

Title 23. Public Utilities and Regulated Industries
Chapter I. State Insurance Department, Department of Commerce
Subchapter B. Life, Health, and Accident
Part 117. Arkansas External Review Rule

Codification Notes. This part as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"Section 1. Authority

This rule is promulgated pursuant to Ark. Code Ann. §§23-61-108, 23-66-205, 23-66-207, 23-99-414, 25-15-203 & 204, and other applicable laws or rules."

"Section 18. Severability

If any provision of this Rule, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 19. Effective Date

This Rule shall be effective January 1, 2012."

Subpart 1. Generally

23 CAR § 117-101. Purpose and intent.

The purpose of this part is to provide uniform standards for the establishment and maintenance of external review procedures to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this part.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-102. Definitions.

For purposes of this part:

(1) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other healthcare service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity (or substantially equivalent term), appropriateness, healthcare setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated;

(2) "Ambulatory review" means utilization review of healthcare services performed or provided in an outpatient setting;

(3) "Authorized representative" means a:

(A) Person to whom a covered person has given express written consent to represent the covered person in an external review;

(B) Person authorized by law to provide substituted consent for a covered person; or

(C) Family member of the covered person or the covered person's treating healthcare professional only when the covered person is unable to provide consent;

(4) "Best evidence" means evidence based on:

(A) Randomized clinical trials;

(B) If randomized clinical trials are not available, cohort studies or case-control studies;

(C) If subdivisions (4)(A) and (B) of this section are not available, case series; or

(D) If subdivisions (4)(A), (B), and (C) of this section are not available, expert opinion;

(5) "Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received;

(6) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(7) "Case series" means an evaluation of a series of patients with a particular outcome, without the use of a control group;

(8) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other healthcare service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for:

(A) Medical necessity (or substantially equivalent term);

(B) Appropriateness;

(C) Healthcare setting;

(D) Level of care; and

(E) Effectiveness;

(9) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of healthcare services;

(10) "Cohort study" means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention or interventions;

(11) "Commissioner" means the Insurance Commissioner;

(12) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment;

(13) "Covered benefits" or "benefits" means those healthcare services to which a covered person is entitled under the terms of a health benefit plan;

(14) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(15) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(16) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;

(17) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would:

(A) Result in a serious:

(i) Impairment to bodily functions; or

(ii) Dysfunction of a bodily organ or part; or

(B) Place the person's health in serious jeopardy;

(18) "Emergency services" means healthcare items and services furnished or required to evaluate and treat an emergency medical condition;

(19) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;

(20) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular:

(A) Service;

(B) Intervention; or

(C) Therapy;

(21) "Facility" means an institution providing healthcare services or a healthcare setting, including, but not limited to:

(A) Hospitals and other licensed inpatient centers;

(B) Ambulatory surgical or treatment centers;

(C) Skilled nursing centers;

(D) Residential treatment centers;

(E) Diagnostic, laboratory, and imaging centers; and

(F) Rehabilitation and other therapeutic health settings;

(22)(A) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee

utilization review organization, at the completion of the health carrier's internal appeal process procedures.

(B) If the health carrier does not have, nor is it required to have, an internal appeal procedure or utilization review procedure, an adverse determination shall be considered a final adverse determination;

(23) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services;

(24) "Healthcare professional" means a physician or other healthcare practitioner licensed, accredited, or certified to perform specified healthcare services consistent with state law;

(25) "Healthcare provider" or "provider" means a healthcare professional or a facility;

(26) "Healthcare services" means services for the diagnosis, prevention, treatment, cure, or relief of:

(A) A health condition;

(B) An illness;

(C) An injury; or

(D) A disease;

(27) "Health carrier" means an entity subject to the insurance laws and rules of Arkansas, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including an accident and health insurance company, a health maintenance organization, a nonprofit hospital and medical service corporation, or any other entity providing a plan of health insurance, health benefits, or healthcare services;

(28) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(A) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(B) The provision of healthcare services to an individual; or

(C) Payment for the provision of healthcare services to an individual;

(29) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

(30) "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that:

(i) Meet nationally recognized requirements for scientific manuscripts;

and

(ii) Submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the United States Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(D)The following standard reference compendia:

(i) The American Hospital Formulary Service Drug Information;

(ii) Drug Facts and Comparisons;

(iii) The American Dental Association Accepted Dental Therapeutics;

and

(iv) The United States Pharmacopoeia drug information;

(E) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

- (i) The United States Agency for Healthcare Research and Quality;
- (ii) The National Institutes of Health;
- (iii) The National Cancer Institute;
- (iv) The National Academy of Sciences;
- (v) The Centers for Medicare & Medicaid Services;
- (vi) The United States Food and Drug Administration; and
- (vii) Any national board recognized by the National Institutes of

Health for the purpose of evaluating the medical value of healthcare services; or

(F) Any other medical or scientific evidence that is comparable to the sources listed in subdivisions (30)(A) – (E) of this section;

(31) "NAIC" means the National Association of Insurance Commissioners;

(32) "Person" means:

- (A) An individual;
- (B) A corporation;
- (C) A partnership;
- (D) An association;
- (E) A joint venture;
- (F) A joint stock company;
- (H) A trust;
- (I) An unincorporated organization;
- (J) Any similar entity; or
- (K) Any combination of the foregoing;

(33) "Prospective review" means utilization review conducted prior to:

- (A) An admission; or
- (B) A course of treatment;

(34) "Protected health information" means health information:

- (A) That identifies an individual who is the subject of the information; or

(B) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

(35) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

(36) "Retrospective review" means a review of medical necessity (or substantially equivalent term) conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of:

- (A) Reimbursement levels;
- (B) Veracity of documentation;
- (C) Accuracy of coding; or
- (D) Adjudication for payment;

(37) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed healthcare service to assess the clinical necessity and appropriateness of the initial proposed healthcare service;

(38)(A) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings.

- (B) Techniques may include:
- (i) Ambulatory review;
 - (ii) Prospective review;
 - (iii) Second opinion;
 - (iv) Certification;
 - (v) Concurrent review;
 - (vi) Case management;
 - (vii) Discharge planning; or
 - (viii) Retrospective review; and

(39) "Utilization review organization" means an entity that conducts utilization review other than a health carrier performing a review for its own health benefit plans.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

Codification Notes. Section 1861(t)(2) of the Social Security Act is codified at 42 U.S.C. § 1395x(t)(2).

23 CAR § 117-103. Applicability and scope.

(a) Except as provided in subsection (b) of this section, this part shall apply to all health carriers.

(b) The provisions of this part shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, short-term limited duration, long-term care insurance, as defined by Arkansas Code § 23-97-203 [repealed], vision care, or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the Insurance Commissioner by rule, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, United States Code, and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

Codification Notes. Arkansas Code § 23-97-203 was repealed by Acts 2005, No. 1697, § 32.

23 CAR § 117-104. Notice of right to external review.

(a)(1) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to 23 CAR § 117-107, 23 CAR § 117-108, or 23 CAR § 117-109 and include the appropriate statements and information set forth in subsection (b) of this section at the same time the health carrier sends written notice of:

(A) An adverse determination upon completion of the health carrier's utilization review process; and

(B) A final adverse determination.

(2) As part of the written notice required under subdivision (a)(1) of this section, a health carrier shall include the following, or substantially equivalent, language:

We have denied your request for the provision of or payment for a healthcare service or course of treatment. You may have the right to have our decision reviewed by healthcare professionals who have no association with us if our decision involved making a judgment as to the medical necessity (or substantially equivalent term), appropriateness, healthcare setting, level of care, or effectiveness of the healthcare service or treatment you requested by submitting a request for external review in writing to the Insurance Commissioner at 1 Commerce Way, Little Rock, AR 72202-2087 or by calling 1-800-852-5494 or 1-501-371-2600.

(3) The Insurance Commissioner may otherwise prescribe the form and content of the notice as required under this section by bulletin, directive, or other publication to health carriers.

(b)(1) The health carrier shall include in the notice required under subsection (a) of this section:

(A) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving an adverse determination set forth in the health carrier's internal appeal procedure or utilization review procedure would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to 23 CAR § 117-108 or 23 CAR § 117-109 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of an appeal involving an adverse determination as set forth in the health carrier's internal appeal procedure or utilization review procedure, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the appeal prior to conducting the expedited external review; and

(ii) The covered person or the covered person's authorized representative may file an appeal under the health carrier's internal appeal process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the appeal with the health carrier for a preservice claim or sixty (60) days for a post-service claim and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative:

(a) May file a request for external review pursuant to 23 CAR § 117-105; and

(b) Shall be considered to have exhausted the health carrier's internal appeal process for purposes of 23 CAR § 117-106; and

(B) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to 23 CAR § 117-107 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to 23 CAR § 117-108; or

(ii) If the final adverse determination concerns:

(a) An admission, availability of care, continued stay, or healthcare service for which the covered person received emergency services but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to 23 CAR § 117-108; or

(b) A denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to 23 CAR § 117-109 or if the covered person's treating physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under 23 CAR § 117-109.

(2) In addition to the information to be provided pursuant to subdivision (b)(1) of this section, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to 23 CAR § 117-116, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized

representative the opportunity to submit additional information and including any forms used to process an external review.

(3) As part of any forms provided under subdivision (b)(2) of this section, the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 C.F.R. § 164.508, by which the covered person, for purposes of conducting an external review under this part, authorizes the health carrier and the covered person's treating healthcare provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-105. Request for external review.

(a)(1) Except for a request for an expedited external review as set forth in 23 CAR § 117-108, all requests for external review shall be made in writing to the Insurance Commissioner.

(2) The commissioner may prescribe the form and content of external review requests required to be submitted under this section by bulletin, directive, or other publication to health carriers.

(b) A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-106. Exhaustion of internal appeal process.

(a)(1) Except as provided in subsection (b) of this section, a request for an external review pursuant to 23 CAR § 117-107, 23 CAR § 117-108, or 23 CAR § 117-109 shall not be made until the covered person has exhausted the health carrier's internal appeal process.

(2) A covered person shall be considered to have exhausted the health carrier's internal appeal process for purposes of this section if the covered person or the covered person's authorized representative:

(A) Has filed an appeal involving an adverse determination pursuant to the health carrier's internal appeal procedure or utilization review procedure; and

(B) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the appeal from the health carrier within thirty (30) days for a preservice claim or sixty (60) days for a post-service claim following the date the covered person or the covered person's authorized representative filed the appeal with the health carrier.

(3) Notwithstanding subdivision (a)(2) of this section, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to the health carrier's internal appeal procedure or utilization review procedure until the covered person has exhausted the health carrier's internal appeal process.

(b)(1)(A) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of an appeal involving an adverse determination as set forth in the health carrier's internal appeal procedure or utilization review procedure, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) Under 23 CAR § 117-108 if the covered person has a medical condition where the timeframe for completion of an expedited review of the appeal involving an adverse determination set forth in the health carrier's internal appeal procedure or utilization review procedure would:

(a) Seriously jeopardize the life or health of the covered person;

or

(b) Jeopardize the covered person's ability to regain maximum function; or

(ii) Under 23 CAR § 117-109 if the:

(a) Adverse determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational; and

(b) Covered person's treating physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(B) Upon receipt of a request for an expedited external review under subdivision (b)(1)(A) of this section, the independent review organization conducting the external review in accordance with the provisions of 23 CAR § 117-108 or 23 CAR § 117-109 shall determine whether the covered person shall be required to complete the expedited review process set forth in the health carrier's internal appeal procedure or utilization review procedure before it conducts the expedited external review.

(C) Upon a determination made pursuant to subdivision (b)(1)(B) of this section that the covered person must first complete the expedited appeal review process set forth in the health carrier's internal review procedure or utilization review procedure, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in 23 CAR § 117-108 until:

(i) Completion of the expedited appeal review process; and

(ii) The covered person's appeal at the completion of the expedited appeal review process remains unresolved.

(2) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal appeal procedures, as set forth in the carrier's internal review procedure, whenever the health carrier agrees to waive the exhaustion requirement.

(c) If the requirement to exhaust the health carrier's internal appeal procedures is waived under subdivision (b)(2) of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in 23 CAR § 117-107 or 23 CAR § 117-109.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-107. Standard external review.

(a)(1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to 23 CAR § 117-104, a covered person or the covered person's authorized representative may file a request for an external review with the Insurance Commissioner.

(2) Within one (1) business day after the date of receipt of a request for external review pursuant to subdivision (a)(1) of this section, the commissioner shall send a copy of the request to the health carrier.

(b) Within five (5) business days following the date of receipt of the copy of the external review request from the commissioner under subdivision (a)(2) of this section, the health carrier shall complete a preliminary review of the request to determine whether the:

(1) Individual is or was a covered person in the health benefit plan at the time the healthcare service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the healthcare service was provided;

(2) Healthcare service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the healthcare service is not covered because it does not meet the health carrier's requirements for:

- (A) Medical necessity (or substantially equivalent term);
- (B) Appropriateness;
- (C) Healthcare setting;

(D) Level of care; or

(E) Effectiveness;

(3) Covered person has exhausted the health carrier's internal appeal process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to 23 CAR § 117-106; and

(4) Covered person has provided all the information and forms required to process an external review, including the release form provided under 23 CAR § 117-104(b).

(c)(1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner, the covered person, and, if applicable, the covered person's authorized representative in writing whether the request is:

(A) Complete; and

(B) Eligible for external review.

(2) If the request:

(A) Is not complete, the health carrier shall:

(i) Inform the covered person and, if applicable, the covered person's authorized representative and the commissioner in writing; and

(ii) Include in the notice what information or materials are needed to make the request complete; or

(B) Is not eligible for external review, the health carrier shall:

(i) Inform the covered person, if applicable, the covered person's authorized representative, and the commissioner in writing; and

(ii) Include in the notice the reasons for its ineligibility.

(3)(A) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice by bulletin, directive, or other publication to health carriers.

(B) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4)(A) The commissioner may:

(i) Determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible; and

(ii) Require that it be referred for external review.

(B) In making a determination under subdivision (c)(4)(A) of this section, the commissioner's decision shall be:

(i) Made in accordance with the terms of the covered person's health benefit plan; and

(ii) Subject to all applicable provisions of this part.

(d)(1) Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (c) of this section, within one (1) business day after the date of receipt of the notice the commissioner shall:

(A) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 23 CAR § 117-111 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(B) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's:

(A) Utilization review process; or

(B) Internal appeal process.

(3)(A) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to subdivision (d)(1) of this

section additional information that the independent review organization shall consider when conducting the external review.

(B) The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

(e)(1) Within five (5) business days after the date of receipt of the notice provided pursuant to subdivision (d)(1) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(2) Except as provided in subdivision (e)(3) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision (e)(1) of this section shall not delay the conduct of the external review.

(3)(A) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision (e)(1) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(B) Within one (1) business day after making the decision under subdivision (e)(3)(A) of this section, the independent review organization shall notify:

- (i) The covered person;
- (ii) If applicable, the covered person's authorized representative;
- (iii) The health carrier; and
- (iv) The commissioner.

(f)(1) The assigned independent review organization shall review:

(A) All of the information and documents received pursuant to subsection (e) of this section; and

(B) Any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision (d)(3) of this section.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision (d)(3) of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

(g)(1) Upon receipt of the information, if any, required to be forwarded pursuant to subdivision (f)(2) of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision (g)(1) of this section shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the healthcare service that is the subject of the adverse determination or final adverse determination.

(4)(A) Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision (g)(3) of this section, the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(B) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (g)(4)(A) of this section.

(h) In addition to the documents and information provided pursuant to subsection (e) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

- (1) The covered person's medical records;
- (2) The attending healthcare professional's recommendation;
- (3) Consulting reports from appropriate healthcare professionals and other documents submitted by the:

- (A) Health carrier;
- (B) Covered person;
- (C) Covered person's authorized representative; or
- (D) Covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by:

- (A) The United States Government; or
- (B) National or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (h)(1) – (6) of this section to the extent the:

- (A) Information or documents are available; and
- (B) Clinical reviewer or reviewers consider appropriate.

(i)(1) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

- (A) The covered person;
- (B) If applicable, the covered person's authorized representative;
- (C) The health carrier; and
- (D) The commissioner.

(2) The independent review organization shall include in the notice sent pursuant to subdivision (i)(1) of this section:

- (A) A general description of the reason for the request for external review;

(B) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(C) The date the external review was conducted;

(D) The date of its decision;

(E) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(F) The rationale for its decision; and

(G) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(3) Upon receipt of a notice of a decision pursuant to subdivision (i)(1) of this section reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(j) The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on:

(1) The nature of the healthcare service that is the subject of the adverse determination or final adverse determination; and

(2) Other circumstances, including conflict of interest concerns pursuant to 23 CAR § 117-112(d).

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-108. Expedited external review.

(a) Except as provided in subsection (f) of this section, a covered person or the covered person's authorized representative may make a request for an expedited external review with the Insurance Commissioner at the time the covered person receives:

(1) An adverse determination if the:

(A) Adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of an appeal involving an adverse determination set forth in the health carrier's internal appeal procedure or utilization review procedure would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) Covered person or the covered person's authorized representative has filed a request for an expedited review of an appeal involving an adverse determination as set forth in the health carrier's internal appeal procedure or utilization review procedure; or

(2) A final adverse determination if the:

(A) Covered person has a medical condition where the timeframe for completion of a standard external review pursuant to 23 CAR § 117-107 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(B) Final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which the covered person received emergency services, but has not been discharged from a facility.

(b)(1) Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

(2)(A) Immediately upon receipt of the request pursuant to subdivision (b)(1) of this section, the health carrier shall determine whether the request meets the reviewability requirements set forth in 23 CAR § 117-107(b).

(B) The health carrier shall immediately notify the commissioner, the covered person, and, if applicable, the covered person's authorized representative of its eligibility determination.

(3)(A) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice by bulletin, directive, or other publication to health carriers.

(B) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(4)(A) The commissioner may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(B) In making a determination under subdivision (b)(4)(A) of this section, the commissioner's decision shall be:

(i) Made in accordance with the terms of the covered person's health benefit plan; and

(ii) Subject to all applicable provisions of this part.

(5)(A) Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 23 CAR § 117-111.

(B) The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection (e) of this section, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's:

(A) Utilization review process; or

(B) Internal appeal process.

(c) Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subdivision (b)(5) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization:

- (1) Electronically;
- (2) By telephone or facsimile; or
- (3) By any other available expeditious method.

(d) In addition to the documents and information provided or transmitted pursuant to subsection (c) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

- (1) The covered person's pertinent medical records;
- (2) The attending healthcare professional's recommendation;
- (3) Consulting reports from appropriate healthcare professionals and other

documents submitted by the:

- (A) Health carrier;
- (B) Covered person;
- (C) Covered person's authorized representative; or
- (D) Covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which:

- (A) Shall include evidence-based standards; and
- (B) May include any other practice guidelines developed by:
 - (i) The United States Government; or
 - (ii) National or professional medical societies, boards, and

associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

(7) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (d)(1) – (6) of this section to the extent the:

(A) Information and documents are available; and

(B) Clinical reviewer or reviewers consider appropriate.

(e)(1) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in 23 CAR § 117-107(b), the assigned independent review organization shall:

(A) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(B) Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the commissioner of the decision.

(2) If the notice provided pursuant to subdivision (e)(1) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(A) Provide written confirmation of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner; and

(B) Include the information set forth in 23 CAR § 117-107(i)(2).

(3) Upon receipt of the notice of a decision pursuant to subdivision (e)(1) of this section reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(f) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

(g) The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done

on a random basis among those approved independent review organizations qualified to conduct the particular external review based on:

(1) The nature of the healthcare service that is the subject of the adverse determination or final adverse determination; and

(2) Other circumstances, including conflict of interest concerns pursuant to 23 CAR § 117-112(d).

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-109. External review of experimental or investigational treatment adverse determinations.

(a)(1) Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to 23 CAR § 117-104 that involves a denial of coverage based on a determination that the healthcare service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Insurance Commissioner.

(2)(A) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision (a)(1) of this section if the covered person's treating physician certifies, in writing, that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(B) Upon receipt of a request for an expedited external review, the commissioner immediately shall notify the health carrier.

(C)(i)(a) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements under subsection (b) of this section.

(b) The health carrier shall immediately notify the commissioner, the covered person, and, if applicable, the covered person's authorized representative of its eligibility determination.

(ii) The commissioner may specify the form for the health carrier's notice of initial determination under subdivision (a)(2)(C)(i) of this section and any supporting information to be included in the notice by bulletin, directive, or other publication to health carriers.

(iii) The notice of initial determination under subdivision (a)(2)(C)(i) of this section shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(D)(i) The commissioner may:

(a) Determine that a request is eligible for external review under subdivision (b)(2) of this section notwithstanding a health carrier's initial determination the request is ineligible; and

(b) Require that it be referred for external review.

(ii) In making a determination under subdivision (a)(2)(D)(i) of this section, the commissioner's decision shall be:

(a) Made in accordance with the terms of the covered person's health benefit plan; and

(b) Subject to all applicable provisions of this part.

(E) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subdivision (b)(2) of this section, the commissioner immediately shall:

(i) Assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 23 CAR § 117-111; and

(ii) Notify the health carrier of the name of the assigned independent review organization.

(F) At the time the health carrier receives the notice of the assigned independent review organization pursuant to subdivision (a)(2)(E) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization:

- (i) Electronically;
- (ii) By telephone or facsimile; or
- (iii) By any other available expeditious method.

(b)(1) Except for a request for an expedited external review made pursuant to subdivision (a)(2) of this section, within one (1) business day after the date of receipt of the request, the commissioner receives a request for an external review, the commissioner shall notify the health carrier.

(2) Within five (5) business days following the date of receipt of the notice sent pursuant to subdivision (b)(1) of this section, the health carrier shall conduct and complete a preliminary review of the request to determine whether the:

(A) Individual is or was a covered person in the health benefit plan at the time the healthcare service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the healthcare service or treatment was provided;

(B) Recommended or requested healthcare service or treatment that is the subject of the adverse determination or final adverse determination:

(i) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(C) Covered person's treating physician has certified that one (1) of the following situations is applicable:

(i) Standard healthcare services or treatments have not been effective in improving the condition of the covered person;

(ii) Standard healthcare services or treatments are not medically appropriate for the covered person; or

(iii) There is no available standard healthcare service or treatment covered by the health carrier that is more beneficial than the recommended or requested healthcare service or treatment described in subdivision (b)(2)(D) of this section;

(D) Covered person's treating physician:

(i) Has recommended a healthcare service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard healthcare services or treatments; or

(ii) Who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the healthcare service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard healthcare services or treatments;

(E) Covered person has exhausted the health carrier's internal appeal process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to 23 CAR § 117-106; and

(F) Covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under 23 CAR § 117-104(b).

(c)(1) Within one (1) business day after completion of the preliminary review, the health carrier shall notify the commissioner, the covered person, and, if applicable, the covered person's authorized representative in writing whether:

(A) The request is complete; and

(B) The request is eligible for external review.

(2) If the request:

(A) Is not complete, the health carrier shall:

(i) Inform in writing the commissioner, the covered person, and, if applicable, the covered person's authorized representative; and

(ii) Include in the notice what information or materials are needed to make the request complete; or

(B) Is not eligible for external review, the health carrier shall:

(i) Inform the covered person, the covered person's authorized representative, if applicable, and the commissioner in writing; and

(ii) Include in the notice the reasons for its ineligibility.

(3)(A) The commissioner may specify the form for the health carrier's notice of initial determination under subdivision (c)(2) of this section and any supporting information to be included in the notice by bulletin, directive, or other publication to health carriers.

(B) The notice of initial determination provided under subdivision (c)(2) of this section shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4)(A) The commissioner may:

(i) Determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible; and

(ii) Require that it be referred for external review.

(B) In making a determination under subdivision (c)(4)(A) of this section, the commissioner's decision shall be:

(i) Made in accordance with the terms of the covered person's health benefit plan; and

(ii) Subject to all applicable provisions of this part.

(5) Whenever a request for external review is determined eligible for external review, the health carrier shall notify:

(A) The commissioner;

(B) The covered person; and

(C) If applicable, the covered person's authorized representative.

(d)(1) Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subdivision (a)(2)(D) or subdivision (c)(5) of this section, the commissioner shall:

(A) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 23 CAR § 117-111 and notify the health carrier of the name of the assigned independent review organization; and

(B) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(2)(A) The commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to subdivision (d)(1) of this section additional information that the independent review organization shall consider when conducting the external review.

(B) The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

(3) Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to subdivision (d)(1) of this section, the assigned independent review organization shall:

(A) Select one (1) or more clinical reviewers, as it determines is appropriate, pursuant to subdivision (d)(4) of this section to conduct the external review; and

(B) Based on the opinion of the clinical reviewer, or opinions if more than one (1) clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4)(A) In selecting clinical reviewers pursuant to subdivision (d)(3)(A) of this section, the assigned independent review organization shall select physicians or other healthcare professionals who:

(i) Meet the minimum qualifications described in 23 CAR § 117-112;

and

(ii) Through clinical experience in the past three (3) years, are:

(a) Experts in the treatment of the covered person's condition;

and

(b) Knowledgeable about the recommended or requested healthcare service or treatment.

(B) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other healthcare professionals to be selected to conduct the external review.

(5) In accordance with subsection (h) of this section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested healthcare service or treatment should be covered.

(6) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review procedure or the health carrier's internal appeal procedure.

(e)(1) Within five (5) business days after the date of receipt of the notice provided pursuant to subdivision (d)(1) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

(2) Except as provided in subdivision (e)(3) of this section, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in subdivision (e)(1) of this section shall not delay the conduct of the external review.

(3)(A) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in subdivision (e)(1) of this section, the assigned independent review organization may:

- (i) Terminate the external review; and
- (ii) Make a decision to reverse the adverse determination or final adverse determination.

(B) Immediately upon making the decision under subdivision (e)(3)(A) of this section, the independent review organization shall notify the:

- (i) Covered person;
- (ii) Covered person's authorized representative, if applicable;
- (iii) Health carrier; and
- (iv) Commissioner.

(f)(1) Each clinical reviewer selected pursuant to subsection (d) of this section shall review:

(A) All of the information and documents received pursuant to subsection (e) of this section; and

(B) Any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subdivision (d)(2) of this section.

(2) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision (d)(2) of this section, within one (1) business day after the receipt of the information the assigned independent review organization shall forward the information to the health carrier.

(g)(1) Upon receipt of the information required to be forwarded pursuant to subdivision (f)(2) of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision (g)(1) of this section shall not delay or terminate the external review.

(3) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested healthcare service or treatment that is the subject of the adverse determination or final adverse determination.

(4)(A) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision (g)(3) of this section, the health carrier shall notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization, and the commissioner in writing of its decision.

(B) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (g)(4)(A) of this section.

(h)(1) Except as provided in subdivision (h)(3) of this section, within twenty (20) days after being selected in accordance with subsection (d) of this section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection (i) of this section on whether the recommended or requested healthcare service or treatment should be covered.

(2) Except for an opinion provided pursuant to subdivision (h)(3) of this section, each clinical reviewer's opinion shall be in writing and include the following information:

(A) A description of the covered person's medical condition;

(B) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the:

(i) Recommended or requested healthcare service or treatment is more likely than not to be beneficial to the covered person than any available standard healthcare services or treatments; and

(ii) Adverse risks of the recommended or requested healthcare service or treatment would not be substantially increased over those of available standard healthcare services or treatments;

(C) A description and analysis of any medical or scientific evidence, as that term is defined in 23 CAR § 117-102(30), considered in reaching the opinion;

(D) A description and analysis of any evidence-based standard, as that term is defined in 23 CAR § 117-102(19); and

(E) Information on whether the reviewer's rationale for the opinion is based on subdivision (i)(5)(A) or subdivision (i)(5)(B) of this section.

(3)(A) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstance requires, but in no event more than five (5) calendar days after being selected in accordance with subsection (d) of this section.

(B) If the opinion provided pursuant to subdivision (h)(3)(A) of this section was not in writing, within forty-eight (48) hours following the date the opinion was provided the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under subdivision (h)(2) of this section.

(i) In addition to the documents and information provided pursuant to subdivision (a)(2) or subsection (e) of this section, each clinical reviewer selected pursuant to subsection (d) of this section, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection (h) of this section:

(1) The covered person's pertinent medical records;
(2) The attending physician or healthcare professional's recommendation;
(3) Consulting reports from appropriate healthcare professionals and other documents submitted by the:

(A) Health carrier;

(B) Covered person;

(C) Covered person's authorized representative; or

(D) Covered person's treating physician or healthcare professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested healthcare service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) Whether:

(A) The recommended or requested healthcare service or treatment has been approved by the United States Food and Drug Administration, if applicable, for the condition; or

(B) Medical or scientific evidence or evidence-based standards demonstrate that the:

(i) Expected benefits of the recommended or requested healthcare service or treatment is more likely than not to be beneficial to the covered person than any available standard healthcare service or treatment; and

(ii) Adverse risks of the recommended or requested healthcare service or treatment would not be substantially increased over those of available standard healthcare services or treatments.

(j)(1)(A) Except as provided in subdivision (j)(1)(B) of this section, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection (i) of this section, the assigned independent review organization, in accordance with subdivision (j)(2) of this section, shall make a decision and provide written notice of the decision to:

(i) The covered person;

(ii) If applicable, the covered person's authorized representative;

(iii) The health carrier; and

(iv) The commissioner.

(B)(i) For an expedited external review, within seventy-two (72) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection (i)

of this section, the assigned independent review organization, in accordance with subdivision (j)(2) of this section, shall:

(a) Make a decision; and

(b) Provide notice of the decision orally or in writing to the persons listed in subdivision (j)(1)(A) of this section.

(ii) If the notice provided under subdivision (j)(1)(B)(i) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the persons listed in subdivision (j)(1)(A) of this section; and

(b) Include the information set forth in subdivision (j)(3) of this section.

(2)(A) If a majority of the clinical reviewers recommend that the recommended or requested healthcare service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(B) If a majority of the clinical reviewers recommend that the recommended or requested healthcare service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(C)(i) If the clinical reviewers are evenly split as to whether the recommended or requested healthcare service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subdivision (j)(2)(A) or subdivision (j)(2)(B) of this section.

(ii) The additional clinical reviewer selected under subdivision (j)(2)(C)(i) of this section shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection (i) of this section.

(iii) The selection of the additional clinical reviewer under this subdivision (j)(2)(C) shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection (d) of this section.

(3) The independent review organization shall include in the notice provided pursuant to subdivision (j)(1) of this section:

(A) A general description of the reason for the request for external review;

(B) The written opinion of each clinical reviewer, including the:

(i) Recommendation of each clinical reviewer as to whether the recommended or requested healthcare service or treatment should be covered; and

(ii) Rationale for the reviewer's recommendation;

(C) The date the independent review organization was assigned by the commissioner to conduct the external review;

(D) The date the external review was conducted;

(E) The date of its decision;

(F) The principal reason or reasons for its decision; and

(G) The rationale for its decision.

(4) Upon receipt of a notice of a decision pursuant to subdivision (j)(1) of this section reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested healthcare service or treatment that was the subject of the adverse determination or final adverse determination.

(k) The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on:

(1) The nature of the healthcare service that is the subject of the adverse determination or final adverse determination; and

(2) Other circumstances, including conflict of interest concerns pursuant to 23 CAR § 117-112(d).

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-110. Binding nature of external review decision.

(a) An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

(b) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

(c) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this part.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-111. Approval of independent review organizations.

(a) The Insurance Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this part.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews under this part an independent review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under 23 CAR § 117-112; and

(2) Shall submit an application for approval in accordance with subsection (d) of this section.

(c) The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(d)(1) Any independent review organization wishing to be approved to conduct external reviews under this part shall:

(A) Submit the application form; and

(B) Include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under 23 CAR § 117-112.

(2)(A) Subject to subdivision (d)(2)(B) of this section, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under 23 CAR § 117-112.

(B) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(3) The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and reapproval.

(e)(1) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under 23 CAR § 117-112.

(2) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under 23 CAR § 117-112, the commissioner shall:

(A) Terminate the approval of the independent review organization; and

(B) Remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this part that is maintained by the commissioner pursuant to subsection (f) of this section.

(f) The commissioner shall maintain and periodically update a list of approved independent review organizations.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-112. Minimum qualification for independent review organizations.

(a) To be approved under 23 CAR § 117-111 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this part that include, at a minimum:

(1) A quality assurance mechanism in place that ensures:

(A) That external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) The selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) The confidentiality of medical and treatment records and clinical review criteria; and

(D) That any person employed by or under contract with the independent review organization adheres to the requirements of this part;

(2) A toll-free telephone service to receive information on a twenty-four-hours-a-day, seven-days-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) Agree to maintain and provide to the Insurance Commissioner the information set out in 23 CAR § 117-114.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate healthcare providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized United States medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's:

(A) Physical, mental, or professional competence; or

(B) Moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a:

(1) Health benefit plan;

(2) National, state, or local trade association of health benefit plans; or

(3) National, state, or local trade association of healthcare providers.

(d)(1) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved pursuant to 23 CAR § 117-111 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier that is the subject of the external review;

(B) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(C) Any officer, director, or management employee of the health carrier that is the subject of the external review;

(D) The healthcare provider, the healthcare provider's medical group, or independent practice association recommending the healthcare service or treatment that is the subject of the external review;

(E) The facility at which the recommended healthcare service or treatment would be provided; or

(F) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(2) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subdivision (d)(1) of this section, the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subdivision (d)(1) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(e)(1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under 23 CAR § 117-111.

(2)(A) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section.

(B) The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this subdivision (e)(2).

(3)(A) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section.

(B) The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(f)(1) An independent review organization shall be unbiased.

(2) An independent review organization shall establish and maintain written procedures to ensure that it is unbiased, in addition to any other procedures required under this section.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-113. Hold harmless for independent review organizations.

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this part, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-114. External review reporting requirements.

(a)(1) An independent review organization assigned pursuant to 23 CAR § 117-107, 23 CAR § 117-108, or 23 CAR § 117-109 to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the Insurance Commissioner, as required under subdivision (a)(2) of this section.

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to subdivision (a)(1) of this section for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate by state, and for each health carrier:

(A) The total number of requests for external review;

(B) The number of requests for external review resolved and, of those resolved, the number resolved:

(i) Upholding the adverse determination or final adverse determination; and

(ii) Reversing the adverse determination or final adverse determination;

(C) The average length of time for resolution;

(D) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(E) The number of external reviews pursuant to 23 CAR § 117-107(g) that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(F) Any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

(b)(1) Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier, on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this part.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to subdivision (b)(1) of this section shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(3) The report shall include in the aggregate, by state and by type of health benefit plan:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subdivision (b)(3)(A) of this section, the number of requests determined eligible for a full external review; and

(C) Any other information the commissioner may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least six (6) years.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-115. Funding of external review.

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

23 CAR § 117-116. Disclosure requirements.

(a)(1) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(2) The disclosure required by subdivision (a)(1) of this section shall be in a format prescribed by the Insurance Commissioner.

(b)(1) The description required under subsection (a) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner.

(2) The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of:

- (A) Medical necessity (or substantially equivalent term);
- (B) Appropriateness;
- (C) Healthcare setting;
- (D) Level of care; or
- (E) Effectiveness.

(3) The statement shall include the telephone number and address of the commissioner.

(c) In addition to subsection (b) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Authority. Arkansas Code §§ 23-61-108, 23-66-207, 23-99-414.

Appendix A. Model Notice of Appeal Rights

Link:

https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/419/23CARpt.117_AppendixA.pdf

Appendix B. Model External Review Request Form

Link:

https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/420/23CARpt.117_AppendixB.pdf

Appendix C. Independent Review Organization External Review Annual Report Form

Link:

https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/423/23CARpt.117_AppendixC.pdf

Appendix D. Model Health Carrier External Review Annual Report Form

Link:

https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/422/23CARpt.117_AppendixD.pdf