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2 91st General Assembly

A Bill

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SENATE BILL 665

4

5 By: Senator Irvin

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For An Act To Be Entitled

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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

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SERVICES FROM AUDIT RECOUPMENT; TO DECLARE AN

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EMERGENCY; AND FOR OTHER PURPOSES.

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Subtitle

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TO CLARIFY CERTAIN PROVISIONS OF THE

18

PRIOR AUTHORIZATION TRANSPARENCY ACT; AND

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TO DECLARE AN EMERGENCY.

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

15 ~~(iv)(iii)~~ (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)(A)~~ 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

/s/Irvin

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APPROVED: 04/03/2017

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