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

State of Arkansas
90th General Assembly
Regular Session, 2015

A Bill

SENATE BILL 318

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO ESTABLISH THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO ENSURE TRANSPARENCY IN USE OF PRIOR AUTHORIZATIONS FOR MEDICAL TREATMENT; AND FOR OTHER PURPOSES.

Subtitle

TO ESTABLISH THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO ENSURE TRANSPARENCY IN USE OF PRIOR AUTHORIZATIONS FOR MEDICAL TREATMENT.

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

SECTION 1. Arkansas Code Title 23, Chapter 66, is amended to add an additional subchapter to read as follows:

Subchapter 8 — Prior Authorization Transparency Act

23-66-801. Title.

This subchapter shall be known and may be cited as the "Prior Authorization Transparency Act".

23-66-802. Legislative findings and intent.

(a) The General Assembly finds that:

(1) A physician-patient relationship is paramount and should not be subject to third-party intrusion; and

(2) Prior authorizations can place attempted cost savings ahead

of optimal patient care.

(b) The General Assembly intends for this subchapter to:

(1) Ensure that prior authorizations do not hinder patient care or intrude on the practice of medicine; and

(2) Guarantee that prior authorizations include the use of written clinical criteria and reviews by appropriate physicians to secure a fair authorization review process for patients.

23-66-803. Definitions.

As used in this subchapter:

(1)(A) "Adverse determination" means a decision by a utilization review entity to deny, reduce, or terminate coverage for a healthcare service furnished or proposed to be furnished to a subscriber on the basis that the healthcare service is not medically necessary or is experimental or investigational in nature.

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

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

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

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

(C) Determined to pay for the healthcare service;

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

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

(A) Serious impairment of bodily function;

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

(C) Death or threat of death;

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

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

(i) Provided by a facility licensed in this state; or

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

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

(7) "Medically necessary healthcare service" means a healthcare service that a physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

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

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

(C) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider;

(8)(A) "Prior authorization" means the process by which a utilization review entity determines the medical necessity and medical appropriateness of a covered healthcare service before the healthcare service is rendered, including without limitation preadmission review, pretreatment review, utilization, and case management.

(B) "Prior authorization" may include the requirement by a health insurer or a utilization review entity that a subscriber or healthcare

provider notify the health insurer or utilization review entity of the subscriber's intent to receive a healthcare service before the healthcare service is provided;

(9)(A) "Subscriber" means an individual eligible to receive healthcare benefits by a health insurer pursuant to a health plan or other health insurance coverage.

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

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

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

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

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

(iv) Severe pain that cannot be managed without prompt medical care.

(B) The rendering of an urgent healthcare service requires expedited prior authorization only, as provided under § 23-66-806; and

(11)(A) "Utilization review entity" means an individual or entity that performs prior authorization for one (1) or more of the following:

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

(ii) An insurer that writes health insurance policies;

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

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

(B) A health insurer is a utilization review entity if it

performs prior authorization.

23-66-804. Disclosure required.

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

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

(b) Before a utilization review entity implements a new or amended prior authorization requirement or restriction as described in subdivision (a)(1) of this section, the utilization review entity shall ensure that the new or amended prior authorization requirement or restriction is not implemented unless the utilization review entity's website has been updated to reflect the new or amended prior authorization requirement or restriction.

(c) If a utilization review entity intends either to implement a new prior authorization requirement or restriction or to amend an existing prior authorization requirement or restriction, the utilization review entity shall provide contracted healthcare providers written notice of the new or amended prior authorization requirement or restriction no less than sixty (60) days before the prior authorization requirement or restriction is implemented.

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

(2) The utilization review entity shall include categories for:

(A) Physician specialty;

(B) Medication or a diagnostic test or procedure;

(C) Indication offered; and

(D) Reason for denial.

23-66-805. Prior authorization — Nonurgent healthcare service.

(a) If a utilization review entity requires prior authorization of a nonurgent healthcare service, the utilization review entity shall make a prior authorization or adverse determination and notify the subscriber and the subscriber's nonurgent healthcare provider of the prior authorization or adverse determination within two (2) business days of obtaining all necessary information to make the prior authorization or adverse determination.

(b) For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

23-66-806. Prior authorization - Urgent healthcare service.

A utilization review entity shall render an expedited prior authorization or an adverse determination concerning an urgent healthcare service and notify the subscriber and the subscriber's healthcare provider of that expedited prior authorization or adverse determination not later than one (1) business day after receiving all information needed to complete the review of the requested urgent healthcare service.

23-66-807. Prior authorization — Emergency healthcare service.

(a) A utilization review entity shall not require prior authorization for prehospital transportation or for provision of an emergency healthcare service.

(b)(1) A utilization review entity shall allow a subscriber and the subscriber's healthcare provider a minimum of twenty-four (24) hours following an emergency admission or provision of an emergency healthcare service for the subscriber or healthcare provider to notify the utilization review entity of the admission or provision of an emergency healthcare service.

(2) If the admission or emergency healthcare service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the emergency healthcare service.

(c)(1) A utilization review entity shall cover emergency healthcare services necessary to evaluate and assess the health condition of a subscriber to stabilize a subscriber.

(2) If a healthcare provider certifies in writing to a utilization review entity within seventy-two (72) hours of a subscriber's admission that the subscriber's condition required an emergency healthcare service, that certification will create a presumption that the emergency healthcare service was medically necessary, and such presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency healthcare service was not medically

necessary.

(d)(1) The determination by a utilization review entity of medical necessity or medical appropriateness of an emergency healthcare service shall not be based on whether the emergency healthcare service was provided by a participating or a nonparticipating healthcare provider.

(2) Restrictions on coverage for an emergency healthcare service provided by a nonparticipating healthcare provider shall not be greater than restrictions that apply on coverage for an emergency healthcare service provided by a participating healthcare provider.

(e)(1) If a subscriber receives an emergency healthcare service that requires an immediate post-evaluation or post-stabilization healthcare service, a utilization review entity shall make an authorization within sixty (60) minutes of receiving a request.

(2) If the authorization is not made within sixty (60) minutes, the emergency healthcare service shall be approved.

23-66-808. Retrospective denial.

(a) A utilization review entity shall not revoke, limit, condition, or restrict a prior authorization for a period of forty-five (45) business days from the date the healthcare provider received the prior authorization.

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

23-66-809. Waiver prohibited.

(a) The provisions of this subchapter shall not be waived by contract.

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