Understanding Reimbursement Issues in Arkansas

A Guide for Health Care Providers and Practice Administration

Arkansas

Example EYLEA HD® (aflibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization

Issue: Plan delays prior authorization.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a request for prior authorization. Plan has not made a decision.

Arkansas Insurance Code Section 23-99-1105 states...

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

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

If a Plan fails to comply with this subchapter, the requested health care services shall be deemed authorized or approved.

Arkansas Insurance Code Section 23-79-2104 states...

- (c) (1) The Plan or utilization review organization shall grant or deny a request for a step therapy protocol exception **within 72 hours** of receiving the request. (2) In cases in which exigent circumstances exist, the Plan or utilization review organization shall grant or deny the request **within 24 hours** of receiving the request.
- (d) (1) A patient covered by a Plan may appeal the denial of a request for a step therapy protocol exception. (2) The Plan shall grant or deny the appeal within 72 hours of receiving the appeal. (3) In cases in which exigent circumstances exist, the Plan shall grant or deny the appeal within 24 hours of receiving the appeal.
- (e) If a response by a Plan or utilization review organization is not received within the time allotted under this section, the request for a step therapy protocol exception or the appeal of a denial of such a request shall be deemed granted.

Arkansas Insurance Code Section 23-99-1103 states...

"Gold card program" means the process described in sections 23-99-1120 — 23-99-1126 under which a health care provider may qualify for an exemption from a Plan's or pharmacy benefits manager's prior authorization requirements.

Arkansas Insurance Code § 23-99-1109 states...

A Plan shall pay a claim for a health care service under the medical benefit of a health benefit plan in the absence of a prior authorization if: (A) At the time the health care service was provided, the patient had been covered by a health benefit plan for 60 days or less; and (B) The health care service is part of a course of treatment initiated before the patient is covered by the Plan.

Arkansas Insurance Code Section 23-99-1112 states...

This subchapter applies to a Plan, whether or not the Plan is acting directly or indirectly through a private utilization review entity or located in this state.



Example EYLEA HD Claim Issues and Applicable State Provisions (cont'd)

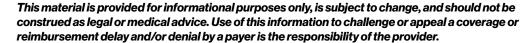
Request for Additional Prompt Payment Filing Deadlines **Provider Appeals** Information **Issue:** Plan delays timely payment pending medical necessity determination. **Issue:** Subsequent request for **Issue:** Claim is past the filing deadline. Issue: Provider appeals. additional information. Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits **Example scenario:** Provider timely Example scenario: Provider wants to a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination. **Example scenario:** Provider submits submits an EYLEA HD claim. Plan challenge Plan's denial or reduction of a claim for EYLEA HD reimbursement. denies the claim for being past the an EYLEA HD claim. Arkansas Department of Insurance Rule 43. Section 12 states... but 31 days later. Plan indicates filing deadline. **Arkansas Department of Insurance** Plan will pay or deny a clean claim within 30 days if submitted electronically and within 45 days if submitted by other payment of claim is pending receipt of **Group Health Insurance Standards** Rule 76. Section 7 states... means. The penalty for failure to comply is 12% interest per annum that will be paid without any action required from additional information. Act Section 8 states... claimant. Internal appeal: Preservice claims **Arkansas Department of Insurance** Written proof of loss must be furnished must be decided within 30 days: Arkansas Insurance Code Section 23-99-1108 states... Rule 43. Section 13 states... to the insurer within 90 days after postservice claims within 60 days. If prior authorization was obtained. Plan will not revoke, limit, condition, or restrict the authorization for a period of 45 Plan will notify the claimant of any the date of loss. Failure to furnish **Arkansas Department of Insurance** business days from the date when provider received the authorization. Any correspondence, contact, or other action additional information that is required proof within that time will not invalidate Rule 76. Section 8 states... by Plan that disclaims, denies, attempts to disclaim, or attempts to deny payment for health care services that were within 30 days of receiving the claim. nor reduce any claim if it was not authorized within the 45-day time period is void. External review: A request for an Plan's notice will explain the additional reasonably possible to furnish proof within that time, provided the proof information that is required. external review must be filed within Arkansas Insurance Code Section 23-99-1109 states... is furnished as soon as reasonably 120 days. (1) A Plan shall not rescind, limit, condition, or restrict an authorization based upon medical necessity unless the Plan possible and in no event, except in The review must be decided within 45 notifies the health care provider at least 3 business days before the scheduled date of the admission, service, procedure. the absence of legal capacity of the days: the decision is binding on Plan. or extension of stav. claimant, later than 1 year from the Arkansas Department of Insurance (2) Notwithstanding subdivision (b) (1) of this section, a Plan may rescind, limit, condition, or restrict an authorization if: time proof is otherwise required. Rule 76. Section 16 states... (A) The subscriber was not covered by the health benefit plan and was not eliqible to receive the requested service under **NOTE:** This provision sets forth the health benefit plan on the date of the admission, service, procedure, or extension of stay; and Form for requesting an external minimum standards. Provider (B) The Plan has provided to the health care provider a means to confirm whether or not the subscriber is covered by review may be downloaded from the should check contract for specific the health benefit plan and eligible to receive the requested service up to the date of admission, service, procedure, or Arkansas Department of Insurance requirements. extension of stav. website. For Providers Out of Network: Arkansas Insurance Code Section 23-99-1302 states... A payor, upon receipt of the claim and notice of the assignment of benefits submitted by the health care provider, shall promptly remit payment of the claim directly to the health care provider. (2) When payment is made directly to the health care provider, the payor shall give written notice of the payment to an enrollee. (3) A violation of this subsection is:

Complaints regarding these and other payer issues can be made to the Arkansas Department of Insurance website.



Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information





EYLEA HD®
(aflibercept) Injection 8 mg

This information is provided to you

(A) An unfair trade practice under § 23-66-206; and (B) Subject to the Trade Practices Act, § 23-66-201 et seq.