

# **WEST VIRGINIA LEGISLATURE**

## **2016 REGULAR SESSION**

**Introduced**

### **Senate Bill 572**

BY SENATOR FERNS

[Introduced February 10, 2016;

Referred to the Committee on Health and Human  
Resources.]

1 A BILL to amend and reenact §33-45-2 of the Code of West Virginia, 1931, as amended, relating  
 2 to defining the criteria which private insurance carriers operating in West Virginia must  
 3 consider in setting rates to providers of health care services.

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

1 That §33-45-2 of the Code of West Virginia, 1931, as amended, be amended and  
 2 reenacted to read as follows:

**ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.**

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

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

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

- 8 (A) Another payor or party is responsible for the claim;
- 9 (B) The insurer is coordinating benefits with another payor;
- 10 (C) The provider has already been paid for the claim;
- 11 (D) The claim was submitted fraudulently; or
- 12 (E) There was a material misrepresentation in the claim.

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

18 written or electronic record of the date of submittal by the person submitting the claim.

19 (3) An insurer shall, within thirty days after receipt of a claim, request electronically or in  
20 writing from the person submitting the claim any information or documentation that the insurer  
21 reasonably believes will be required to process and pay the claim or to determine if the claim is a  
22 clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one  
23 request, and shall if necessary, within fifteen days of the receipt of the information from the first  
24 request, only request or require additional information one additional time if ~~such~~ the additional  
25 information could not have been reasonably identified at the time of the original request or to  
26 specifically identify a material failure to provide the information requested in the initial request.  
27 Upon receipt of the information requested under this subsection which the insurer reasonably  
28 believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an  
29 insurer shall either pay or deny the claim within thirty days. No insurer may refuse to pay a claim  
30 for health care services rendered pursuant to a provider contract which are covered benefits if the  
31 insurer fails to timely notify the person submitting the claim within thirty days of receipt of the claim  
32 of the additional information requested unless such failure was caused in material part by the  
33 person submitting the claims: *Provided*, That nothing herein ~~shall~~ precludes such an insurer from  
34 imposing a retroactive denial of payment of such a claim if permitted by the provider contract  
35 unless such retroactive denial of payment of the claim would violate subdivision (7), subsection  
36 (a) of this section. This subsection does not require an insurer to pay a claim that is not a clean  
37 claim except as provided herein.

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

43 (5) Every insurer shall establish and implement reasonable policies to permit any provider

44 with which there is a provider contract:

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

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

49 (i) Precertification or authorization of coverage decisions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

84 (i) The claim was submitted fraudulently;

85 (ii) The claim contained material misrepresentations;

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

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

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

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

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

95 (i) Upon receipt of explanation for retroactive denial, the provider shall reimburse the plan

96 within thirty days for allowing an offset against future payments or provide written notice of dispute.

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

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

101 (C) A health plan may retroactively deny a claim only for the reasons set forth in  
102 subparagraphs (iii), (iv), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year  
103 from the date the claim was originally paid. There shall be no time limitations for retroactively  
104 denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

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

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

110 (B) The manner in which reimbursement is calculated by the insurer: *Provided*, That in  
111 setting reimbursement rates for any provider that is subject to the provisions of article five-b,  
112 chapter sixteen of this code rates are required to be set by comparison of similar providers within  
113 the geographic area of the provider: *Provided, however*, That reimbursement rates may not be  
114 set by comparison of rates of any out of state facility regardless of its proximity to any provider  
115 licensed under the provisions of article five-b, chapter sixteen of this code; and

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

119 (9) No amendment to any provider contract or to any addenda, schedule or exhibit, or new  
120 addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve  
121 payment or delivery of care by the provider, or to the range of health care services reasonably

122 expected to be delivered by that type of provider, is effective as to the provider, unless the provider  
123 has been provided with the applicable portion of the proposed amendment, or of the proposed  
124 new addenda, schedule or exhibit, and has failed to notify the insurer within twenty business days  
125 of receipt of the documentation of the provider's intention to terminate the provider contract at the  
126 earliest date thereafter permitted under the provider contract.

127 ~~In the event that~~ If the insurer's provision of a policy required to be provided under  
128 subdivision (8) or (9) of this subsection would violate any applicable copyright law, the insurer  
129 may instead comply with this section by providing a clear, written explanation of the policy as it  
130 applies to the provider.

131 (11) The insurer shall complete a credential check of any new provider and accept or reject  
132 the provider within four months following the submission of the provider's completed application:  
133 *Provided*, That time frame may be extended for an additional three months because of delays in  
134 primary source verification. The insurer shall make available to providers a list of all information  
135 required to be included in the application. A provider who is permitted by the insurer to provide  
136 services and who provides services during the credentialing period shall be paid for the services  
137 if the provider's application is approved.

138 (b) Without limiting the foregoing, in the processing of any payment of claims for health  
139 care services rendered by providers under provider contracts and in performing under its provider  
140 contracts, every insurer subject to regulation by this article shall adhere to and comply with the  
141 minimum fair business standards required under subsection (a) of this section. The commissioner  
142 ~~has jurisdiction to~~ may determine if an insurer has violated the standards set forth in subsection  
143 (a) of this section by failing to include the requisite provisions in its provider contracts. The  
144 commissioner ~~has jurisdiction to~~ may determine if the insurer has failed to implement the minimum  
145 fair business standards set out in subdivisions (1) and (2), subsection (a) of this section in the  
146 performance of its provider contracts.

147 (c) No insurer is in violation of this section if its failure to comply with this section is caused

148 in material part by the person submitting the claim or if the insurer's compliance is rendered  
149 impossible due to matters beyond the insurer's reasonable control, such as an act of God,  
150 insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

NOTE: The purpose of this bill is to define the criteria which private insurance carriers operating in West Virginia must consider in setting rates. The bill provides that in setting reimbursement rates for any provider that is subject to the provisions of article five-b, chapter sixteen of this code rates are required to be set by comparison of similar providers within the geographic area of the provider and that reimbursement rates may not be set by comparison of rates of any out of state facility regardless of its proximity to any provider of health care services licensed under the provisions of article five-b, chapter sixteen of this code.

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