WEST VIRGINIA CODE CHAPTER 33 ARTICLE 16H

WV Legislature

§33-16H-1. Definitions.

As used in this article:

(1) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

(2) "External review" means a review of a final adverse determination by an independent review organization.

(3) "Final adverse determination" means an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been deemed exhausted.

(4) "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by an issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including short-term and catastrophic health insurance policies and policies that pay on a cost-incurred basis, but excludes the excepted benefits defined in 42 U. S. C. §300gg-91 and policies, contracts, certificates or agreements excluded by rules promulgated pursuant to section four of this article.

(5) "Health plan issuer" or "issuer" means an entity required to be licensed under this chapter that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including an accident and sickness insurance company, a health maintenance corporation, a health care corporation, a health or hospital service corporation, and a fraternal benefit society.

(6) "Independent review organization" means an entity approved by the commissioner to conduct external reviews of final adverse determinations.

(7) "Utilization review" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedure and facilities.

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§33-16H-2. Issuer requirements.

An issuer shall, in accordance with rules promulgated pursuant to section four of this article, develop processes for utilization review and internal grievance procedures and shall make external review available with respect to all adverse determinations.

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§33-16H-3. Judicial review; enforcement.

(a) An individual or issuer may seek judicial review of a final decision rendered by an independent review organization by filing a petition in the circuit court within sixty days after receipt of notice of such decision.

(1) Venue for a petition filed pursuant to this section is the county in which the individual resides or, if the individual is a non-resident, the county in which he or she works or, if he or she does not work in this state, the county in which his or her employer is located, or if none of these counties are applicable, in Kanawha County.

(2) The issuer shall provide benefits pursuant to the final external review decision, including by making payment on a disputed claim, unless or until there is a judicial decision otherwise.

(3) If the issuer files a petition pursuant to this section and the individual substantially prevails, the issuer shall be responsible for the reasonable attorney's fees of the individual.

(b) A decision issued by an independent review organization pursuant to this article may be enforced in the same manner as an order of the commissioner.

(c) This article does not create any new cause of action or eliminate any presently existing cause of action.

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§33-16H-4. Rule-making authority; applicability.

(a) The commissioner shall propose legislative rules for approval by the Legislature in accordance with the provisions of article three, chapter twenty-nine-a of this code to implement the provisions of this article, including, but not limited to, rules to:

(1) Define the scope of the applicability of this article;

(2) Establish requirements for all issuers with regard to utilization review and for internal grievance procedures and external review of adverse determinations, which rules shall be based on the corresponding model acts adopted by the National Association of Insurance Commissioners and, with respect to external review, shall meet or exceed the minimum consumer protections established by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152); and

(3) Provide for judicial review pursuant to subsection (a), section three of this article, which rules shall be based on the provisions of this code and rules governing judicial review of contested cases under the State Administrative Procedures Act.

(b) Notwithstanding the provisions of section one, article twenty-three of this chapter; section four, article twenty-four of this chapter; section six, article twenty-five of this chapter; and section twenty-four, article twenty-five-a of this chapter, this article and the rules promulgated under this article are applicable to all health benefits plans and supersede any provisions to the contrary in this chapter or in any rules promulgated under this chapter.

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