State of Arkansas
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As Engrossed: S3/15/11

A Bill

SENATE BILL 839

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO PROTECT PATIENTS BY ENSURING THAT PRIOR AUTHORIZATION PROCEDURES DO NOT INTRUDE ON THE PHYSICIAN-PATIENT RELATIONSHIP OR PUT COST SAVINGS AHEAD OF OPTIMAL PATIENT CARE; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO PROTECT PATIENTS BY ENSURING THAT PRIOR AUTHORIZATION PROCEDURES DO NOT INTRUDE ON THE PHYSICIAN-PATIENT RELATIONSHIP OR PUT COST SAVINGS AHEAD OF OPTIMAL PATIENT CARE.

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

SECTION 1. Arkansas Code Title 23, Chapter 99, Subchapter 4 is amended to add an additional section to read as follows:

20-99-418. Prior authorization.

(b) As used in this section:

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

(2) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in the state;

(3)(A) "Healthcare insurer" means Medicaid, an insurance

1 *company, a health maintenance organization, a hospital and medical service*
2 *corporation, and a self-insured health plan for employees of a governmental*
3 *entity.*
4 *(B) "Healthcare insurer" does not include workers'*
5 *compensation plans;*
6 *(4) "Healthcare provider" means a doctor of medicine, a doctor*
7 *of osteopathy, or another health care professional acting within the scope of*
8 *practice for which he or she is licensed in Arkansas;*
9 *(5) "Healthcare service" means a health care procedure,*
10 *treatment, service, or product, including without limitation prescription*
11 *drugs and durable medical equipment ordered by a health care provider;*
12 *(6) "Medicaid" means the state-federal medical assistance*
13 *program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396*
14 *et seq;*
15 *(7) "Prior authorization" means the process by which a*
16 *healthcare insurer or a healthcare insurer's contracted private review agent*
17 *determines the medical necessity or medical appropriateness, or both of*
18 *otherwise covered healthcare services before the rendering of the healthcare*
19 *services including without limitation:*
20 *(A) Preadmission review;*
21 *(B) Pretreatment review;*
22 *(C) Utilization review;*
23 *(D) Case management; and*
24 *(E) Any requirement that a patient or healthcare provider*
25 *notify the healthcare insurer or a utilization review agent before providing*
26 *a healthcare service.*
27 *(8)(A) "Private review agent" means a nonhospital-affiliated*
28 *person or entity performing utilization review on behalf of:*
29 *(i) An employer of employees in the State of*
30 *Arkansas; or*
31 *(ii) A third party that provides or administers*
32 *hospital and medical benefits to citizens of this state, including:*
33 *(a) A health maintenance organization issued a*
34 *certificate of authority under and by virtue of the laws of the State of*
35 *Arkansas; and*
36 *(b) A health insurer, nonprofit health service*

1 *plan, health insurance service organization, or preferred provider*
2 *organization or other entity offering health insurance policies, contracts,*
3 *or benefits in this state.*
4 *(B) "Private review agent" includes a healthcare insurer*
5 *if the healthcare insurer performs prior authorization determinations.*
6 *(C) "Private review agent" does not include automobile,*
7 *homeowner, or casualty and commercial liability insurers or their employees,*
8 *agents, or contractors;*
9 *(9) "Step therapy" means a protocol by a healthcare insurer*
10 *requiring that a patient not be allowed coverage of a prescription drug*
11 *ordered by the patient's healthcare provider until other less expensive drugs*
12 *have been tried;*
13 *(b) The purpose of this section is to ensure that prior authorization*
14 *determination protocols safeguard a patient's best interests.*
15 *(c)(1) An adverse prior authorization determination made by a*
16 *utilization review agent shall be based on the medical necessity or*
17 *appropriateness of the health care services and shall be based on written*
18 *clinical criteria.*
19 *(2) An adverse prior authorization determination shall be made*
20 *by a qualified health care professional licensed in Arkansas.*
21 *(d) This section applies to a healthcare insurer whether or not the*
22 *healthcare insurer is acting directly or through a private review agent.*
23 *(e) If the patient or the patient's healthcare provider, or both*
24 *receive verbal notification of the adverse prior authorization determination,*
25 *the qualified healthcare professional who makes an adverse prior*
26 *authorization determination shall provide the information required for the*
27 *written notice under subdivision (f)(1) of this section.*
28 *(f) Written notice of an adverse prior authorization determination*
29 *shall be provided to the patient and the patient's healthcare provider*
30 *requesting the prior authorization.*
31 *(g) The written notice required under subsection (e) of this section*
32 *shall include:*
33 *(1)(A) The name, title, address, and telephone number of*
34 *healthcare professional responsible for making the adverse determination.*
35 *(B) For a physician, the notice shall identify the*
36 *physician's board certification status or board eligibility.*

1 *(C) The notice under this subsection shall identify each*
2 *state in which the health care professional is licensed and the license*
3 *number issued to the professional by each state;*
4 *(2) The written clinical criteria, and any internal rule,*
5 *guideline, or protocol on which the health care insurer relied when making*
6 *the adverse prior authorization determination and how those provisions apply*
7 *to the patient's specific medical circumstance;*
8 *(3) Information for the patient and the patient's healthcare*
9 *provider through which the patient or healthcare provider may request a copy*
10 *of any report developed by personnel performing the utilization review that*
11 *led to the adverse prior authorization determination; and*
12 *(4)(A) Information explaining to the patient and the patient's*
13 *healthcare provider of the right to appeal the adverse prior authorization*
14 *determination.*
15 *(B) The information required under subdivisions (f)(4)(A)*
16 *of this section shall include instructions concerning how an appeal may be*
17 *perfected and how the patient and the patient's healthcare provide may ensure*
18 *that written materials supporting the appeal will be considered in the appeal*
19 *process.*
20 *(h)(1) When a healthcare service for the treatment or diagnosis of any*
21 *medical condition is restricted or denied for use by prior authorization or*
22 *step therapy or a fail first protocol in favor of a healthcare service*
23 *preferred by the healthcare insurer, the patient's healthcare provider shall*
24 *have access to a clear and convenient process to expeditiously request an*
25 *override of that restriction or denial from the healthcare insurer.*
26 *(2) An override requested under subdivision (g)(1) of this*
27 *section shall be expeditiously granted under the following circumstances:*
28 *(A) The healthcare provider can demonstrate, based on*
29 *sound clinical evidence, that the preferred healthcare service required under*
30 *the prior authorization or step therapy or fail first protocol has been*
31 *ineffective in the treatment of the patient's disease or medical condition;*
32 *or*
33 *(B) Based on sound clinical evidence or medical and*
34 *scientific evidence:*
35 *(i) The health care provider can demonstrate that*
36 *the preferred healthcare service required under the prior authorization or*

1 *step therapy or fail first protocol is expected or likely to be ineffective*
2 *based on the known relevant physical or mental characteristics of the patient*
3 *and known characteristics of the preferred healthcare service required by the*
4 *healthcare insurer; or*
5 *(ii) The health care provider can demonstrate that*
6 *the preferred healthcare service required under the prior authorization or*
7 *step therapy or fail first protocol will be clinically ineffective because it*
8 *will cause or will likely cause an adverse reaction in or other physical harm*
9 *to the patient.*
10 *(3) The duration of any step therapy or fail first protocol*
11 *shall not be longer than a period of fourteen (14) days past the day on which*
12 *the treatment is deemed clinically ineffective by the patient's healthcare*
13 *provider under subdivision (g)(2) of this section.*
14 *(i) Requested healthcare services shall be deemed preauthorized if a*
15 *healthcare insurer fails to comply with this section.*
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17 /s/Irvin
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