notice of the fact of a covered loss and of the amount of the loss. If such written notice is not furnished to Plan as to the entire claim, any partial amount supported by written notice will be overdue if not paid **within 30 days** after such written notice is furnished to Plan. Any part or all of the remainder of the claim that is subsequently supported by written notice will be overdue if not paid **within 30 days** after written notice is furnished to Plan.

All overdue payments bear simple interest at the rate of 7.5% per year.

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.

Wisconsin Insurance Code Section 628.46 states...

Unless otherwise provided by law, a Plan shall promptly pay every insurance claim.

- A claim shall be overdue if not paid **within 30 days** after the Plan is furnished written notice of the fact of a covered loss and of the amount of the loss
- If such written notice is not furnished to the Plan as to the entire claim, any partial amount supported by written notice is overdue **if not paid within 30 days** after such written notice is furnished to the Plan
- Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid **within 30 days** after written notice is furnished to the Plan
- Any payment shall not be deemed overdue if the Plan has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished to the Plan

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.

Wisconsin Insurance Code Section 631.81 states...

Timeliness of notice: If notice or proof of loss is furnished as soon as reasonably possible and **within 1 year** after the time it was required by Plan, failure to furnish such notice or proof within the time required by Plan does not invalidate or reduce a claim unless Plan is prejudiced thereby and it was reasonably possible to meet the time limit.

Method of giving notice: It is a sufficient service of notice or proof of loss if a first-class postage-prepaid envelope addressed to Plan and containing the proper notice or proof is deposited in any US post office within the time prescribed. The commissioner may expressly approve clauses requiring more expeditious methods of notice where that is reasonable.

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.

Wisconsin Administrative Code Rule Ins 18.03 states...

Standard appeal: An **internal grievance** will be resolved **within 30 calendar days** of receiving the grievance. If Plan is unable to resolve the grievance in that time, the time period may be extended **an additional 30 calendar days** if Plan provides written notification to the insured and the insured's authorized representative, if applicable, of all of the following:

- The Plan has not resolved the grievance
- When resolution of the grievance may be expected
- The reason additional time is needed

Wisconsin Administrative Code Rule Ins 18.05 states...

An expedited grievance shall be resolved as expeditiously as the insured's health condition requires but **no more than 72 hours** after receipt. A Plan, upon written request, shall mail or electronically mail a copy of the insured's complete policy to the insured or the insured's authorized representative as expeditiously as the grievance is handled.

Wisconsin Insurance Code Section 632.835 states...

An external appeal must be filed **within 120 days**. **For a standard review**, the independent review organization (IRO) shall, **within 30 business days** after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection.

For an expedited review: The IRO shall make its decision **within 72 hours** after the expiration of the time limits for receipt of all documents and information.

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

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

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.