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 non-urgent 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...

"Health care insurer" (or Plan) means an entity that is subject to state insurance regulation, including an insurance company, a health maintenance organization, a hospital and medical service corporation, a risk-based provider organization, and a sponsor of a nonfederal self-funded governmental Plan; or **has any subscribers in this state**.

Arkansas Insurance Code Section 23-99-1111 states...

(3)(A) When an adverse determination is issued by a utilization review entity that questions the medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the utilization review entity shall provide in the notice of adverse determination the name and telephone number of a physician who possesses a current and unrestricted license in this state with whom the requesting health care provider may have a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the intervention.

(B) The requesting health care provider may contact the reviewing physician at the telephone number provided with the adverse determination under subdivision (c)(3)(A) of this section within 1 business day of receipt of the adverse determination for an urgent service, or within 2 business days of receipt of the adverse determination for a nonurgent service, to engage in the discussion of the patient's treatment plan and the clinical basis for the intervention under subdivision (c)(3)(A) of this section.

(C)(i) Following any discussion under subdivision (c)(3)(B) of this section, the utilization review entity shall notify the health care provider whether or not the adverse determination decision remains the same or the service is approved.

(ii) The notice under subdivision (c)(3)(C)(i) of this section shall be provided:

(a) Within 1 business day of the discussion under subdivision (c)(3)(B) of this section between the provider and physician for an urgent service; or

(b) Within 2 business days of the discussion under subdivision (c)(3)(B) of this section between the provider and physician for a nonurgent service.

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.

Arkansas Code Insurance Code Section 23-99-1120 states...

Initial exemption from prior authorization requirements for health care providers providing certain health care services.

(a)(1) Except as provided under subdivision (a)(2) of this section, beginning on and after January 1, 2024, a health care provider that received approval for 90% or more of the health care provider's prior authorization requests based on a review of the health care provider's utilization of the particular health care services from January 1, 2022, through June 30, 2022, shall not be required to obtain prior authorization for a particular health care service and shall be considered exempt from prior authorization requirements through September 30, 2024.

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	Request for Additional Information	Filing Deadlines	Provider Appeals
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.	**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.	**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.	**Issue:** Provider appeals. **Example scenario:** Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.
Arkansas Department of Insurance Rule 43, Section 12 states...	**Arkansas Department of Insurance Rule 43, Section 13 states...**	**Group Health Insurance Standards Act Section 8 states...**	**Arkansas Department of Insurance Rule 76, Section 7 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.	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.	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.	**Internal appeal:** Preservice claims must be decided **within 30 days**; postservice claims **within 60 days**.
Arkansas Insurance Code Section 23-99-1108 states...			**Arkansas Department of Insurance Rule 76, Section 8 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.			**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 Insurance Code Section 23-99-1109 states...			**Arkansas Department of Insurance Rule 76, Section 16 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.			Form for requesting an external review may be downloaded from the Arkansas Department of Insurance 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: (A) An unfair trade practice under § 23-66-206; and (B) Subject to the Trade Practices Act, § 23-66-201 et seq.			

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