

Senate Bill No. 296

(By Senator Cann)

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[Introduced January 8, 2014; referred to the Committee on Banking
and Insurance; and then to the Committee on the Judiciary.]

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

1 §33-25-20 of said code; to amend and reenact §33-25A-8b of
2 said code; to amend said code by adding thereto a new section,
3 designated §33-25A-81; to amend and reenact §33-25A-31 of said
4 code; and to amend said code by adding thereto two new
5 sections, designated §33-28-8 and §33-28-9, all relating to
6 creating the West Virginia Fair Health Insurance Act of 2014;
7 defining "illusionary benefit" to require benefits to cover at
8 least seventy-five percent of health care service;
9 establishing reasonable copays among common insurance needs;
10 preventing insurance companies from discriminating against
11 licensed health care practitioners to whom they will pay for
12 a covered service; preventing insurance companies from
13 arbitrarily defining medically necessary rehabilitation
14 services to avoid making payment for a covered service or for
15 a service that should be covered; making physical therapy and
16 rehabilitation services a mandated covered service for any
17 health insurance plan; and increasing the monetary criminal
18 penalty for insurance companies that violate any provisions of
19 the chapter.

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

21 That §33-4-7 of the Code of West Virginia, 1931, as amended,
22 be repealed; that said code be amended by adding thereto a new
23 section, designated §33-1-22; that §33-4-8 of said code be amended

1 and reenacted; that §33-15-4d and §33-15-14 of said code be amended
2 and reenacted; that said code be amended by adding thereto a new
3 section, designated §33-15-22; that §33-16-3h and §33-16-10 of said
4 code be amended and reenacted; that said code be amended by adding
5 thereto a new section, designated §33-16-18; that said code be
6 amended by adding thereto three new sections, designated
7 §33-16D-17, §33-16D-18 and §33-16D-19; that §33-24-7c of said code
8 be amended and reenacted; that §33-24-43 of said code be amended
9 and reenacted; that said code be amended by adding thereto a new
10 section, designated §33-24-7m; that §33-25-8b of said code be
11 amended and reenacted; that said code be amended by adding thereto
12 a new section, designated §33-25-8j; that §33-25-20 of said code be
13 amended and reenacted; that §33-25A-8b of said code be amended and
14 reenacted; that said code be amended by adding thereto a new
15 section, designated §33-25A-81; that §33-25A-31 of said code be
16 amended and reenacted; and that said code be amended by adding
17 thereto two new sections, designated §33-28-8 and §33-28-9, all to
18 read as follows:

19 **ARTICLE 1. DEFINITIONS.**

20 **§33-1-22. Illusory benefit and policy.**

21 "Illusory benefit" means a copayment, or coinsurance, or
22 codeductible, or combination thereof, outside of the annual
23 contract deductible, which exceeds twenty-five percent of the

1 contractual fee paid by an accident and sickness insurance company,
2 fraternal benefit society, nonprofit health service corporation,
3 nonprofit hospital service corporation, nonprofit medical service
4 corporation, prepaid health plan, dental care plan, vision care
5 plan, pharmaceutical plan, health maintenance organization, and all
6 similar type organizations to the network provider for covered
7 services under the beneficiary's health insurance policy.

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

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

18 **ARTICLE 4. GENERAL PROVISIONS.**

19 **§33-4-8. General penalty.**

20 In addition to the refusal to renew, suspension or revocation
21 of a license, or penalty in lieu of the foregoing, because of
22 violation of any provision of this chapter, it is a misdemeanor for
23 any person to violate any provision of this chapter unless the

1 violation is declared to be a felony by this chapter or other law
2 of this state. Unless another penalty is provided in this chapter
3 or by the laws of this state, every person convicted of a
4 misdemeanor for the violation of any provision of this chapter
5 shall be fined not ~~more~~ less than \$1,000 per occurrence nor more
6 than \$10,000 per occurrence or confined in jail not more than six
7 months, or both fined and confined.

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

9 **§33-15-4d. Third party reimbursement for rehabilitation services.**

10 (a) Notwithstanding any provision of any policy, provision,
11 contract, plan or agreement to which this article applies, any
12 entity regulated by this article shall, on or after July 1, ~~1991~~
13 2014, provide as benefits to all subscribers and members coverage
14 for rehabilitation services as hereinafter set forth, unless
15 rejected by the insured.

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

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

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

- 19 (1) Stroke;
20 (2) Spinal cord injury;
21 (3) Congenital deformity;
22 (4) Amputation;
23 (5) Major multiple trauma;

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

1 licensed by the State of West Virginia. The distinct part unit
2 must meet the requirements of Section 2803.61 of the Medicare
3 Provider Reimbursement Manual, Part 1, as published by the U.S.
4 Health Care Financing Administration;

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

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

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

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

18 **§33-15-14. 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
23 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, ~~and~~ nurse practitioners and
4 their licensed assistants, who provide medical services, benefits
5 or procedures which are within the scope of each respective
6 provider's license. Any limitation or condition placed upon
7 services, diagnoses or treatment by, or payment to any particular
8 type of licensed provider shall apply equally to all types of
9 licensed providers without unfair discrimination as to the usual
10 and customary treatment procedures of any of the aforesaid
11 providers.

12 **§33-15-22. Copayments and coinsurance.**

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

19 (a) Copayments in health benefit plans may not exceed the
20 following amounts:

21 (1) Preventive services, \$30;

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

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

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

3 (5) Outpatient surgery, \$500;

4 (6) Inpatient admission, \$500 per day up to a maximum of
5 \$2,500 per admission;

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

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

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

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

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

22 (e) "Network coinsurance" means the percentage of the
23 contractual fee of the network provider for covered services and

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

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

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

14 **§33-16-3h. 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 2014, 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
23 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
23 in a combination:

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

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

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

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

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

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

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

23 **§33-16-10. Policies discriminating among health care providers.**

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

17 **§33-16-18. Copayments and coinsurance.**

18 "Copayment" means a specific dollar amount or percentage not
19 to exceed twenty-five percent of covered charges, except as
20 otherwise provided by statute, that the subscriber must pay upon
21 receipt of covered health care services and which is set at an
22 amount or percentage consistent with allowing subscriber access to
23 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.

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

19 **ACCIDENT AND SICKNESS INSURANCE POLICIES.**

20 **§33-16D-17. Copayments and coinsurance.**

21 "Copayment" means a specific dollar amount or percentage not
22 to exceed twenty-five percent of covered charges, except as
23 otherwise provided by statute, that the subscriber must pay upon

1 receipt of covered health care services and which is set at an
2 amount or percentage consistent with allowing subscriber access to
3 health care services.

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

6 (1) Preventive services, \$30;

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

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

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

11 (5) Outpatient surgery, \$500;

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

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

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

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

22 (c) "Family out-of-pocket limit" means the maximum dollar
23 amount that a family shall pay in combination as copayment,

1 deductible and coinsurance for network covered services and
2 supplies in a calendar, contract or policy year.

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

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

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

21 **§33-16D-18. Policies discriminating among health care providers.**

22 Notwithstanding any other provisions of law, when any health
23 insurance policy, health care services plan or other contract

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

14 **§33-16D-19. 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, 2014,
18 provide as benefits to all subscribers and members coverage for
19 rehabilitation services as hereinafter set forth, unless rejected
20 by the insured.

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

23 (1) Stroke;

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

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

3 (a) Notwithstanding any provision of any policy, provision,
4 contract, plan or agreement to which this article applies, any
5 entity regulated by this article shall, on or after July 1, ~~1991~~
6 2014, provide as benefits to all subscribers and members coverage
7 for rehabilitation services as hereinafter set forth, unless
8 rejected by the insured.

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

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

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

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

12 (1) Stroke;

13 (2) Spinal cord injury;

14 (3) Congenital deformity;

15 (4) Amputation;

16 (5) Major multiple trauma;

17 (6) Fracture of femur;

18 (7) Brain injury;

19 (8) Polyarthrititis, including rheumatoid arthritis;

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

23 (10) Cardiac disorders, including, but not limited to, acute

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

4 (11) Burns;

5 (12) Orthopedic Disorders;

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

8 (14) Fall prevention and treatment.

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

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

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

21 (3) A hospital duly licensed by the State of West Virginia
22 which meets the requirements for cardiac rehabilitation as
23 described in Section 35-25, Transmittal 41, dated August, 1989, as

1 promulgated by the U.S. Health Care Financing Administration.

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

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

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

11 **§33-24-7m. Copayments and coinsurance.**

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

18 (a) Copayments in health benefit plans may not exceed the
19 following amounts:

20 (1) Preventive services, \$30;

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

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

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

2 (5) Outpatient surgery, \$500;

3 (6) Inpatient admission, \$500 per day up to a maximum of
4 \$2,500 per admission;

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

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

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

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

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

21 (e) "Network coinsurance" means the percentage of the
22 contractual fee of the network provider for covered services and
23 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 **§33-24-43. Policies discriminating among health care providers.**

13 Notwithstanding any other provisions of law, when any health
14 insurance policy, health care services plan or other contract
15 provides for the payment of medical expenses, benefits or
16 procedures, ~~such~~ the policy, plan or contract shall be construed to
17 include payment to all health care providers including, but not
18 limited to, medical physicians, osteopathic physicians, podiatric
19 physicians, chiropractic physicians, physical therapists,
20 occupational therapists, midwives, ~~and~~ nurse practitioners and
21 their licensed assistants, who provide medical services, benefits
22 or procedures which are within the scope of each respective
23 provider's license. Any limitation or condition placed upon

1 services, diagnoses or treatment by, or payment to any particular
2 type of licensed provider shall apply equally to all types of
3 licensed providers without unfair discrimination as to the usual
4 and customary treatment procedures of any of the aforesaid
5 providers.

6 **ARTICLE 25. HEALTH CARE CORPORATIONS.**

7 **§33-25-8b. Third party reimbursement for rehabilitation services.**

8 (a) Notwithstanding any provision of any policy, provision,
9 contract, plan or agreement to which this article applies, any
10 entity regulated by this article shall, on or after July 1, ~~1991~~
11 2014, provide as benefits to all subscribers and members coverage
12 for rehabilitation services as hereinafter set forth, unless
13 rejected by the insured.

14 (b) Medically necessary rehabilitation services. --
15 Rehabilitation, as part of an individual's health care, is
16 considered medically necessary as determined by the qualified
17 health care provider based on the results of an evaluation and when
18 provided for the purpose of preventing, minimizing or eliminating
19 impairments, activity limitations or participation restrictions.
20 Rehabilitation services are delivered throughout the episode of
21 care by the qualified health care provider or under his or her
22 direction and supervision; requires the knowledge, clinical
23 judgment and abilities of the qualified health care provider; takes

1 into consideration the potential benefits and harms to the
2 patient/client; and is not provided exclusively for the convenience
3 of the patient/client. Rehabilitation services are provided using
4 evidence of effectiveness and applicable standards of practice and
5 is considered medically necessary if the type, amount and duration
6 of services outlined in the plan of care increase the likelihood of
7 meeting one or more of these stated goals: to improve function,
8 minimize loss of function, or decrease risk of injury and disease.

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

- 17 (1) Stroke;
- 18 (2) Spinal cord injury;
- 19 (3) Congenital deformity;
- 20 (4) Amputation;
- 21 (5) Major multiple trauma;
- 22 (6) Fracture of femur;
- 23 (7) Brain injury;

1 (8) Polyarthrititis, including rheumatoid arthritis;

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

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

9 (11) Burns;

10 (12) Orthopedic Disorders;

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

13 (14) Fall prevention and treatment;

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

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

21 (2) A distinct part rehabilitation unit in a hospital duly
22 licensed by the State of West Virginia. The distinct part unit
23 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 **§33-25-8j. 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 by statute, that the subscriber must pay upon
20 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.

23 (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
23 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 **§33-25-20. 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, ~~such~~ the policy, plan or contract shall be construed to
22 include payment to all health care providers including, but not
23 limited to, medical physicians, osteopathic physicians, podiatric

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

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

12 **§33-25A-8b. Third party reimbursement for rehabilitation**
 13 **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 2014, 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
 23 health care provider based on the results of an evaluation and when

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

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

23 (1) Stroke;

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

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

22 **§33-25A-81. Copayments and coinsurance.**

23 "Copayment" means a specific dollar amount or percentage not

1 to exceed twenty-five percent of covered charges, except as
2 otherwise provided for by statute, that the subscriber must pay
3 upon receipt of covered health care services and which is set at an
4 amount or percentage consistent with allowing subscriber access to
5 health care services.

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

8 (1) Preventive services, \$30;

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

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

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

13 (5) Outpatient surgery, \$500;

14 (6) Inpatient admission, \$500 per day up to a maximum of
15 \$2,500 per admission;

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

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

22 (b) Network copayment may not be applied to any service or
23 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.

23 **§33-25A-31. Policies discriminating among health care providers.**

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

12 **§33-28-9. Third party reimbursement for rehabilitation services.**

13 (a) Notwithstanding any provision of any policy, provision,
14 contract, plan or agreement to which this article applies, any
15 entity regulated by this article shall, on or after July 1, 2014,
16 provide as benefits to all subscribers and members coverage for
17 rehabilitation services as hereinafter set forth, unless rejected
18 by the insured.

19 (b) *Medically necessary rehabilitation services.* --
20 Rehabilitation, as part of an individual's health care, is
21 considered medically necessary as determined by the qualified
22 health care provider based on the results of an evaluation and when
23 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;
23 (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
23 Manual, Part 1, as published by the U.S. Health Care Financing

1 Administration;

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

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

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

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

17 (f) A policy, provision, contract, plan or agreement shall
18 apply to rehabilitation services the same deductibles, coinsurance
19 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 2014. The bill defines "illusory 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, §33-24-7m, §33-25-8j, §33-25A-8l, §33-28-8 and §33-28-9 are new; therefore, strike-throughs and underscoring have been omitted.