ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Arkansas Insurance Department

Department Arkansas Department of Commerce

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Statutory Authority for Promulgating Rules Ark. Code Ann. §23-79-1503, 23-79-1501, and Act 955 of 2021

Rule Title: Final Rule 111 Craniofacial Anomaly Reconstructive Surgery Coverage

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ **(Must be more than 10 days after filing date.)**

Date

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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Contact Person	E-mail Address	Date
Clara D. Mezza	clara.mezza@arkansas.gov	04/22/2022

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

_____
Signature

501-683-3497 clara.mezza@arkansas.gov
Phone Number **E-mail Address**

Insurance Administrative Coordinator
Title

04/22/2022
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

RULE 111

CRANIOFACIAL ANOMALY RECONSTRUCTIVE SURGERY COVERAGE "WENDELYN'S CRANIOFACIAL LAW"

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SECTION 1. AUTHORITY

This Rule is issued pursuant to Ark. Code Ann. § 23-79-1503 which requires the Arkansas Insurance Department ("AID") to issue rules for the implementation and administration of coverage for craniofacial anomaly reconstructive surgery and recommended treatment under Ark. Code Ann. § 23-79-1501 et seq. This Rule is also issued to implement Act 955 of 2021, "An Act to Modify the Law Concerning Craniofacial Coverage and to Establish Wendelyn's Craniofacial Law" (hereafter, Act 955, formerly codified from Act 1226 of 2013 and Act 373 of 2015).

SECTION 2. DEFINITIONS

For purposes of this Rule, the following definitions will apply:

(1) "acquired craniofacial anomaly" means a craniofacial condition caused or brought on only by trauma or tumor.

(2) "craniofacial anomaly" means the abnormal development of the skull and face.

(3) "healthcare service" means a healthcare procedure, treatment, or service provided by a medical provider.

(4) "medical provider" means a person who performs healthcare services for patients with a craniofacial anomaly.

(5) "nonurgent" healthcare service means any craniofacial healthcare service which is not urgent.

(6) "reconstructive surgery" means the use of surgery to alter the form and function of cranial facial tissues due to a congenital or acquired musculoskeletal disorder, including surgery to alter the form and function of the skull and face.

(7) "surgical team member" means a surgical member of an American Cleft Palate-Craniofacial Association ("ACPA") approved team who specializes in craniofacial anomaly reconstructive surgery or a surgical member of an approved team with requisite and equivalent craniofacial surgical experience in the field of service requested to be reviewed.

(8) "urgent healthcare service" means a craniofacial healthcare service for a non-life-threatening condition that, in the opinion of a provider with knowledge of a craniofacial patient's medical condition, requires prompt medical care in order to prevent:

(A) A serious threat to life, limb, or eyesight;

(B) Worsening impairment of a bodily function that threatens the body's ability to regain maximum function;

(C) Worsening dysfunction or damage of any bodily organ or part that threatens the body's ability to recover from the dysfunction or damage; or

(D) Severe pain that cannot be managed without prompt medical care.

SECTION 3. COVERAGE REQUIREMENTS FOR HEALTH INSURERS UNDER THIS RULE

(a) Health insurers shall be subject to all Sections of this Rule.

(b) Pursuant to Ark. Code Ann. § 23-79-1502(b), a health benefit plan shall provide coverage for dental and vision care as approved by an ACPA approved surgical team member following the requirements of this section.

(c) A health benefit plan shall include coverage for the following:

(1) On an annual basis, or during the course of a year:

(A) Sclera contact lenses, including coatings;

(B) Office visits;

(C) An ocular impression of each eye;

(D) Autologous serum eye drops;

(E) eye weights, either surgically and/or external eye weights in one or both eyes as directed by an eye specialist, as needed;

(2) (A) Every two (2) years, two (2) hearing aids and two (2) hearing aid molds for each ear.

(B) As used in this section, "hearing aids" includes behind the ear, in the ear, wearable bone conductions, surgically implanted bone conduction services, and cochlear implants; and

(d) A health benefit plan, or any third-party administrator for the plan, shall not require mail order, walkin clinics, or in-network protocols, for compliance with any audiology or other services, as mandated by this Rule.

(e) Any additional tests or procedures that are medically necessary for a craniofacial patient and any diagnostic service incidental to the provision of these benefits in this Section.

(f) For healthcare services to be performed by a nationally approved cleft-craniofacial team, or recommended healthcare services to be performed by a medical provider that is not on a nationally approved cleft-craniofacial team, a request for written authorization or approval shall be reviewed by the administrator (health insurer) of the health benefit plan:

(A) Within two (2) working days from the request by a nationally approved cleft-craniofacial surgical team member, or by a medical provider that is not on a nationally approved cleft-craniofacial team if the request is accompanied by an Attestation in the form established by this Rule that is signed by a surgical team member of an APCA Approved Team, for a nonurgent case; or

(B) Within twenty-four (24) hours from the request by a nationally approved cleft-craniofacial surgical team member, or by a medical provider that is not on a nationally approved cleft-craniofacial team if the request is accompanied by an Attestation in the form established by this Rule that is signed by a surgical team member of an APCA Approved Team for an urgent case. The health insurer must be familiar with or willing to become familiar with the particular craniofacial diagnoses in question and recommended procedure prior to making a determination. The standards in this section shall follow the Prior Authorization Transparency Initiative.

SECTION 4. MEDICAL PROVIDER OFFICE REQUIREMENTS FOR ACPA APPROVED TEAMS

(a) Medical Provider Office Requirements for ACPA Approved Teams.

(b) For healthcare services that are recommended by a surgical member of a nationally approved cleft-craniofacial team, a request for written authorization shall be submitted to the health benefit plan:

(A) At least two (2) working days before the proposed service date, by a nationally approved cleft-craniofacial surgical team, for a nonurgent case; or

(B) At least twenty-four (24) hours before the proposed services date, by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

(c) Every needed service or recommended procedure shall be authorized by an Attestation in the form established by this Rule that is signed by a surgical team member of an APCA Approved team, and thereafter be monitored under the coordinated treatment plan until the completion of such services by the nationally approved cleft-craniofacial surgical team member.

(d) The standards in this section shall follow the Prior Authorization Transparency Initiative.

SECTION 5. MEDICAL PROVIDER OFFICE REQUIREMENTS FOR NON ACPA APPROVED TEAM MEMBERS

(a) Medical Provider Office Requirements for Non APCA Approved Team members. A medical provider that is not on a nationally approved cleft craniofacial team shall communicate and respond within two (2) working days from the request to any medical information requests made by the nationally approved cleft-craniofacial surgical team member who made the recommendation described in this Rule.

(b) For healthcare services that are recommended by a surgical team member of a nationally approved cleft-craniofacial team that are to be performed by a medical provider that is not on a nationally approved cleft-craniofacial team, a request for written authorization or approval shall be submitted to the health benefit plan:

(i) At least two (2) working days before the proposed service date as recommended by a nationally approved cleft-craniofacial surgical team member, for a nonurgent case; or

(ii) Within twenty-four (24) hours before the proposed service date as recommended by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

(c) The recommended needed services shall be the subject of an attestation delivered by a surgical team member of an APCA Approved Team to the medical provider and thereafter be monitored under the coordinated treatment plan until the completion of such services by the nationally approved cleft-craniofacial surgical team member.

(d) A medical provider that is not on a nationally approved cleft-craniofacial team shall comply with Section 7 for referrals for services.

(e) The standards in this section shall follow the Prior Authorization Transparency Initiative.

(f) For claims to be admitted or paid under this Section, for purposes of this Section, a medical provider that is not on a nationally approved cleft-craniofacial team shall submit to the health benefit plan a signed attestation form (Exhibit "A") by a surgical team member of an ACPA Approved Team. The health benefit plan shall have two (2) working days from the submission date to review such claim(s) for nonurgent cases and twenty-four (24) hours for urgent cases.

SECTION 6. CODING FEE FOR EVALUATION

Every health benefit plan covering residents or enrollees in this State shall cover charges for evaluations performed by a nationally approved cleft-craniofacial team in its review of proposed services under Section Five (5) of this Rule. The coding designation number and fee amount for such charges shall be the same for all health benefit plans pursuant to an explanatory bulletin by the Commissioner which will be issued annually or as needed.

SECTION 7. ATTESTATION OR AUTHORIZATION FORM

For services to be reviewed under Section Five (5) of this Rule, the medical provider that is not on a nationally approved cleft-craniofacial team shall use the Attestation or Authorization form which shall be designated as Wendelyn's Craniofacial Law Authorization Form as Exhibit "A" to this Rule.

ALAN MCCLAIN
INSURANCE COMMISSIONER

4/22/22

DATE

APPENDIX A

ATTESTATION OF SURGICAL MEMBER OF AN
AMERICAN CLEFT PALATE-CRANIO-FACIAL ASSOCIATION
APPROVED TEAM

I, _____, am a Member of _____
NAME NAME OF

_____, a cleft-craniofacial team approved by
ORGANIZATION
the American Cleft Palate-Craniofacial Association.

On _____, 20_____, I examined _____and
PATIENT NAME
reviewed his/her medical records. In addition, I examined the proposed treatment plan submitted by Dr. _____. Copies of the medical records
PROVIDER'S NAME
and treatment plan accompany this document.

As a result of these examinations, I attest that Mr./ Ms. _____
PATIENT'S LAST NAME
suffers from craniofacial anomaly. I further attest that the proposed treatment plan will provide surgery and treatment that are medically necessary to improve a functional impairment that results from the craniofacial anomaly.

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE