

Stricken language would be deleted from and underlined language would be added to present law.

1 State of Arkansas *As Engrossed: S3/16/17 S3/20/17*  
2 91st General Assembly **A Bill**  
3 Regular Session, 2017

SENATE BILL 665

4  
5 By: Senator Irvin  
6

7 **For An Act To Be Entitled**

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

14  
15  
16 **Subtitle**

17 *TO CLARIFY CERTAIN PROVISIONS OF THE*  
18 *PRIOR AUTHORIZATION TRANSPARENCY ACT; AND*  
19 *TO DECLARE AN EMERGENCY.*  
20  
21

22 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:  
23

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

26 23-63-1808. Application – Audit recoupment.

27 The provisions of this subchapter that allow for audit recoupment from  
28 healthcare providers do not apply to a service that was authorized under §  
29 23-99-1109, § 23-99-1113, or § 23-99-1116, except as provided for in § 23-99-  
30 1109(b).

31  
32 SECTION 2. Arkansas Code § 23-99-1103 is amended to read as follows:  
33 23-99-1103. Definitions.

34 As used in this subchapter:

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



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

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

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

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

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

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

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

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

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

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

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

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

1 subject to a prior authorization requirement;

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

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

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

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

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

20 (B) "Healthcare insurer" does not include workers'  
21 *compensation plans or Medicaid*.

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

24 (9) "Healthcare provider" means:

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

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

30 (10)(A) "Healthcare service" means a healthcare procedure,  
31 treatment, or service+

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

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

1 provider.

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

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

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

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

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

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

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

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

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

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

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

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

7           (B) “Prior authorization” may include the requirement ~~by a~~  
8 ~~health insurer or a utilization review entity~~ that a subscriber or healthcare  
9 provider notify the health insurer or utilization review entity of the  
10 subscriber’s intent to receive a healthcare service before the healthcare  
11 service is provided;

12           ~~(17)~~(15) “Self-insured health plan for employees of governmental  
13 entity” means a trust established under § 14-54-101 et seq. or § 25-20-104 to  
14 provide benefits such as accident and health benefits, death benefits,  
15 disability benefits, and disability income benefits;

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

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

23           (B) “Subscriber” includes a subscriber’s legally  
24 authorized representative;

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

27           (A) There is no expectation of recovery; and

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

30           ~~(20)~~(19) “Urgent healthcare service” means a healthcare service  
31 for a non-life-threatening condition that, in the opinion of a physician with  
32 knowledge of a subscriber’s medical condition, requires prompt medical care  
33 in order to prevent:

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

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

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

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

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

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

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

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

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

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

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

24  
 25 SECTION 3. Arkansas Code § 23-99-1104 is amended to read as follows:

26 23-99-1104. Disclosure required.

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

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

33 ~~(3)~~(4) Utilization review entities that have, by contract with  
 34 vendors or third-party administrators, agreed to use licensed, proprietary,  
 35 or copyrighted protected clinical criteria from the vendors or  
 36 administrators, may satisfy the disclosure requirement under subdivision

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

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

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

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

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

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

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

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

31 (A) Physician specialty;

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

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

35 (D) Reason for denial.

36

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

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

9  
10 SECTION 5. Arkansas Code § 23-99-1108 is amended to read as follows:

11 23-99-1108. ~~Retrospective denial~~ Subscribers with terminal illness -  
12 Denial of prior authorization for covered prescription pain medication  
13 prohibited.

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

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

24  
25 SECTION 6. Arkansas Code § 23-99-1109 is amended to read as follows:

26 23-99-1109. ~~Waiver prohibited~~ Rescission of prior authorizations -  
27 Denial of payment for prior authorized services - Limitations.

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

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



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

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

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

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

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

20 (1) The authorized healthcare service was never performed;

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

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

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

1           (5) The authorization was granted more than ninety (90) days  
 2 before the authorized healthcare service is provided.

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

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

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

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

15           (e) A service authorized and guaranteed for payment under this section  
 16 for which the prior authorization is not rescinded or reversed under  
 17 subsection (b) of this section is not subject to audit recoupment under § 23-  
 18 63-1801 et seq., except as provided for in subsection (b) of this section.

19  
 20           SECTION 7. Arkansas Code § 23-99-1110 is amended to read as follows:

21           23-99-1110. ~~State physician required Waiver prohibited.~~

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

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

29  
 30           SECTION 8. Arkansas Code § 23-99-1111 is amended to read as follows:

31           23-99-1111. ~~Application Requests for prior authorization – Qualified~~  
 32 persons authorized to review and approve – Adverse determinations to be made  
 33 only by Arkansas-licensed physicians.

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

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

1 and

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

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

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

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

20 ~~(2)(A) A utilization review entity shall provide a method by~~  
21 ~~which a physician may request that a prior authorization request be reviewed~~  
22 ~~by a physician in the same specialty as the physician making the request, by~~  
23 ~~a physician in another appropriate specialty, or by a pharmacologist.~~

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

27

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

29 23-99-1112. ~~Form of notice~~ Application of subchapter.

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

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

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

1 ~~include:~~

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

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

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

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

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

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

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

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

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

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

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

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

12  
13           SECTION 10. Arkansas Code § 23-99-1113 is amended to read as follows:

14           23-99-1113. ~~Failure to comply with subchapter~~ Requested healthcare  
15 ~~services deemed approved~~ Benefit inquiries authorized.

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

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

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

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

35           (c)(1) A healthcare insurer, either directly or through a utilization  
36 review entity, shall respond to a benefit inquiry authorized in subsection

1 (a) of this section within ten (10) business days of receipt of information  
2 required to make a decision on the benefit inquiry.

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

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

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

11 (f) A healthcare service approved under the benefit inquiry process  
12 authorized in this section is not subject to audit recoupment under § 23-63-  
13 1801 et seq., except as provided for in § 23-99-1109(b).

14  
15 SECTION 11. Arkansas Code § 23-99-1114 is amended to read as follows:  
16 23-99-1114. Standardized form required Limitations on step therapy.

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

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

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

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

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

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

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

1 ~~deemed authorized or approved.~~

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

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

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

16 (b) In order to ensure compliance with this section, if a healthcare  
17 insurer or utilization review entity changes its pharmacy benefits manager,  
18 the healthcare insurer or utilization review entity shall provide the new  
19 pharmacy benefits manager with adequate historical claims data to identify  
20 all subscribers who have been required to utilize step therapy and the  
21 results of that step therapy.

22 (c) Notwithstanding subsection (a) of this section, a utilization  
23 review entity may require the utilization of step therapy if:

24 (1) A new drug has been introduced to treat the patient's  
25 condition or an existing therapy is considered clinically appropriate for  
26 treatment of the patient's condition; or

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

30  
31 SECTION 12. Arkansas Code Title 23, Chapter 99, Subchapter 11, is  
32 amended to add additional sections to read as follows:

33 23-99-1115. Notice requirements – Process for appealing adverse  
34 determination and restriction or denial of healthcare service.

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

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

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

6           (1) The following information:

7           (A) The name, title, and telephone number of the physician  
8 responsible for making the adverse determination, and, in the event that the  
9 physician responsible for making the adverse decision is not available, a  
10 telephone number where a peer-to-peer contact with another physician  
11 regarding the adverse determination can be made;

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

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

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

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

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

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

30           (i) Instructions concerning how to perfect an appeal  
31 and how the subscriber and the subscriber's healthcare provider may ensure  
32 that written materials supporting the appeal will be considered in the appeal  
33 process; and

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



1 Department.

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

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

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

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

19  
20 23-99-1116. Failure to comply with subchapter – Requested healthcare  
21 services deemed approved.

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

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

27  
28 23-99-1117. Standardized form required for prescription drug benefits.

29 (a) On and after January 1, 2017, to establish uniformity in the  
30 submission of prior authorization forms for prescription drugs, a utilization  
31 review entity shall utilize only a single standardized prior authorization  
32 form for obtaining approval in written or electronic form for prescription  
33 drug benefits.

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

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

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

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

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

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

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

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

19  
20 23-99-1118. Rules.

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

23  
24 SECTION 13. EMERGENCY CLAUSE. It is found and determined by the  
25 General Assembly of the State of Arkansas that healthcare insurers and  
26 utilization review entities are denying medically necessary healthcare  
27 services; that by changing the prior authorization procedure to prevent the  
28 denial of medically necessary healthcare services by healthcare insurers and  
29 utilization review entities, Arkansas consumers will receive proper  
30 healthcare; and that unless this act becomes effective on August 1, 2017,  
31 utilization review entities and healthcare insurers will not know the  
32 specific effective date by which changes in computer systems must be made so  
33 that patients will not face the likelihood of going without potentially life-  
34 saving healthcare treatment or their providers will not be forced to provide  
35 treatment without compensation. Therefore, an emergency is declared to  
36 exist, and this act being necessary for the preservation of the public peace,

1 health, and safety shall become effective on August 1, 2017.

2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36

/s/ Irvin