

**TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE**

**SERIES 96
HEALTH PLAN ISSUER INTERNAL
GRIEVANCE PROCEDURE**

Section.

- 114-96-1. General.
- 114-96-2. Definitions.
- 114-96-3. Grievance Reporting and Recordkeeping Requirements.
- 114-96-4. Grievance Review Procedures.
- 114-96-5. First Level Reviews of Grievances Involving an Adverse Determination.
- 114-96-6. Standard Reviews of Grievances Not Involving an Adverse Determination.
- 114-96-7. Expedited Review of Grievances Involving an Adverse Determination.
- 114-96-8. Penalties.

**Title 114, Series 96
Legislative Rule
Insurance Commissioner**

**TITLE 114
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**SERIES 96
HEALTH PLAN ISSUER INTERNAL
GRIEVANCE PROCEDURE**

§114-96-1. General.

1.1. Scope. – The purpose of this rule is to provide standards for the establishment and maintenance of procedures by issuers to assure that covered persons have the opportunity for the appropriate resolution of grievances. This rule is based upon the National Association of Insurance Commissioners’ “Health Carrier Grievance Procedure Act” (Model #72), as amended in 2012. To the extent feasible, this rule should be construed consistently with related state and federal laws, but to the extent any provision conflicts with a provision of other related rules in this title (including, but not limited to, series 43, 46, 50, 51 and 53 of this title), the provisions of this rule shall control and take precedence.

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

1.3. Filing Date. --

1.4. Effective Date. --

§114-96-2. 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 healthcare 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

Title 114, Series 96
Legislative Rule
Insurance Commissioner

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 as 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.

Title 114, Series 96
Legislative Rule
Insurance Commissioner

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. "Final adverse determination" means an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been exhausted.

2.17. "Grievance" means a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint, regarding:

2.17.a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

Title 114, Series 96
Legislative Rule
Insurance Commissioner

2.17.b. Claims payment, handling or reimbursement for health care services; or

2.17.c. Matters pertaining to the contractual relationship between a covered person and an issuer.

2.18. “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, except as otherwise specifically exempted in this definition.

2.18.a. “Health benefit plan” does not include:

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

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

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

2.18.a.4. Workers’ compensation or similar insurance;

2.18.a.5. Automobile medical payment insurance;

2.18.a.6. Credit-only insurance;

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

2.18.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.

2.18.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:

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

2.18.b.2. Benefits for long-term care, nursing home care, home health

Title 114, Series 96
Legislative Rule
Insurance Commissioner

care, community-based care, or any combination thereof; or

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

2.18.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:

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

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

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

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

2.18.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

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

2.19. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

2.20. “Health care provider” or “provider” means a health care professional or a facility.

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

2.22. “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,

Title 114, Series 96
Legislative Rule
Insurance Commissioner

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.

2.23. “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.

2.24. “Network” means the group of participating providers providing services to a managed care plan.

2.25. “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.

2.26. “Person” means in 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.

2.27. “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.

2.28. “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:

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

2.28.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.

2.29. “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.

Title 114, Series 96
Legislative Rule
Insurance Commissioner

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

2.31. "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.

2.32. "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:

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

2.32.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.

2.32.c. Except as provided in subdivision 2.35.b, 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.

2.32.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.

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

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

§114-96-3. Grievance Reporting and Recordkeeping Requirements.

3.1. An issuer shall maintain written records to document all grievances received,

Title 114, Series 96
Legislative Rule
Insurance Commissioner

including the notices and claims associated with the grievances.

3.1.a. The records of all grievances initiated in each calendar year shall be arranged in a separate register, the contents and form of which shall be prescribed by the Commissioner.

3.1.b. The records shall be retained for the longer of five years or until the Commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

3.1.c. The issuer shall make the records available for examination by the Commissioner and such other persons designated by the Commissioner.

3.2. An issuer shall annually submit to the Commissioner, at such time and in a format prescribed by the Commissioner, a report containing a compilation and analysis of the grievances filed, their disposition and their underlying causes.

§114-96-4. Grievance Review Procedures.

4.1. Whenever an issuer fails to adhere to the requirements of section 5 or section 7 with respect to receiving and resolving grievances involving an adverse determination, 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.*

4.1.a. Notwithstanding subsection 4.1, the provisions of section 5 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 the control of the issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the covered person.

4.1.a.1. The exception provided in subdivision 4.1.a does not apply if the violation is part of a pattern or practice of violations by the issuer.

4.1.a.2. An issuer shall, within ten days of receiving a written request from a covered person, provide a written explanation of the basis, if any, for asserting that the alleged violation of section 5 or 7 does not entitle the covered person to claim exhaustion.

4.1.b. If an independent review organization rejects the grievance involving an

Title 114, Series 96
Legislative Rule
Insurance Commissioner

adverse determination for immediate review on the basis that the issuer met the requirements of the exception provided in subdivision 4.1.a., the covered person has the right to resubmit and pursue a review of the grievance under this rule.

4.1.b.1. In this case, within a reasonable time but not exceeding ten days after the independent review organization rejects the grievance involving an adverse determination for immediate review, the issuer shall provide to the covered person notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule.

4.1.b.2. For purposes of calculating the time period for re-filing the benefit request or claim under this paragraph, the time period shall begin to run upon the covered person's receipt of the notice of opportunity to resubmit.

4.2. An issuer shall file a copy of the procedures required under subsection 4.1, including all forms used to process requests made pursuant to section 5, 6 and 7, with the Commissioner. Any subsequent material modifications to the documents also shall be filed. The Commissioner may disapprove a filing received in accordance with subdivision a of this subsection that fails to comply with this rule.

4.3. In addition to subsection 4.2, an issuer shall file annually with the Commissioner, as part of its annual report required by section 3, a certificate of compliance stating that the issuer has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this rule.

4.4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

4.5. The grievance procedure documents shall include a statement of a covered person's right to contact the Commissioner's office for assistance at any time. The statement shall include the telephone number and address for the Commissioner's office.

§114-96-5. First Level Reviews of Grievances Involving an Adverse Determination.

5.1. Within 180 days after receipt of a notice of an adverse determination sent pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, a covered person may file a grievance with the issuer requesting a first level review of the adverse determination.

5.2. First Level Review.

Title 114, Series 96
Legislative Rule
Insurance Commissioner

5.2.a. The issuer shall provide the covered person with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the issuer.

5.2.b. In providing for a first level review under this section, the issuer shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision.

5.2.c. In ensuring the independence and impartiality of individuals involved in making the first level review decision, the issuer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

5.3. Clinical Peers; Reviewers.

5.3.a. In the case of a review of an adverse determination involving utilization review, the issuer shall designate a review panel of health care professionals, none of whom shall have been involved in the initial adverse determination.

5.3.b. If a panel designated pursuant to subdivision 5.3.a does not include a clinical peer, then the issuer shall ensure a clinical peer is available for consultation to the panel and the panel shall consult with such clinical peer.

5.3.c. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person, without regard to whether the information was submitted or considered in making the initial adverse determination.

5.4. A covered person does not have the right to attend, or have a representative in attendance, at the first level review, but the covered person is entitled to:

5.4.a.. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

5.4.b. Receive from the issuer, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. For purposes of this subsection, a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

Title 114, Series 96
Legislative Rule
Insurance Commissioner

5.4.b.1. Was relied upon in making the benefit determination;

5.4.b.2 Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

5.4.b.3 Demonstrates that, in making the benefit determination, the issuer or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

5.4.b.4 Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

5.5. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection 5.6, the time period shall begin on the date the grievance requesting the review is filed with the issuer in accordance with the issuer's procedures established pursuant to section 4 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5.6. Notifications.

5.6.a. An issuer shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in subdivisions 5.6.b and 5.6.c.

5.6.b. With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the issuer shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty days after the date of the issuer's receipt of the grievance requesting the first level review pursuant to subsection 5.1.

5.6.c. With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the issuer shall notify and issue a decision within a reasonable period of time, but no later than sixty days after the date of the issuer's receipt of the grievance requesting the first level review made pursuant to subsection 5.1.

5.7. Prior to issuing a decision in accordance with the time-frames provided in subsection 5.6, the issuer shall provide free of charge to the covered person any new or additional evidence, relied upon or generated by the issuer, or at the direction of the issuer, in connection with the

Title 114, Series 96
Legislative Rule
Insurance Commissioner

grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person a reasonable opportunity to respond prior to that date. Before the issuer issues or provides notice of a final adverse determination in accordance with the time-frames provided in subsection 5.6 that is based on new or additional rationale, the issuer shall provide the new or additional rationale to the covered person free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

5.8. The decision issued pursuant to subsection 5.6 shall set forth in a manner calculated to be understood by the covered person:

5.8.a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

5.8.b. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

5.8.c. 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 subdivision, an issuer:

5.8.c.1. 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

5.8.c.2. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

5.8.d. A statement of the reviewers' understanding of the covered person's grievance;

5.8.e. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

5.8.f. A reference to the evidence or documentation used as the basis for the decision;

5.8.g. For a first level review decision issued pursuant to subsection 5.6 that

Title 114, Series 96
Legislative Rule
Insurance Commissioner

upholds the grievance:

5.8.g.1. The specific reason or reasons for the final adverse determination, including denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in reaching the denial;

5.8.g.2. The reference to the specific plan provision on which the determination is based;

5.8.g.3. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in subdivision 5.4.b, to the covered person's benefit request;

5.8.g.4. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either 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 the same will be provided free of charge to the covered person upon request;

5.8.g.5. If the final 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 judgement 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 provide to the covered person free of charge upon request; and

5.8.g.6. If applicable, instructions for requesting:

5.8.g.6.A. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination as provided in paragraph 5.4.g.4; and

5.8.g.6.B. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 5.4.g.5;

5.8.h. If applicable, a statement indicating:

5.8.h.1. A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to section 7;

Title 114, Series 96
Legislative Rule
Insurance Commissioner

5.8.h.2. The written procedures governing the voluntary review, including any required time frame for the review;

5.8.h.3. A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to W. Va. Code of St. R. §114-97-1 *et seq.* if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and

5.8.h.4. The covered person's right to bring a civil action in a court of competent jurisdiction;

5.8.i. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

5.8.j. Notice of the covered person's right to contact the Commissioner's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

5.9. An issuer shall provide the notice required under subsection 5.8 in a culturally and linguistically appropriate manner in accordance with federal regulations.

5.9.a. To be considered to meet the requirements of this subsection, the issuer shall:

5.9.a.1. 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;

5.9.a.2. Provide, upon request, a notice in any applicable non-English language; and

5.9.a.3. 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 carrier.

5.9.b. For purposes of this subsection, 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 percent or more of the population residing in the county is literate only in the same non-English

**Title 114, Series 96
Legislative Rule
Insurance Commissioner**

language, as determined in published federal guidance.

§114-96-6. Standard Reviews of Grievances Not Involving an Adverse Determination.

6.1. An issuer shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

6.2. The procedures shall permit a covered person to file a grievance that does not involve an adverse determination with the issuer under this section.

6.2.a. A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection 6.3 to consider when conducting the review.

6.2.b.. The issuer shall make the provisions of subdivision 6.2.a known to the covered person within three working days after the date of receiving the grievance.

6.3. Upon receipt of the grievance, an issuer shall designate a person or persons to conduct the standard review of the grievance.

6.3.a. The issuer may not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

6.3.b. The issuer shall provide the covered person with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the issuer.

6.4. The issuer shall notify in writing the covered person of the decision within twenty working days after the date of receipt of the request for a standard review of a grievance filed pursuant to subsection 6.2.

6.4.a. Subject to subdivision 6.4.b, if, due to circumstances beyond the issuer's control, the issuer cannot make a decision and notify the covered person pursuant to subsection 6.4 within twenty working days, the issuer may take up to an additional ten working days to issue a written decision.

6.4.b.. An issuer may extend the time for making and notifying the covered person in accordance with subdivision 6.4.a, if, on or before the twentieth working day after the

Title 114, Series 96
Legislative Rule
Insurance Commissioner

date of receiving the request for a standard review of a grievance, the issuer provides written notice to the covered person of the extension and the reasons for the delay.

6.5. The written decision issued pursuant to subsection 6.4 shall contain:

6.5.a. The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);

6.5.b. A statement of the reviewers' understanding of the covered person's grievance;

6.5.c. The reviewer's decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the issuer's position;

6.5.d. A reference to the evidence or documentation used as the basis for the decision;

6.5.e. If applicable, a statement indicating:

6.5.e.1. A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to section 7; and

6.5.e.2. The written procedures governing the voluntary review, including a required time frame for the review; and

6.5.f. Notice of the covered person's right, at any time to contact the Commissioner's office, including the telephone number and address of the Commissioner's office.

§114-96-7. Expedited Reviews of Grievances Involving an Adverse Determination.

7.1. An issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

7.2. In addition to subsection 5.1, an issuer shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

Title 114, Series 96
Legislative Rule
Insurance Commissioner

7.3. The procedures shall allow a covered person to request an expedited review under this section orally or in writing.

7.4. An issuer shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

7.5. In an expedited review, all necessary information, including the issuer's decision shall be transmitted between the issuer and the covered person by telephone, facsimile or the most expeditious method available.

7.6. An expedited review decision shall be made and the covered person shall be notified of the decision in accordance with subsection 7.8 as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the receipt of the request for the expedited review. If the expedited review of a grievance involves an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7.7. For purposes of calculating the time periods within which a decision is required to be made under subsection 7.6, the time period within which the decision 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 4 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

7.8. Decision Notification.

7.8.a. A notification of a decision under this section shall, in a manner calculated to be understood by the covered person, set forth:

7.8.a.1. The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

7.8.a.2. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

7.8.a.3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding

Title 114, Series 96
Legislative Rule
Insurance Commissioner

meaning. For purposes of this paragraph, an issuer:

7.8.a.3.A. Shall upon request provide to the covered person, as soon as practicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning, associated with any adverse determination; and

7.8.a.3.B. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

7.8.a.4. A statement of the reviewers' understanding of the covered person's grievance;

7.8.a.5. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

7.8.a.6. A reference to the evidence or documentation used as the basis for the decision; and

7.8.a.7. If the decision involves a final adverse determination, the notice shall provide:

7.8.a.7.A. The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as description on the issuer's standard, if any, that was used in reaching denial;

7.8.a.7.B. Reference to the specific plan provisions on which the determination is based;

7.8.a.7.C. 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;

7.8.a.7.D. 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;

Title 114, Series 96
Legislative Rule
Insurance Commissioner

7.8.a.7.E. If the final 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;

7.8.a.7.F. If applicable, instructions for requesting:

7.8.a.7.F.1. A copy of the rule guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subparagraph 7.8.a.7.D;

7.8.a.7.F.2. The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph 7.8.a.7.E;

7.8.a.7.F.3. A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to W. Va. Code of St. R. §114-97-1 et. seq.;

7.8.a.7.F.4. A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

7.8.a.7.F.5. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

7.8.a.7.F.6. A notice of the covered person's right to contact the Commissioner for assistance with respect to any claim grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

7.8.b. An issuer shall provide the notice required under this section as set forth in subsection 5.9.

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

7.8.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;

**Title 114, Series 96
Legislative Rule
Insurance Commissioner**

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

7.8.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 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.

7.8.c. 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.

§114-96-8. 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.