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2001 MAY -2 P 11: 25

OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 2001

ENROLLED

**COMMITTEE SUBSTITUTE
FOR
House Bill No. 2486**

(By Mr. Speaker, Mr. Kiss, and Delegates Angotti,
Amores, Beane, Cann and R. M. Thompson)

Passed April 14, 2001

In Effect July 1, 2001

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H. B. 2486

(BY MR. SPEAKER, MR. KISS, AND DELEGATES ANGOTTI,
AMORES, BEANE, CANN AND R. M. THOMPSON)

[Passed April 14, 2001; in effect July 1, 2001.]

AN ACT amend chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto a new article, designated article forty-three, all relating to establishing claim settlement practices for insurers providing certain health insurance coverages; defining terms; establishing procedures and criteria for payment of claims by insurers; excepting certain providers and other entities from this article; providing procedures to review and appeal claims; requiring interest paid for failure to pay certain claims; requiring certain information be provided to insurer and providers to verify claims; providing timely payment of certain claims; requiring notice of failure to pay claim; providing procedures for retroactive approval and denial of claims; establishing requirements for payment of certain providers; prohibiting penalizing a provider who invokes the rights under this article; authorizing legislative

rulemaking authority to the insurance commissioner; and providing that the insurance commissioner may not adjudicate claims made pursuant to this article.

Be it enacted by the Legislature of West Virginia:

That chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended by adding thereto a new article, designated article forty-three, all to read as follows:

ARTICLE 43. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-43-1. Definitions.

1 As used in this article:

2 (1) "Claim" means each individual request for reimburse-
3 ment or proof of loss made by or on behalf of an insured or a
4 provider to an insurer, or its intermediary, administrator or
5 representative, with which the provider has a provider contract
6 for payment for health care services under any health plan.

7 (2) "Clean claim" means a claim: (A) That has no material
8 defect or impropriety, including all reasonably required
9 information and substantiating documentation, to determine
10 eligibility or to adjudicate the claim; or (B) with respect to
11 which an insurer has failed timely to notify the person submit-
12 ting the claim of any such defect or impropriety in accordance
13 with section two of this article.

14 (3) "Commissioner" means the insurance commissioner of
15 West Virginia.

16 (4) "Health care services" means items or services fur-
17 nished to any individual for the purpose of preventing, alleviat-
18 ing, curing, or healing human illness, injury or physical or
19 mental disability.

20 (5) "Health plan" means any individual or group health care
21 plan, subscription contract, evidence of coverage, certificate,
22 health services plan; medical or hospital services plan as
23 defined in article twenty four of this chapter; accident and
24 sickness insurance policy or certificate; managed care health
25 insurance plan, or health maintenance organization subject to
26 state regulation pursuant to article twenty-five-a of this chapter;
27 which is offered, arranged, issued or administered in the state
28 by an insurer authorized under this chapter, a third-party
29 administrator or an intermediary. Health plan does not mean:
30 (A) Coverages issued pursuant to Title XVIII of the Social
31 Security Act, 42 U.S.C. §1395 et seq. (Medicare), Title XIX of
32 the Social Security Act, 42 U.S.C. §1396 et seq. or Title XX of
33 the Social Security Act, 42 U.S.C. §1397 et seq. (Medicaid), 5
34 U.S.C. §8901 et seq., or 10 U.S.C. §1071 et seq. (CHAMPUS);
35 article sixteen, chapter five of this code (PEIA); (B) accident
36 only, credit or disability insurance, long-term care insurance,
37 CHAMPUS supplement, Medicare supplement, workers'
38 compensation coverages or limited benefits policy as defined in
39 article sixteen-e of this chapter, or (C) any a third-party
40 administrator or an intermediary acting on behalf of providers
41 as denoted in subparagraphs (A) and (B).

42 (6) "Insured" means a person who is provided health
43 insurance coverage or other health care services coverage from
44 an insurer under a health plan.

45 (7) "Insurer" means any person required to be licensed
46 under this chapter which offers or administers as a third party
47 administrator health insurance; operates a health plan subject to
48 this chapter; or provides or arranges for the provision of health
49 care services through networks or provider panels which are
50 subject to regulation as the business of insurance under this
51 chapter. "Insurer" also includes intermediaries. "Insurer" does
52 not include:

- 53 (A) Credit accident and sickness insurance;
- 54 (B) Accident and sickness policies which provide benefits
55 for loss of income due to disability;
- 56 (C) Any policy of liability of workers' compensation
57 insurance;
- 58 (D) Hospital indemnity or other fixed indemnity insurance;
- 59 (E) Life insurance, including endowment or annuity
60 contracts, or contracts supplemental thereto, which contain only
61 provisions relating to accident and sickness insurance that: (i)
62 Provide additional benefits in cases of death by accidental
63 means; or (ii) operate to safeguard the contracts against lapse,
64 in the event that the insured shall become totally and perma-
65 nently disabled as defined by the contract or supplemental
66 contract; and
- 67 (F) Property and Casualty insurance.
- 68 (8) "Provider contract" means any contract between a
69 provider and (A) an insurer' (B) a health plan; or (C) an
70 intermediary, relating to the provision of health care services.
- 71 (9) "Retroactive denial" means the practice of denying
72 previously paid claims by withholding or setting off against
73 payments, or in any other manner reducing or affecting the
74 future claim payments to the provider, or to seek direct cash
75 reimbursement from a provider for a payment previously made
76 to the provider.
- 77 (10) "Provider" means a person or other entity which holds
78 a valid license to provide specific health care services in this
79 state.
- 80 (11) "Intermediary" means a physician, hospital, physician-
81 hospital organization, independent provider organization or
82 independent provider network which receives compensation for

83 arranging one or more health care services to be rendered by
84 providers to insureds of a health plan or insurer. An intermedi-
85 ary does not include an individual provider or group practice
86 that utilizes only its employees, partners or shareholders and
87 their professional licenses to render services.

**§33-43-2. Minimum fair business standards contract provisions
required; processing and payment of health care
services; provider claims; commissioner's juris-
diction.**

1 (a) Every provider contract entered into, amended, extended
2 or renewed by an insurer on or after the first day of August, two
3 thousand one, shall contain specific provisions which shall
4 require the insurer to adhere to and comply with the following
5 minimum fair business standards in the processing and payment
6 of claims for health care services:

7 (1) An insurer shall either pay or deny a clean claim within
8 forty days of receipt of the claim if submitted manually and
9 within thirty days of receipt of the claim if submitted electroni-
10 cally, except in the following circumstances:

- 11 (A) Another payor or party is responsible for the claim;
- 12 (B) The insurer is coordinating benefits with another payor;
- 13 (C) The provider has already been paid for the claim;
- 14 (D) The claim was submitted fraudulently; or
- 15 (E) There was a material misrepresentation in the claim.

16 (2) Each insurer shall maintain a written or electronic
17 record of the date of receipt of a claim. The person submitting
18 the claim shall be entitled to inspect the record on request and
19 to rely on that record or on any other relevant evidence as proof

20 of the fact of receipt of the claim. If an insurer fails to maintain
21 an electronic or written record of the date a claim is received,
22 the claim shall be considered received three business days after
23 the claim was submitted based upon the written or electronic
24 record of the date of submittal by the person submitting the
25 claim.

26 (3) An insurer shall, within thirty days after receipt of a
27 claim, request electronically or in writing from the person
28 submitting the claim any information or documentation that the
29 insurer reasonably believes will be required to process and pay
30 the claim or to determine if the claim is a clean claim. The
31 insurer shall use all reasonable efforts to ask for all desired
32 information in one request, and shall if necessary, within fifteen
33 days of the receipt of the information from the first request,
34 only request or require additional information one additional
35 time if such additional information could not have been
36 reasonably identified at the time of the original request or to
37 specifically identify a material failure to provide the informa-
38 tion requested in the initial request. Upon receipt of the
39 information requested under this subsection which the insurer
40 reasonably believes will be required to adjudicate the claim or
41 to determine if the claim is a clean claim, an insurer shall either
42 pay or deny the claim within thirty days. No insurer may refuse
43 to pay a claim for health care services rendered pursuant to a
44 provider contract which are covered benefits if the insurer fails
45 to timely notify the person submitting the claim within thirty
46 days of receipt of the claim of the additional information
47 requested unless such failure was caused in material part by the
48 person submitting the claims: *Provided* that nothing herein shall
49 preclude such an insurer from imposing a retroactive denial of
50 payment of such a claim if permitted by the provider contract
51 unless such retroactive denial of payment of the claim would
52 violate subdivision seven, subsection (a) of this section. This
53 subsection does not require an insurer to pay a claim that is not
54 a clean claim except as provided herein.

55 (4) Interest, at a rate of ten percent per annum, accruing
56 after the forty-day period provided in subdivision (1), subsec-
57 tion (a) of this section owing or accruing on any claim under
58 any provider contract or under any applicable law, shall be paid
59 and accompanied by an explanation of the assessment on each
60 claim of interest paid, without necessity of demand, at the time
61 the claim is paid or within thirty days thereafter.

62 (5) Every insurer shall establish and implement reasonable
63 policies to permit any provider with which there is a provider
64 contract:

65 (A) To promptly confirm in advance during normal
66 business hours by a process agreed to between the parties
67 whether the health care services to be provided are a covered
68 benefit; and

69 (B) To determine the insurer's requirements applicable to
70 the provider (or to the type of health care services which the
71 provider has contracted to deliver under the provider contract)
72 for:

73 (i) Precertification or authorization of coverage decisions;

74 (ii) Retroactive reconsideration of a certification or
75 authorization of coverage decision or retroactive denial of a
76 previously paid claim;

77 (iii) Provider-specific payment and reimbursement method-
78 ology; and

79 (iv) Other provider-specific, applicable claims processing
80 and payment matters necessary to meet the terms and condi-
81 tions of the provider contract, including determining whether a
82 claim is a clean claim.

83 (C) Every insurer shall make available to the provider

84 within twenty business days of receipt of a request, reasonable
85 access either electronically or otherwise, to all the policies that
86 are applicable to the particular provider or to particular health
87 care services identified by the provider. In the event the
88 provision of the entire policy would violate any applicable
89 copyright law, the insurer may instead comply with this
90 subsection by timely delivering to the provider a clear explana-
91 tion of the policy as it applies to the provider and to any health
92 care services identified by the provider.

93 (6) Every insurer shall pay a clean claim if the insurer has
94 previously authorized the health care service or has advised the
95 provider or enrollee in advance of the provision of health care
96 services that the health care services are medically necessary
97 and a covered benefit, unless:

98 (A) The documentation for the claim provided by the
99 person submitting the claim clearly fails to support the claim as
100 originally authorized; or

101 (B) The insurer's refusal is because:

102 (i) Another payor or party is responsible for the payment;

103 (ii) The provider has already been paid for the health care
104 services identified on the claim;

105 (iii) The claim was submitted fraudulently or the authoriza-
106 tion was based in whole or material part on erroneous informa-
107 tion provided to the insurer by the provider, enrollee, or other
108 person not related to the insurer;

109 (iv) The person receiving the health care services was not
110 eligible to receive them on the date of service and the insurer
111 did not know, and with the exercise of reasonable care could
112 not have known, of the person's eligibility status;

113 (v) There is a dispute regarding the amount of charges
114 submitted; or

115 (vi) The service provided was not a covered benefit and the
116 insurer did not know, and with the exercise of reasonable care
117 could not have known, at the time of the certification that the
118 service was not covered.

119 (7) A previously paid claim may be retroactively denied
120 only in accordance with this subdivision.

121 (A) No insurance company may retroactively deny a
122 previously paid claim unless:

123 (i) The claim was submitted fraudulently;

124 (ii) The claim contained material misrepresentations;

125 (iii) The claim payment was incorrect because the provider
126 was already paid for the health care services identified on the
127 claim or the health care services were not delivered by the
128 provider;

129 (iv) The provider was not entitled to reimbursement;

130 (v) The service provided was not covered by the health
131 benefit plan; or

132 (vi) The insured was not eligible for reimbursement.

133 (B) A provider to whom a previously paid claim has been
134 denied by a health plan in accordance with this section shall,
135 upon receipt of notice of retroactive denial by the plan, notify
136 the health plan within forty days of the provider's intent to pay
137 or demand written explanation of the reasons for the denial.

138 (i) Upon receipt of explanation for retroactive denial, the
139 provider shall reimburse the plan within thirty days for allowing

140 an offset against future payments or provide written notice of
141 dispute.

142 (ii) Disputes shall be resolved between the parties within
143 thirty days of receipt of notice of dispute. The parties may agree
144 to a process to resolve the disputes in a provider contract.

145 (iii) Upon resolution of dispute, the provider shall pay any
146 amount due or provide written authorization for an offset
147 against future payments.

148 (C) A health plan may retroactively deny a claim only for
149 the reasons set forth in subparagraphs (iii), (iv), (v) and (vi),
150 paragraph (A) of this subdivision seven for a period of one year
151 from the date the claim was originally paid. There shall be no
152 time limitations for retroactively denying a claim for the
153 reasons set forth in subparagraphs (i) and (ii) above.

154 (8) No provider contract may fail to include or attach at the
155 time it is presented to the provider for execution:

156 (A) The fee schedule, reimbursement policy or statement as
157 to the manner in which claims will be calculated and paid
158 which is applicable to the provider or to the range of health care
159 services reasonably expected to be delivered by that type of
160 provider on a routine basis; and

161 (B) All material addenda, schedules and exhibits thereto
162 applicable to the provider or to the range of health care services
163 reasonably expected to be delivered by that type of provider
164 under the provider contract.

165 (9) No amendment to any provider contract or to any
166 addenda, schedule or exhibit, or new addenda, schedule,
167 exhibit, applicable to the provider to the extent that any of them
168 involve payment or delivery of care by the provider, or to the
169 range of health care services reasonably expected to be deliv-

170 ered by that type of provider, is effective as to the provider,
171 unless the provider has been provided with the applicable
172 portion of the proposed amendment, or of the proposed new
173 addenda, schedule or exhibit, and has failed to notify the insurer
174 within twenty business days of receipt of the documentation of
175 the provider's intention to terminate the provider contract at the
176 earliest date thereafter permitted under the provider contract.

177 (10) In the event that the insurer's provision of a policy
178 required to be provided under subdivision (8) or (9) of this
179 subsection would violate any applicable copyright law, the
180 insurer may instead comply with this section by providing a
181 clear, written explanation of the policy as it applies to the
182 provider.

183 (11) The insurer shall complete a credential check of any
184 new provider and accept or reject the provider within four
185 months following the submission of the provider's completed
186 application: *Provided*, that time frame may be extended for an
187 additional three months because of delays in primary source
188 verification. The insurer shall make available to providers a list
189 of all information required to be included in the application. A
190 provider who is permitted by the insurer to provide services and
191 who provides services during the credentialing period shall be
192 paid for the services if the provider's application is approved.

193 (b) Without limiting the foregoing, in the processing of any
194 payment of claims for health care services rendered by provid-
195 ers under provider contracts and in performing under its
196 provider contracts, every insurer subject to regulation by this
197 article shall adhere to and comply with the minimum fair
198 business standards required under subsection (a) of this section.
199 The commissioner has jurisdiction to determine if an insurer
200 has violated the standards set forth in subsection (a) of this
201 section by failing to include the requisite provisions in its
202 provider contracts. The commissioner has jurisdiction to

203 determine if the insurer has failed to implement the minimum
204 fair business standards set out in subdivisions (1) and (2),
205 subsection (a) of this section in the performance of its provider
206 contracts.

207 (c) No insurer is in violation of this section if its failure to
208 comply with this section is caused in material part by the person
209 submitting the claim or if the insurer's compliance is rendered
210 impossible due to matters beyond the insurer's reasonable
211 control, such as an act of God, insurrection, strike, fire, or
212 power outages, which are not caused in material part by the
213 insurer.

§33-43-3. Damages, attorney fees and costs available to providers upon insurer's violation of article or breach of contract provisions.

1 Any provider who suffers loss as the result of an insurer's
2 violation of any provision of this article or an insurer's breach
3 of any provider contract provision required by this article is
4 entitled to initiate an action to recover actual damages. The
5 commissioner shall not be deemed to be a "trier of fact" for
6 purposes of this section.

§33-43-4. Providers invoking rights protected.

1 No insurer or its network, provider panel or intermediary
2 may terminate or fail to renew the employment or other
3 contractual relationship with a provider, or any provider
4 contract, or otherwise penalize any provider, for invoking any
5 of the provider's rights under this article or under the provider
6 contract.

§33-43-5. Commissioner authorized to propose rules.

1 The commissioner is authorized to propose rules for
2 legislative approval in accordance with the provisions of article

3 three, chapter twenty-nine-a of this code, to implement the
4 provisions of this article.

§33-43-6. Commissioner's authority.

1 Nothing in this article shall limit or modify the commis-
2 sioner's duties and authority under article two of this chapter.

§33-43-7. Contractual alternative reimbursement arrangements.

1 This article shall not apply to provider contracts in which
2 payment is rendered by periodic, capitation or withhold
3 payments.

§33-43-8. Exemptions.

1 (a) The provisions of this article do not apply to claims that
2 are not covered under the terms of the health plan.

3 (b) Nothing in this article shall preclude the right of a
4 provider or insurer to pursue any other administrative, civil or
5 criminal proceedings or remedies permitted under state or
6 federal law.

7 (c) The provisions of this article do not apply when there is
8 a good faith dispute about the legitimacy of amount of the
9 claim, or when there is a reasonable basis supported by specific
10 information that such claim was submitted fraudulently or with
11 material misrepresentation.

12 (d) An insurer shall not be considered to be in violation of
13 this article if the insurer's failure to comply is caused in
14 material part by the person submitting the claim or the health
15 insurer's compliance is rendered impossible due to matters
16 beyond the insurer's reasonable control.

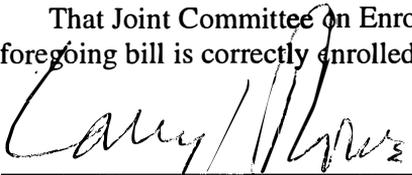
17 (e) A provider shall not be considered to be in violation of
18 this article if the failure to comply is caused in material part by

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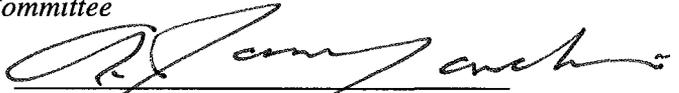
19 the insured or the provider's compliance is rendered impossible
20 due to matters beyond the provider's reasonable control.

21 (f) The provisions of this article do not apply to services
22 provided outside the state.

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.



Chairman Senate Committee



Chairman House Committee

Originating in the House.

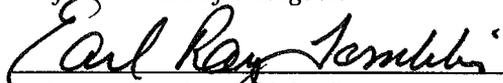
In effect July 1, 2001.



Clerk of the Senate



Clerk of the House of Delegates

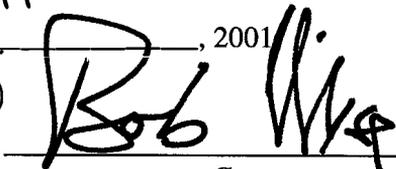


President of the Senate



Speaker of the House of Delegates

The within is approved this the 2nd
day of May, 2001.



Governor

PRESENTED TO THE

GOVERNOR

Date 4/24/01

Time 4:45pm