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).

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.

"Benefit Inquiry" means an inquiry by an Arkansas licensed healthcare provider to a ~~healthcare insurer~~ utilization review entity related to medical necessity, coverage or payment for prospective

healthcare services, including prescription drugs, for an enrolled member of a healthcare plan of the applicable healthcare insurer for services or prescription drugs which are not subject to prior authorization requirements of the utilization review entity.

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.

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(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.

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. 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.

Section 8. Retrospective Denials on Prior Authorizations

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

Section 9. 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.

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

Any utilization review entity responding to a benefit inquiry in which the healthcare provider's billed charge for such services exceeds $1,500.00 shall comply with the Prior Authorization Transparency Act. No utilization review entity shall be required to provide a healthcare provider with a response under the Act if a healthcare plan or policy is not in-force at the time of such inquiry, or in the event that the member is not covered or insured under such plan at the time of such inquiry. A h utilization review entity may require the healthcare provider to provide information in the inquiry describing the member or healthcare plan identification to expedite the inquiry.

Section 11. Effective Date.

The effective date of this Rule is February 19, 2018.

ALLEN W. KERR
INSURANCE COMMISSIONER

1/19/2018

DATE