State of Arkansas *As Engrossed: S3/16/17*
91st General Assembly **A Bill**
Regular Session, 2017 SENATE BILL 665

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO CLARIFY CERTAIN PROVISIONS OF THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO LIMIT RETROSPECTIVE DENIALS OF AUTHORIZED SERVICES; TO AUTHORIZE BENEFIT INQUIRIES; TO EXEMPT AUTHORIZED SERVICES FROM AUDIT RECOUPMENT; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO CLARIFY CERTAIN PROVISIONS OF THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 63, Subchapter 18, is amended to add an additional section to read as follows:

23-63-1808. Application — Audit recoupment.

The provisions of this subchapter that allow for audit recoupment from healthcare providers do not apply to a service that was authorized under § 23-99-1109, § 23-99-1113, or *§ 23-99-1116, except as provided for in § 23-99-1109(b).*

SECTION 2. Arkansas Code § 23-99-1103 is amended to read as follows:

23-99-1103. Definitions.

As used in this subchapter:

(1)(A) "Adverse determination" means a decision by a utilization review entity to deny, reduce, or terminate coverage for a healthcare service

furnished or proposed to be furnished to a subscriber on the basis that the healthcare service is not medically necessary or is experimental or investigational in nature.

(B) "Adverse determination" does not include a decision to deny, reduce, or terminate coverage for a healthcare service on any basis other than medical necessity or that the healthcare service is experimental or investigational in nature;

(2) "Authorization" means that a utilization review entity has:

(A) Reviewed the information provided concerning a healthcare service furnished or proposed to be furnished;

(B) Found that the requirements for medical necessity and appropriateness of care have been met; and

(C) Determined to pay for the healthcare service according to the provisions of the health benefit plan;

(3) "Clinical criteria" means any written policy, written screening procedures, drug formularies, lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and other criteria or rationale used by the utilization review entity to determine the medical necessity ~~and appropriateness~~ of a healthcare service;

(4)(A) "Emergency healthcare service" means a healthcare service provided in a fixed facility in the first few hours after an injury or after the onset of an acute medical or obstetric condition that manifests itself by one (1) or more symptoms of such severity, including severe pain, that in the absence of immediate medical care, the injury or medical or obstetric condition would reasonably be expected to result in:

~~(A)~~(i) Serious impairment of bodily function;

~~(B)~~(ii) Serious dysfunction of or damage to any bodily organ or part; or

~~(C)~~(iii) Death or threat of death.

(B) "Emergency healthcare service" includes t*he medically necessary surgical* treatment of a condition discovered in the course of a surgical procedure originally intended for another *purpose, so long as the subsequent surgical procedure is a covered benefit under the healthcare plan, and* whether or not the originally intended surgical procedure or the subsequent surgical procedure for the condition discovered during surgery is

subject to a prior authorization requirement;

(5) "Expedited prior authorization" means prior authorization and notice of that prior authorization for an urgent healthcare service to a subscriber or the subscriber's healthcare provider within one (1) business day after the utilization review entity receives all information needed to complete the review of the requested urgent healthcare service;

(6) "Fail first" means a protocol ~~by a healthcare insurer~~ requiring that a healthcare service preferred by a ~~healthcare insurer~~ utilization review entity shall fail to help a patient before the patient receives coverage for the healthcare service ordered by the patient's healthcare provider;

(7)(A) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered *by a healthcare insurer in this state~~;~~.*

(B) "Health benefit plan" does not include a plan that includes only dental benefits or eye and vision care benefits;

(8)(A) "Healthcare insurer" means an insurance company, health maintenance organization, self-insured health plan for employees of a governmental entity, and a hospital and medical service corporation.

(B) "Healthcare insurer" does not include workers' c*ompensation plans or Medicaid~~;~~.*

(C) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits;

(9) "Healthcare provider" means:

(A) ~~a~~ A doctor of medicine, a doctor of osteopathy, or another licensed healthcare professional acting within the professional's licensed scope of practice; or

(B) A healthcare facility licensed in the state where the facility is located to provide healthcare services;

(10)(A) "Healthcare service" means a healthcare procedure, treatment, or service~~:~~

~~(i) Provided~~ provided by a ~~facility licensed in this state or in the state where the facility is located; or~~

~~(ii) Provided by a doctor of medicine, a doctor of osteopathy, or by a healthcare professional within the scope of practice for which the healthcare professional is licensed in this state~~ healthcare

provider.

(B) "Healthcare service" includes the provision of pharmaceutical products or services or durable medical equipment;

(11) "Medicaid" means the state-federal medical assistance program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.;

(12)(A) "~~Medically~~ Medical necessity" or "medically necessary ~~healthcare service~~" means a healthcare service that a healthcare provider provides to a patient ~~in a manner~~ that is:

~~(A)~~(i) In accordance with generally accepted standards of medical practice;

~~(B)~~(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

~~(C)~~(iii) Not primarily for the economic benefit of ~~the~~ a health ~~plans and purchasers~~ plan or purchaser or for the convenience of the patient, treating physician, or other healthcare provider.

(B) "Medical necessity" includes the terms "medical appropriateness", "primary coverage criteria", and any other terminology used by a utilization review entity that refers to a determination that is based in whole or in part on clinical justification for a healthcare service;

~~(13) "Nonmedical approval" means a decision by a utilization review entity to approve coverage and payment for a healthcare service according to the provisions of the health benefit plan on any basis other than whether the healthcare service is medically necessary or is experimental or investigational in nature;~~

~~(14) "Nonmedical denial" means a decision by a utilization review entity to deny, reduce, or terminate coverage for a healthcare service on any basis other than whether the healthcare service is medically necessary or the healthcare service is experimental or investigational in nature;~~

~~(15) "Nonmedical review" means the process by which a utilization review entity decides to approve or deny coverage of or payment for a healthcare service before or after it is given on any basis other than whether the healthcare service is medically necessary or the healthcare service is experimental or investigational in nature;~~

(13) "Prescription pain medication" means any medication prescribed as treatment for pain;

~~(16)(A)~~(14)(A) "Prior authorization" means the process by which a utilization review entity determines the medical necessity ~~and medical appropriateness~~ of an otherwise covered healthcare service before the healthcare service is rendered, including without limitation preadmission review, pretreatment review, utilization review, ~~and~~ case management, fail first protocol, and step therapy.

(B) "Prior authorization" may include the requirement ~~by a health insurer or a utilization review entity~~ that a subscriber or healthcare provider notify the health insurer or utilization review entity of the subscriber's intent to receive a healthcare service before the healthcare service is provided;

~~(17)~~(15) "Self-insured health plan for employees of governmental entity" means a trust established under § 14-54-101 et seq. or § 25-20-104 to provide benefits such as accident and health benefits, death benefits, disability benefits, and disability income benefits;

~~(18)~~(16) "Step therapy" means a protocol ~~by a healthcare insurer~~ requiring that a subscriber shall not be allowed coverage of a prescription drug ordered by the subscriber's healthcare provider until other less expensive drugs have been tried;

~~(19)(A)~~(17)(A) "Subscriber" means an individual eligible to receive coverage of healthcare services by a healthcare insurer under a health benefit plan.

(B) "Subscriber" includes a subscriber's legally authorized representative;

(18) "Terminal illness" means an illness, a progressive disease, or an advanced disease state from which:

(A) There is no expectation of recovery; and

(B) Death as a result of the illness or disease is reasonably expected within six (6) months;

~~(20)~~(19) "Urgent healthcare service" means a healthcare service for a non-life-threatening condition that, in the opinion of a physician with knowledge of a subscriber's medical condition, requires prompt medical care in order to prevent:

(A) A serious threat to life, limb, or eyesight;

(B) Worsening impairment of a bodily function that threatens the body's ability to regain maximum function;

(C) Worsening dysfunction or damage of any bodily organ or part that threatens the body's ability to recover from the dysfunction or damage; or

(D) Severe pain that cannot be managed without prompt medical care; and

~~(21)(A)~~(20)(A) "Utilization review entity" means an individual or entity that performs prior authorization ~~or nonmedical review~~ for at least one (1) of the following:

(i) ~~An employer with employees in this state who are covered under a health benefit plan or health insurance policy;~~

~~(ii) An~~ A healthcare insurer ~~that writes health insurance policies~~;

~~(iii)~~(ii) A preferred provider organization or health maintenance organization; or

~~(iv)~~(iii) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a healthcare provider in this state under a policy, health benefit plan, or contract.

(B) A ~~health~~ healthcare insurer is a utilization review entity if it performs prior authorization.

(C) "Utilization review entity" does not include an insurer of automobile, homeowner, or casualty and commercial liability insurance or the insurer's employees, agents, or contractors.

SECTION 3. Arkansas Code § 23-99-1104 is amended to read as follows:

23-99-1104. Disclosure required.

(a)(1) A utilization review entity shall ~~post~~ disclose all of its prior authorization ~~and nonmedical review~~ requirements and restrictions, including any written clinical criteria, ~~on the public part of~~ in a publicly accessible manner on its website.

(2) The information described in subdivision (a)(1) of this section shall be explained in detail and in clear and ordinary terms.

(3)(A) Utilization review entities that have, by contract with vendors or third-party administrators, agreed to use licensed, proprietary, or copyrighted protected clinical criteria from the vendors or administrators, may satisfy the disclosure requirement under subdivision

(a)(1) of this section by making all relevant proprietary clinical criteria available to a healthcare provider that submits a prior authorization request to the utilization review *entity* through a secured link on the utilization review entity's website that is accessible to the healthcare provider from the public part of its website as long as any link or access restrictions to the *information do not cause any delay to the healthcare provider.*

(B) For out-of-network providers, a utilization review entity may meet the requirements of this subdivision (a)(3) by:

(i) Providing the healthcare provider with temporary electronic access in a timely manner to a secure site to review copyright-protected clinical criteria; or

(ii) Disclosing copyright-protected clinical criteria in a timely manner to a healthcare provider through other electronic or telephonic means.

(b) Before a utilization review entity implements a new or amended prior authorization ~~or nonmedical review~~ requirement or restriction as described in subdivision (a)(1) of this section, the utilization review entity shall update its website to reflect the new or amended requirement or restriction.

(c) Before implementing a new or amended prior authorization ~~or nonmedical review~~ requirement or restriction, a utilization review entity shall provide contracted healthcare providers written notice of the new or amended requirement or restriction at least sixty (60) days before implementation of the new or amended requirement or restriction.

(d)(1) A utilization review entity shall make statistics available regarding prior authorization approvals and denials ~~and nonmedical approvals and denials~~ on its website in a readily accessible format.

(2) The statistics made available by a utilization review entity under this subsection shall ~~include categories for~~ categorize approvals and denials by:

(A) Physician specialty;

(B) Medication or ~~a~~ diagnostic test or procedure;

(C) ~~Indication~~ Medical indication offered as justification for the prior authorization request; and

(D) Reason for denial.

SECTION 4. Arkansas Code § 23-99-1107(d)(1), concerning the prior authorization of an emergency healthcare service, is amended to read as follows:

(d)(1) The determination by a utilization review entity of medical necessity ~~or medical appropriateness~~ of an emergency healthcare service shall not be based on whether the emergency healthcare service was provided by a healthcare provider that is a member of the health benefit plan's provider network.

SECTION 5. Arkansas Code § 23-99-1108 is amended to read as follows:

23-99-1108. ~~Retrospective denial~~ Subscribers with terminal illness — Denial of prior authorization for covered prescription pain medication prohibited.

~~(a) A utilization review entity shall not revoke, limit, condition, or restrict an authorization for a period of forty-five (45) business days from the date the healthcare provider received the authorization~~ If a subscriber's covered prescription pain medication requires a prior authorization, then the prior authorization shall not be denied if the subscriber has a terminal illness.

~~(b) Any correspondence, contact, or other action by a utilization review entity that disclaims, denies, attempts to disclaim, or attempts to deny payment for healthcare services that have been authorized within the forty-five-day period under subsection (a) of this section is void.~~

SECTION 6. Arkansas Code § 23-99-1109 is amended to read as follows:

23-99-1109. ~~Waiver prohibited~~ Rescission of prior authorizations — Denial of payment for prior authorized services — Limitations.

(a) ~~The provisions of this subchapter shall not be waived by contract~~ A decision on a request for prior authorization by a utilization review entity shall include a determination as to whether or not the individual is covered by a health benefit plan and eligible to receive the requested service under the health benefit plan.

(b)(1) ~~Any contractual arrangements or actions taken in conflict with this subchapter or that purport to waive any requirements of this subchapter are void~~ A utilization review entity shall not rescind, limit, condition, or *restrict an authorization based upon medical necessity unless the utilization*

review entity notifies the healthcare provider at least three (3) business days before the scheduled date of the admission, service, procedure, or extension of stay.

(2) Notwithstanding subdivision (b)(1) of this section, a utilization review entity may rescind, limit, condition, or restrict an authorization if:

(A) The subscriber was not covered by the health benefit plan and was not eligible to receive the requested service under the health benefit plan on the date of the admission, service, procedure, or extension of stay; and

(B) The utilization review entity has provided to the healthcare provider a means to confirm whether or not the subscriber is covered by the health benefit plan and eligible to receive the requested service up to the date of admission, service, procedure, or extension of stay.

(c) A healthcare insurer shall pay a claim for a healthcare service for which prior authorization was received regardless of the terminology used by the utilization review entity or health benefit plan when reviewing the claim, unless:

(1) The authorized healthcare service was never performed;

(2) The submission of the claim for the healthcare service with respect to the subscriber was not timely under the terms of the applicable provider contract or policy;

(3) The subscriber had not exhausted contract or policy benefit limitations based on information available to the utilization review entity or healthcare insurer at the time of the authorization but subsequently exhausted contract or policy benefit limitations after the authorization was issued, in which case the utilization review entity or healthcare insurer shall include language in the notice of authorization to the subscriber and healthcare provider that the visits or services authorized might exceed the limits of the contract or policy and would accordingly not be covered under the contract or policy;

(4) There is specific information available for review by the *appropriate state or federal agency* that the subscriber or healthcare provider has engaged in material misrepresentation, fraud, or abuse regarding the claim for the authorized service; or

(5) The authorization was granted more than twelve (12) months before the authorized healthcare service is provided.

(d)(1)(A) A utilization review entity doing business in this state shall *strive to implement no later than July 1, 2018, a mechanism by which healthcare* providers may request prior authorizations through an automated electronic *system as an alternative to telephone-based prior authorization systems.*

(B) The State Insurance Department may promulgate a rule mandating the implementation of a mechanism described in this subsection and defining the services to which this subsection applies.

(2) A healthcare provider shall retain the ability to use either the automated electronic system or a telephone-based system.

(3) The automated electronic system shall be capable of handling benefit inquiries under § 23-99-1113.

(e) A service authorized and guaranteed for payment under this section for which the prior authorization is not rescinded or reversed under subsection (b) of this section is not subject to audit recoupment under § 23-*63-1801 et seq., except as provided for in subsection (b) of this section.*

SECTION 7. Arkansas Code § 23-99-1110 is amended to read as follows:

23-99-1110. ~~State physician required~~ Waiver prohibited.

(a) ~~A physician shall be licensed by the Arkansas State Medical Board before making recommendations or decisions regarding prior authorization or nonmedical review requests~~ The provisions of this subchapter shall not be waived by contract.

(b) Any contractual arrangements or actions taken in conflict with this subchapter or that purport to waive any requirements of this subchapter are void.

SECTION 8. Arkansas Code § 23-99-1111 is amended to read as follows:

23-99-1111. ~~Application~~ Requests for prior authorization — Qualified persons authorized to review and approve — Adverse determinations to be made only by Arkansas-licensed physicians.

(a) ~~This subchapter applies to:~~

~~(1) A healthcare insurer, whether or not the healthcare insurer is acting directly or indirectly through a private utilization review entity;~~

~~and~~

~~(2)(A) A self-insured health plan for employees of governmental entities.~~

~~(B) A self-insured plan for employees of governmental entities is not subject to § 23-99-1112(b)(4)(C) or the Arkansas State Medical Board, State Board of Health, or the State Insurance Department~~ The initial review of information submitted in support of a request for prior authorization may be conducted by a qualified person employed or contracted by a utilization review entity.

(b) ~~This subchapter applies to any healthcare service, whether or not the health benefit plan requires prior authorization or nonmedical review for the healthcare service~~ A request for prior authorization may be approved by a qualified person employed or contracted by a utilization review entity.

(c)(1) ~~A request by a healthcare provider for authorization or approval of a service regulated under this subchapter before it is given shall be subject to this subchapter~~ An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas issued by the Arkansas State Medical Board.

(2)(A) A utilization review entity shall provide a method by which a physician may request that a prior authorization request be reviewed by a *physician in another appropriate specialty or by a pharmacologist.*

(B) If a request is made under subdivision (c)(2)(A) of this section, the reviewing physician or pharmacologist is not required to meet the requirements of subdivision (c)(1) of this section.

SECTION 9. Arkansas Code § 23-99-1112 is amended to read as follows:

23-99-1112. ~~Form of notice~~ Application of subchapter.

~~(a)(1) Notice of an adverse determination or a nonmedical denial shall be provided to the healthcare provider that initiated the prior authorization or nonmedical review.~~

~~(2) Notice may be made by fax or hard copy letter sent by regular mail or verbally, as requested by the subscriber's healthcare provider.~~

~~(b) The written or verbal notice required under this section shall include:~~

~~(1)(A) The name, title, address, and telephone number of the healthcare professional responsible for making the adverse determination or nonmedical denial.~~

~~(B) For a physician, the notice shall identify the physician's board certification status or board eligibility.~~

~~(C) The notice under this section shall identify each state in which the healthcare professional is licensed and the license number issued to the professional by each state;~~

~~(2) The written clinical criteria, if any, and any internal rule, guideline, or protocol on which the healthcare insurer relied when making the adverse determination or nonmedical denial and how those provisions apply to the subscriber's specific medical circumstance;~~

~~(3) Information for the subscriber and the subscriber's healthcare provider that describes the procedure through which the subscriber or healthcare provider may request a copy of any report developed by personnel performing the review that led to the adverse determination or nonmedical denial; and~~

~~(4)(A) Information that explains to the subscriber and the subscriber's healthcare provider the right to appeal the adverse determination or nonmedical denial.~~

~~(B) The information required under subdivision (b)(4)(A) of this section shall include instructions concerning how to perfect an appeal and how the subscriber and the subscriber's healthcare provider may ensure that written materials supporting the appeal will be considered in the appeal process.~~

~~(C) The information required under subdivision (b)(4)(A) of this section shall include addresses and telephone numbers to be used by healthcare providers and subscribers to make complaints to the Arkansas State Medical Board, the State Board of Health, and the State Insurance Department.~~

~~(c)(1) When a healthcare service for the treatment or diagnosis of any medical condition is restricted or denied for use by nonmedical review, step therapy, or a fail first protocol in favor of a healthcare service preferred by the healthcare insurer, the subscriber's healthcare provider shall have access to a clear and convenient process to expeditiously request an override of that restriction or denial from the healthcare insurer.~~

~~(2) Upon request, the subscriber's healthcare provider shall be~~

~~provided contact information, including a phone number, for a person to initiate the request for an expeditious override of the restriction or denial.~~

~~(d) The appeal process described in subdivisions (b)(2)-(4) of this section shall not apply when a healthcare service is denied due to the fact that the healthcare service is not a covered service under the health benefit plan.~~

This subchapter applies to a healthcare insurer, whether or not the healthcare insurer is acting directly or indirectly through a private utilization review entity.

SECTION 10. Arkansas Code § 23-99-1113 is amended to read as follows:

23-99-1113. ~~Failure to comply with subchapter — Requested healthcare services deemed approved~~ Benefit inquiries authorized.

(a)(1) ~~If a healthcare insurer or self-insured health plan for employees of governmental entities fails to comply with this subchapter, the requested healthcare services shall be deemed authorized or approved~~ An in-network or out-of-network healthcare provider may submit a benefit inquiry to a healthcare insurer or utilization review entity for a healthcare service not yet provided to determine whether or not the healthcare service meets medical necessity and all other requirements for payment under a health benefit plan *if the healthcare service is provided to a specific subscriber.*

(2)(A) The State Insurance Department shall issue a rule on or before January 1, 2018, that defines which benefits are subject to the requirements of this section.

(B) Until a rule is promulgated under subdivision (a)(2)(A) of this section, all benefit inquiries shall be processed according to this section.

(b) If a healthcare insurer or utilization review entity lacks sufficient information to respond to a benefit inquiry, the healthcare insurer or utilization review entity shall notify the healthcare provider within two (2) business days of the additional information that is required to respond to the benefit inquiry.

(c)(1) A healthcare insurer, either directly or through a utilization review entity, shall respond to a benefit inquiry authorized in subsection (a) of this section within ten (10) business days of receipt of information

required to make a decision on the benefit inquiry.

(2) Responses to a benefit inquiry shall be provided in the same form and manner as responses to requests for prior authorization.

(d) Every healthcare insurer shall provide a convenient and accessible procedure for healthcare providers to submit benefit inquiries under this section.

(e) Sections 23-99-1109 — 23-99-1111 and 23-99-1114 — 23-99-1116 apply to the benefit inquiry process of any healthcare insurer or utilization review entity.

(f) A healthcare service approved under the benefit inquiry process authorized in this section is not subject to audit recoupment under § 23-63-*1801 et seq., except as provided for in § 23-99-1109(b).*

SECTION 11. Arkansas Code § 23-99-1114 is amended to read as follows:

23-99-1114. ~~Standardized form required~~ Limitations on step therapy.

~~(a) On and after January 1, 2014, to establish uniformity in the submission of prior authorization and nonmedical review forms, a healthcare insurer shall utilize only a single standardized prior authorization and nonmedical review form for obtaining approval in written or electronic form for prescription drug benefits.~~

~~(b) A healthcare insurer may make the form required under subsection (a) of this section accessible through multiple computer operating systems.~~

~~(c) The form required under subsection (a) of this section shall:~~

~~(1) Not exceed two (2) pages; and~~

~~(2) Be designed to be submitted electronically from a prescribing provider to a healthcare insurer.~~

~~(d) This section does not prohibit prior authorization or nonmedical review by verbal means without a form.~~

~~(e) If a healthcare insurer fails to use or accept the form developed under this section or fails to respond as soon as reasonably possible, but no later than one (1) business day for prior authorizations for urgent healthcare services, sixty (60) minutes for emergency healthcare services, or seventy-two (72) hours for all other services, after receipt of a completed prior authorization or nonmedical review request using the form developed under this section, the prior authorization or nonmedical review request is deemed authorized or approved.~~

~~(f)(1) On and after January 1, 2014, each healthcare insurer shall submit its prior authorization and nonmedical review form to the State Insurance Department to be kept on file.~~

~~(2) A copy of a subsequent replacement or modification of a healthcare insurer's prior authorization and nonmedical review form shall be filed with the department within fifteen (15) days before the form is used or before implementation of the replacement or modification.~~

(a) If a utilization review entity has required a healthcare provider to utilize step therapy for a specific prescription drug for a subscriber, the utilization review entity shall not require the healthcare provider to utilize step therapy a second time for that same prescription drug, even though the utilization review entity or healthcare insurer may change its prescribed drug formulary or change to a new or different pharmacy benefits *manager or utilization review entity.*

(b) In order to ensure compliance with this section, if a healthcare insurer or utilization review entity changes its pharmacy benefits manager, the healthcare insurer or utilization review entity shall:

(1) Provide the new pharmacy benefits manager with adequate historical claims data to identify all subscribers who have been required to utilize step therapy and the results of that step therapy; or

(2) Require that the pharmacy benefits manager provide a mechanism for a point-of-sale override of a step therapy edit based on information from the prescriber or the pharmacist that step therapy for the same drug has previously been utilized.

(c) Notwithstanding subsection (a) of this section, a utilization review entity may require the utilization of step therapy when the same drug is prescribed if:

(1) A new drug has been introduced to treat the patient's condition or an existing drug has been approved for treatment of the patient's condition since the step therapy was required; or

(2) The patient's medical or physical condition has changed substantially since the step therapy was required that makes the use of repeat step therapy appropriate.

(d) If a utilization review entity or healthcare insurer requires step therapy under subsection (c) of this section, the utilization review entity shall inform the prescriber of the clinical basis for the step therapy

requirement.

SECTION 12. Arkansas Code Title 23, Chapter 99, Subchapter 11, is amended to add additional sections to read as follows:

23-99-1115. Notice requirements — Process for appealing adverse determination and restriction or denial of healthcare service.

(a)(1) Notice of an adverse determination shall be provided to the healthcare provider that initiated the prior authorization.

(2) Notice may be made by electronic mail, fax, or hard copy letter sent by regular mail or verbally, as requested by the subscriber's healthcare provider.

(b) The written or verbal notice required under this section shall include:

(1) The following information:

(A) The name, title, address, and telephone number of the physician responsible for making the adverse determination;

(B) The reviewing physician's board certification status *or board eligibility; and*

(C) A list of states in which the reviewing physician is licensed and the license number issued to the reviewing physician by each state.

(2) The written clinical criteria, if any, and any internal rule, guideline, or protocol on which the utilization review entity relied when making the adverse determination and how those provisions apply to the subscriber's specific medical circumstance;

(3) Information for the subscriber and the subscriber's healthcare provider that describes the procedure through which the subscriber or healthcare provider may request a copy of any report developed by personnel performing the review that led to the adverse determination; and

(4)(A) Information that explains to the subscriber and the subscriber's healthcare provider the right to appeal the adverse determination.

(B) The information required under subdivision (b)(4)(A) of this section shall include:

(i) Instructions concerning how to perfect an appeal and how the subscriber and the subscriber's healthcare provider may ensure

that written materials supporting the appeal will be considered in the appeal process; and

(ii)(a) Addresses and telephone numbers to be used by healthcare providers and subscribers to make complaints to the Arkansas State Medical Board, the State Board of Health, and the State Insurance Department.

(b) Subdivision (b)(4)(B)(ii)(a) of this section does not apply to self-insured plans for employees of governmental entities.

(c)(1) When a healthcare service for the treatment or diagnosis of any medical condition is restricted or denied in favor of step therapy or a fail first protocol preferred by the utilization review entity, the subscriber's healthcare provider shall have access to a clear and convenient process to expeditiously request an override of that restriction or denial from the utilization review entity or healthcare insurer.

(2) Upon request, the subscriber's healthcare provider shall be provided contact information, including a phone number, for a person to initiate the request for an expeditious override of the restriction or denial.

(d) The appeal process described in subdivision (b)(4) of this section shall not apply when a healthcare service is denied because the healthcare service is within a category of healthcare services not covered by the health benefit plan.

23-99-1116. Failure to comply with subchapter — Requested healthcare services deemed approved.

(a) If a healthcare insurer or utilization review entity fails to comply with this subchapter, the requested healthcare services shall be deemed authorized or approved.

(b) A healthcare service that is authorized or approved under this section is not subject to audit recoupment under § 23-63-1801 et seq.

23-99-1117. Standardized form required for prescription drug benefits.

(a) On and after January 1, 2017, to establish uniformity in the submission of prior authorization forms for prescription drugs, a utilization review entity shall utilize only a single standardized prior authorization

form for obtaining approval in written or electronic form for prescription drug benefits.

(b) A utilization review entity may make the form required under subsection (a) of this section accessible through multiple computer operating systems.

(c) The form required under subsection (a) of this section shall:

(1) Not exceed two (2) pages; and

(2) Be designed to be submitted electronically from a prescribing provider to a utilization review entity.

(d) This section does not prohibit prior authorization by verbal means without a form.

(e) If a utilization review entity fails to use or accept the form developed under this section or fails to respond as soon as reasonably possible, but no later than seventy-two (72) hours, after receipt of a completed prior authorization request using the form developed under this section, the prior authorization request is deemed authorized or approved.

(f)(1) On and after January 1, 2017, each utilization review entity shall submit its prior authorization form to the State Insurance Department to be kept on file.

(2) A copy of a subsequent replacement or modification of a utilization review entity's prior authorization form shall be filed with the department within fifteen (15) days before the form is used or before *implementation of the replacement or modification.*

23-99-1118. Rules.

The State Insurance Department may promulgate rules for the implementation of this subchapter.

SECTION 13. EFFECTIVE DATE. This act is effective on and after August 1, 2017.

/s/Irvin