TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE

SERIES 95
UTILIZATION REVIEW AND BENEFIT DETERMINATION

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SERIES 95
UTILIZATION REVIEW AND BENEFIT DETERMINATION

§114-95-1. General.

1.1. Scope. -- This rule establishes standards and criteria for the structure and operation of utilization review and benefit determination, processes designed to facilitate ongoing assessment and management of health care services. This rule applies to any issuer offering a health benefit plan that provides or performs utilization review services, including prospective review or retrospective review benefit determinations and to any designee of the issuer or any utilization review organization that performs such functions on the issuer's behalf. This rule is based on the National Association of Insurance Commissioners' "Utilization Review Model Act" (Model 73), as amended in 2012.

1.2. Authority. -- W. Va. Code §33-2-10 & §33-16H-4.

1.3. Filing Date. -- June 6, 2014.

1.4. Effective Date. -- July 6, 2014.

§114-95-2. Definitions.

2.1. "Adverse determination" means a determination by an issuer or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

2.2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

2.3. "Authorized representative" means:

2.3.a. A person to whom a covered person has given express written consent to represent the covered person in an external review;

2.3.b. A person authorized by law to provide substituted consent for a covered person;

2.3.c. In a situation in which a covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional;

2.3.d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

2.3.e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

2.4. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

2.5. "Certification" means a determination by an issuer or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit under the issuer's health benefit plan has been reviewed and, based on the information provided, satisfies the issuer's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

2.6. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.

2.7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the issuer to determine the medical necessity and appropriateness of health care services.

2.8. "Commissioner" means the West Virginia Insurance Commissioner.

2.9. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

2.10. "Covered benefits" or "benefits" means those health care services to which a covered person is legally entitled under the terms of a health benefit plan.

2.11. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan; whenever this rule provides for action by or notice to a covered person, it shall be deemed to include action by or notice to such covered person's authorized representative.

2.12. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

2.13. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

2.14. "Emergency services" means with respect to an emergency medical condition:

2.14.a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2.14.b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

2.15. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

2.16. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by an issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, but excluding the excepted benefits defined in 42 U.S.C. § 300gg-91 and as otherwise specifically excepted in this rule.

2.16.a. "Health benefit plan" does not include:

2.16.a.1. Coverage only for accident, or disability income insurance or any combination thereof;

2.16.a.2. Coverage issued as a supplement to liability insurance;

2.16.a.3. Liability insurance, including general liability insurance and automobile liability insurance;

2.16.a.4. Workers' compensation or similar insurance;

2.16.a.5. Automobile medical payment insurance;

2.16.a.6. Credit-only insurance;

2.16.a.7. Coverage for on-site medical clinics; and

2.16.a.8. Other similar insurance coverage specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

2.16.b. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

2.16.b.1. Limited scope dental or vision benefits;

2.16.b.2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

2.16.b.3. Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

2.16.c. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

2.16.c.1. Coverage only for a specified disease or illness; or

2.16.c.2. Hospital indemnity or other fixed indemnity insurance.

2.16.d. "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

2.16.d.1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2.16.d.2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

2.16.d.3. Similar supplemental coverage provided to coverage under a group health plan.

2.17. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with West Virginia law.

2.18. "Health care provider" or "provider" means a health care professional or a facility.

2.19. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

2.20. "Issuer" means an entity required to be licensed under the insurance laws and regulations of West Virginia that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, fraternal benefit society, or any other entity providing a health benefit plan.

2.21. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the issuer.

2.22. "Network" means the group of participating providers providing services to a managed care plan.

2.23. "Participating provider" means a provider who, under a contract with the issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the issuer.

2.24. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

2.25. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with an issuer's

requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

2.26. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

2.26.a. The cancellation or discontinuance of coverage has only a prospective effect; or

2.26.b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

2.27. "Retrospective review" means any review of a request for a benefit that is not a prospective review request. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

2.28. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

2.29. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

2.30. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

2.30.a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2.30.b. In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.;

2.30.c. Except as provided in subdivision 2.30.d, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the issuer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

2.30.d. Any request that an attending health care professional, with knowledge of the covered person's medical condition, determines is an urgent care request within the meaning of this subsection shall be treated as an urgent care request.

2.31. "Utilization review" means a system for the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedure and facilities.

2.32. "Utilization review organization" means an entity that conducts utilization review, other than an issuer performing utilization review for its own health benefit plans.

§114-95-3. Corporate Oversight of Utilization Review Program.

An issuer shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the issuer and for ensuring that all requirements of this rule are met. The issuer also shall ensure that appropriate personnel have operational responsibility for the conduct of the issuer's utilization review program.

§114-95-4. Contracting.

Whenever an issuer contracts to have a utilization review organization or other entity perform the utilization review functions required by this rule, the Commissioner shall hold the issuer responsible for monitoring the activities of the utilization review organization or entity with which the issuer contracts and for ensuring that the requirements of this rule are met.

§114-95-5. Scope and Content of Utilization Review Program.

5.1. An issuer shall implement a written utilization review program that describes all review activities and procedures, both delegated and non-delegated, for:

5.1.a. The filing of benefit requests;

5.1.b. The notification of utilization review and benefit determinations; and

5.1.c. The review of adverse determinations in accordance with W. Va. Code of St. R. §114- 96-1 *et seq.*, "Health Plan Issuer Internal Grievance Procedure".

5.2. The program document shall describe the following:

5.2.a. Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;

5.2.b. Data sources and clinical review criteria used in decision-making;

5.2.c. Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

5.2.d. Data collection processes and analytical methods used in assessing utilization of health care services;

5.2.e. Provisions for assuring confidentiality of clinical and proprietary information;

5.2.f. The organizational structure (e.g. utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the issuer's governing body; and

5.2.g. The staff position functionally responsible for day-to-day program management.

§114-95-6. Operational Requirements.

6.1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. An issuer may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. An issuer shall make available its clinical review criteria upon request by a person authorized by the Commissioner or by statute or legislative rule to receive such information.

6.2. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

6.3. **Exhaustion.**

6.3.a. Whenever an issuer fails to adhere to the requirements of section 7 or 8 with respect to making utilization review and benefit determinations of a benefit request or

claim, the covered person shall be deemed to have exhausted the provisions of this rule and may file a request for external review in accordance with the procedures outlined in W. Va. Code of St. R. §114-97-1 *et seq.*

6.3.a.1. Notwithstanding subdivision 6.3.a, the provisions of sections 7 or 8 of this rule shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the issuer demonstrates that the violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the covered person.

6.3.a.2. The exception described in paragraph 6.3.a.1 is inapplicable if the violation is part of a pattern or practice of violations by the issuer.

6.3.a.3. Within ten days of receiving a request from a covered person, an issuer shall provide a written explanation of why it believes that any alleged violation of sections 7 or 8 of this rule does not constitute a sufficient basis to trigger the exhaustion provisions of subdivision 6.3.a.

6.3.a.4. The Commissioner shall resolve any issues raised by an issuer as to whether a covered person may, in accordance with paragraph 6.3.a.1, be deemed to have exhausted the provisions of this rule, and the Commissioner's written notice of a determination that such exhaustion requirements have not been met shall also inform the covered person that he or she may resubmit and, as appropriate, pursue a review of the benefit request or claim under this rule or file a grievance pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*

6.3.a.5. For purposes of calculating the time period for refiling the benefit request or claim, the time period shall begin to run upon the covered person's receipt of the notice of opportunity to resubmit.

6.4. An issuer shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

6.5. An issuer shall routinely assess the effectiveness and efficiency of its utilization review program.

6.6. An issuer's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the issuer to monitor and manage health care services effectively.

6.7. If an issuer delegates any utilization review activities to a utilization review organization, the issuer shall maintain adequate oversight, which shall include:

6.7.a. A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

6.7.b. Evidence of formal approval of the utilization review organization's program by the issuer; and

6.7.c. A process by which the issuer evaluates the performance of the utilization review organization.

6.8. The issuer shall coordinate the utilization review program with other medical management activity conducted by the issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction and risk management.

6.9. An issuer shall provide covered persons and participating providers with access to its review staff by a toll-free telephone number.

6.10. When conducting utilization review, the issuer shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

6.11. In conducting utilization review, the issuer shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination, including not basing decisions regarding hiring, compensation, termination, promotion or other similar matters upon the likelihood that the individual will support the denial of benefits.

§114-95-7. Procedures for Standard Utilization Review and Benefit Determinations.

7.1. **Time periods.**

7.1.a. **Written procedures**. An issuer shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the issuer by covered persons and for notifying covered persons of its determinations with respect to these requests within the specified time frames required under this section.

7.1.b. **Calculation of days**. For purposes of calculating the time periods within which prospective and retrospective review determinations are required to be made, the time period within which the determination is required to be made shall begin on the date the request is received by the issuer in accordance with the issuer's procedures established pursuant to section 5 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

7.1.c. **Prospective review determinations.** Within a reasonable period of time appropriate to the covered person's medical condition but in no event later than fifteen days after receiving the request for a prospective review determination, an issuer shall notify the covered person of such determination.

7.1.d. **Retrospective review determinations**. For retrospective review determinations, an issuer shall notify the covered person of such determination within a reasonable period of time, but in no event later than thirty days after receiving the benefit request.

7.1.e. **Concurrent review determinations**. For a concurrent review determination, if an issuer has previously certified an ongoing course of treatment to be provided over a period of time or number of treatments:

7.1.e.1. Any reduction or termination by the issuer during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination;

7.1.e.2. The issuer shall notify the covered person of the adverse determination in accordance with subsection 7.3 at a time sufficiently in advance of the reduction or termination to allow the covered person to file a grievance to request a review of the adverse determination pursuant to W. Va. Code of St. R. §114 -96-1 *et seq*. and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated; and

7.1.e.3. The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person with respect to the internal review request made pursuant to W. Va. Code of St. R. §114 -96-1 *et seq*.

7.1.f. **Extensions.**

7.1.f.1. The time period for making a prospective or retrospective review determination and notifying the covered person of such determination pursuant to subdivision

7.1.a may be extended one time by the issuer for up to fifteen days, provided the issuer determines that an extension is necessary due to matters beyond the its control and notifies the covered person, prior to the expiration of the initial fifteen-day time period for a prospective review and the expiration of the initial thirty-day time period for a retrospective review, of the circumstances requiring the extension of time and the date by which the issuer expects to make a determination.

7.1.f.2. If the extension under this subdivision is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request and give the covered person at least forty-five days from the date of receipt of the notice to provide the specified information.

7.2. **Failure to meet issuer's filing procedures.**

7.2.a. Whenever the issuer receives a prospective or retrospective review request from a covered person that fails to meet the issuer's filing procedures, the issuer shall notify the covered person within five days of this failure and provide in the notice information on the proper procedures to be followed for filing a request; such notice tolls the time periods in which the issuer must make its determination until the earlier of the date on which the covered person responds to the request for additional information or the date on which the specified information was to have been submitted, and the issuer may deny the certification of the requested benefit if the covered person fails to respond within the extended period.

7.2.b. The provisions of subdivision 7.2.a only apply in the case of a failure that is a communication by a covered person that is received by a person or organizational unit of the issuer responsible for handling benefit matters and that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

7.3. **Adverse determinations.**

7.3.a. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

7.3.a.1. Information sufficient to identify the benefit request or claim involved, including any applicable dates of service, health care provider and claim amount, if applicable;

7.3.a.2. A statement describing the availability, upon request, of the

diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; a request for the diagnosis code and treatment information shall not, in itself, be deemed a request to file a grievance for review of an adverse determination pursuant to W. Va. Code of St. R. §114-96-1 *et seq.* or a request for external review;

7.3.a.3. The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in denying the benefit request or claim;

7.3.a.4. Reference to the specific plan provisions on which the determination is based;

7.3.a.5. A description of any additional material or information necessary for the covered person to perfect the benefit request and an explanation of why the material or information is necessary;

7.3.a.6. A description of the issuer's grievance procedures established pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, including any time limits applicable to those procedures;

7.3.a.7. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of same will be provided free of charge to the covered person upon request;

7.3.a.8. An explanation of the scientific or clinical judgment for making any determination based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, applying the terms of the health benefit plan to the covered person's medical circumstances; and

7.3.a.9. A statement explaining the availability of and contact information for assistance through the Commissioner's office.

7.3.b. An issuer shall provide the notice required under this subsection 7.3 in a culturally and linguistically appropriate manner.

7.3.b.1. To be considered to meet the requirements of this subdivision, the issuer shall:

7.3.b.1.A. Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

7.3.b.1.B. Provide, upon request, a notice in any applicable non-English language; and

7.3.b.1.C. Include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearing indicating how to access the language services provided by the issuer.

7.3.b.2. For purposes of this subdivision, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

7.3.c. If the adverse determination is a rescission, the issuer shall provide at least thirty calendar days' notice to a covered person before coverage may be rescinded, regardless of whether the rescission applies to an individual only, to an entire group, or to individuals in a group, in addition to any applicable disclosures required under subdivision 7.3.a:

7.3.c.1. Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

7.3.c.2. An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

7.3.c.3. Notice that the covered person may, prior to the date the advance notice of the proposed rescission ends, immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to W. Va. Code of St. R. §114-96-1 *et seq.;*

7.3.c.4. A description of the issuer's grievance procedures established pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, including any time limits applicable to those procedures; and

7.3.c.5. The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

§114-95-8. Procedures for Expedited Utilization Review and Benefit Determinations.

8.1. An issuer shall establish written procedures in accordance with this section for receiving benefit requests from covered persons and for making and notifying covered persons of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

8.1.a. Such procedures must include that, in the case of a failure by a covered person to provide sufficient information, the issuer shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four hours after receipt of the request, and the issuer shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight hours after notifying the covered person of the failure to submit sufficient information. The provisions of this subdivision only apply in the case of a failure that is a communication by a covered person that is received by a person or organizational unit of the issuer responsible for handling benefit matters and that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

8.1.b. For an urgent care request, unless the covered person has failed to provide sufficient information for the issuer to determine whether, or to what extent, the benefits requested are covered benefits or payable under the issuer's health benefit plan, the issuer shall notify the covered person of the issuer's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two hours after the receipt of the request by the issuer.

8.1.b.1. If the covered person has failed to provide sufficient information for the issuer to determine whether, or to what extent, the benefits requested are covered benefits or payable under the issuer's health benefit plan, the issuer shall notify the covered person as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request, either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed. The issuer shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information.

8.1.b.2. The issuer shall notify the covered person of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight hours after the earlier of:

81.b.2.A. The issuer's receipt of the requested specified information; or

8.1.b.2.B. The end of the period provided for the covered person to submit the requested specified information.

8.1.b.3. If the covered person fails to submit the information before the end of the period of the extension, as specified in subparagraph 8.1.b.2.B, the issuer may deny the certification of the requested benefit.

8.1.c. For concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the issuer shall make a determination with respect to the request and notify the covered person of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four hours after the issuer's receipt of the request.

8.1.d. For purposes of calculating the time periods within which a determination is required to be made under subsection 8.2, the time period within which the determination is required to be made shall begin on the date the request is filed with the issuer in accordance with the issuer's procedures established pursuant to section 5 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8.2. **Notice Requirements.**

8.2.a. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth;

8.2.a.1. Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

8.2.a.2. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, an issuer:

8.2.a.2.A. Shall provide to the covered person, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and

8.2.a.2.B. May not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, or a request for external review;

8.2.a.3. The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in denying the benefit request or claim;

8.2.a.4. Reference to the specific plan provisions on which the determination is based;

8.2.a.5. A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

8.2.a.6. A description of the issuer's internal review and expedited review procedures established pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, including any time limits applicable to those procedures;

8.2.a.7. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

8.2.a.8. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

8.2.a.9. If applicable, instructions for requesting:

8.2.a.9.A. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with paragraph 8.2.a.7; or

8.2.a.9.B. The written statement of the scientific or clinical

rationale for the adverse determination in accordance with paragraph 8.2.a.8; and

8.2.a.10. A statement explaining the availability of and the right of the covered person, as appropriate, to contact the Commissioner's office at any time for assistance or, upon completion of the issuer's grievance procedures process as provided under W. Va. Code of St. R. §114-96-1 *et seq.*, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the Commissioner's office.

8.2.b. An issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with subdivision 7.3.b.

8.2.c. If the adverse determination is a rescission, the issuer shall provide, in addition to any applicable disclosures required under subdivision 8.2.a, the disclosures set forth in subdivision 7.3.c:

8.2.d.. An issuer may provide the notice required under this section orally, in writing or electronically. If notice of the adverse determination is provided orally, the issuer shall provide written or electronic notice of the adverse determination within three days following the oral notification.

§114-95-9. Emergency Services.

9.1. When conducting utilization review or making a benefit determination for emergency services, an issuer that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

9.2. An issuer shall cover emergency services to screen and stabilize a covered person in the following manner:

9.2.a. Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

9.2.b. Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;

9.2.c. If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

9.2.d. If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of subdivision 9.3.b; and

9.2.e. Without regard to any other term or condition of coverage, other than:

9.2.e.1. The exclusion of or coordination of benefits;

9.2.e.2. An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act (PHSA); or

9.2.e.3. Applicable cost-sharing, as provided in subdivisions 9.3.a or 9.3.b.

9.3. For in-network emergency services, coverage of emergency services shall be subject to applicable co-payments, coinsurance and deductibles.

9.3.a. For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

9.3.b. Notwithstanding subdivision 9.3.a, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the issuer is required to pay under this paragraph.

9.3.c. An issuer complies with the requirements of this subsection if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

9.3.c.1. The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

9.3.c.2. The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

9.3.c.3. The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

9.3.d. For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, paragraph 9.3.c.1 does not apply. If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in paragraph 9.3.c.1 is the median of these negotiated amounts.

9.3.d.1. Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

9.3.d.2. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.

9.3.d.3. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.

9.4. For immediately required post-evaluation or post-stabilization services, an issuer shall provide access to designated representative twenty-four hours a day, seven days a week, to facilitate review.

§114-95-10. Confidentiality Requirements.

An issuer shall annually certify in writing to the Commissioner that the utilization review program of the issuer or its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

§114-95-11. Disclosure Requirements.

11.1. In the certificate of coverage or member handbook provided to covered persons, an issuer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

11.2. An issuer shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

11.3. An issuer shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

§114-95-12. Penalties.

Any issuer failing to comply with the requirements of this rule is subject to the penalties prescribed in W. Va. Code §33-3-11.