Arkansas Review Processes

Authorization

The State of Arkansas uses the term "Authorization" to refer to Utilization Review (UR), which is the determination as to whether or not a service meets a health plan's criteria for medical necessity.

There are 3 forms of UR:

- Prospective or Pre-determination—when a service is reviewed before it is rendered.
- Concurrent—when a service is reviewed as it is rendered, i.e., inpatient hospitalizations.
- Retrospective—when a service is reviewed after it has been rendered.

Prospective or Pre-determination

A pre-determination may be requested by the insured or a provider when either party would like to know if a service would be considered medically necessary prior to the service being rendered. We will review the information given in the pre-determination request for completeness, ensuring we have appropriate information for medical necessity review.

1. We will request additional information as needed to establish medical necessity, e.g., office notes, pre-op photos, visual fields, etc.
2. The review will be conducted by our Medical Director who will make one of the following recommendations:
    a) Request additional medical information needed to support necessity for service.
    b) Approve the requested service. When approved we will a send letter of approval to the provider and insured.
    c) Refer to an Independent Review Organization (IRO) if it appears procedure may not meet the plan's definition of medical necessity. This process should take no more than 16 working days.
3. The IRO review process follows:

a) When sending file to IRO we will include the description of the proposed procedure, associated medical records, correspondence and a copy of the plan's medical necessity definition.

b) After the IRO has made their decision:

i. If the IRO determines the proposed procedure is NOT medically necessary, we will deny the request and include the denial reason in notice to the person that requested the review and the insured. The denial will be expressed in clear terms giving the contractual basis or medical rationale in detail. The denial will include a reference to the evidence or documentation used as the basis for the decision.

ii. If proposed procedure was determined to be medically necessary, we will send a letter of approval to provider and insured.

Concurrent

Our company does not perform concurrent UR. If the health plan has a precertification requirement, please refer any questions to the plan's Utilization Review Organization. Their name and toll-free number can be found on the ID card.

Retrospective Review

When a post-claim review is required we utilize this process:

1. We will request additional information as needed to establish medical necessity, e.g., office notes, pre-op photos, visual fields, etc.

2. The review will be conducted by our Medical Director who will make one of the following recommendations:

   a) Request additional medical information needed to support necessity for service.

   b) Allow the service.

   c) Refer to an Independent Review Organization (IRO) if it appears procedure may not meet the plan's definition of medical necessity. This process should take no more than 16 working days.

3. The IRO review process follows:

   a) When sending file to IRO we will include the description of the proposed procedure, associated medical records, correspondence and a copy of the plan's medical necessity definition.

b) After the IRO has made their decision:

i. If the IRO determines the proposed procedure is NOT medically necessary, we will deny the claim and include the denial reason in notice to the provider and the insured. The denial will be expressed in clear terms giving the contractual basis or medical rationale in detail. The denial will include a reference to the evidence or documentation used as the basis for the decision.

ii. If proposed procedure was determined to be medically necessary, we will allow the claim.

Independent Review Organization Requirements

The Independent Review Organization (IRO) is required to be

- Licensed, authorized or certified in the state in which the claim is incurred;
- Compliant with all state requirements for an IRO;
- URAC or NCQA accredited.

Nonmedical Review

Charges are reviewed against plan provisions to determine the benefits available. This process includes confirming that:

1. Coverage is in force for the claimant;
2. Charges are for an eligible expense;
3. Services are not excluded by the plan; and
4. Benefits are correctly calculated.

If you have further questions about our company's review process you can reach our company by calling toll-free 1-800-899-6520.