# Understanding Reimbursement Issues in Wyoming

A Guide for Health Care Providers and Practice Administration

**Wyoming**

## 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.

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

**Urgent care claims:** In the case of a claim involving urgent care, 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), the claimant is deemed to have exhausted all remedies and may proceed to external review.

**Wyoming Insurance Code Section 26-40-201 states...**

For a prospective review of a nonurgent case, Plan will issue a determination **within 15 calendar days** of receiving the request for a utilization management determination. This time period may be extended 1 time for **up to 15 calendar days** provided that Plan:

- Determines that an extension is necessary because of matters beyond Plan's control
- Notifies the patient, prior to the expiration of the initial 15-calendar-day period, of the circumstances requiring the extension and the date when Plan expects to make a decision
- If the patient fails to submit necessary information to decide the case, specifically describes in the notice of extension the required information and gives the patient **at least 45 calendar days** from receipt of notice to respond to Plan's request for more information

### 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 46 days later, claim is still pending medical necessity determination.

**Wyoming Insurance Code Section 26-15-124 states...**

Plan will reject or accept and pay a claim for benefits under a health insurance policy **within 45 days** of receiving the proofs of loss and supporting evidence.

If it is determined that Plan refuses to pay the full amount of a loss covered by the policy and the refusal is unreasonable or without cause, any court in which judgment is rendered for the claimant may also award a reasonable sum as an attorney's fee and interest at 10% per year.

### Request for Additional Information

**Issue:** Subsequent request for additional information.

**Example scenario:** Provider submits a claim for EYLEA HD reimbursement, but 46 days later, Plan indicates payment of claim is pending receipt of additional information.

**Wyoming Insurance Code Section 26-15-124 states...**

Plan will reject or accept and pay a claim for benefits under a health insurance policy **within 45 days** of receiving the proofs of loss and supporting evidence.

Requests for additional information by Plan should be made **within 45 days** of receipt of claim.

### 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.

**Group Health Insurance Standards Act Section 8 states...**

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.

### Provider Appeals

**Issue:** Provider appeals.

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

**Wyoming Insurance Code Section 26-40-201 states...**

**Internal appeal:**

**For standard appeals**, a claimant shall have **no less than 30 days** in which to file a request for the review provided in subsection (c) of this section, and such review shall be completed by the Plan and a decision delivered to the claimant **no later than 45 days** after receipt of a request for review.

**For expedited appeals**, a statement describing a procedure for having the claim denial reviewed by the Plan, including all applicable time limits, requirements, and a process for having an expedited review initiated as expeditiously as the claimant's medical condition or circumstances require, and in any event **within 72 hours**, where: (a) The time frame for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function.

**External appeal:**

**Filing deadline: Within 120 days** of receiving the written explanation required by subsection (e) of this section, a claimant may request an external review of the decision which is the subject of the explanation by filing a written request for such review.

**For a standard review, within 45 days** after the date of receipt of the request for external review, the assigned independent review organization (IRO) shall provide written notice to the claimant, the Plan, and the commissioner of its decision to uphold or reverse the decision of the Plan that the provision of or payment for medical services, procedures, or supplies requested by the claimant are not medically necessary.

**For an expedited review**, the commissioner shall adopt regulations establishing an expedited review by an external review organization as expeditiously as the claimant's medical condition or circumstances require, but in no event **more than 72 hours** after the date of receipt of the request for an expedited external review.

The Plan against whom a request for external review is filed shall pay the costs of the IRO's review.

**Complaints regarding these and other payer issues can be made to the Wyoming Department 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.

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05/2024 US.EHD.24.03.0060

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