# 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.

**On the following page:** Prompt Payment | Request for Additional Information | Filing Deadlines | Provider Appeals

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

### Prompt Payment

**Issue:** Plan delays timely payment pending medical necessity determination.

**Example scenario:** Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination.

**Arkansas Department of Insurance Rule 43, Section 12 states...**

Plan will pay or deny a clean claim **within 30 days** if submitted electronically and **within 45 days** if submitted by other means. The penalty for failure to comply is 12% interest per annum that will be paid without any action required from claimant.

**Arkansas Insurance Code Section 23-99-1108 states...**

If prior authorization was obtained, Plan will not revoke, limit, condition, or restrict the authorization for a period of **45 business days** from the date when provider received the authorization. Any correspondence, contact, or other action by Plan that disclaims, denies, attempts to disclaim, or attempts to deny payment for health care services that were authorized within the 45-day time period is void.

**Arkansas Insurance Code Section 23-99-1109 states...**

(1) A Plan shall not rescind, limit, condition, or restrict an authorization based upon medical necessity unless the Plan notifies the health care provider **at least 3 business days** before the scheduled date of the admission, service, procedure, or extension of stay.

(2) Notwithstanding subdivision (b) (1) of this section, a Plan may rescind, limit, condition, or restrict an authorization if:
(A) The subscriber was not covered by the health benefit plan and was not eligible to receive the requested service under the health benefit plan on the date of the admission, service, procedure, or extension of stay; and
(B) The Plan has provided to the health care provider a means to confirm whether or not the subscriber is covered by the health benefit plan and eligible to receive the requested service up to the date of admission, service, procedure, or extension of stay.

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

### Request for Additional Information

**Issue:** Subsequent request for additional information.

**Example scenario:** Provider submits a claim for EYLEA HD reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.

**Arkansas Department of Insurance Rule 43, Section 13 states...**

Plan will notify the claimant of any additional information that is required **within 30 days** of receiving the claim. Plan's notice will explain the additional information that is required.

### Filing Deadlines

**Issue:** Claim is past the filing deadline.

**Example scenario:** Provider timely submits an EYLEA HD claim. Plan denies the claim for being past the filing deadline.

**Group Health Insurance Standards Act Section 8 states...**

Written proof of loss must be furnished to the insurer **within 90 days** after the date of loss. Failure to furnish proof within that time will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, **later than 1 year** from the time proof is otherwise required.

**NOTE:** This provision sets forth minimum standards. Provider should check contract for specific requirements.

### Provider Appeals

**Issue:** Provider appeals.

**Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

**Arkansas Department of Insurance Rule 76, Section 7 states...**

**Internal appeal:** Preservice claims must be decided **within 30 days**; postservice claims **within 60 days**.

**Arkansas Department of Insurance Rule 76, Section 8 states...**

**External review:** A request for an external review must be filed **within 120 days**.

The review must be decided **within 45 days**; the decision is binding on Plan.

**Arkansas Department of Insurance Rule 76, Section 16 states...**

Form for requesting an external review may be downloaded from the Arkansas Department of Insurance website.

**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**

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***This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.***

**Reference:** Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg