

WEST VIRGINIA LEGISLATURE

2019 REGULAR SESSION

ENROLLED

House Bill 2954

BY DELEGATE SUMMERS

[Passed March 7, 2019; in effect ninety days from
passage.]

1 AN ACT to amend and reenact §33-45-1 and §33-45-2 of the Code of West Virginia, 1931, as
2 amended, all relating to ethics and fairness in insurer business practices; clarifying
3 “provider” definition; correcting citations; and requiring payment for services of a provider
4 who provides services during the credentialing period.

Be it enacted by the Legislature of West Virginia:

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-45-1. Definitions.

1 As used in this article:

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

6 (2) “Clean claim” means a claim:

7 (A) That has no material defect or impropriety, including all reasonably required
8 information and substantiating documentation, to determine eligibility or to adjudicate the claim;
9 or

10 (B) With respect to which an insurer has failed timely to notify the person submitting the
11 claim of any such defect or impropriety in accordance with section two of this article.

12 (3) “Commissioner” means the Insurance Commissioner of West Virginia.

13 (4) “Health care services” means items or services furnished to any individual for the
14 purpose of preventing, alleviating, curing, or healing human illness, injury or physical or mental
15 disability.

16 (5) “Health plan” means any individual or group health care plan, subscription contract,
17 evidence of coverage, certificate, health services plan; medical or hospital services plan as
18 defined in article twenty four of this chapter; accident and sickness insurance policy or certificate;
19 managed care health insurance plan, or health maintenance organization subject to state

20 regulation pursuant to §33-25a-1 *et seq.*, of this code; which is offered, arranged, issued or
21 administered in the state by an insurer authorized under this chapter, a third-party administrator
22 or an intermediary. Health plan does not mean:

23 (A) Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §1395
24 *et seq.* (Medicare), Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* or Title XX of the
25 Social Security Act, 42 U.S.C. §1397 *et seq.* (Medicaid), 5 U.S.C. §8901 *et seq.*, or 10 U.S.C.
26 §1071 *et seq.* (CHAMPUS); or §5-16-1 *et seq.*, of this code (PEIA);

27 (B) Accident only, credit or disability insurance, long-term care insurance, CHAMPUS
28 supplement, Medicare supplement, workers' compensation coverages or limited benefits policy
29 as defined in article sixteen-e of this chapter; or

30 (C) Any a third-party administrator or an intermediary acting on behalf of providers as
31 denoted in §33-45-1(5)(A) or §33-45-1(5)(B) of this code.

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

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

39 (A) Credit accident and sickness insurance;

40 (B) Accident and sickness policies which provide benefits for loss of income due to
41 disability;

42 (C) Any policy of liability of workers' compensation insurance;

43 (D) Hospital indemnity or other fixed indemnity insurance;

44 (E) Life insurance, including endowment or annuity contracts, or contracts supplemental
45 thereto, which contain only provisions relating to accident and sickness insurance that:

46 (i) Provide additional benefits in cases of death by accidental means; or
47 (ii) Operate to safeguard the contracts against lapse, in the event that the insured shall
48 become totally and permanently disabled as defined by the contract or supplemental contract;

49 and

50 (F) Property and casualty insurance.

51 (8) "Provider contract" means any contract between a provider and

52 (A) An insurer;

53 (B) A health plan; or

54 (C) An intermediary, relating to the provision of health care services.

55 (9) "Retroactive denial" means the practice of denying previously paid claims by
56 withholding or setting off against payments, or in any other manner reducing or affecting the future
57 claim payments to the provider, or to seek direct cash reimbursement from a provider for a
58 payment previously made to the provider.

59 (10) "Provider" means a person or other entity which holds a valid license or permit,
60 including a valid temporary license or permit pursuant to chapter 30 of this code, to provide
61 specific health care services in this state.

62 (11) "Intermediary" means a physician, hospital, physician-hospital organization,
63 independent provider organization, or independent provider network which receives
64 compensation for arranging one or more health care services to be rendered by providers to
65 insureds of a health plan or insurer. An intermediary does not include an individual provider or
66 group practice that utilizes only its employees, partners or shareholders and their professional
67 licenses to render services.

**§33-45-2. Minimum fair business standards contract provisions required; processing and
payment of health care services; provider claims; commissioner's jurisdiction.**

1 (a) Every provider contract entered into, amended, extended, or renewed by an insurer on
2 or after August 1, 2001, shall contain specific provisions which shall require the insurer to adhere

3 to and comply with the following minimum fair business standards in the processing and payment
4 of claims for health care services:

5 (1) An insurer shall either pay or deny a clean claim within 40 days of receipt of the claim
6 if submitted manually and within 30 days of receipt of the claim if submitted electronically, except
7 in the following circumstances:

8 (A) Another payor or party is responsible for the claim;

9 (B) The insurer is coordinating benefits with another payor;

10 (C) The provider has already been paid for the claim;

11 (D) The claim was submitted fraudulently; or

12 (E) There was a material misrepresentation in the claim.

13 (2) Each insurer shall maintain a written or electronic record of the date of receipt of a
14 claim. The person submitting the claim shall be entitled to inspect the record on request and to
15 rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If
16 an insurer fails to maintain an electronic or written record of the date a claim is received, the claim
17 shall be considered received three business days after the claim was submitted based upon the
18 written or electronic record of the date of submittal by the person submitting the claim.

19 (3) An insurer shall, within 30 days after receipt of a claim, request electronically or in
20 writing from the person submitting the claim any information or documentation that the insurer
21 reasonably believes will be required to process and pay the claim or to determine if the claim is a
22 clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one
23 request, and shall if necessary, within 15 days of the receipt of the information from the first
24 request, only request or require additional information one additional time if such additional
25 information could not have been reasonably identified at the time of the original request or to
26 specifically identify a material failure to provide the information requested in the initial request.
27 Upon receipt of the information requested under this subsection which the insurer reasonably
28 believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an

29 insurer shall either pay or deny the claim within 30 days. No insurer may refuse to pay a claim for
30 health care services rendered pursuant to a provider contract which are covered benefits if the
31 insurer fails to timely notify the person submitting the claim within 30 days of receipt of the claim
32 of the additional information requested unless such failure was caused in material part by the
33 person submitting the claims: *Provided*, That nothing herein shall preclude such an insurer from
34 imposing a retroactive denial of payment of such a claim if permitted by the provider contract
35 unless such retroactive denial of payment of the claim would violate §33-45-2(a)(7) of this code.
36 This subsection does not require an insurer to pay a claim that is not a clean claim except as
37 provided herein.

38 (4) Interest, at a rate of 10 percent per annum, accruing after the 40-day period provided
39 in §33-45-2(a)(1) of this code owing or accruing on any claim under any provider contract or under
40 any applicable law, shall be paid and accompanied by an explanation of the assessment on each
41 claim of interest paid, without necessity of demand, at the time the claim is paid or within 30 days
42 thereafter.

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

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

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

49 (i) Precertification or authorization of coverage decisions;

50 (ii) Retroactive reconsideration of a certification or authorization of coverage decision or
51 retroactive denial of a previously paid claim;

52 (iii) Provider-specific payment and reimbursement methodology; and

53 (iv) Other provider-specific, applicable claims processing and payment matters necessary
54 to meet the terms and conditions of the provider contract, including determining whether a claim
55 is a clean claim.

56 (C) Every insurer shall make available to the provider within 20 business days of receipt
57 of a request, reasonable access either electronically or otherwise, to all the policies that are
58 applicable to the particular provider or to particular health care services identified by the provider.
59 In the event the provision of the entire policy would violate any applicable copyright law, the
60 insurer may instead comply with this subsection by timely delivering to the provider a clear
61 explanation of the policy as it applies to the provider and to any health care services identified by
62 the provider.

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

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

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

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

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

71 (iii) The claim was submitted fraudulently or the authorization was based in whole or
72 material part on erroneous information provided to the insurer by the provider, enrollee, or other
73 person not related to the insurer;

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

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

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

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

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

84 (i) The claim was submitted fraudulently;

85 (ii) The claim contained material misrepresentations;

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

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

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

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

91 (B) A provider to whom a previously paid claim has been denied by a health plan in
92 accordance with this section shall, upon receipt of notice of retroactive denial by the plan, notify
93 the health plan within 40 days of the provider's intent to pay or demand written explanation of the
94 reasons for the denial.

95 (i) Upon receipt of explanation for retroactive denial, the provider shall reimburse the plan
96 within 30 days for allowing an offset against future payments or provide written notice of dispute.

97 (ii) Disputes shall be resolved between the parties within 30 days of receipt of notice of
98 dispute. The parties may agree to a process to resolve the disputes in a provider contract.

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

101 (C) A health plan may retroactively deny a claim only for the reasons set forth in §33-45-
102 2(a)(7)(A)(iii) through §33-45-2(a)(7)(A)(vi) of this code for a period of one year from the date the

103 claim was originally paid. There shall be no time limitations for retroactively denying a claim for
104 the reasons set forth in §33-45-2(a)(7)(A)(i) and §33-45-2(a)(7)(A)(ii) of this code.

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

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

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

113 (9) No amendment to any provider contract or to any addenda, schedule, or exhibit, or
114 new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve
115 payment or delivery of care by the provider, or to the range of health care services reasonably
116 expected to be delivered by that type of provider, is effective as to the provider, unless the provider
117 has been provided with the applicable portion of the proposed amendment, or of the proposed
118 new addenda, schedule, or exhibit, and has failed to notify the insurer within 20 business days of
119 receipt of the documentation of the provider's intention to terminate the provider contract at the
120 earliest date thereafter permitted under the provider contract.

121 (10) In the event that the insurer's provision of a policy required to be provided under §33-
122 45-2(a)(8) and §33-45-2(a)(9) of this code would violate any applicable copyright law, the insurer
123 may instead comply with this section by providing a clear, written explanation of the policy as it
124 applies to the provider.

125 (11) The insurer shall complete a credential check of any new provider and accept or reject
126 the provider within four months following the submission of the provider's completed application:
127 *Provided*, That time frame may be extended for an additional three months because of delays in
128 primary source verification. The insurer shall make available to providers a list of all information

129 required to be included in the application. A provider who provides services during the
130 credentialing period shall be paid for the services: *Provided*, That nothing in this subdivision
131 prevents an insurer from obtaining refund of overpayments to a provider when the provider fails
132 to become credentialed after having gone through the credentialing process.

133 (b) Without limiting the foregoing, in the processing of any payment of claims for health
134 care services rendered by providers under provider contracts and in performing under its provider
135 contracts, every insurer subject to regulation by this article shall adhere to and comply with the
136 minimum fair business standards required under §33-45-2(a) of this code. The commissioner has
137 jurisdiction to determine if an insurer has violated the standards set forth in §33-45-2(a) of this
138 code by failing to include the requisite provisions in its provider contracts. The commissioner has
139 jurisdiction to determine if the insurer has failed to implement the minimum fair business standards
140 set out in §33-45-2(a)(1) and §33-45-2(a)(2) of this code in the performance of its provider
141 contracts.

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

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

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Chairman, House Committee

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Chairman, Senate Committee

Originating in the House.

In effect ninety days from passage.

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Clerk of the House of Delegates

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Clerk of the Senate

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Speaker of the House of Delegates

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President of the Senate

The within this the.....
day of, 2019.

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Governor