WEST VIRGINIA LEGISLATURE

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

2019 REGULAR SESSION

ENROLLED

House Bill 2954

BY DELEGATE SUMMERS

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

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

As used in this article:

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

(2) "Clean claim" means a claim:

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

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

(3) "Commissioner" means the Insurance Commissioner of West Virginia.

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

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

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

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

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

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

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

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

(A) Credit accident and sickness insurance;

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

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

(D) Hospital indemnity or other fixed indemnity insurance;

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

(i) Provide additional benefits in cases of death by accidental means; or

(ii) Operate to safeguard the contracts against lapse, in the event that the insured shall become totally and permanently disabled as defined by the contract or supplemental contract; and

(F) Property and casualty insurance.

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

(A) An insurer;

(B) A health plan; or

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

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

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

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

(a) Every provider contract entered into, amended, extended, or renewed by an insurer on or after August 1, 2001, shall contain specific provisions which shall require the insurer to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

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

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

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

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

(D) The claim was submitted fraudulently; or

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

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

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

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

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

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

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

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

(i) Precertification or authorization of coverage decisions;

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

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

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

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

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

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

(B) The insurer's refusal is because:

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

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

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

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

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

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

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

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

(i) The claim was submitted fraudulently;

(ii) The claim contained material misrepresentations;

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

(iv) The provider was not entitled to reimbursement;

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

(vi) The insured was not eligible for reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer's compliance is rendered impossible due to matters beyond the insurer's reasonable control, such as an act of God, 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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OFFICE WEST VIRGINIA
SECRETARY OF STATE

Moore Capito
....
Chairman, House Committee

Mark R Maynard
....
Chairman, Senate Committee

Originating in the House.

In effect ninety days from passage.

Stephen J. Harris
....
Clerk of the House of Delegates

Lee Cassis
....
Clerk of the Senate

Roger Hanshaw
....
Speaker of the House of Delegates

Mitch B. Carmichael
....
President of the Senate

The within is approved this the 25th

day of March, 2019.

Jim Justice
....
Governor

PRESENTED TO THE GOVERNOR

MAR 2 9 2019

Time 2:37 pm