

**H. B. 2918**

(By Delegates Ferns, Miley, Hartman, Guthrie,  
Moore, Manchin, Ferro, Marcum, Sponaugle,  
Sobonya and Storch)

[Introduced March 13, 2013; referred to the  
Committee on Health and Human Resources then the  
Judiciary.]

A BILL to repeal §33-4-7 of the Code of West Virginia, 1931, as amended; to amend said code by adding thereto a new section, designated §33-1-22; to amend and reenact §33-4-8 of said code; to amend and reenact §33-15-4d and §33-15-14 of said code; to amend said code by adding thereto a new section, designated §33-15-22; to amend and reenact §33-16-3h and §33-16-10 of said code; to amend said code by adding thereto a new section, designated §33-16-18; to amend said code by adding thereto three new sections, designated §33-16D-17, §33-16D-18 and §33-16D-19; to amend and reenact §33-24-7c and §33-24-43 of said code; to amend said code by adding thereto a new section, designated §33-24-71; to amend and reenact §33-25-8b of said code; to amend said code by adding thereto a new section, designated §33-25-8i; to amend and reenact §33-25-20; to amend and reenact §33-25A-8b of said code; to amend said code by adding thereto a new section, designated

1 §33-25A-8k; to amend and reenacted §33-25A-31 of said code;  
2 and to amend said code by adding thereto two new sections,  
3 designated §33-28-8 and §33-28-9, all relating to creating the  
4 West Virginia Fair Health Insurance Act of 2013; defining  
5 "illusionary benefit" to require benefits to cover at least  
6 seventy-five percent of health care service; establishing  
7 reasonable copays among common insurance needs; preventing  
8 insurance companies from discriminating against licensed  
9 health care practitioners to whom they will pay for a covered  
10 service; preventing insurance companies from arbitrarily  
11 defining medically necessary rehabilitation services to avoid  
12 making payment for a covered service or for a service that  
13 should be covered; making physical therapy and rehabilitation  
14 services a mandated covered service for any health insurance  
15 plan; and increasing the monetary criminal penalty for  
16 insurance companies that violate any provisions of the  
17 chapter.

18 *Be it enacted by the Legislature of West Virginia:*

19 That §33-4-7 of the Code of West Virginia, 1931, as amended,  
20 be repealed; that said code be amended by adding thereto a new  
21 section, designated §33-1-22; that §33-4-8 of said code be amended  
22 and reenacted; that §33-15-4d and §33-15-14 of said code be amended  
23 and reenacted; that said code be amended by adding thereto a new  
24 section, designated §33-15-22; that §33-16-3h and §33-16-10 of said

1 code be amended and reenacted; that said code be amended by adding  
2 thereto a new section, designated §33-16-18; that said code be  
3 amended by adding thereto three new sections, designated  
4 §33-16D-17, §33-16D-18 and §33-16D-19; that §33-24-7c of said code  
5 be amended and reenacted; that said code be amended by adding  
6 thereto a new section, designated §33-24-71; that §33-24-43 of said  
7 code be amended and reenacted; that §33-25-8b of said code be  
8 amended and reenacted; that said code be amended by adding thereto  
9 a new section, designated §33-25-8i; that §33-25-20 of said code be  
10 amended and reenacted; that §33-25A-8b of said code be amended and  
11 reenacted; that said code be amended by adding thereto a new  
12 section, designated §33-25A-8k; that §33-25A-31 of said code be  
13 amended and reenacted; and that said code be amended by adding  
14 thereto two new sections, designated §33-28-8 and §33-28-9, all to  
15 read as follows:

16 **ARTICLE 1. DEFINITIONS.**

17 **§33-1-22. Illusory benefit and policy.**

18 "Illusory benefit" means a copayment, or coinsurance, or  
19 codeductible, or combination thereof, outside of the annual  
20 contract deductible, which exceeds twenty-five percent of the  
21 contractual fee paid by an accident and sickness insurance company,  
22 fraternal benefit society, nonprofit health service corporation,  
23 nonprofit hospital service corporation, nonprofit medical service  
24 corporation, prepaid health plan, dental care plan, vision care

1 plan, pharmaceutical plan, health maintenance organization, and all  
2 similar type organizations to the network provider for covered  
3 services under the beneficiary's health insurance policy.

4 "Policy" means any policy, contract, plan or agreement of  
5 accident and sickness insurance, and credit accident and sickness  
6 insurance, delivered or issued for delivery in this state by any  
7 company subject to this article; any certificate, contract or  
8 policy issued by a fraternal benefit society; and any certificate  
9 issued pursuant to a group insurance policy delivered or issued for  
10 delivery in this state.

11 An insurer is prohibited from issuing policy that imposes an  
12 illusory benefit on beneficiaries for services provided by any of  
13 its network providers.

14 **ARTICLE 4. GENERAL PROVISIONS.**

15 **§33-4-8. General penalty.**

16 In addition to the refusal to renew, suspension or revocation  
17 of a license, or penalty in lieu of the foregoing, because of  
18 violation of any provision of this chapter, it is a misdemeanor for  
19 any person to violate any provision of this chapter unless the  
20 violation is declared to be a felony by this chapter or other law  
21 of this state. Unless another penalty is provided in this chapter  
22 or by the laws of this state, every person convicted of a  
23 misdemeanor for the violation of any provision of this chapter  
24 shall be fined not ~~more~~ less than \$1,000 per occurrence nor more

1 than \$10,000 per occurrence or confined in jail not more than six  
2 months, or both fined and confined.

3 **ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.**

4 **§33-15-4d. Third party reimbursement for rehabilitation services.**

5 (a) Notwithstanding any provision of any policy, provision,  
6 contract, plan or agreement to which this article applies, any  
7 entity regulated by this article shall, on or after July 1, ~~1991~~  
8 2013, provide as benefits to all subscribers and members coverage  
9 for rehabilitation services as hereinafter set forth, unless  
10 rejected by the insured.

11 (b) Medically necessary rehabilitation services. --  
12 Rehabilitation, as part of an individual's health care, is  
13 considered medically necessary as determined by the qualified  
14 health care provider based on the results of an evaluation and when  
15 provided for the purpose of preventing, minimizing or eliminating  
16 impairments, activity limitations or participation restrictions.  
17 Rehabilitation services are delivered throughout the episode of  
18 care by the qualified health care provider or under his or her  
19 direction and supervision; requires the knowledge, clinical  
20 judgment, and abilities of the qualified health care provider;  
21 takes into consideration the potential benefits and harms to the  
22 patient/client; and is not provided exclusively for the convenience  
23 of the patient/client. Rehabilitation services are provided using  
24 evidence of effectiveness and applicable standards of practice and

1 is considered medically necessary if the type, amount and duration  
2 of services outlined in the plan of care increase the likelihood of  
3 meeting one or more of these stated goals: to improve function,  
4 minimize loss of function, or decrease risk of injury and disease.

5 ~~(b)~~ (c) For purposes of this article and section,  
6 "rehabilitation services" includes those services which are  
7 designed to remediate patient's condition or restore patients to  
8 their optimal physical, medical, psychological, social, emotional,  
9 vocational and economic status. Rehabilitative services include by  
10 illustration and not limitation diagnostic testing, assessment,  
11 monitoring or treatment of the following conditions individually or  
12 in a combination:

- 13 (1) Stroke;
- 14 (2) Spinal cord injury;
- 15 (3) Congenital deformity;
- 16 (4) Amputation;
- 17 (5) Major multiple trauma;
- 18 (6) Fracture of femur;
- 19 (7) Brain injury;
- 20 (8) Polyarthrititis, including rheumatoid arthritis;
- 21 (9) Neurological disorders, including, but not limited to,  
22 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
23 dystrophy and Parkinson's disease;
- 24 (10) Cardiac disorders, including, but not limited to, acute

1 myocardial infarction, angina pectoris, coronary arterial  
2 insufficiency, angioplasty, heart transplantation, chronic  
3 arrhythmias, congestive heart failure, valvular heart disease;

4 (11) Burns;

5 (12) Orthopedic Disorders;

6 (13) Chronic Diseases including, but not limited to, diabetes,  
7 hypertension and obesity;

8 (14) Fall prevention and treatment;.

9 ~~(c)~~ (d) Rehabilitative services includes care rendered by any  
10 of the following:

11 (1) A hospital duly licensed by the State of West Virginia  
12 that meets the requirements for rehabilitation hospitals as  
13 described in Section 2803.2 of the Medicare Provider Reimbursement  
14 Manual, Part 1, as published by the U.S. Health Care Financing  
15 Administration;

16 (2) A distinct part rehabilitation unit in a hospital duly  
17 licensed by the State of West Virginia. The distinct part unit  
18 must meet the requirements of Section 2803.61 of the Medicare  
19 Provider Reimbursement Manual, Part 1, as published by the U.S.  
20 Health Care Financing Administration;

21 (3) A hospital duly licensed by the State of West Virginia  
22 which meets the requirements for cardiac rehabilitation as  
23 described in Section 35-25, Transmittal 41, dated August, 1989, as  
24 promulgated by the U.S. Health Care Financing Administration.

1        (4) Physical Therapists, Occupational Therapists and Speech  
2 Language Pathologists; (qualified health care professionals  
3 currently authorized under federal law (42 C.F.R. § 484.4)

4        ~~(d)~~ (e) Rehabilitation services do not include services for  
5 mental health, chemical dependency, vocational rehabilitation,  
6 long-term maintenance or custodial services.

7        ~~(e)~~ (f) A policy, provision, contract, plan or agreement may  
8 apply to rehabilitation services the same deductibles, coinsurance  
9 and other limitations as apply to other covered services.

10 **§33-15-14. Policies discriminating among health care providers.**

11        Notwithstanding any other provisions of law, when any health  
12 insurance policy, health care services plan or other contract  
13 provides for the payment of medical expenses, benefits or  
14 procedures, ~~such~~ the policy, plan or contract shall be construed to  
15 include payment to all health care providers including, but not  
16 limited to, medical physicians, osteopathic physicians, podiatric  
17 physicians, chiropractic physicians, physical therapists,  
18 occupational therapists, midwives, ~~and~~ nurse practitioners and  
19 their licensed assistants, who provide medical services, benefits  
20 or procedures which are within the scope of each respective  
21 provider's license. Any limitation or condition placed upon  
22 services, diagnoses or treatment by, or payment to any particular  
23 type of licensed provider shall apply equally to all types of  
24 licensed providers without unfair discrimination as to the usual



1 and customary treatment procedures of any of the aforesaid  
2 providers.

3 **§33-15-22. Copayments and coinsurance.**

4 "Copayment" means a specific dollar amount or percentage not  
5 to exceed twenty-five percent of covered charges, except as  
6 otherwise provided by statute, that the subscriber must pay upon  
7 receipt of covered health care services and which is set at an  
8 amount or percentage consistent with allowing subscriber access to  
9 health care services.

10 (a) Copayments in health benefit plans may not exceed the  
11 following amounts:

12 (1) Preventive services, \$30;

13 (2) Primary care provider office visit, including physical,  
14 occupational and speech therapists, \$30;

15 (3) Specialist physician office visit, \$75;

16 (4) Emergency room visit, \$100;

17 (5) Outpatient surgery, \$500;

18 (6) Inpatient admission, \$500 per day up to a maximum of  
19 \$2,500 per admission;

20 (7) Magnetic resonance imaging, computerized axial tomography  
21 and positron emission tomography, \$100;

22 (8) For any other services and supplies, the copayment is to  
23 be determined so that the carrier insures seventy-five percent or  
24 more of the aggregate risk for the service or supply to which the

1 copayment is applied.

2 (b) Network copayment may not be applied to any service or  
3 supply to which network coinsurance is applied.

4 (c)"Family out-of-pocket limit" means the maximum dollar  
5 amount that a family shall pay in combination as copayment,  
6 deductible and coinsurance for network covered services and  
7 supplies in a calendar, contract or policy year.

8 (d)"Individual out-of-pocket limit" means the maximum dollar  
9 amount that a covered person shall pay as copayment, deductible and  
10 coinsurance for services and supplies provided by network providers  
11 in a calendar, contract or policy year.

12 (e)"Network coinsurance" means the percentage of the  
13 contractual fee of the network provider for covered services and  
14 supplies specified in the contract between the provider and the  
15 carrier that must be paid by the covered person, under the health  
16 benefit plan, subject to network deductible and network  
17 out-of-pocket limit.

18 (f) All amounts paid as copayment, coinsurance and deductible  
19 count toward the out-of-pocket limit, and may not be excluded  
20 because of the nature of the service rendered, the illness or  
21 condition being treated, or for any other reason, except carriers  
22 may, provided the terms of the health benefit plan so state, elect  
23 to exclude from the out-of-pocket limit the cost sharing associated  
24 with prescription drug coverage, whether provided as part of the

1 health benefit plan or as a rider.

2 **ARTICLE 16. GROUP ACCIDENT AND SICKNESS INSURANCE.**

3 **§33-16-3h. Third party reimbursement for rehabilitation services.**

4 (a) Notwithstanding any provision of any policy, provision,  
5 contract, plan or agreement to which this article applies, any  
6 entity regulated by this article shall, on or after July 1, ~~1991~~  
7 2013, provide as benefits to all subscribers and members coverage  
8 for rehabilitation services as hereinafter set forth, unless  
9 rejected by the insured.

10 (b) Medically necessary rehabilitation services. --  
11 Rehabilitation, as part of an individual's health care, is  
12 considered medically necessary as determined by the qualified  
13 health care provider based on the results of an evaluation and when  
14 provided for the purpose of preventing, minimizing or eliminating  
15 impairments, activity limitations or participation restrictions.  
16 Rehabilitation services are delivered throughout the episode of  
17 care by the qualified health care provider or under his or her  
18 direction and supervision; requires the knowledge, clinical  
19 judgment, and abilities of the qualified health care provider;  
20 takes into consideration the potential benefits and harms to the  
21 patient/client; and is not provided exclusively for the convenience  
22 of the patient/client. Rehabilitation services are provided using  
23 evidence of effectiveness and applicable standards of practice and  
24 is considered medically necessary if the type, amount and duration

1 of services outlined in the plan of care increase the likelihood of  
2 meeting one or more of these stated goals: to improve function,  
3 minimize loss of function, or decrease risk of injury and disease.

4 ~~(b)~~ (c) For purposes of this article and section,  
5 "rehabilitation services" includes those services which are  
6 designed to remediate patient's condition or restore patients to  
7 their optimal physical, medical, psychological, social, emotional,  
8 vocational and economic status. Rehabilitative services include by  
9 illustration and not limitation diagnostic testing, assessment,  
10 monitoring or treatment of the following conditions individually or  
11 in a combination:

- 12 (1) Stroke;
- 13 (2) Spinal cord injury;
- 14 (3) Congenital deformity;
- 15 (4) Amputation;
- 16 (5) Major multiple trauma;
- 17 (6) Fracture of femur;
- 18 (7) Brain injury;
- 19 (8) Polyarthrititis, including rheumatoid arthritis;
- 20 (9) Neurological disorders, including, but not limited to,  
21 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
22 dystrophy and Parkinson's disease;
- 23 (10) Cardiac disorders, including, but not limited to, acute  
24 myocardial infarction, angina pectoris, coronary arterial

1 insufficiency, angioplasty, heart transplantation, chronic  
2 arrhythmias, congestive heart failure, valvular heart disease;

3 (11) Burns;

4 (12) Orthopedic Disorders;

5 (13) Chronic Diseases including, but not limited to, diabetes,  
6 hypertension and obesity;

7 (14) Fall prevention and treatment;

8 ~~(c)~~ (d) Rehabilitative services includes care rendered by any  
9 of the following:

10 (1) A hospital duly licensed by the State of West Virginia  
11 that meets the requirements for rehabilitation hospitals as  
12 described in Section 2803.2 of the Medicare Provider Reimbursement  
13 Manual, Part 1, as published by the U.S. Health Care Financing  
14 Administration;

15 (2) A distinct part rehabilitation unit in a hospital duly  
16 licensed by the State of West Virginia. The distinct part unit  
17 must meet the requirements of Section 2803.61 of the Medicare  
18 Provider Reimbursement Manual, Part 1, as published by the U.S.  
19 Health Care Financing Administration;

20 (3) A hospital duly licensed by the State of West Virginia  
21 which meets the requirements for cardiac rehabilitation as  
22 described in Section 35-25, Transmittal 41, dated August, 1989, as  
23 promulgated by the U.S. Health Care Financing Administration.

24 (4) Physical Therapists, Occupational Therapists and Speech

1 Language Pathologists; (qualified health care professionals  
2 currently authorized under federal law (42 C.F.R. § 484.4)

3 ~~(d)~~ (e) Rehabilitation services do not include services for  
4 mental health, chemical dependency, vocational rehabilitation,  
5 long-term maintenance or custodial services.

6 ~~(e)~~ (f) A policy, provision, contract, plan or agreement may  
7 apply to rehabilitation services the same deductibles, coinsurance  
8 and other limitations as apply to other covered services.

9 **§33-16-10. Policies discriminating among health care providers.**

10 Notwithstanding any other provisions of law, when any health  
11 insurance policy, health care services plan or other contract  
12 provides for the payment of medical expenses, benefits or  
13 procedures, ~~such~~ the policy, plan or contract shall be construed to  
14 include payment to all health care providers including , but not  
15 limited to, medical physicians, osteopathic physicians, podiatric  
16 physicians, chiropractic physicians, physical therapists,  
17 occupational therapists, midwives, ~~and~~ nurse practitioners and  
18 their licensed assistants, who provide medical services, benefits  
19 or procedures which are within the scope of each respective  
20 provider's license. Any limitation or condition placed upon  
21 services, diagnoses or treatment by, or payment to any particular  
22 type of licensed provider shall apply equally to all types of  
23 licensed providers without unfair discrimination as to the usual  
24 and customary treatment procedures of any of the aforesaid

1 providers.

2 **§33-16-18. Copayments and coinsurance.**

3 "Copayment" means a specific dollar amount or percentage not  
4 to exceed twenty-five percent of covered charges, except as  
5 otherwise provided by statute, that the subscriber must pay upon  
6 receipt of covered health care services and which is set at an  
7 amount or percentage consistent with allowing subscriber access to  
8 health care services.

9 (a) Copayments in health benefit plans may not exceed the  
10 following amounts:

11 (1) Preventive services, \$30;

12 (2) Primary care provider office visit, including physical,  
13 occupational and speech therapists, \$30;

14 (3) Specialist physician office visit, \$75;

15 (4) Emergency room visit, \$100;

16 (5) Outpatient surgery, \$500;

17 (6) Inpatient admission, \$500 per day up to a maximum of  
18 \$2,500 per admission;

19 (7) Magnetic resonance imaging, computerized axial tomography  
20 and positron emission tomography, \$100;

21 (8) For any other services and supplies, the copayment is to  
22 be determined so that the carrier insures seventy-five percent or  
23 more of the aggregate risk for the service or supply to which the  
24 copayment is applied.

1       (b) Network copayment may not be applied to any service or  
2 supply to which network coinsurance is applied.

3       (c)"Family out-of-pocket limit" means the maximum dollar  
4 amount that a family shall pay in combination as copayment,  
5 deductible and coinsurance for network covered services and  
6 supplies in a calendar, contract or policy year.

7       (d)"Individual out-of-pocket limit" means the maximum dollar  
8 amount that a covered person shall pay as copayment, deductible and  
9 coinsurance for services and supplies provided by network providers  
10 in a calendar, contract or policy year.

11       (e)"Network coinsurance" means the percentage of the  
12 contractual fee of the network provider for covered services and  
13 supplies specified in the contract between the provider and the  
14 carrier that must be paid by the covered person, under the health  
15 benefit plan, subject to network deductible and network  
16 out-of-pocket limit.

17       (f) All amounts paid as copayment, coinsurance and deductible  
18 count toward the out-of-pocket limit, and may not be excluded  
19 because of the nature of the service rendered, the illness or  
20 condition being treated, or for any other reason, except carriers  
21 may, provided the terms of the health benefit plan so state, elect  
22 to exclude from the out-of-pocket limit the cost sharing associated  
23 with prescription drug coverage, whether provided as part of the  
24 health benefit plan or as a rider.



1 **ARTICLE 16D.     MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER**  
2                                   **ACCIDENT AND SICKNESS INSURANCE POLICIES.**

3 **§33-16D-17.   Copayments and coinsurance.**

4       "Copayment" means a specific dollar amount or percentage not  
5 to exceed twenty-five percent of covered charges, except as  
6 otherwise provided by statute, that the subscriber must pay upon  
7 receipt of covered health care services and which is set at an  
8 amount or percentage consistent with allowing subscriber access to  
9 health care services.

10       (a) Copayments in health benefit plans may not exceed the  
11 following amounts:

12           (1) Preventive services, \$30;

13           (2) Primary care provider office visit, including physical,  
14 occupational and speech therapists, \$30;

15           (3) Specialist physician office visit, \$75;

16           (4) Emergency room visit, \$100;

17           (5) Outpatient surgery, \$500;

18           (6) Inpatient admission, \$500 per day up to a maximum of  
19 \$2,500 per admission;

20           (7) Magnetic resonance imaging, computerized axial tomography  
21 and positron emission tomography, \$100;

22           (8) For any other services and supplies, the copayment is to  
23 be determined so that the carrier insures seventy-five percent or  
24 more of the aggregate risk for the service or supply to which the

1 copayment is applied.

2 (b) Network copayment may not be applied to any service or  
3 supply to which network coinsurance is applied.

4 (c)"Family out-of-pocket limit" means the maximum dollar  
5 amount that a family shall pay in combination as copayment,  
6 deductible and coinsurance for network covered services and  
7 supplies in a calendar, contract or policy year.

8 (d)"Individual out-of-pocket limit" means the maximum dollar  
9 amount that a covered person shall pay as copayment, deductible and  
10 coinsurance for services and supplies provided by network providers  
11 in a calendar, contract or policy year.

12 (e)"Network coinsurance" means the percentage of the  
13 contractual fee of the network provider for covered services and  
14 supplies specified in the contract between the provider and the  
15 carrier that must be paid by the covered person, under the health  
16 benefit plan, subject to network deductible and network  
17 out-of-pocket limit.

18 (f) All amounts paid as copayment, coinsurance and deductible  
19 count toward the out-of-pocket limit, and may not be excluded  
20 because of the nature of the service rendered, the illness or  
21 condition being treated, or for any other reason, except carriers  
22 may, provided the terms of the health benefit plan so state, elect  
23 to exclude from the out-of-pocket limit the cost sharing associated  
24 with prescription drug coverage, whether provided as part of the

1 health benefit plan or as a rider.

2 **§33-16D-18. Policies discriminating among health care providers.**

3 Notwithstanding any other provisions of law, when any health  
4 insurance policy, health care services plan or other contract  
5 provides for the payment of medical expenses, benefits or  
6 procedures, the policy, plan or contract shall be construed to  
7 include payment to all health care providers including, but not  
8 limited to, medical physicians, osteopathic physicians, podiatric  
9 physicians, chiropractic physicians, physical therapists,  
10 occupational therapists, midwives, nurse practitioners and their  
11 licensed assistants, who provide medical services, benefits or  
12 procedures which are within the scope of each respective provider's  
13 license. Any limitation or condition placed on services, diagnoses  
14 or treatment by, or payment to any particular type of licensed  
15 provider shall apply equally to all types of licensed providers  
16 without unfair discrimination as to the usual and customary  
17 treatment procedures of any of the aforesaid providers.

18 **§33-16D-19. Third party reimbursement for rehabilitation services.**

19 (a) Notwithstanding any provision of any policy, provision,  
20 contract, plan or agreement to which this article applies, any  
21 entity regulated by this article shall, on or after July 1, 2013,  
22 provide as benefits to all subscribers and members coverage for  
23 rehabilitation services as hereinafter set forth, unless rejected  
24 by the insured.

1       (b) Medically necessary rehabilitation services. --  
2 Rehabilitation, as part of an individual's health care, is  
3 considered medically necessary as determined by the qualified  
4 health care provider based on the results of an evaluation and when  
5 provided for the purpose of preventing, minimizing or eliminating  
6 impairments, activity limitations or participation restrictions.  
7 Rehabilitation services are delivered throughout the episode of  
8 care by the qualified health care provider or under his or her  
9 direction and supervision; requires the knowledge, clinical  
10 judgment, and abilities of the qualified health care provider;  
11 takes into consideration the potential benefits and harms to the  
12 patient/client; and is not provided exclusively for the convenience  
13 of the patient/client. Rehabilitation services are provided using  
14 evidence of effectiveness and applicable standards of practice and  
15 is considered medically necessary if the type, amount and duration  
16 of services outlined in the plan of care increase the likelihood of  
17 meeting one or more of these stated goals: to improve function,  
18 minimize loss of function, or decrease risk of injury and disease.  
19       (c) For purposes of this article and section, "rehabilitation  
20 services" includes those services which are designed to remediate  
21 patient's condition or restore patients to their optimal physical,  
22 medical, psychological, social, emotional, vocational and economic  
23 status. Rehabilitative services include by illustration and not  
24 limitation diagnostic testing, assessment, monitoring or treatment

1 of the following conditions individually or in a combination:

2 (1) Stroke;

3 (2) Spinal cord injury;

4 (3) Congenital deformity;

5 (4) Amputation;

6 (5) Major multiple trauma;

7 (6) Fracture of femur;

8 (7) Brain injury;

9 (8) Polyarthrititis, including rheumatoid arthritis;

10 (9) Neurological disorders, including, but not limited to,  
11 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
12 dystrophy and Parkinson's disease;

13 (10) Cardiac disorders, including, but not limited to, acute  
14 myocardial infarction, angina pectoris, coronary arterial  
15 insufficiency, angioplasty, heart transplantation, chronic  
16 arrhythmias, congestive heart failure and valvular heart disease;

17 (11) Burns;

18 (12) Orthopedic Disorders;

19 (13) Chronic Diseases including, but not limited to, diabetes,  
20 hypertension and obesity;

21 (14) Fall prevention and treatment;

22 (d) Rehabilitative services includes care rendered by any of  
23 the following:

24 (1) A hospital duly licensed by the State of West Virginia

1 that meets the requirements for rehabilitation hospitals as  
2 described in Section 2803.2 of the Medicare Provider Reimbursement  
3 Manual, Part 1, as published by the U.S. Health Care Financing  
4 Administration;

5 (2) A distinct part rehabilitation unit in a hospital duly  
6 licensed by the State of West Virginia. The distinct part unit  
7 must meet the requirements of Section 2803.61 of the Medicare  
8 Provider Reimbursement Manual, Part 1, as published by the U.S.  
9 Health Care Financing Administration;

10 (3) A hospital duly licensed by the State of West Virginia  
11 which meets the requirements for cardiac rehabilitation as  
12 described in Section 35-25, Transmittal 41, dated August, 1989, as  
13 promulgated by the U.S. Health Care Financing Administration.

14 (4) Physical Therapists, Occupational Therapists and Speech  
15 Language Pathologists; (qualified health care professionals  
16 currently authorized under federal law (42 C.F.R. § 484.4)

17 (e) Rehabilitation services do not include services for mental  
18 health, chemical dependency, vocational rehabilitation, long-term  
19 maintenance or custodial services.

20 (f) A policy, provision, contract, plan or agreement shall  
21 apply to rehabilitation services the same deductibles, coinsurance  
22 and other limitations as apply to other covered services.

23 **ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE**  
24 **CORPORATIONS, DENTAL SERVICE CORPORATIONS AND**

1                                   **HEALTH SERVICE CORPORATIONS.**2 **§33-24-7c. Third party reimbursement for rehabilitation services.**

3           (a) Notwithstanding any provision of any policy, provision,  
4 contract, plan or agreement to which this article applies, any  
5 entity regulated by this article shall, on or after July 1, ~~1991~~  
6 2013, provide as benefits to all subscribers and members coverage  
7 for rehabilitation services as hereinafter set forth, unless  
8 rejected by the insured.

9           (b) Medically necessary rehabilitation services. --

10 Rehabilitation, as part of an individual's health care, is  
11 considered medically necessary as determined by the qualified  
12 health care provider based on the results of an evaluation and when  
13 provided for the purpose of preventing, minimizing or eliminating  
14 impairments, activity limitations or participation restrictions.  
15 Rehabilitation services are delivered throughout the episode of  
16 care by the qualified health care provider or under his or her  
17 direction and supervision; requires the knowledge, clinical  
18 judgment, and abilities of the qualified health care provider;  
19 takes into consideration the potential benefits and harms to the  
20 patient/client; and is not provided exclusively for the convenience  
21 of the patient/client. Rehabilitation services are provided using  
22 evidence of effectiveness and applicable standards of practice and  
23 is considered medically necessary if the type, amount and duration  
24 of services outlined in the plan of care increase the likelihood of

1 meeting one or more of these stated goals: to improve function,  
2 minimize loss of function, or decrease risk of injury and disease.

3 ~~(b)~~ (c) For purposes of this article and section,  
4 "rehabilitation services" includes those services which are  
5 designed to remediate patient's condition or restore patients to  
6 their optimal physical, medical, psychological, social, emotional,  
7 vocational and economic status. Rehabilitative services include by  
8 illustration and not limitation diagnostic testing, assessment,  
9 monitoring or treatment of the following conditions individually or  
10 in a combination:

- 11 (1) Stroke;
- 12 (2) Spinal cord injury;
- 13 (3) Congenital deformity;
- 14 (4) Amputation;
- 15 (5) Major multiple trauma;
- 16 (6) Fracture of femur;
- 17 (7) Brain injury;
- 18 (8) Polyarthrititis, including rheumatoid arthritis;
- 19 (9) Neurological disorders, including, but not limited to,  
20 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
21 dystrophy and Parkinson's disease;
- 22 (10) Cardiac disorders, including, but not limited to, acute  
23 myocardial infarction, angina pectoris, coronary arterial  
24 insufficiency, angioplasty, heart transplantation, chronic



1 arrhythmias, congestive heart failure, valvular heart disease;

2 (11) Burns;

3 (12) Orthopedic Disorders;

4 (13) Chronic Diseases including, but not limited to, diabetes,  
5 hypertension, and obesity;

6 (14) Fall prevention and treatment.

7 ~~(c)~~ (d) Rehabilitative services includes care rendered by any  
8 of the following:

9 (1) A hospital duly licensed by the State of West Virginia  
10 that meets the requirements for rehabilitation hospitals as  
11 described in Section 2803.2 of the Medicare Provider Reimbursement  
12 Manual, Part 1, as published by the U.S. Health Care Financing  
13 Administration;

14 (2) A distinct part rehabilitation unit in a hospital duly  
15 licensed by the State of West Virginia. The distinct part unit  
16 must meet the requirements of Section 2803.61 of the Medicare  
17 Provider Reimbursement Manual, Part 1, as published by the U.S.  
18 Health Care Financing Administration;

19 (3) A hospital duly licensed by the State of West Virginia  
20 which meets the requirements for cardiac rehabilitation as  
21 described in Section 35-25, Transmittal 41, dated August, 1989, as  
22 promulgated by the U.S. Health Care Financing Administration.

23 (4) Physical Therapists, Occupational Therapists and Speech  
24 Language Pathologists; (qualified health care professionals

1 currently authorized under federal law (42 C.F.R. § 484.4)

2 ~~(d)~~ (e) Rehabilitation services do not include services for  
3 mental health, chemical dependency, vocational rehabilitation,  
4 long-term maintenance or custodial services.

5 ~~(e)~~ (f) A policy, provision, contract, plan or agreement may  
6 apply to rehabilitation services the same deductibles, coinsurance  
7 and other limitations as apply to other covered services.

8 **§33-24-71. Copayments and coinsurance.**

9 "Copayment" means a specific dollar amount or percentage not  
10 to exceed twenty-five percent of covered charges, except as  
11 otherwise provided for by statute, that the subscriber must pay  
12 upon receipt of covered health care services and which is set at an  
13 amount or percentage consistent with allowing subscriber access to  
14 health care services.

15 (a) Copayments in health benefit plans may not exceed the  
16 following amounts:

17 (1) Preventive services, \$30;

18 (2) Primary care provider office visit, including physical,  
19 occupational and speech therapists, \$30;

20 (3) Specialist physician office visit, \$75;

21 (4) Emergency room visit, \$100;

22 (5) Outpatient surgery, \$500;

23 (6) Inpatient admission, \$500 per day up to a maximum of  
24 \$2,500 per admission;

1       (7) Magnetic resonance imaging, computerized axial tomography  
2 and positron emission tomography, \$100;

3       (8) For any other services and supplies, the copayment is to  
4 be determined so that the carrier insures seventy-five percent or  
5 more of the aggregate risk for the service or supply to which the  
6 copayment is applied.

7       (b) Network copayment may not be applied to any service or  
8 supply to which network coinsurance is applied.

9       (c)"Family out-of-pocket limit" means the maximum dollar  
10 amount that a family shall pay in combination as copayment,  
11 deductible and coinsurance for network covered services and  
12 supplies in a calendar, contract or policy year.

13       (d)"Individual out-of-pocket limit" means the maximum dollar  
14 amount that a covered person shall pay as copayment, deductible and  
15 coinsurance for services and supplies provided by network providers  
16 in a calendar, contract or policy year.

17       (e)"Network coinsurance" means the percentage of the  
18 contractual fee of the network provider for covered services and  
19 supplies specified in the contract between the provider and the  
20 carrier that must be paid by the covered person, under the health  
21 benefit plan, subject to network deductible and network  
22 out-of-pocket limit.

23       (f) All amounts paid as copayment, coinsurance and deductible  
24 count toward the out-of-pocket limit, and may not be excluded

1 because of the nature of the service rendered, the illness or  
2 condition being treated, or for any other reason, except carriers  
3 may, provided the terms of the health benefit plan so state, elect  
4 to exclude from the out-of-pocket limit the cost sharing associated  
5 with prescription drug coverage, whether provided as part of the  
6 health benefit plan or as a rider.

7 **§33-24-43. Policies discriminating among health care providers.**

8       Notwithstanding any other provisions of law, when any health  
9 insurance policy, health care services plan or other contract  
10 provides for the payment of medical expenses, benefits or  
11 procedures, ~~such~~ the policy, plan or contract shall be construed to  
12 include payment to all health care providers including, but not  
13 limited to, medical physicians, osteopathic physicians, podiatric  
14 physicians, chiropractic physicians, physical therapists,  
15 occupational therapists, midwives, ~~and~~ nurse practitioners and  
16 their licensed assistants, who provide medical services, benefits  
17 or procedures which are within the scope of each respective  
18 provider's license. Any limitation or condition placed upon  
19 services, diagnoses or treatment by, or payment to any particular  
20 type of licensed provider shall apply equally to all types of  
21 licensed providers without unfair discrimination as to the usual  
22 and customary treatment procedures of any of the aforesaid  
23 providers.

24 **ARTICLE 25. HEALTH CARE CORPORATIONS.**

1 **§33-25-8b. Third party reimbursement for rehabilitation services.**

2 (a) Notwithstanding any provision of any policy, provision,  
3 contract, plan or agreement to which this article applies, any  
4 entity regulated by this article shall, on or after July 1, ~~1991~~  
5 2013, provide as benefits to all subscribers and members coverage  
6 for rehabilitation services as hereinafter set forth, unless  
7 rejected by the insured.

8 (b) Medically necessary rehabilitation services. --

9 Rehabilitation, as part of an individual's health care, is  
10 considered medically necessary as determined by the qualified  
11 health care provider based on the results of an evaluation and when  
12 provided for the purpose of preventing, minimizing or eliminating  
13 impairments, activity limitations or participation restrictions.  
14 Rehabilitation services are delivered throughout the episode of  
15 care by the qualified health care provider or under his or her  
16 direction and supervision; requires the knowledge, clinical  
17 judgment and abilities of the qualified health care provider; takes  
18 into consideration the potential benefits and harms to the  
19 patient/client; and is not provided exclusively for the convenience  
20 of the patient/client. Rehabilitation services are provided using  
21 evidence of effectiveness and applicable standards of practice and  
22 is considered medically necessary if the type, amount and duration  
23 of services outlined in the plan of care increase the likelihood of  
24 meeting one or more of these stated goals: to improve function,

1 minimize loss of function, or decrease risk of injury and disease.

2 ~~(b)~~ (c) For purposes of this article and section,  
3 "rehabilitation services" includes those services which are  
4 designed to remediate patient's condition or restore patients to  
5 their optimal physical, medical, psychological, social, emotional,  
6 vocational and economic status. Rehabilitative services include by  
7 illustration and not limitation diagnostic testing, assessment,  
8 monitoring or treatment of the following conditions individually or  
9 in a combination:

- 10 (1) Stroke;
- 11 (2) Spinal cord injury;
- 12 (3) Congenital deformity;
- 13 (4) Amputation;
- 14 (5) Major multiple trauma;
- 15 (6) Fracture of femur;
- 16 (7) Brain injury;
- 17 (8) Polyarthrititis, including rheumatoid arthritis;
- 18 (9) Neurological disorders, including, but not limited to,  
19 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
20 dystrophy and Parkinson's disease;
- 21 (10) Cardiac disorders, including, but not limited to, acute  
22 myocardial infarction, angina pectoris, coronary arterial  
23 insufficiency, angioplasty, heart transplantation, chronic  
24 arrhythmias, congestive heart failure, valvular heart disease;

1 (11) Burns;

2 (12) Orthopedic Disorders;

3 (13) Chronic Diseases including, but not limited to, diabetes,  
4 hypertension and obesity;

5 (14) Fall prevention and treatment;

6 ~~(c)~~ (d) Rehabilitative services includes care rendered by any  
7 of the following:

8 (1) A hospital duly licensed by the State of West Virginia  
9 that meets the requirements for rehabilitation hospitals as  
10 described in Section 2803.2 of the Medicare Provider Reimbursement  
11 Manual, Part 1, as published by the U.S. Health Care Financing  
12 Administration;

13 (2) A distinct part rehabilitation unit in a hospital duly  
14 licensed by the State of West Virginia. The distinct part unit  
15 must meet the requirements of Section 2803.61 of the Medicare  
16 Provider Reimbursement Manual, Part 1, as published by the U.S.  
17 Health Care Financing Administration;

18 (3) A hospital duly licensed by the State of West Virginia  
19 which meets the requirements for cardiac rehabilitation as  
20 described in Section 35-25, Transmittal 41, dated August, 1989, as  
21 promulgated by the U.S. Health Care Financing Administration.

22 (4) Physical Therapists, Occupational Therapists and Speech  
23 Language Pathologists; (qualified health care professionals  
24 currently authorized under federal law (42 C.F.R. § 484.4)

1       ~~(d)~~ (e) Rehabilitation services do not include services for  
2 mental health, chemical dependency, vocational rehabilitation,  
3 long-term maintenance or custodial services.

4       ~~(e)~~ (f) A policy, provision, contract, plan or agreement may  
5 apply to rehabilitation services the same deductibles, coinsurance  
6 and other limitations as apply to other covered services.

7 **§33-25-8i. Copayments and coinsurance.**

8       "Copayment" means a specific dollar amount or percentage not  
9 to exceed twenty-five percent of covered charges, except as  
10 otherwise provided by statute, that the subscriber must pay upon  
11 receipt of covered health care services and which is set at an  
12 amount or percentage consistent with allowing subscriber access to  
13 health care services.

14       (a) Copayments in health benefit plans may not exceed the  
15 following amounts:

16       (1) Preventive services, \$30;

17       (2) Primary care provider office visit, including physical,  
18 occupational and speech therapists, \$30;

19       (3) Specialist physician office visit, \$75;

20       (4) Emergency room visit, \$100;

21       (5) Outpatient surgery, \$500;

22       (6) Inpatient admission, \$500 per day up to a maximum of  
23 \$2,500 per admission;

24       (7) Magnetic resonance imaging, computerized axial tomography



1 and positron emission tomography, \$100;

2 (8) For any other services and supplies, the copayment is to  
3 be determined so that the carrier insures seventy-five percent or  
4 more of the aggregate risk for the service or supply to which the  
5 copayment is applied.

6 (b) Network copayment may not be applied to any service or  
7 supply to which network coinsurance is applied.

8 (c)"Family out-of-pocket limit" means the maximum dollar  
9 amount that a family shall pay in combination as copayment,  
10 deductible and coinsurance for network covered services and  
11 supplies in a calendar, contract or policy year.

12 (d)"Individual out-of-pocket limit" means the maximum dollar  
13 amount that a covered person shall pay as copayment, deductible and  
14 coinsurance for services and supplies provided by network providers  
15 in a calendar, contract or policy year.

16 (e)"Network coinsurance" means the percentage of the  
17 contractual fee of the network provider for covered services and  
18 supplies specified in the contract between the provider and the  
19 carrier that must be paid by the covered person, under the health  
20 benefit plan, subject to network deductible and network  
21 out-of-pocket limit.

22 (f) All amounts paid as copayment, coinsurance and deductible  
23 count toward the out-of-pocket limit, and may not be excluded  
24 because of the nature of the service rendered, the illness or

1 condition being treated, or for any other reason, except carriers  
2 may, provided the terms of the health benefit plan so state, elect  
3 to exclude from the out-of-pocket limit the cost sharing associated  
4 with prescription drug coverage, whether provided as part of the  
5 health benefit plan or as a rider.

6 **§33-25-20. Policies discriminating among health care providers.**

7       Notwithstanding any other provisions of law, when any health  
8 insurance policy, health care services plan or other contract  
9 provides for the payment of medical expenses, benefits or  
10 procedures, ~~such~~ the policy, plan or contract shall be construed to  
11 include payment to all health care providers including, but not  
12 limited to, medical physicians, osteopathic physicians, podiatric  
13 physicians, chiropractic physicians, physical therapists,  
14 occupational therapists, midwives, ~~and~~ nurse practitioners and  
15 their licensed assistants, who provide medical services, benefits  
16 or procedures which are within the scope of each respective  
17 provider's license. Any limitation or condition placed upon  
18 services, diagnoses or treatment by, or payment to any particular  
19 type of licensed provider shall apply equally to all types of  
20 licensed providers without unfair discrimination as to the usual  
21 and customary treatment procedures of any of the aforesaid  
22 providers.

23 **ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.**

24 **§33-25A-8b. Third party reimbursement for rehabilitation**

1                   **services.**

2           (a) Notwithstanding any provision of any policy, provision,  
3 contract, plan or agreement to which this article applies, any  
4 entity regulated by this article shall, on or after July 1, ~~1991~~  
5 2013, provide as benefits to all subscribers and members coverage  
6 for rehabilitation services as hereinafter set forth, unless  
7 rejected by the insured.

8           (b) Medically necessary rehabilitation services. --

9 Rehabilitation, as part of an individual's health care, is  
10 considered medically necessary as determined by the qualified  
11 health care provider based on the results of an evaluation and when  
12 provided for the purpose of preventing, minimizing or eliminating  
13 impairments, activity limitations or participation restrictions.  
14 Rehabilitation services are delivered throughout the episode of  
15 care by the qualified health care provider or under his or her  
16 direction and supervision; requires the knowledge, clinical  
17 judgment, and abilities of the qualified health care provider;  
18 takes into consideration the potential benefits and harms to the  
19 patient/client; and is not provided exclusively for the convenience  
20 of the patient/client. Rehabilitation services are provided using  
21 evidence of effectiveness and applicable standards of practice and  
22 is considered medically necessary if the type, amount and duration  
23 of services outlined in the plan of care increase the likelihood of  
24 meeting one or more of these stated goals: to improve function,

1 minimize loss of function, or decrease risk of injury and disease.

2 ~~(b)~~ (c) For purposes of this article and section,  
3 "rehabilitation services" includes those services which are  
4 designed to remediate patient's condition or restore patients to  
5 their optimal physical, medical, psychological, social, emotional,  
6 vocational and economic status. Rehabilitative services include by  
7 illustration and not limitation diagnostic testing, assessment,  
8 monitoring or treatment of the following conditions individually or  
9 in a combination:

- 10 (1) Stroke;
- 11 (2) Spinal cord injury;
- 12 (3) Congenital deformity;
- 13 (4) Amputation;
- 14 (5) Major multiple trauma;
- 15 (6) Fracture of femur;
- 16 (7) Brain injury;
- 17 (8) Polyarthrititis, including rheumatoid arthritis;
- 18 (9) Neurological disorders, including, but not limited to,  
19 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
20 dystrophy and Parkinson's disease;
- 21 (10) Cardiac disorders, including, but not limited to, acute  
22 myocardial infarction, angina pectoris, coronary arterial  
23 insufficiency, angioplasty, heart transplantation, chronic  
24 arrhythmias, congestive heart failure, valvular heart disease;

1 (11) Burns;

2 (12) Orthopedic Disorders;

3 (13) Chronic Diseases including, but not limited to, diabetes,  
4 hypertension and obesity;

5 (14) Fall prevention and treatment;

6 ~~(c)~~ (d) Rehabilitative services includes care rendered by any  
7 of the following:

8 (1) A hospital duly licensed by the State of West Virginia  
9 that meets the requirements for rehabilitation hospitals as  
10 described in Section 2803.2 of the Medicare Provider Reimbursement  
11 Manual, Part 1, as published by the U.S. Health Care Financing  
12 Administration;

13 (2) A distinct part rehabilitation unit in a hospital duly  
14 licensed by the State of West Virginia. The distinct part unit  
15 must meet the requirements of Section 2803.61 of the Medicare  
16 Provider Reimbursement Manual, Part 1, as published by the U.S.  
17 Health Care Financing Administration;

18 (3) A hospital duly licensed by the State of West Virginia  
19 which meets the requirements for cardiac rehabilitation as  
20 described in Section 35-25, Transmittal 41, dated August, 1989, as  
21 promulgated by the U.S. Health Care Financing Administration.

22 (4) Physical Therapists, Occupational Therapists and Speech  
23 Language Pathologists; (qualified health care professionals  
24 currently authorized under federal law (42 C.F.R. § 484.4)

1       ~~(d)~~ (e) Rehabilitation services do not include services for  
2 mental health, chemical dependency, vocational rehabilitation,  
3 long-term maintenance or custodial services.

4       ~~(e)~~ (f) A policy, provision, contract, plan or agreement may  
5 apply to rehabilitation services the same deductibles, coinsurance  
6 and other limitations as apply to other covered services.

7 **§33-25A-8k. Copayments and coinsurance.**

8       "Copayment" means a specific dollar amount or percentage not  
9 to exceed twenty-five percent of covered charges, except as  
10 otherwise provided for by statute, that the subscriber must pay  
11 upon receipt of covered health care services and which is set at an  
12 amount or percentage consistent with allowing subscriber access to  
13 health care services.

14       (a) Copayments in health benefit plans may not exceed the  
15 following amounts:

16       (1) Preventive services, \$30;

17       (2) Primary care provider office visit, including physical,  
18 occupational and speech therapists, \$30;

19       (3) Specialist physician office visit, \$75;

20       (4) Emergency room visit, \$100;

21       (5) Outpatient surgery, \$500;

22       (6) Inpatient admission, \$500 per day up to a maximum of  
23 \$2,500 per admission;

24       (7) Magnetic resonance imaging, computerized axial tomography

1 and positron emission tomography, \$100;

2 (8) For any other services and supplies, the copayment is to  
3 be determined so that the carrier insures seventy-five percent or  
4 more of the aggregate risk for the service or supply to which the  
5 copayment is applied.

6 (b) Network copayment may not be applied to any service or  
7 supply to which network coinsurance is applied.

8 (c) "Family out-of-pocket limit" means the maximum dollar  
9 amount that a family shall pay in combination as copayment,  
10 deductible and coinsurance for network covered services and  
11 supplies in a calendar, contract or policy year.

12 (d) "Individual out-of-pocket limit" means the maximum dollar  
13 amount that a covered person shall pay as copayment, deductible and  
14 coinsurance for services and supplies provided by network providers  
15 in a calendar, contract or policy year.

16 (e) "Network coinsurance" means the percentage of the  
17 contractual fee of the network provider for covered services and  
18 supplies specified in the contract between the provider and the  
19 carrier that must be paid by the covered person, under the health  
20 benefit plan, subject to network deductible and network  
21 out-of-pocket limit.

22 (f) All amounts paid as copayment, coinsurance and deductible  
23 count toward the out-of-pocket limit, and may not be excluded  
24 because of the nature of the service rendered, the illness or

1 condition being treated, or for any other reason, except carriers  
2 may, provided the terms of the health benefit plan so state, elect  
3 to exclude from the out-of-pocket limit the cost sharing associated  
4 with prescription drug coverage, whether provided as part of the  
5 health benefit plan or as a rider.

6 **§33-25A-31. Policies discriminating among health care providers.**

7       Notwithstanding any other provisions of law, when any health  
8 insurance policy, health care services plan or other contract  
9 provides for the payment of medical expenses, benefits or  
10 procedures, ~~such~~ the policy, plan or contract shall be construed to  
11 include payment to all health care providers including, but not  
12 limited to, medical physicians, osteopathic physicians, podiatric  
13 physicians, chiropractic physicians, physical therapists,  
14 occupational therapists, midwives, ~~and~~ nurse practitioners and  
15 their licensed assistants, who provide medical services, benefits  
16 or procedures which are within the scope of each respective  
17 provider's license. Any limitation or condition placed upon  
18 services, diagnoses or treatment by, or payment to any particular  
19 type of licensed provider shall apply equally to all types of  
20 licensed providers without unfair discrimination as to the usual  
21 and customary treatment procedures of any of the aforesaid  
22 providers.

23 **ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM**  
24 **STANDARDS.**



1 **§33-28-8. Policies discriminating among health care providers.**

2 Notwithstanding any other provisions of law, when any health  
3 insurance policy, health care services plan or other contract  
4 provides for the payment of medical expenses, benefits or  
5 procedures, the policy, plan or contract shall be construed to  
6 include payment to all health care providers including, but not  
7 limited to, medical physicians, osteopathic physicians, podiatric  
8 physicians, chiropractic physicians, physical therapists,  
9 occupational therapists, midwives, nurse practitioners and their  
10 licensed assistants, who provide medical services, benefits or  
11 procedures which are within the scope of each respective provider's  
12 license. Any limitation or condition placed upon services,  
13 diagnoses or treatment by, or payment to any particular type of  
14 licensed provider shall apply equally to all types of licensed  
15 providers without unfair discrimination as to the usual and  
16 customary treatment procedures of any of the aforesaid providers.

17 **§33-28-9. Third party reimbursement for rehabilitation services.**

18 (a) Notwithstanding any provision of any policy, provision,  
19 contract, plan or agreement to which this article applies, any  
20 entity regulated by this article shall, on or after July 1, 2013,  
21 provide as benefits to all subscribers and members coverage for  
22 rehabilitation services as hereinafter set forth, unless rejected  
23 by the insured.

24 (b) *Medically necessary rehabilitation services.* --

1 Rehabilitation, as part of an individual's health care, is  
2 considered medically necessary as determined by the qualified  
3 health care provider based on the results of an evaluation and when  
4 provided for the purpose of preventing, minimizing or eliminating  
5 impairments, activity limitations or participation restrictions.  
6 Rehabilitation services are delivered throughout the episode of  
7 care by the qualified health care provider or under his or her  
8 direction and supervision; requires the knowledge, clinical  
9 judgment, and abilities of the qualified health care provider;  
10 takes into consideration the potential benefits and harms to the  
11 patient/client; and is not provided exclusively for the convenience  
12 of the patient/client. Rehabilitation services are provided using  
13 evidence of effectiveness and applicable standards of practice and  
14 is considered medically necessary if the type, amount and duration  
15 of services outlined in the plan of care increase the likelihood of  
16 meeting one or more of these stated goals: to improve function,  
17 minimize loss of function, or decrease risk of injury and disease.

18 (c) For purposes of this article and section, "rehabilitation  
19 services" includes those services which are designed to remediate  
20 patient's condition or restore patients to their optimal physical,  
21 medical, psychological, social, emotional, vocational and economic  
22 status. Rehabilitative services include by illustration and not  
23 limitation diagnostic testing, assessment, monitoring or treatment  
24 of the following conditions individually or in a combination:

- 1       (1) Stroke;
- 2       (2) Spinal cord injury;
- 3       (3) Congenital deformity;
- 4       (4) Amputation;
- 5       (5) Major multiple trauma;
- 6       (6) Fracture of femur;
- 7       (7) Brain injury;
- 8       (8) Polyarthritiis, including rheumatoid arthritis;
- 9       (9) Neurological disorders, including, but not limited to,  
10 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular  
11 dystrophy and Parkinson's disease;
- 12       (10) Cardiac disorders, including, but not limited to, acute  
13 myocardial infarction, angina pectoris, coronary arterial  
14 insufficiency, angioplasty, heart transplantation, chronic  
15 arrhythmias, congestive heart failure, valvular heart disease;
- 16       (11) Burns;
- 17       (12) Orthopedic Disorders;
- 18       (13) Chronic Diseases including, but not limited to, diabetes,  
19 hypertension and obesity;
- 20       (14) Fall prevention and treatment;
- 21       (d) Rehabilitative services includes care rendered by any of  
22 the following:
- 23       (1) A hospital duly licensed by the State of West Virginia  
24 that meets the requirements for rehabilitation hospitals as

1 described in Section 2803.2 of the Medicare Provider Reimbursement  
2 Manual, Part 1, as published by the U.S. Health Care Financing  
3 Administration;

4 (2) A distinct part rehabilitation unit in a hospital duly  
5 licensed by the State of West Virginia. The distinct part unit  
6 must meet the requirements of Section 2803.61 of the Medicare  
7 Provider Reimbursement Manual, Part 1, as published by the U.S.  
8 Health Care Financing Administration;

9 (3) A hospital duly licensed by the State of West Virginia  
10 which meets the requirements for cardiac rehabilitation as  
11 described in Section 35-25, Transmittal 41, dated August, 1989, as  
12 promulgated by the U.S. Health Care Financing Administration.

13 (4) Physical Therapists, Occupational Therapists and Speech  
14 Language Pathologists; (qualified health care professionals  
15 currently authorized under federal law (42 C.F.R. § 484.4)

16 (e) Rehabilitation services do not include services for mental  
17 health, chemical dependency, vocational rehabilitation, long-term  
18 maintenance or custodial services.

19 (f) A policy, provision, contract, plan or agreement shall  
20 apply to rehabilitation services the same deductibles, coinsurance  
21 and other limitations as apply to other covered services.

NOTE: The purpose of this bill is to create the West Virginia Fair Health Insurance Act of 2013. The bill defines "illusionary

benefit" to require benefits to cover at least seventy-five percent of health care service. It establishes reasonable copays among common insurance needs. It prevents insurance companies from discriminating against licensed health care practitioners to whom they will pay for a covered service. The bill prevents insurance companies from arbitrarily defining medically necessary rehabilitation services to avoid making payment for a covered service or for a service that should be covered. The bill makes physical therapy and rehabilitation services a mandated covered service for any health insurance plan. And, the bill increases the monetary criminal penalty for insurance companies that violate any provisions of the chapter.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.

§33-1-22, §33-15-22, §33-16-18, §33-16D-17, §33-16D-18, §33-16D-19, §33-24-71, §33-25-8i, §33-25A-8k, §33-28-8 and §33-28-9 are new; therefore, they have been completely underscored.