AMERICAN SOCIETY OF PLASTIC SURGEONS ® THE PLASTIC SURGERY FOUNDATION ™
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SESPRS
Southeastern Society of Plastic and Reconstructive Surgeons

November 30, 2021

Booth Rand, *Managing Attorney*
Arkansas Department of Insurance
1 Commerce Way
Little Rock, AR 72202

RE: Support of Proposed Amended Rule 111

Dear Mr. Rand:

On behalf of the Southeastern Society of Plastic and Reconstructive Surgeons (SESPRS) and the American Society of Plastic Surgeons (ASPS), we write in support of Proposed Amended Rule 111. ASPS is the largest association of plastic surgeons in the world, and in conjunction with the SESPRS, represents more than 7,000 members and 94 percent of all board-certified plastic surgeons in the United States – including 38 board-certified plastic surgeons in Arkansas. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

Children with a congenital anomaly or birth defect or disorder who do not receive treatment at an early age face long-term physical and psychological injuries. Despite the ability of reconstructive surgical efforts to improve the outlook for these children, many insurers often claim that these services are "cosmetic" in nature, especially subsequent stage surgeries. However, the American Medical Association defines surgery performed on abnormal structures of the body caused by congenital defects or developmental abnormalities as reconstructive, not cosmetic. Furthermore, insurers frequently overlook the dental and orthodontic needs of these patients – which are essential to their achieving normal form and function – and mislead affected patients and the public when deeming these procedures cosmetic.

Proposed Amended Rule 111 will address the problem of insurance denials for reconstructive surgery and necessary adjunctive care for children suffering from congenital or development deformities. With your leadership, we can help children suffering from deformities and disfigurement receive coverage for the treatment they need.

We strongly support Proposed Amended Rule 111. Please do not hesitate to contact Patrick Hermes, ASPS's Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions.

Sincerely,

J. Peter Rubin, MD

J. Peter Rubin, MD, MBA, FACS
President, American Society of Plastic Surgeons

Jorge De la Torre, MD, FACS, MSHA
President, Southeastern Society of Plastic & Reconstructive Surgeons

Booth Rand

From: Booth Rand
Sent: Monday, December 6, 2021 12:22 PM
To: Johnson, Lacey A.
Subject: RE: BLR - Proposed Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

Yes

Sincerely,

Booth Rand
Managing Attorney
One Commerce Way, Suite 102
Little Rock, AR 72202
(501) 371-2827
booth.rand@arkansas.gov

Please be advised that my emails or responses are not intended to be binding Orders, Rules, Bulletins or Directives of the Arkansas Insurance Commissioner. This is an informal communication or reply which represents my best judgment at the time and does not constitute an advisory opinion, does not necessarily represent the formal position of AID, and does not bind or otherwise obligate or commit the agency to the views expressed.

From: Johnson, Lacey A. <johnsonla@blr.arkansas.gov>
Sent: Monday, December 6, 2021 11:30 AM
To: Booth Rand <booth.rand@arkansas.gov>
Subject: RE: BLR - Proposed Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

Thank you!

I asked that third question because I noticed that § 3(c)-(e) of the proposed rules specifically lists out everything included in A.C.A § 23-79-1502(d) except the dehumidifier. To clarify, the Insurance Department still requires health benefit plans to cover a dehumidifier as required by Act 955?

From: Booth Rand [mailto:booth.rand@arkansas.gov]
Sent: Monday, December 6, 2021 7:14 AM
To: Johnson, Lacey A.
Subject: RE: BLR - Proposed Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

1. We are supplying them in this Rule because the statute does not.
2. We will consider adding that.
3. No, we are just adding items not in the statute.

Sincerely,

Booth Rand

Managing Attorney
One Commerce Way, Suite 102
ttle Rock, AR 72202
501) 371-2827
booth.rand@arkansas.gov

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From: Booth Rand
Sent: Wednesday, December 1, 2021 7:45 AM
To: Johnson, Lacey A. <johnsonla@blr.arkansas.gov>
Subject: RE: BLR - Proposed Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

Lacey, I'll respond to these on Friday. Thanks.

Sincerely,

Booth Rand
Managing Attorney
One Commerce Way, Suite 102
ttle Rock, AR 72202
501) 371-2827
booth.rand@arkansas.gov

Please be advised that my emails or responses are not intended to be binding Orders, Rules, Bulletins or Directives of the Arkansas Insurance Commissioner. This is an informal communication or reply which represents my best judgment at the time and does not constitute an advisory opinion, does not necessarily represent the formal position of AID, and does not bind or otherwise obligate or commit the agency to the views expressed.

From: Johnson, Lacey A. <johnsonla@blr.arkansas.gov>
Sent: Monday, November 22, 2021 12:00 PM
To: Booth Rand <booth.rand@arkansas.gov>
Subject: BLR - Proposed Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

Good morning,

I have just finished reviewing the proposed changes to Rule 111 and I have a few questions about them.

1. Is there a specific source for the definitions of "acquired craniofacial anomaly" and "urgent healthcare service," or were these definitions created for this rule?

2. Section 3(c), which lists out what health benefit plans must cover, mostly tracks with the list provided in Ark. Code Ann. § 23-79-1502(d). However, the statute states that a health benefit plan must include coverage "if medically necessary." Is there a reason the language regarding medical necessity was not included in the rule?

3. Ark. Code Ann. § 23-79-1502(d)(3) provides coverage for a dehumidifier every four years. Is there a reason this item was omitted from the list in the proposed rule?

I appreciate your assistance in answering these questions.

Thank you,

Lacey A. Johnson
Legislative Attorney, Administrative Rules Review Section
Bureau of Legislative Research
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501.683.1916

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December 9, 2021

VIA EMAIL

Booth Rand, Esq.
Managing Attorney
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202
Booth.rand@arkansas.gov

Re: Proposed Amended Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage

Dear Mr. Rand:

These comments on proposed amended Rule 111 are submitted on behalf of Dean McNeel DDS and Ozark Prosthodontics in response to the Amended Notice of Public Hearing issued November 3, 2021, and in anticipation of the public hearing scheduled for December 10, 2021. Please submit them as part of the record at the hearing. While not exhaustive, these comments address the most significant issues with the proposed Rule.

The stated purpose of Act 955 of 2021 is to "serve residents in this state who are in need of healthcare services to treat individuals with craniofacial anomalies." [Act 955, Emergency Clause.] The statute requires Health Benefit Plans to include coverage and benefits for reconstructive surgery and related medical care for a person diagnosed as having a craniofacial anomaly if the care is medically necessary to improve a functional impairment "as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft-Palate-Craniofacial Association in Chapel Hill, North Carolina." Arkansas Children's Hospital (ACH) has the only ACPA approved team in Arkansas. In contrast to the goals of the statute, in its present form the proposed amended Rule will *restrict* access to critical services for patients with a craniofacial anomaly.

Initiation of Referral for Covered Services - Proposed Rule § 5.

As amended by Act 955 of 2021, the statute states that services included in the required coverage "shall be *authorized* by a surgical member of a nationally approved cleft-craniofacial team of the American Cleft Palate-Craniofacial Association." Ark. Code Ann. § 23-79-1502(c)(1) (emphasis added). The statute only requires that the services be *authorized* by a surgical team

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member. However, the Rule changes the authorization requirement to a requirement that the team not only authorize but *initiate* a *referral* for covered services. This change is not supported by the statute and will result in the denial of care to patients with a craniofacial anomaly.

Under the proposed Rule, "recommended services **shall initiate from a referral to** the medical provider . . . **by** the nationally approved cleft-craniofacial team." [Proposed Rule, § 5(c).] To "initiate" is "to start or begin (something)." https://www.merriam-webster.com/dictionary/initiate. In the medical community, a referral is the act of sending or directing a patient to another provider for treatment. The statute does not require every craniofacial anomaly patient in Arkansas to become a patient of ACH or another out-of-state ACPA approved team to obtain a referral for these critical services. Nor would such a requirement be reasonable since many such patients are adults. In fact, in the past, it has been reported that some adult patients with a craniofacial anomaly have been refused care by ACH precisely because they are adults. However, the proposed Rule is drafted in such a way that, in Arkansas, only ACH can "initiate" a "referral" to a medical provider who is not on the ACH ACPA approved team. [Proposed Rule, § 5(c).] In sum, the text of the proposed Rule can be construed as requiring that only ACH can begin the process of a patient receiving care from a provider who is not on ACH's craniofacial team, and that a non-team provider can only provide care if a referral is made by ACH to it in the first place. This requirement is not in the statute, and it will restrict care.

As you know, in recent years at least one Health Insurer has rejected claims for coverage under the statute based on a strict interpretation of the statute as requiring every member of the ACH team to see the patient (whether an adolescent or adult) and approve the proposed services. Act 955 was intended in part to stop that from occurring by allowing a surgical member of a team to authorize services by a non-team member provider. However, the language of the proposed Rule could similarly be asserted by a Health Insurer to reject authorization requests that arise from a non-team member submitting an authorization request with supporting documentation to the ACH team, as opposed to the team *initiating* the referral for services to the non-team member provider. It is not a stretch to envision a Health Insurer responding to a non-team member provider's preauthorization request with a request for that non-team member's referral from an ACPA approved team, even if the preauthorization request is accompanied by an Attestation, and then denying preauthorization based on the absence of a referral initiating the recommended services in the first place. Consequently, care will potentially be denied to adults who are not patients of ACH and for whom ACH will not accept appointments. This is completely inconsistent with the legislative intent behind Act 955 and an unnecessary limitation of the statute.

Although the Department has indicated that the intent of the Rule is that a provider can submit a patient's file to an ACPA approved team with a request that a surgical member of the team review it and sign an attestation that the treatment is medically necessary, I respectfully submit that this is not the process outlined in the text of the proposed Rule. If this is the Department's intent, it could be easily accomplished by a Rule that does not create an initiation requirement and contemplates a medical provider that is not on the team submitting a request for authorization to the ACPA team on behalf of its patient, supported with relevant medical records. This would be consistent with the stated objective of the statute to serve residents who need these services, and it would make the covered services more readily available to patients. It would avoid

the bottleneck that will be created if every craniofacial patient across the State of Arkansas is required to become a patient of ACH or obtain a referral from ACH before consulting a non-team member provider.

Similarly, the proposed Rule is flawed because it contemplates that the surgical member of an ACPA approved team will submit the preauthorization request to a Health Insurer, even for services that are to be provided by a provider that is not a member of the team. This is not only unreasonable, but also *impossible*. Under any plan, a request for preauthorization must be submitted *by the provider who will be providing the services and submitting the claim for payment*. ACH cannot submit a preauthorization request for an unaffiliated provider. The proposed Rule should address the applicability of the 2-day review requirement to a preauthorization request submitted to a Health Insurer directly by a non-team member provider if the request is supported with an authorization, or attestation, from a team member. Again, history tells us that the failure of the proposed Rule to address this circumstance could result in coverage denials to the patients who are supposed to be benefitted by the statute.

In addition, the use of the undefined terms "craniofacial provider" and "non craniofacial provider" appears unnecessary and will create ambiguity in the Rule. Even a medical provider that is not a member of an ACPA approved team may provide craniofacial services and would therefore be a craniofacial provider under any common understanding of the term. It is therefore inappropriate and confusing to refer to such a medical provider as a "non craniofacial provider." It is sufficient for purposes of the Rule to refer to providers as those who are members of an ACPA approved team and those who are not.

In addition, sections 4(b) and 5(b) of the proposed Rule appear to contain typos with respect to the use of the words "within" and "from." Any preauthorization must necessarily be acted upon before, not after, the date the services are to be provided. It would seem that the submissions referenced in those sections should be submitted to the health benefit plan before the proposed service date.

Attestation of Surgical Member of ACPA approved team – Proposed Rule, App. A.

Although not published with the proposed Rule, you have provided me with a copy of the "Appendix A: Attestation of Surgical Member of an American Cleft Palate-Cranio-Facial Association Approved Team." This Attestation is also problematic and will further restrict availability of care. The requirement that the Attestation be notarized imposes an additional requirement on ACPA approved teams that will hinder access to care. The authorization required by the statute is no different than other medical records and there is no requirement that preauthorization requests and supporting medical records submitted to Health Insurers be notarized. Not all teams have a notary public readily available to facilitate the notarization of every Attestation, and such a requirement will therefore unnecessarily burden the process for obtaining authorization.

The Attestation in Appendix A also appears to require that the signing team member be an M.D. or D.O. No such requirement exists in the statute. An unofficial survey of teams across the

region reveals that some surgical members of ACPA approved teams are neither an M.D. nor a D.O. For example, some teams are headed by an oral surgeon who is a D.D.S. The Attestation should not require or imply that only an M.D. or D.O. may authorize proposed services. This would be a serious and significant alteration of the statute resulting in less availability of care for patients.

Finally, the Attestation's requirement that the attesting team member be a "board certified surgeon" suffers from the same problem. No such requirement appears in the statute and imposing it will eliminate some ACPA approved teams. This is completely contrary to the legislature's intent to make ACPA approved teams outside of this state available to patients inside this state as set forth in the emergency clause of Act 955:

> SECTION 8. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that this state has a limited number of approved certified craniofacial specialists to review and treat individuals with craniofacial anomalies; **that increasing healthcare coverage for craniofacial patients allows a nationally approved cleft-craniofacial team outside of this state to provide healthcare services for residents of this state can decrease the delay in treatment**; and that this act is immediately necessary because there are residents in this state who are in need of healthcare services to treat individuals with craniofacial anomalies.

The Attestation should not require or imply that only a "board certified surgeon" who is an M.D. or D.O. may authorize proposed services.

In conclusion, I respectfully submit that the Department should revise the proposed amended Rule to address these very serious issues so that the final Rule is consistent with the legislative intent behind Act 955 and makes care more (and certainly not less) readily available to patients with craniofacial anomalies. With these comments, I am respectfully submitting a markup in redline form with proposed alternative language.

Thank you for your consideration.

Sincerely,

Grant E. Fortson

GEF
Encl. (markup of proposed Rule 111)

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 ACPA 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)~~ (3) 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 others services, as mandated by this Rule.

~~(e)~~ (4) 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~~d) 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~~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, 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 ACPA 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 ACPA 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~~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~~At least two (2) working days ~~from~~before the proposed service date~~appointment date or services rendered date~~, by a nationally approved cleft-craniofacial surgical team, for a nonurgent case; or

(B) ~~Within~~At least twenty-four (24) hours ~~from~~before the proposed service date~~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 NON ACPA APPROVED TEAM MEMBERS~~CRANIOFACIAL PROVIDERS~~

(a) Medical Provider Office Requirements for Non ACPA Approved Team members~~craniofacial 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~~ request to any medical information requests made by the nationally approved cleft-craniofacial surgical team member who ~~initiated~~made the recommendation described in this Rule~~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~~At least two (2) working days ~~from~~before the proposed service date~~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~~At least twenty-four (24) hours ~~from~~before the proposed service date~~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 the subject of an attestation delivered by a surgical team member of an ACPA Approved Team ~~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~~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 subsection (b) 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 ~~non-craniofacial 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.

ALAN MCCLAIN
INSURANCE COMMISSIONER

_____

DATE

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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December 1, 2021

The Honorable Booth Rand
Managing Attorney
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Proposed Amended Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage, "Wendelyn's Craniofacial Law – Craniofacial Coverage"

Dear Mr. Rand:

In response to the notice issued by the Arkansas Insurance Department on November 3, 2021. in connection with "Proposed Amended Rule 111: Craniofacial Anomaly Reconstructive Surgery Coverage," I am writing to provide comments on behalf of Arkansas Blue Cross and Blue Shield.

Arkansas Blue Cross supports the two principal goals of Rule 111 and its implementing law, Ark. Code Ann. §§23-79-1501 *et seq.* as amended by Act 955 of 2021. Those goals are

1. To assure individuals are accurately diagnosed with craniofacial anomaly; and

2. To assure that patients with craniofacial anomaly receive appropriate treatment.

The proposed amended rule implements the first goal by requiring in Section 7 the use of the "Attestation or Authorization form." However, the proposed rule limits the use of the rule to only noncraniofacial providers. Further, Section 7 does not explain how the attestation form shall be used. In accordance with Ark. Code Ann. §§23-79-1502(c), Section 7 should be revised to require the authorization form, completed and executed by a surgical member of a nationally approved cleft-craniofacial team, be submitted with all written authorizations of approval (claims) to health benefit plans for coverage of craniofacial anomaly treatment, whether the provider of proposed surgical services is a member of a nationally approved craniofacial team or not.

The proposed amended rule attempts to implement the second goal by requiring in Section 6 that health benefit plans providing coverage to Arkansans to cover charges for evaluations performed by a nationally approved cleft-craniofacial team in connection with a submission to the health benefit plan for its written authorization of coverage of craniofacial anomaly treatment. A payment structure afforded by submission of typical evaluation and management codes is commonly insufficient to reimburse the level of engagement, sophistication and experience required of and by a nationally approved team to guide the patient and treating provider to the best course of action. We at Arkansas

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Blue Cross recognize the need to adequately reimburse approved cleft-craniofacial teams for their determination of craniofacial anomaly and oversight of treatment. We propose that health benefit plans enter into contracts with an approved craniofacial team based upon expected hours of effort of various team members to perform a comprehensive, multidisciplinary evaluation and to arrive at an appropriate determination initially as well as to offer longitudinal oversight to the provider of services.

Since the initial enactment of the craniofacial anomaly law in 2013, Arkansas Blue Cross has received very few craniofacial anomaly claims with certification by an approved cleft-craniofacial team. The work to provide this information is time consuming and requires input from a number of physicians representing various specialties. Arkansas Blue Cross offers its assistance to the Commissioner in developing the evaluation reimbursements for approved cleft-craniofacial teams.

I have the following comments and recommendations about specific provisions of the proposed amended rule:

Provision	Comment or Recommendation
Section 2	Add a definition of "Administrator of the Health Benefit Plan." Subsection 3(f) refers to the administrator as "health insurer," but this in inaccurate if the health benefit plan is self-funded, providing health services to state and public school employees. Ark. Code Ann. §23-79-1501(2)(A).
Subsection 2(8)	Remove "for a non-life-threatening condition." This phrase is unnecessary and confusing because one of the reasons that a condition is urgent is a serious threat to life.
Subsection 3(c)(f)(B)	Delete the sentence "The standards in this section shall follow the Prior Authorization Transparency Initiative." Replace this sentence with specific standards from the Prior Authorization Transparency Act that are applicable to the provider and health benefit plan.
Sections 4 and 5	Although Arkansas Blue Cross and other health benefit plans are subject to this rule; however, I do not believe health benefit plans have any duties or obligations under Sections 4 and 5.

Ms. Zane Chrisman and I plan to be present at the hearing on December 10, 2021 and will be happy to further explain our comments or answer yours or the hearing officer's questions.

Respectfully submitted,

Frank B. Sewall

FBS:ad
enclosure

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) *"Administrator of the health benefit plan" means the person or organizational unit within the insurer, health maintenance organization, hospital medical service corporation or self-insured governmental or church plan underwriting the health benefit plan that is responsible for receiving and administering claims.*

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

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

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

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

(7) "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.

(8) "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.

(9) "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 dropseye weights, either surgically and/or external eye weights in one orboth 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 others 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~~ *health benefit plan* 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.*~~

(C) A health benefit plan may disapprove a request for written authorization of craniofacial treatment submitted in accordance with [this rule] if

(1) a surgical member of a nationally approved cleft-craniofacial team fails to submit the Authorization form set out in Exhibit A to this rule together with medical records utilized by the surgical member in making the finding of craniofacial anomaly and concurrence with the proposed treatment plan;

(2) the individual to receive the craniofacial anomaly treatment was not covered by the health benefit plan; or

(3) a treatment or service in request is not covered by the health benefit plan and not mandated by Ark. Code Ann. §§23-79-1501 et seq.

(D) A health benefit plan may subsequently deny a claim for reimbursement for craniofacial treatment previously authorized if:

(1) the treatment was never performed;

(2) specific information available for review by the appropriate state or federal agency shows that the subscriber or healthcare provider engaged in material misrepresentation, fraud or abuse regarding the claim.

(3) the authorization was granted more than ninety (90) days before the authorized healthcare services are provided.

SECTION 4. MEDICAL PROVIDER OFFICE REQUIREMENTS FOR ACPAAPPROVED 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~~ ***All providers submitting a request for written authorization of coverage for craniofacial anomaly treatment from a health benefit plan shall include in their request*** **the Attestation or Authorization form which shall bedesignated as Wendelyn's Craniofacial Law Authorization Form** ***set out*** **as Exhibit "A" to thisRule.**

SECTION 8. EFFECTIVE DATE

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

_____

ALAN MCCLAIN
INSURANCE COMMISSIONER

_____

DATE

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

~~FOR NONCRANIOFACIAL PROVIDERS~~

I, [NAME], M.D. or D.O., am a board certified surgeon and a Member of [Name of organization], a cleft-craniofacial team approved by the American Cleft Palate-Craniofacial Association.

On _____, 20__, I examined [Patient's Name] and reviewed his/her medical records. In addition, I examined the proposed treatment plan submitted by Dr. [provider's name]. Copies of the medical records 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_____

STATE OF ARKANSAS
COUNTY OF_____

On this _____ day of _____, 20_____, before me, _____, a Notary Public, appeared the within named _____ to me personally well known (or satisfactorily proven to be such person), who stated and acknowledged that [he, she or they] had so signed, executed and delivered said foregoing instrument for the consideration, uses and purposes therein mentioned and set forth.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal this _____ day of _____, 20_____.

_____ (Seal)

Signature of Notary Public

My Commission Expires: _____

December 10, 2021

Booth Rand, Managing Attorney
Arkansas Department of Insurance
1 Commerce Way
Little Rock, AR 72202

RE: Strongly Support Proposed Amended Rule 111

Dear Mr. Rand,

I, Wendelyn Yvonne Osborne, am writing to publicly state that I strongly support Proposed Amended Rule 111.

In February of 2000, I was to have much needed surgery, but I was told by my Federal Insurance Company that the needed procedure was considered "cosmetic", therefore it was denied. I then reached out to my Arkansas Federal Delegation, taking my very first steps in what is now known as Wendelyn's Craniofacial Law.

Wendelyn's Craniofacial Law is a mandate that provides much needed protection for those of us living with a craniofacial anomaly from well-intentioned doctors who do not have proper training nor experience in treating craniofacial anomalies.

I was born at Perin Air Force Base in Sherman, Texas. At eight months, I developed double pneumonia. An upper chest x-ray was taken, the attending physician was alarmed that my bones were solid white, NOT shadowy, as they should have been. At this point, my parents were told, once I was well, to take me to Lackland Air Force Base, in San Antonio, Texas, so they could figure out what was going on with me. At ten months, I was diagnosed as the 16th case in medical history with Craniometaphyseal Dysplasia, a rare form of a group of rare conditions known as Craniofacial Anomalies. Cleft Lip and/or Palate is the most common craniofacial diagnosis.

As if being first-time parents wasn't nerve racking enough, to be told your child is one of 16 cases in the world with such diagnosis but to also be told your child would never walk nor live to be 10, even though the life expectancy of this condition was 14, the fear and helplessness my parents must have felt? Just like parents feel today when they are told their child has a craniofacial

anomaly. They are like, a cranio what? It took my parents six years to find a doctor who would even look at me, because back in the 60s, doctors were not in the habit of saying, "I don't know". Finally, when I was six years old, my parents found a doctor who was willing to see me and put my parents in touch with a plastic surgeon, who then recruited an otolaryngologist and an orthodontist. I had my first of numerous surgical procedures while I was in the first grade. I missed a lot of school due to these numerous surgeries, but I didn't let that get in the way of graduating from high school when I was supposed to. I even went off to college when I was told I couldn't do such, even earning two advanced degrees.

In January of 2017, after experiencing excruciating migraines that were keeping me from being able to fully live life, I reached out to my craniofacial plastic surgeon, and he ordered a CT of my skull. He consulted with the pediatric neurosurgeon on the craniofacial team and the consensus was to do a Bi-Lateral Craniotomy as soon as possible. One of the characteristics of my condition is that my bones, which are very dense, are still growing, thus putting pressure on my cranial nerves, affecting my I, II, III, VII and VIII nerves, meaning my optic nerves, facial nerves and auditory nerves are greatly impacted.

Boy! Was I ever so grateful that I had my craniofacial plastic and pediatric neurosurgeon performing this surgical procedure. Even they, who each had 30+ years of training and surgical experience in treating craniofacial anomalies, were taken aback by what they saw once they got into my cranium. My brain was NOT the bumpy shape of a cauliflower, my bones were pressing so tightly up against everything else in my cranium and since it didn't have anywhere else to grow, it started growing into my brain. The pediatric neurosurgeon had to intricately pick out the bone from my brain without affecting any of my bodily functions. I'd sure hate to have had a non-craniofacial plastic or pediatric neurosurgeon doing this procedure. I can confidently say that I am able to write this letter to you because these two craniofacial specialists were able to fall on their 30+ years of surgical experience and figure out how to successfully handle what they were unexpectedly presented with. When I went in for my post-operative appointment two months later, I was told that had I not had this Bi-Lateral Craniotomy when I did, this bone growth would have been fatal within five years.

Treating craniofacial anomalies is a very complex process, in that when you take one step forward, you take five steps backwards at the same time. When you go in and address an area that needs to be corrected, then that in itself creates a problem(s) where there wasn't a problem prior. Those not trained or experienced in treating craniofacial anomalies think they can do what they are very good at on a craniofacial patient and get the same result(s). This just isn't the correct scenario at all. Therefore, it is imperative that craniofacial patients have a craniofacial team in place that are all trained and experienced in treating craniofacial anomalies, which in themselves are very rare with just over 2% of the United States population and just over 5,000 Arkansans living with one of the many craniofacial diagnoses, if not multiple craniofacial diagnoses.

Booth, did you know that in treating craniofacial anomalies, orthodontists are used in 100% of ALL craniofacial cases, whereas periodontists, prosthodontists and other dental specialties are used maybe 2% in ALL craniofacial cases? It's true! Personally, I have had five different sets of braces, meaning, my parents or I paid for five "different" sets of braces. It doesn't take a rocket scientist to realize five sets of braces is not the norm.

In addition, I have had the unfortunate experience of having well-intentioned non-craniofacial trained nor experienced doctors do procedures on me, of which I am living with the ramifications of their lack of proper experience and training. Did you know surgeons trained and experienced in craniofacial anomalies spend a lot of their time, trying to correct what the well-intentioned non-craniofacially trained/experienced doctor did? These doctors get to walk away and not have to face the consequences of their actions, while the craniofacial patient have to live with unnecessary, physical pain on a regular basis, just as I do. These unintentional mistakes are never ever fully fixed. I just think this is a crying shame, when it could have been avoided.

In closing, I just want to say, when I set out in 2000 to educate everyone about the "ins" and "outs" of living with a craniofacial anomaly, I did so using my own personal experience and the many craniofacial patients and their families that I have had the fortune of getting to know on a personal level. You, see? It's not "just" about all the medical appointments and surgeries, it's also about the ignorance we face on a daily basis as well as people just being outright mean in addition to the name calling because we don't look as they think we should. We as humans were ALL made in God's image. God has a purpose for EVERYONE, including those He has chosen to live with

craniofacial anomalies, which is a dauting journey to travel on all levels. Having to fight insurance companies and being forced to go to medical specialists who are not adequately trained or adequately experienced in craniofacial anomalies, shouldn't be our life. Thus, is why Wendelyn's Craniofacial Law purposely has everything begin and end with the ACPA craniofacial approved surgical team member, in order to minimize the harm to craniofacial patients from well-intentioned doctors.

Again, I strongly support proposed amended Rule 111.

Thank you for your time,

Wendelyn Y. Osborne, Craniofacial Patient/Advocate

PS,
I have never benefitted from my own law. I have spent 21 years shedding my blood, sweat and tears educating of the "ins" and "outs" of living with a craniofacial anomaly because it is the right thing to do, not for what I can gain from it.