WEST VIRGINIA CODE: §33-25C-4

§33-25C-4. Access to appropriate health services.

(a) Each managed care plan must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers after six months with the change becoming effective no later than the beginning of the month next following the enrollee's request for the change.

(b) The enrollee's managed care plan may not provide to any provider or any primary care physician an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, to the provider or primary care physician as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(c) A managed care plan shall have a procedure by which an enrollee, upon diagnosis with a life-threatening, degenerative or disabling condition or disease, either of which requires specialized health care over a prolonged period of time, may receive a standing referral to a specialist with expertise in that condition or disease who will be responsible for and capable of providing and coordinating the member's specialty care. When a standing referral is made, the managed care plan shall periodically review the referral for continued necessity.

(d) Each managed care plan must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. The referral shall be first to a specialist located in the geographic area of the plan in which the enrollee resides and if an appropriate specialist is not available in the area, then to a specialist located elsewhere within the plan. If the type of medical specialist who is appropriate for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers in a manner consistent with their managed care contract.

(e) Each managed care plan must, upon the request of an enrollee, provide access by the enrollee to a second opinion regarding a diagnosis or treatment plan requiring a serious or complex procedure, from a qualified participating provider.

(f) Each managed care plan must, at the option of the enrollee, continue to cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees. The plan's obligation to continue to cover the primary care physician's services is contingent upon the primary care physician's acceptance and compliance with the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the managed care plan assign new enrollees to the terminated

provider.