DRAFT
RULE 115
PRIOR AUTHORIZATION TRANSPARENCY ACT

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Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. §§ 23-99-1118, 23-99-1113(a)(2)(A), 23-61-108(a)(1), and 23-61-108(b)(1), ~~and 23-99-414.~~

Section 2. Purpose

The purpose of this Rule is to implement Act 815 of 2017 of the 91st Arkansas General Assembly, ~~Act 1106 of 2015 of the Arkansas 90th General Assembly,~~ "An Act To Clarify Certain Provisions Of The Prior Authorization Transparency Act~~To Establish Prior Authorization Transparency~~" (hereafter, the "Prior Authorization Transparency Act").

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Section 3. Applicability and Scope

This Rule applies to all health benefit plans as defined in Ark. Code Ann. § 23-99-1103(7).

Section 4. Definitions

Unless otherwise separately defined in this rule, ~~and consistent with state law,~~ the terms or phrases as used in this rule shall follow the definitions of such terms or phrases as defined in Ark. Code Ann. § 23-99-1103, **or as later amended in the Prior Authorization Transparency Act subchapter.**

Section 5. Publication of Prior Authorization and Nonmedical Review Criteria & Statistics

A utilization review entity shall follow the disclosure requirements under Ark. Code Ann. § 23-99-1104.

A. Updating Statistical Reporting Data Required Under Ark. Code Ann. § 23-99-1104.

For the statistical reporting data required under Ark. Code Ann. § 23-99-1104(d), a utilization review entity shall update the required statistics in the format and manner as required by Ark. Code Ann. § 23-99-1104(d) once each quarter of each year from the effective date of this Rule.

B. Effective Date For Reporting, Retention of Statistical Information & Application of Statistics and Clinical Criteria.

1. A utilization review entity is required to disclose the statistical information required under Ark. Code Ann. § 23-99-1104(d) for statistics from health benefit plans occurring on and after July 22, 2015.~~on and after the effective date of the Prior Authorization Transparency Act, which is July 22, 2015, and is not required to disclose statistical information from the time prior to the effective date of that Act.~~

2. A utilization review entity shall disclose and maintain the statistical information as required under Ark. Code Ann. § 23-99-1104(d) for at least a three (3) year rolling time period.

3. A utilization review entity is required to disclose statistical reporting data under Ark. Code Ann. § 23-99-1104(d) for Arkansas resident insureds in the individual market or Arkansas resident enrollees or certificate holders in health benefit plans as defined under Ark. Code Ann. § 23-99-1103(7).

4. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(A) related to the disclosure of prior authorization data, the term, "physician specialty" refers to the medical specialty of the treating physician who has submitted the prior authorization request and not to the specialty of the medical reviewer of the utilization review entity. A utilization review entity shall disclose the physician specialty data to the extent that the utilization review entity has received physician specialty information at the time the prior authorization request is submitted

~~5. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(a)(1) related to the disclosure by a utilization review entity of non-medical review requirements and restrictions, the term "non-medical review," as defined in Ark. Code Ann. § 23-99-1103(15), refers to the deadlines, filing procedures, or other administrative requirements of the utilization review entity for a provider to obtain or qualify for a prior authorization.~~

5.6. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(C), related to the disclosure of prior authorization data, the term, "indication offered," means the medical indication, i.e., relevant diagnosis, given by the healthcare provider for the medication, test, or procedure.

67. ~~Publication of "Proprietary" Medical Clinical Criteria. Pursuant to Ark. Code Ann. § 23-99-1104(a)(1), a utilization review entity shall post all of its prior authorization and nonmedical review requirements and restrictions, including any written clinical criteria, on the public part of its website. However, for insurers or utilization review entities, which have, by contract with vendors or third-party administrators, agreed to use licensed, proprietary or copyright protected clinical criteria~~

~~from such vendors or administrators, a utilization review entity may, as an alternative means of compliance, make all relevant proprietary clinical criteria available to any medical providers submitting a prior authorization request to the utilization review entity, both for in-network and out of network providers, via a link accessible to the provider from the public part of its website as long as any link or access restrictions to such information causes no delay to the provider.~~

~~8. Deemer Provision. Pursuant to Ark. Code Ann. § 23-99-1113, if a utilization review entity fails to comply with the provisions of the Prior Authorization Transparency Act, the requested healthcare services shall be deemed authorized or approved. This provision however only deems approved the healthcare services which are the subject of the prior authorizations or nonmedical review which failed to follow the requirements of the Act and does not deem approved all denials which follow the provisions of this Act.~~

Section 6. Deemer Provisions

A. Pursuant to Ark. Code Ann. § 23-99-1116(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. Pursuant to Ark. Code Ann. § 23-99-1116(b), a healthcare service that is authorized or approved under this section is not subject to audit recoupment under Ark. Code Ann. § 23-63-1801 et seq.

Section ~~7~~6. Persons Conducting Reviews

A utilization review entity shall follow the requirements under Ark. Code Ann. § 23-99-1111 related to the required qualifications for persons conducting prior authorization reviews. ~~A utilization review entity's initial or first line review of a prior authorization request may be conducted by a person employed or contracted by the utilization review entity, who is not a person licensed in Arkansas as a physician. This person may also collect from the provider any other required additional medical or administrative information needed to process or review the request. However, any adverse determination, as defined in Ark. Code Ann. § 23-99-1103(1), of a prior authorization request, must be made by a physician licensed in Arkansas pursuant to the qualifications stated in Ark. Code Ann. § 23-99-1110 and § 23-86-123.~~

Section ~~8~~7. Retrospective Denials on Prior Authorizations

A utilization review entity shall follow the provisions in Ark. Code Ann. § 23-99-1109 related to permissible recissions of prior authorizations. ~~Pursuant to Ark. Code Ann. § 23-99-1108, 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.~~

Section ~~9~~8. Accelerated Prior Authorizations

Nothing in the "Prior Authorization Transparency Act" is intended to prohibit or restrict a utilization review entity from approving a prior authorization request from a healthcare provider in a more expedited time period than the minimums set out in the provisions of the Act or this Rule.

~~Section 10. Benefit Inquiries Subject To Prior Authorization Requirements.~~

~~Pursuant to Ark. Code Ann. § 23-99-1113(a)(2)(A), the following benefit inquiries are subject to the requirements in Ark. Code Ann. § 23-99-1113:~~

~~Any benefit inquiry related to medical necessity or appropriateness is a benefit inquiry required to follow prior authorization requirements, regardless of allowed charge amount;~~

~~Any hospital in-patient or out-patient service or ambulatory surgical center service, regardless of medical necessity, in which the allowable charge for the service is $1,000 or more;~~

~~Any other medical provider service, including any diagnostic service, regardless of medical necessity, in which the allowable charge for the service is $500 or more.~~

Section 10. Benefit Inquiries Subject To Prior Authorization Requirements.

(a) Pursuant to Ark. Code Ann. § 23-99-1113(a)(2)(A), the following benefit inquiries are subject to the requirements of~~in~~ Ark. Code Ann. § 23-99-1113:

(1) Any benefit inquiry related to medical necessity or appropriateness is a benefit inquiry required to follow prior authorization requirements, regardless of allowed charge amount;

(2~~1~~) Any benefit inquiry for hospital in-patient or out-patient service or ambulatory surgical center service for a specific subscriber to determine if the service meets any medical necessity and other requirements for payment, regardless of medical necessity, in which the Medicare allowable charge for the service is $1,500.00 or more;

(3~~2~~) Any benefit inquiry for other medical provider service, including any diagnostic service, for a specific subscriber to determine if the service meets any medical necessity and other requirements for payment regardless of medical necessity, including any benefit inquiry for a covered prescription drug, in which the Medicare allowable charge for the service or drug is $1,000.00 or more.

(4~~3~~) For purposes of this section, in the event there is no Medicare allowable amount established under Medicare for a service or a prescription drug, the service or prescription drug shall be according to usual and customary billed charges.

Section 11~~9~~. Effective Date.

The effective date of this Rule is January 1, 2018~~7~~. .

ALLEN W. KERR
INSURANCE COMMISSIONER

DATE

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Section 1. Authority

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Section 2. Purpose

The purpose of this Rule is to implement Act 815 of 2017 of the 91st Arkansas General Assembly, "An Act To Clarify Certain Provisions Of The Prior Authorization Transparency Act(hereafter, the "Prior Authorization Transparency Act").

Section 3. Applicability and Scope

This Rule applies to all health benefit plans as defined in Ark. Code Ann. § 23-99-1103(7).

Section 4. Definitions

Unless otherwise separately defined in this rule, the terms or phrases as used in this rule shall follow the definitions of such terms or phrases as defined in Ark. Code Ann. § 23-99-1103, **or as later amended in the Prior Authorization Transparency Act subchapter.**

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3. A utilization review entity is required to disclose statistical reporting data under Ark. Code Ann. § 23-99-1104(d) for Arkansas resident insureds in the individual market or Arkansas resident enrollees or certificate holders in health benefit plans as defined under Ark. Code Ann. § 23-99-1103(7).

4. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(A) related to the disclosure of prior authorization data, the term, "physician specialty" refers to the medical specialty of the treating physician who has submitted the prior authorization request and not to the specialty of the medical reviewer of the utilization review entity. A utilization review entity shall disclose the physician specialty data to the extent that the utilization review entity has received physician specialty information at the time the prior authorization request is submitted

5. For purposes of interpretation of Ark. Code Ann. § 23-99-1104(d)(2)(C), related to the disclosure of prior authorization data, the term, "indication offered," means the medical indication, i.e., relevant diagnosis, given by the healthcare provider for the medication, test, or procedure.

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A. Pursuant to Ark. Code Ann. § 23-99-1116(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.

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(2) Any benefit inquiry for hospital in-patient or out-patient service or ambulatory surgical center service for a specific subscriber to determine if the service meets any medical necessity and other requirements for payment, regardless of medical necessity, in which the Medicare allowable charge for the service is $1,500.00 or more;

(3) Any benefit inquiry for other medical provider service, including any diagnostic service, for a specific subscriber to determine if the service meets any medical necessity and other requirements for payment regardless of medical necessity, including any benefit inquiry for a covered prescription drug, in which the Medicare allowable charge for the service or drug is $1,000.00 or more.

(4) For purposes of this section, in the event there is no Medicare allowable amount established under Medicare for a service or a prescription drug, the service or prescription drug shall be according to usual and customary billed charges.

Section 11. Effective Date.

The effective date of this Rule is January 18, 2018.

ALLEN W. KERR
INSURANCE COMMISSIONER

DATE