WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4197

FISCAL NOTE

By Delegate Pritt

[Introduced January 14, 2026; referred to the

Committee on Health and Human Resources then

Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new section, designated §5-16B-6b, relating to requiring coverage for PANDAS and PANS; providing definitions; clarifying the type of coverage; establishing billing procedures; clarifying treatments; and providing rule-making authority.

Be it enacted by the Legislature of West Virginia:

ARTICLE 16B. WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM.

§5-16B-6b. Required coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).

(a) For the purpose of this section:

(1) "Managed care organization" or "MCO" means an essential community health service provider that participates in the program; and

(2) "Medically necessary" means:

(A) Enrollees in the program are eligible to receive only those medical items and services that are:

(i) Within the scope of defined benefits for which the enrollee is eligible under the program; and

(ii) Determined by the agency to be medically necessary.

(B) To be determined to be medically necessary, a medical item or service must be recommended by a physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of the physician's license who is treating the enrollee and must satisfy each of the following criteria:

(i) It must be required in order to diagnose or treat an enrollee's medical condition. The convenience of an enrollee, the enrollee's family, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary;

(ii) It must be safe and effective. To qualify as safe and effective, the type and level of

medical item or service must be consistent with the symptoms or diagnosis and treatment of the particular medical condition, and the reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on the enrollee's condition and scientifically supported evidence;

(iii) It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee. When applied to medical items or services delivered in an inpatient setting, it further means that the medical item or service cannot be safely provided for the same or lesser cost to the person in an outpatient setting. Where there are less costly alternative courses of diagnosis or treatment, including less costly alternative settings, that are adequate for the medical condition of the enrollee, more costly alternative courses of diagnosis or treatment are not medically necessary. An alternative course of diagnosis or treatment may include observation, lifestyle or behavioral changes or, where appropriate, no treatment at all; and

(iv)(I) It must not be experimental or investigational. A medical item or service is experimental or investigational if there is inadequate empirically-based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating another condition;

(II) Use of a drug or biological product that has not been approved under a new drug application for marketing by the United States Food and Drug Administration (FDA) is deemed experimental;

(III) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose will not be deemed medically necessary unless the use can be shown to be widespread, to be generally accepted by the professional medical community as an effective and proven treatment in the setting and for the condition for which it is used, and to satisfy the requirements of paragraph (B)(i)-(iii) of this section.

(C) It is the responsibility of the agency ultimately to determine what medical items and services are medically necessary for the program. The fact that a provider has prescribed, recommended or approved a medical item or service does not, in itself, make such item or service medically necessary.

(D) The medical necessity standard set forth in this section shall govern the delivery of all services and items to all enrollees or classes of beneficiaries in the program. The agency is authorized to make limited special provisions for particular items or services, such as long-term care, or such as may be required for compliance with federal law.

(b) The agency shall require every group health insurance contract, and every group hospital or medical expense insurance policy, plan, and group policy delivered, issued for delivery, amended, or renewed in this state by an MCO on or after January 1, 2027, to provide coverage for physician prescribed treatment, deemed medically necessary of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). Such treatment must include antibiotics, medication, behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Benefits provided under this section are not subject to a greater co-payment, deductible, or coinsurance than another similar benefit provided by the MCO. Coverage authorization must be provided in a timely manner consistent with insurance rules for urgent treatments.

(c) A group or individual policy of accident and health insurance or managed care must not deny or delay coverage for medically necessary treatment under this section solely because the recipient previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the recipient has been diagnosed with or received treatment for their condition under a different diagnostic name, such as autoimmune encephalopathy. For the purposes of this section, coverage of PANDAS and PANS must adhere to the treatment recommendations developed by a medical professional consortium convened for the purposes of researching,

identifying, and publishing best practice standards for diagnosis and treatment of such disorders that are accessible for medical professionals and are based on evidence of positive patient outcomes. Coverage for a form of medically necessary treatment must not be limited over the lifetime of a recipient or by the duration of a policy period. This section does not prevent an MCO from requesting treatment notes and anticipated duration of treatment and outcomes.

(d) For billing and diagnosis purposes, PANDAS and PANS must be coded as autoimmune encephalitis until the American Medical Association and the Centers for Medicare and Medicaid Services create and assign a specific code for PANDAS and PANS. Thereafter, PANDAS and PANS may be coded as autoimmune encephalitis, PANDAS, or PANS. If a new common name or code is utilized for PANDAS and PANS, then this section applies to patients with conditions under that new common name or code.

(e) The secretary shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code which he or she finds necessary to effectuate the provisions of this article.

NOTE: The purpose of this bill is to provide coverage for physician prescribed treatment, deemed medically necessary, of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).

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