

# ARKANSAS REGISTER

## Proposed Rule Cover Sheet



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Previous Agency Name, If Applicable \_\_\_\_\_

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Name of Rule \_\_\_\_\_

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Location and Time of Public Meeting \_\_\_\_\_



Michael Preston  
SECRETARY OF COMMERCE

Alan McClain  
COMMISSIONER,  
ARKANSAS INSURANCE  
DEPARTMENT

DATE: OCTOBER 29, 2021

TO: ALL HEALTH INSURERS & HMOs, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: PROPOSED AMENDED RULE 111: CRANIOFACIAL ANOMALY RECONSTRUCTIVE SURGERY COVERAGE

### **NOTICE OF PUBLIC HEARING**

Please find attached or available by electronic publication by the Arkansas Insurance Department ("AID") Proposed Amended Rule 111, "CRANIOFACIAL ANOMALY RECONSTRUCTIVE SURGERY COVERAGE."

Pursuant to Arkansas Administrative Procedures Act, and other applicable laws or rules, NOTICE is hereby given that a PUBLIC HEARING will be held on November 30, 2021 at 10:00 A.M., in the Second Floor Hearing Room ("Diamond Mine Room 203"), at the Arkansas Department of Commerce, 1 Commerce Way, Little Rock, AR 72202.

The purpose of the Public Hearing will be to determine whether the Director should adopt the Proposed Amended Rule 111, "CRANIOFACIAL ANOMALY RECONSTRUCTIVE SURGERY COVERAGE." The Arkansas Insurance Commissioner is proposing a rule which implements Act 955 of 2021 pertaining to craniofacial anomaly coverage.

All interested persons are encouraged to make comments, statements, or opinions to the address below or attend the Public Hearing and present, orally or in writing, statements, arguments or opinions on the proposed Rule. All licensees and other interested persons are responsible for notifying all their personnel, agents, and employees about this Public Hearing.

Persons wishing to testify or make comments are requested to submit intended statements in writing in advance. Direct your inquiries to: Booth Rand, Managing Attorney, Arkansas Insurance Department, 501-371-2820, email: [booth.rand@arkansas.gov](mailto:booth.rand@arkansas.gov). A copy of the proposed Rule may be obtained or viewed at <https://www.insurance.arkansas.gov/pages/industry-regulation/legal/proposed-rules/>.

Sincerely,

*Booth Rand*

Booth Rand  
Managing Attorney  
Arkansas Insurance Department

## **PROPOSED AMENDED 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, walk-in 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 non craniofacial provider, 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, for a nonurgent case; or

(B) Within twenty-four (24) hours from the request by a nationally approved cleft-craniofacial surgical team member, 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 FOR CRANIOFACIAL PROVIDERS**

(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) Within two (2) working days from the appointment date or services rendered date, by a nationally approved cleft-craniofacial surgical team, for a nonurgent case; or

(B) Within twenty-four (24) hours from the appointment date or services rendered date, by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

(c) Every needed service or recommended procedure shall be initiated from 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 NONCRANIOFACIAL PROVIDERS**

(a) **Medical Provider Office Requirements for Noncraniofacial Providers.** A medical provider that is not on a nationally approved cleft craniofacial team shall communicate and respond within two (2) working days from the appointment or services rendered date to any medical information requests made by the nationally approved cleft-craniofacial surgical team member who initiated the recommendation described in this section.

(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) Within two (2) working days from the appointment date or date of the requested services as recommended by a nationally approved cleft-craniofacial surgical team member, for a nonurgent case; or

(ii) Within twenty-four (24) hours from the appointment date or date of requested services as recommended by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

(c) The recommended needed services shall be initiated from a referral 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) The noncraniofacial provider shall comply with Section 7 for referrals for services.

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

## **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 noncraniofacial provider shall use the Attestation or Authorization form which shall be designated as Wendelyn's Craniofacial Law Authorization Form as Exhibit "A" to this Rule.

#### **SECTION 8. EFFECTIVE DATE**

The effective date of this Rule is January 1, 2022.

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**ALAN MCCLAIN**  
**INSURANCE COMMISSIONER**

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**DATE**