

1 a new section, designated §33-25-8i; to amend and reenact
2 §33-25-20 of said code; to amend and reenact §33-25A-8b of
3 said code; to amend said code by adding thereto a new section,
4 designated §33-25A-8k; to amend and reenact §33-25A-31 of said
5 code; and to amend said code by adding thereto two new
6 sections, designated §33-28-8 and §33-28-9, all relating to
7 creating the West Virginia Fair Health Insurance Act of 2013;
8 defining "illusionary benefit" to require benefits to cover at
9 least seventy-five percent of health care service;
10 establishing reasonable copays among common insurance needs;
11 preventing insurance companies from discriminating against
12 licensed health care practitioners to whom they will pay for
13 a covered service; preventing insurance companies from
14 arbitrarily defining medically necessary rehabilitation
15 services to avoid making payment for a covered service or for
16 a service that should be covered; making physical therapy and
17 rehabilitation services a mandated covered service for any
18 health insurance plan; and increasing the monetary criminal
19 penalty for insurance companies that violate any provisions of
20 the chapter.

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

22 That §33-4-7 of the Code of West Virginia, 1931, as amended,

1 be repealed; that said code be amended by adding thereto a new
2 section, designated §33-1-22; that §33-4-8 of said code be amended
3 and reenacted; that §33-15-4d and §33-15-14 of said code be amended
4 and reenacted; that said code be amended by adding thereto a new
5 section, designated §33-15-22; that §33-16-3h and §33-16-10 of said
6 code be amended and reenacted; that said code be amended by adding
7 thereto a new section, designated §33-16-18; that said code be
8 amended by adding thereto three new sections, designated
9 §33-16D-17, §33-16D-18 and §33-16D-19; that §33-24-7c of said code
10 be amended and reenacted; that §33-24-43 of said code be amended
11 and reenacted; that said code be amended by adding thereto a new
12 section, designated §33-24-71; that §33-25-8b of said code be
13 amended and reenacted; that said code be amended by adding thereto
14 a new section, designated §33-25-8i; that §33-25-20 of said code be
15 amended and reenacted; that §33-25A-8b of said code be amended and
16 reenacted; that said code be amended by adding thereto a new
17 section, designated §33-25A-8k; that §33-25A-31 of said code be
18 amended and reenacted; and that said code be amended by adding
19 thereto two new sections, designated §33-28-8 and §33-28-9, all to
20 read as follows:

21 **ARTICLE 1. DEFINITIONS.**

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

1 "Illusory benefit" means a copayment, or coinsurance, or
2 codeductible, or combination thereof, outside of the annual
3 contract deductible, which exceeds twenty-five percent of the
4 contractual fee paid by an accident and sickness insurance company,
5 fraternal benefit society, nonprofit health service corporation,
6 nonprofit hospital service corporation, nonprofit medical service
7 corporation, prepaid health plan, dental care plan, vision care
8 plan, pharmaceutical plan, health maintenance organization, and all
9 similar type organizations to the network provider for covered
10 services under the beneficiary's health insurance policy.

11 "Policy" means any policy, contract, plan or agreement of
12 accident and sickness insurance, and credit accident and sickness
13 insurance, delivered or issued for delivery in this state by any
14 company subject to this article; any certificate, contract or
15 policy issued by a fraternal benefit society; and any certificate
16 issued pursuant to a group insurance policy delivered or issued for
17 delivery in this state.

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

21 **ARTICLE 4. GENERAL PROVISIONS.**

22 **§33-4-8. General penalty.**

1 In addition to the refusal to renew, suspension or revocation
2 of a license, or penalty in lieu of the foregoing, because of
3 violation of any provision of this chapter, it is a misdemeanor for
4 any person to violate any provision of this chapter unless the
5 violation is declared to be a felony by this chapter or other law
6 of this state. Unless another penalty is provided in this chapter
7 or by the laws of this state, every person convicted of a
8 misdemeanor for the violation of any provision of this chapter
9 shall be fined not ~~more~~ less than \$1,000 per occurrence nor more
10 than \$10,000 per occurrence or confined in jail not more than six
11 months, or both fined and confined.

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

13 **§33-15-4d. Third party reimbursement for rehabilitation services.**

14 (a) Notwithstanding any provision of any policy, provision,
15 contract, plan or agreement to which this article applies, any
16 entity regulated by this article shall, on or after July 1, ~~1991~~
17 2013, provide as benefits to all subscribers and members coverage
18 for rehabilitation services as hereinafter set forth, unless
19 rejected by the insured.

20 **(b) Medically necessary rehabilitation services. --**
21 Rehabilitation, as part of an individual's health care, is
22 considered medically necessary as determined by the qualified

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

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

1 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, 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 ~~(c)~~ (d) Rehabilitative services includes care rendered by any

1 of the following:

2 (1) A hospital duly licensed by the State of West Virginia
3 that meets the requirements for rehabilitation hospitals as
4 described in Section 2803.2 of the Medicare Provider Reimbursement
5 Manual, Part 1, as published by the U.S. Health Care Financing
6 Administration;

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

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

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

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

22 ~~(e)~~ (f) A policy, provision, contract, plan or agreement may

1 apply to rehabilitation services the same deductibles, coinsurance
2 and other limitations as apply to other covered services.

3 **§33-15-14. Policies discriminating among health care providers.**

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

20 **§33-15-22. Copayments and coinsurance.**

21 "Copayment" means a specific dollar amount or percentage not
22 to exceed twenty-five percent of covered charges, except as

1 otherwise provided by statute, that the subscriber must pay upon
2 receipt of covered health care services and which is set at an
3 amount or percentage consistent with allowing subscriber access to
4 health care services.

5 (a) Copayments in health benefit plans may not exceed the
6 following amounts:

7 (1) Preventive services, \$30;

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

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

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

12 (5) Outpatient surgery, \$500;

13 (6) Inpatient admission, \$500 per day up to a maximum of
14 \$2,500 per admission;

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

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

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

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

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

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

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

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

2 **§33-16-3h. 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

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

1 dystrophy and Parkinson's disease;

2 (10) Cardiac disorders, including, but not limited to, acute
3 myocardial infarction, angina pectoris, coronary arterial
4 insufficiency, angioplasty, heart transplantation, chronic
5 arrhythmias, congestive heart failure, valvular heart disease;

6 (11) Burns;

7 (12) Orthopedic Disorders;

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

10 (14) Fall prevention and treatment;

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

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

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

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

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

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

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

14 **§33-16-10. Policies discriminating among health care providers.**

15 Notwithstanding any other provisions of law, when any health
16 insurance policy, health care services plan or other contract
17 provides for the payment of medical expenses, benefits or
18 procedures, ~~such~~ the policy, plan or contract shall be construed to
19 include payment to all health care providers including , but not
20 limited to, medical physicians, osteopathic physicians, podiatric
21 physicians, chiropractic physicians, physical therapists,
22 occupational therapists, midwives, ~~and~~ nurse practitioners and

1 their licensed assistants, who provide medical services, benefits
2 or procedures which are within the scope of each respective
3 provider's license. Any limitation or condition placed upon
4 services, diagnoses or treatment by, or payment to any particular
5 type of licensed provider shall apply equally to all types of
6 licensed providers without unfair discrimination as to the usual
7 and customary treatment procedures of any of the aforesaid
8 providers.

9 **§33-16-18. Copayments and coinsurance.**

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

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

18 (1) Preventive services, \$30;

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

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

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

1 (5) Outpatient surgery, \$500;

2 (6) Inpatient admission, \$500 per day up to a maximum of
3 \$2,500 per admission;

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

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

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

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

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

20 (e) "Network coinsurance" means the percentage of the
21 contractual fee of the network provider for covered services and
22 supplies specified in the contract between the provider and the

1 carrier that must be paid by the covered person, under the health
2 benefit plan, subject to network deductible and network
3 out-of-pocket limit.

4 (f) All amounts paid as copayment, coinsurance and deductible
5 count toward the out-of-pocket limit, and may not be excluded
6 because of the nature of the service rendered, the illness or
7 condition being treated, or for any other reason, except carriers
8 may, provided the terms of the health benefit plan so state, elect
9 to exclude from the out-of-pocket limit the cost sharing associated
10 with prescription drug coverage, whether provided as part of the
11 health benefit plan or as a rider.

12 **ARTICLE 16D. MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER**

13 **ACCIDENT AND SICKNESS INSURANCE POLICIES.**

14 **§33-16D-17. Copayments and coinsurance.**

15 "Copayment" means a specific dollar amount or percentage not
16 to exceed twenty-five percent of covered charges, except as
17 otherwise provided by statute, that the subscriber must pay upon
18 receipt of covered health care services and which is set at an
19 amount or percentage consistent with allowing subscriber access to
20 health care services.

21 (a) Copayments in health benefit plans may not exceed the
22 following amounts:

- 1 (1) Preventive services, \$30;
- 2 (2) Primary care provider office visit, including physical,
3 occupational and speech therapists, \$30;
- 4 (3) Specialist physician office visit, \$75;
- 5 (4) Emergency room visit, \$100;
- 6 (5) Outpatient surgery, \$500;
- 7 (6) Inpatient admission, \$500 per day up to a maximum of
8 \$2,500 per admission;
- 9 (7) Magnetic resonance imaging, computerized axial tomography
10 and positron emission tomography, \$100;
- 11 (8) For any other services and supplies, the copayment is to
12 be determined so that the carrier insures seventy-five percent or
13 more of the aggregate risk for the service or supply to which the
14 copayment is applied.
- 15 (b) Network copayment may not be applied to any service or
16 supply to which network coinsurance is applied.
- 17 (c) "Family out-of-pocket limit" means the maximum dollar
18 amount that a family shall pay in combination as copayment,
19 deductible and coinsurance for network covered services and
20 supplies in a calendar, contract or policy year.
- 21 (d) "Individual out-of-pocket limit" means the maximum dollar
22 amount that a covered person shall pay as copayment, deductible and

1 coinsurance for services and supplies provided by network providers
2 in a calendar, contract or policy year.

3 (e) "Network coinsurance" means the percentage of the
4 contractual fee of the network provider for covered services and
5 supplies specified in the contract between the provider and the
6 carrier that must be paid by the covered person, under the health
7 benefit plan, subject to network deductible and network
8 out-of-pocket limit.

9 (f) All amounts paid as copayment, coinsurance and deductible
10 count toward the out-of-pocket limit, and may not be excluded
11 because of the nature of the service rendered, the illness or
12 condition being treated, or for any other reason, except carriers
13 may, provided the terms of the health benefit plan so state, elect
14 to exclude from the out-of-pocket limit the cost sharing associated
15 with prescription drug coverage, whether provided as part of the
16 health benefit plan or as a rider.

17 **§33-16D-18. Policies discriminating among health care providers.**

18 Notwithstanding any other provisions of law, when any health
19 insurance policy, health care services plan or other contract
20 provides for the payment of medical expenses, benefits or
21 procedures, the policy, plan or contract shall be construed to
22 include payment to all health care providers including, but not

1 limited to, medical physicians, osteopathic physicians, podiatric
2 physicians, chiropractic physicians, physical therapists,
3 occupational therapists, midwives, nurse practitioners and their
4 licensed assistants, who provide medical services, benefits or
5 procedures which are within the scope of each respective provider's
6 license. Any limitation or condition placed on services, diagnoses
7 or treatment by, or payment to any particular type of licensed
8 provider shall apply equally to all types of licensed providers
9 without unfair discrimination as to the usual and customary
10 treatment procedures of any of the aforesaid providers.

11 **§33-16D-19. Third party reimbursement for rehabilitation services.**

12 (a) Notwithstanding any provision of any policy, provision,
13 contract, plan or agreement to which this article applies, any
14 entity regulated by this article shall, on or after July 1, 2013,
15 provide as benefits to all subscribers and members coverage for
16 rehabilitation services as hereinafter set forth, unless rejected
17 by the insured.

18 (b) *Medically necessary rehabilitation services.* --
19 Rehabilitation, as part of an individual's health care, is
20 considered medically necessary as determined by the qualified
21 health care provider based on the results of an evaluation and when
22 provided for the purpose of preventing, minimizing or eliminating

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

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

21 (1) Stroke;

22 (2) Spinal cord injury;

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

22 **ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE**

1 **CORPORATIONS, DENTAL SERVICE CORPORATIONS AND**
2 **HEALTH SERVICE CORPORATIONS.**

3 **§33-24-7c. 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

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

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

- 14 (1) Stroke;
- 15 (2) Spinal cord injury;
- 16 (3) Congenital deformity;
- 17 (4) Amputation;
- 18 (5) Major multiple trauma;
- 19 (6) Fracture of femur;
- 20 (7) Brain injury;
- 21 (8) Polyarthrititis, including rheumatoid arthritis;
- 22 (9) Neurological disorders, including, but not limited to,

1 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular
2 dystrophy and Parkinson's disease;

3 (10) Cardiac disorders, including, but not limited to, acute
4 myocardial infarction, angina pectoris, coronary arterial
5 insufficiency, angioplasty, heart transplantation, chronic
6 arrhythmias, congestive heart failure, valvular heart disease;

7 (11) Burns;

8 (12) Orthopedic Disorders;

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

11 (14) Fall prevention and treatment.

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

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

19 (2) A distinct part rehabilitation unit in a hospital duly
20 licensed by the State of West Virginia. The distinct part unit
21 must meet the requirements of Section 2803.61 of the Medicare
22 Provider Reimbursement Manual, Part 1, as published by the U.S.

1 Health Care Financing Administration;

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

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

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

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

15 **§33-24-71. Copayments and coinsurance.**

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

22 (a) Copayments in health benefit plans may not exceed the

1 following amounts:

2 (1) Preventive services, \$30;

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

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

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

7 (5) Outpatient surgery, \$500;

8 (6) Inpatient admission, \$500 per day up to a maximum of
9 \$2,500 per admission;

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

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

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

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

22 (d) "Individual out-of-pocket limit" means the maximum dollar

1 amount that a covered person shall pay as copayment, deductible and
2 coinsurance for services and supplies provided by network providers
3 in a calendar, contract or policy year.

4 (e) "Network coinsurance" means the percentage of the
5 contractual fee of the network provider for covered services and
6 supplies specified in the contract between the provider and the
7 carrier that must be paid by the covered person, under the health
8 benefit plan, subject to network deductible and network
9 out-of-pocket limit.

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

18 **§33-24-43. Policies discriminating among health care providers.**

19 Notwithstanding any other provisions of law, when any health
20 insurance policy, health care services plan or other contract
21 provides for the payment of medical expenses, benefits or
22 procedures, ~~such~~ the policy, plan or contract shall be construed to

1 include payment to all health care providers including, but not
 2 limited to, medical physicians, osteopathic physicians, podiatric
 3 physicians, chiropractic physicians, physical therapists,
 4 occupational therapists, midwives, ~~and~~ nurse practitioners and
 5 their licensed assistants, who provide medical services, benefits
 6 or procedures which are within the scope of each respective
 7 provider's license. Any limitation or condition placed upon
 8 services, diagnoses or treatment by, or payment to any particular
 9 type of licensed provider shall apply equally to all types of
 10 licensed providers without unfair discrimination as to the usual
 11 and customary treatment procedures of any of the aforesaid
 12 providers.

13 **ARTICLE 25. HEALTH CARE CORPORATIONS.**

14 **§33-25-8b. Third party reimbursement for rehabilitation services.**

15 (a) Notwithstanding any provision of any policy, provision,
 16 contract, plan or agreement to which this article applies, any
 17 entity regulated by this article shall, on or after July 1, ~~1991~~
 18 2013, provide as benefits to all subscribers and members coverage
 19 for rehabilitation services as hereinafter set forth, unless
 20 rejected by the insured.

21 (b) Medically necessary rehabilitation services. --
 22 Rehabilitation, as part of an individual's health care, is

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

17 ~~(b)~~ (c) For purposes of this article and section,
18 "rehabilitation services" includes those services which are
19 designed to remediate patient's condition or restore patients to
20 their optimal physical, medical, psychological, social, emotional,
21 vocational and economic status. Rehabilitative services include by
22 illustration and not limitation diagnostic testing, assessment,

1 monitoring or treatment of the following conditions individually or
2 in a combination:

3 (1) Stroke;

4 (2) Spinal cord injury;

5 (3) Congenital deformity;

6 (4) Amputation;

7 (5) Major multiple trauma;

8 (6) Fracture of femur;

9 (7) Brain injury;

10 (8) Polyarthrititis, including rheumatoid arthritis;

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

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

18 (11) Burns;

19 (12) Orthopedic Disorders;

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

22 (14) Fall prevention and treatment;

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

3 (1) A hospital duly licensed by the State of West Virginia
4 that meets the requirements for rehabilitation hospitals as
5 described in Section 2803.2 of the Medicare Provider Reimbursement
6 Manual, Part 1, as published by the U.S. Health Care Financing
7 Administration;

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

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

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

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

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

4 **§33-25-8i. Copayments and coinsurance.**

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

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

13 (1) Preventive services, \$30;

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

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

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

18 (5) Outpatient surgery, \$500;

19 (6) Inpatient admission, \$500 per day up to a maximum of
20 \$2,500 per admission;

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

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

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

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

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

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

21 (f) All amounts paid as copayment, coinsurance and deductible
22 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 **§33-25-20. 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

1 providers.

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

3 **§33-25A-8b. Third party reimbursement for rehabilitation**
4 **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

1 of the patient/client. Rehabilitation services are provided using
2 evidence of effectiveness and applicable standards of practice and
3 is considered medically necessary if the type, amount and duration
4 of services outlined in the plan of care increase the likelihood of
5 meeting one or more of these stated goals: to improve function,
6 minimize loss of function, or decrease risk of injury and disease.

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

- 15 (1) Stroke;
- 16 (2) Spinal cord injury;
- 17 (3) Congenital deformity;
- 18 (4) Amputation;
- 19 (5) Major multiple trauma;
- 20 (6) Fracture of femur;
- 21 (7) Brain injury;
- 22 (8) Polyarthrititis, including rheumatoid arthritis;

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

4 (10) Cardiac disorders, including, but not limited to, acute
5 myocardial infarction, angina pectoris, coronary arterial
6 insufficiency, angioplasty, heart transplantation, chronic
7 arrhythmias, congestive heart failure, valvular heart disease;

8 (11) Burns;

9 (12) Orthopedic Disorders;

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

12 (14) Fall prevention and treatment;

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

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

20 (2) A distinct part rehabilitation unit in a hospital duly
21 licensed by the State of West Virginia. The distinct part unit
22 must meet the requirements of Section 2803.61 of the Medicare

1 Provider Reimbursement Manual, Part 1, as published by the U.S.
2 Health Care Financing Administration;

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

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

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

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

16 **§33-25A-8k. Copayments and coinsurance.**

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

1 (a) Copayments in health benefit plans may not exceed the
2 following amounts:

3 (1) Preventive services, \$30;

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

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

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

8 (5) Outpatient surgery, \$500;

9 (6) Inpatient admission, \$500 per day up to a maximum of
10 \$2,500 per admission;

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

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

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

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

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

5 (e) "Network coinsurance" means the percentage of the
6 contractual fee of the network provider for covered services and
7 supplies specified in the contract between the provider and the
8 carrier that must be paid by the covered person, under the health
9 benefit plan, subject to network deductible and network
10 out-of-pocket limit.

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

19 **§33-25A-31. Policies discriminating among health care providers.**

20 Notwithstanding any other provisions of law, when any health
21 insurance policy, health care services plan or other contract
22 provides for the payment of medical expenses, benefits or

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

14 **ARTICLE 28. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM**
15 **STANDARDS.**

16 **§33-28-8. Policies discriminating among health care providers.**

17 Notwithstanding any other provisions of law, when any health
18 insurance policy, health care services plan or other contract
19 provides for the payment of medical expenses, benefits or
20 procedures, the policy, plan or contract shall be construed to
21 include payment to all health care providers including, but not
22 limited to, medical physicians, osteopathic physicians, podiatric

1 physicians, chiropractic physicians, physical therapists,
2 occupational therapists, midwives, nurse practitioners and their
3 licensed assistants, who provide medical services, benefits or
4 procedures which are within the scope of each respective provider's
5 license. Any limitation or condition placed upon services,
6 diagnoses or treatment by, or payment to any particular type of
7 licensed provider shall apply equally to all types of licensed
8 providers without unfair discrimination as to the usual and
9 customary treatment procedures of any of the aforesaid providers.

10 **§33-28-9. Third party reimbursement for rehabilitation services.**

11 (a) Notwithstanding any provision of any policy, provision,
12 contract, plan or agreement to which this article applies, any
13 entity regulated by this article shall, on or after July 1, 2013,
14 provide as benefits to all subscribers and members coverage for
15 rehabilitation services as hereinafter set forth, unless rejected
16 by the insured.

17 (b) *Medically necessary rehabilitation services.* --
18 Rehabilitation, as part of an individual's health care, is
19 considered medically necessary as determined by the qualified
20 health care provider based on the results of an evaluation and when
21 provided for the purpose of preventing, minimizing or eliminating
22 impairments, activity limitations or participation restrictions.

1 Rehabilitation services are delivered throughout the episode of
2 care by the qualified health care provider or under his or her
3 direction and supervision; requires the knowledge, clinical
4 judgment, and abilities of the qualified health care provider;
5 takes into consideration the potential benefits and harms to the
6 patient/client; and is not provided exclusively for the convenience
7 of the patient/client. Rehabilitation services are provided using
8 evidence of effectiveness and applicable standards of practice and
9 is considered medically necessary if the type, amount and duration
10 of services outlined in the plan of care increase the likelihood of
11 meeting one or more of these stated goals: to improve function,
12 minimize loss of function, or decrease risk of injury and disease.

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

- 20 (1) Stroke;
- 21 (2) Spinal cord injury;
- 22 (3) Congenital deformity;

- 1 (4) Amputation;
- 2 (5) Major multiple trauma;
- 3 (6) Fracture of femur;
- 4 (7) Brain injury;
- 5 (8) Polyarthrititis, including rheumatoid arthritis;
- 6 (9) Neurological disorders, including, but not limited to,
7 multiple sclerosis, motor neuron diseases, polyneuropathy, muscular
8 dystrophy and Parkinson's disease;
- 9 (10) Cardiac disorders, including, but not limited to, acute
10 myocardial infarction, angina pectoris, coronary arterial
11 insufficiency, angioplasty, heart transplantation, chronic
12 arrhythmias, congestive heart failure, valvular heart disease;
- 13 (11) Burns;
- 14 (12) Orthopedic Disorders;
- 15 (13) Chronic Diseases including, but not limited to, diabetes,
16 hypertension and obesity;
- 17 (14) Fall prevention and treatment;
- 18 (d) Rehabilitative services includes care rendered by any of
19 the following:
- 20 (1) A hospital duly licensed by the State of West Virginia
21 that meets the requirements for rehabilitation hospitals as
22 described in Section 2803.2 of the Medicare Provider Reimbursement

1 Manual, Part 1, as published by the U.S. Health Care Financing
2 Administration;

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

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

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

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

18 (f) A policy, provision, contract, plan or agreement shall
19 apply to rehabilitation services the same deductibles, coinsurance
20 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, strike-throughs and underscoring have been omitted.