

**WEST VIRGINIA  
SECRETARY OF STATE  
KEN HECHLER  
ADMINISTRATIVE LAW  
DIVISION**

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OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

Form #6

**NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED  
BY THE WEST VIRGINIA LEGISLATURE**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

AMENDMENT TO AN EXISTING RULE: YES  NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: \_\_\_\_\_

TITLE OF RULE BEING AMENDED: \_\_\_\_\_

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: Series 56

TITLE OF RULE BEING PROPOSED: Quality Assurance Standards for  
Prepaid Limited Health Service Organizations

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) SB 232

SECTION 64-7-2 (c), PASSED ON March 1, 2000

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE  
FOLLOWING DATE: April 24, 2000

  
Authorized Signature

**PROMULGATION HISTORY**  
**WEST VIRGINIA INSURANCE COMMISSION**  
**QUALITY ASSURANCE STANDARDS FOR**  
**PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS**  
**TITLE 114, SERIES 56**

06/08/99	Notice of Comment Period Filed
07/08/99	Last Date Comments Were Received
07/12/99	Agency Approved Legislative Rule Filed
08/16/99	Date Reviewed by Legislative Rule-Making Review Committee
04/24/00	Filing Date
04/24/00	Effective Date



STATE OF WEST VIRGINIA  
Offices of the Insurance Commissioner

Legal Division

CECIL H. UNDERWOOD  
Governor

HANLEY C. CLARK  
Insurance Commissioner

April 24, 2000

**HAND DELIVERED**

Ms. Judy Cooper, Director  
Administrative Law Division  
Office of Secretary of State  
State Capitol  
Charleston, West Virginia 25305

Dear Ms. Cooper:

Attached for filing with your office is the "final filing" form for the rule Series 56 titled "Quality Assurance Standards for Prepaid Limited Health Service Organizations." This rule was authorized in Senate Bill 232 and passed by the Legislature on March 1, 2000.

We are also providing your office with a computer disk containing the aforementioned rule and a hard copy of the promulgation history of that rule. The filing date and effective date have already been inserted onto the computer disk.

If you have any questions about the enclosed forms or the computer disk, please do not hesitate to call me.

Sincerely,

A handwritten signature in cursive script that reads "Donna S. Quesenberry".

Donna S. Quesenberry  
General Counsel

DSQ/jz  
Attachments

FILED

**114CSR56**  
**WEST VIRGINIA LEGISLATIVE RULE**  
**INSURANCE COMMISSION**

APR 24 10 12 AM '00

**SERIES 56**  
**QUALITY ASSURANCE STANDARDS FOR**  
**PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS**

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

Section

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- 114-56-3. Goals of a Quality Assurance Program.
- 114-56-4. Requirements of a Quality Assurance Program.
- 114-56-5. Quality Management & Improvement.
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- 114-56-8. Members' Rights & Responsibilities.
- 114-56-9. Preventive Health Services.
- 114-56-10. Treatment Records.
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**114CSR56**  
**WEST VIRGINIA LEGISLATIVE RULE**  
**INSURANCE COMMISSION**

**SERIES 56**  
**QUALITY ASSURANCE STANDARDS FOR**  
**PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS**

**§ 114-56-1. General.**

1.1. Scope. -- The purpose of this rule is to set forth standards for quality assurance programs established as a component of a prepaid limited health service organization's overall structure.

1.2. Authority. -- W. Va. Code §§ 33-2-10, 33-25D-7, and 33-25D-22.

1.3. Filing Date. -- April 24, 2000

1.4. Effective Date. -- April 24, 2000

**§ 114-56-2. Definitions.**

2.1. "Accountability" means the responsibility of a department or individual for achieving defined goals.

2.2. "Appropriateness" means the extent to which a particular procedure, treatment, test or service is clearly indicated, not excessive, adequate in quantity and provided in the setting best suited to the patient's or member's needs.

2.3. "Clinician" means a state-recognized provider including, but not limited to, physicians, psychologists and psychiatrists who specialize in clinical studies or practice.

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

2.5. "Coordinating provider" means the provider of a particular limited health service who is chosen or designated for each subscriber and who will be responsible for coordinating the provision of that particular limited health service to the subscriber, including necessary referrals to other providers of the limited health service: Provided, That if a subscriber is also enrolled in a health maintenance organization, the coordinating provider shall send a written report at least annually to the subscriber's primary care physician, as defined in article twenty-five-a of this chapter, describing the limited health service provided to the subscriber: Provided, however, That the coordinating provider may disclose data or information only as permitted under W. Va. Code § 33-25D-12.

2.6. “Credentialing” means the process by which a prepaid limited health service organization authorizes, contracts with or employs providers, who are licensed to practice independently, to provide services to its members.

2.7. “DEA” means Drug Enforcement Administration, the federal agency that issues licenses to prescribe and dispense scheduled drugs.

2.8. “Delegation” or “delegated” means the formal process by which a prepaid limited health service organization gives a contractor the authority to perform certain functions on its behalf, such as credentialing, utilization review and quality assurance. A prepaid limited health service organization can delegate the authority to perform a function but cannot delegate the responsibility for assuring the function is performed properly.

2.9. “Governing body” means an individual, group or agency with the ultimate authority and responsibility for the overall operation of the organization.

2.10. “Limited health service” and “health care service” means mental or behavioral health services (including mental illness, mental retardation, developmental disabilities, substance abuse, and chemical dependency), together with any services or goods included in the furnishing to any individual of a limited health service. “Limited health services” does not include inpatient services, hospital surgical services or emergency services except as such services are provided incident to and directly related to a limited health service set forth in this subsection.

2.11. “Member,” “subscriber” or “enrollee” means an individual who has been voluntarily enrolled in a prepaid limited health service organization, including individuals on whose behalf a contractual arrangement has been entered into with a prepaid limited health service organization to receive limited health services.

2.12. “Oversight” means the monitoring and direction of a set of activities by individuals responsible for the execution of the activities resulting in the achievement of desired outcomes.

2.13. “Practice guidelines” or “protocols” means systematically developed statements to assist patient and provider decisions about appropriate health care for specific clinical circumstances. Practice guidelines are usually based on such authoritative sources as clinical literature and expert consensus.

2.14. “Preauthorization” means prior assessment that proposed limited health services are covered by the member’s benefit plan and are appropriate for a particular member.

2.15. “Prepaid limited health service organization” means a public or private organization which provides, or otherwise makes available to enrollees, limited health services and which:

a. Receives premiums for the provision of limited health services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;

b. Provides limited health services primarily:

1. Directly through an exclusive panel of physicians or other providers who are employees or partners of the organization;

2. Through arrangements with individual physicians or other providers or one or more groups of physicians or other providers organized on a group practice or individual practice arrangement; or

3. Some combination of paragraphs 1 and 2 of this subdivision.

2.16. "Provider" means any physician or other person or organization licensed or otherwise authorized in this state to furnish a health care service.

2.17. "Quality assurance" means an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of the enrollee's care, pursue opportunities to improve the enrollee's care and to resolve identified problems at the prevailing professional standard of care.

2.18. "Quality improvement work plan" means an annual plan that describes with timeliness the specific planned quality assurance activities that will be carried out within the quality assurance program.

2.19. "Quality of care" means the degree to which limited health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

2.20. "Treatment record" means the record in which clinical information relating to the provision of physical, social and mental services is recorded and stored either electronically or on paper.

2.21. "Utilization management" means a system for the evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities.

### **§ 114-56-3. Goals of a Quality Assurance Program.**

3.1. The goals of a prepaid limited health service organization's quality assurance program shall be to:

a. Assure the provision of appropriate limited health services delivered to members, while simultaneously addressing the effectiveness of quality of care;

- b. Monitor, evaluate and improve the quality of care for limited health services;
- c. Provide a systematic process that promotes the delivery of appropriate care in a timely, effective and efficient manner, while maintaining the quality of care for limited health services;
- d. Direct members and providers toward the goal of quality and cost effective care for limited health services.

3.2. A prepaid limited health service organization's quality assurance program shall include a mechanism for identifying potential utilization management issues and linking them to the PLHSO's utilization management program.

#### **§ 114-56-4. Requirements of a Quality Assurance Program.**

4.1. A prepaid limited health service organization shall develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules.

a. If, at any time, the commissioner determines that the quality assurance program of the prepaid limited health service organization has become deficient in any significant area, the commissioner, in addition to other remedies available, may establish a corrective action plan that the PLHSO must follow as a condition to the issuance or maintenance of a certificate of authority.

4.2. Each application for a certificate of authority or renewal thereof filed with the commissioner pursuant to the Prepaid Limited Health Service Organization Act, W. Va. Code §§ 33-25D-1 et seq., shall be accompanied by a description of a prepaid limited health service organization's quality assurance program, which shall include, but not be limited to, the requirements of the quality assurance program set forth in this rule. The PLHSO's quality assurance program may be inspected by providers, enrollees or their agents at the offices of the commissioner pursuant to the provisions of the West Virginia Freedom of Information Act, W.Va. Code §§ 29B-1-1 et seq.

a. Pursuant to the requirements of W. Va. Code § 33-25D-3, a prepaid limited health service organization shall file notice with the commissioner prior to any modification of the quality assurance program.

4.3. A prepaid limited health service organization shall have a program for quality assurance which clearly defines the structure, design and responsibilities of both delegated and non-delegated activities.

a. The basic components of the quality assurance program shall include:

1. Organizational arrangements and responsibilities for quality management and improvement processes;

2. A documented utilization management program;
3. Written policies and procedures for credentialing and recredentialing physicians and other licensed providers who fall under the scope of the prepaid limited health services organization;
4. A written policy addressing enrollees' rights and responsibilities; and
5. The adoption of practice guidelines for the use of preventive health services.

4.4. If a prepaid limited health service organization delegates any quality assurance activity to contractors, there shall be evidence of oversight and auditing of the contracted activity.

a. The PLHSO shall maintain a written description of the delegated activities, the contractor's accountability for the activities, the frequency of reporting to the PLHSO, the process by which the delegation will be evaluated and the remedies available, including revocation of delegation, if the contractor does not fulfill its obligations.

b. The PLHSO shall maintain evidence of its regular evaluation and approval of the delegated activities by the contractor.

c. The PLHSO shall be responsible for monitoring the activities of the contractor to which it delegates quality assurance activities and for ensuring that the requirements of this rule are met.

4.5. No prepaid limited health service organization may place restrictions upon any provider or coordinating provider which would serve to limit the communication of advice or options regarding treatment available to the member, subscriber or enrollee or would act in any way to limit the communication between the provider and his or her patient. A PLHSO may not prevent any provider from advising an enrollee whether or not a treatment is covered by the plan.

a. No prepaid limited health service organization may provide to any provider or any coordinating provider an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, to the provider or coordinating provider as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar conditions.

4.6. Data or information pertaining to the diagnoses, treatment or health of a member obtained from the member or from a provider by a prepaid limited health service organization is confidential and shall not be disclosed to any person except:

a. To the extent that it may be necessary to carry out the purposes of these rules and as allowed by state law;

- b. Upon the express consent of the member;
- c. Pursuant to statute or court order for the production of evidence or the discovery thereof;
- d. In the event of a claim or litigation between the member and the prepaid limited health service organization where the data or information is pertinent, regardless of whether the information is in the form of paper, preserved on microfilm, or stored in computer retrievable form.

4.7 If any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant is disclosed pursuant to the provisions of subsection 4.6, the prepaid limited health service organization making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data.

#### **§ 114-56-5. Quality Management & Improvement.**

5.1. Organizational arrangements and responsibilities for quality management and improvement processes shall be clearly defined and assigned to appropriate individuals.

- a. There shall be a detailed written description of the program which shall be reviewed annually and updated as necessary.
- b. A senior executive shall be responsible for program implementation.
- c. A medical director shall be employed by the prepaid limited health service organization and have substantial involvement in quality improvement activities.
- d. A committee shall be created to oversee quality improvement and shall include PLHSO providers as active participants. The committee shall keep contemporaneous written records reflecting all of its actions.
- e. The role, structure and function, including frequency of meetings, of the quality improvement committee shall be specified in the program description.
- f. Adequate resources including, but not limited to, personnel, analytic capabilities and data resources shall be dedicated to meet program needs.
- g. A written quality improvement work plan shall be prepared annually and shall include: the objectives, scope and planned projects or activities for the year; planned monitoring of previously identified issues, including tracking of issues over time; and planned evaluation of the quality improvement program.

5.2. The quality improvement committee shall be accountable to the governing body of a prepaid limited health service organization. The governing body shall consist of the board of

directors or a committee of senior management in instances where the board's participation with quality improvement is indirect. There must be documented evidence of a formally designated structure, accountability at the highest levels of the organization and ongoing and continuous oversight of quality assurance.

a. The governing body shall formally designate a subcommittee to provide oversight of quality improvement or formally decide to provide such oversight as a committee of the whole.

b. There must be written documentation that the governing body has reviewed and approved the written overall quality improvement program and the annual quality improvement work plan.

c. The governing body or designated committee shall regularly receive written reports from the quality improvement program delineating actions taken and improvements made.

d. All quality assurance information shall be considered in recredentialing, recontracting and annual performance evaluations.

5.3. All findings, conclusions, recommendations, actions taken, and results of actions taken as a result of the quality improvement process shall be documented and reported to the appropriate individuals and committees in the prepaid limited health service organization and through established quality improvement standards.

a. Quality improvement activities shall be coordinated with other performance monitoring activities including, but not limited to, utilization management, risk management and resolution, monitoring of member complaints and grievances, assessment of member satisfaction and review of treatment records.

b. Quality improvement shall be coordinated with other management functions of the prepaid limited health service organization such as network changes, benefits redesign, treatment management systems, practice feedback to providers and patient education.

5.4. Requirements to participate in quality improvement activities shall be incorporated into all provider contracts and employment agreements. Contracts shall specify that hospitals and other contractors will allow the prepaid limited health service organization access to members' treatment records. Contracts shall also specify that the prepaid limited health service organization allows open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient.

5.5. The quality improvement program must be ongoing and designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided members and to pursue opportunities for improvements.

a. The scope of the program shall be comprehensive and shall include quality of clinical care and quality of service.

b. Members shall be afforded opportunities to participate in and offer suggestions on quality improvement.

c. A prepaid limited health service organization shall monitor and evaluate clinical issues from inpatient facility services, partial facility services, or ambulatory services; high-volume diagnoses or services; and high-risk diagnoses services, or special populations such as child and adolescent mental health, substance abuse, suicidality, persons with serious and persistent mental illness, or persons with dual diagnoses. Such monitoring and evaluation shall reflect members of its covered population.

5.6. A prepaid limited health service organization shall adopt and use practice guidelines or explicit criteria that are based on reasonable scientific evidence.

a. The guidelines shall be reviewed and updated as needed.

b. The guidelines and any updates shall be communicated in writing to all providers.

5.7. A PLHSO shall develop and implement mechanisms for:

a. Assessing performance against practice guidelines;

b. Evaluating member continuity and coordination of care;

c. Detecting under- and over-utilization; and

d. Assessing patient outcomes.

5.8. A prepaid limited health service organization shall establish written standards for the availability of coordinating providers. The standards shall be based on the needs of its member population to ensure the availability and accessibility of limited health services, and urgent, emergency and member services. The standards must ensure that the organization's referral and triage functions are appropriately implemented and monitored.

5.9. A prepaid limited health service organization shall develop indicators, a data collection system and data analysis capabilities to track quality improvement.

a. Indicators shall be objective, measurable and based on current knowledge and clinical experience and shall be used to monitor and evaluate all aspects of care and services identified.

b. A PLHSO shall have performance goals or a bench marking process for each indicator.

c. Appropriate methods and frequency of data collection shall be used for each indicator.

d. Appropriate clinicians shall be used to evaluate data on the clinical performance of providers.

e. Multidisciplinary teams shall be used, where indicated, to analyze and address systems issues.

5.10. If a prepaid limited health service organization receives ten or more complaints from members or enrollees within a six-month period that relate to the same or similar subject matter, the prepaid limited health service organization shall develop a specific written plan of action as to the resolution of the complaints and file a report with the commissioner on how the complaints were successfully resolved.

5.11. A prepaid limited health service organization shall ensure continuity and coordination throughout its continuum of limited health services, and collaborate with relevant health delivery systems and primary care providers to ensure the exchange of patient information in a timely, effective and confidential manner.

#### **§ 114-56-6. Utilization Management Program.**

6.1. A prepaid limited health service organization shall have a documented utilization management program which shall include, at a minimum, performance goals, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of limited health services.

a. The UM program shall have a mechanism for evaluating and updating the program description on a periodic basis which shall be specified by the prepaid limited health service organization.

6.2. The UM program shall have written utilization review decision protocols based on reasonable medical evidence.

a. A prepaid limited health service organization shall have criteria for appropriateness of a limited health service clearly documented and available, upon request, to participating physicians.

b. A prepaid limited health service organization shall establish a mechanism for checking the consistency of the application of criteria utilized by reviewers.

c. A prepaid limited health service organization shall establish a mechanism for updating review criteria on a periodic basis which shall be specified by the prepaid limited health service organization.

6.3. The UM program shall have professionally accepted, pre-established criteria for the preauthorization of services and for concurrent review of admissions.

a. A prepaid limited health service organization shall, on a timely basis, make efforts to obtain all necessary information, including pertinent clinical information, and consultation with the treating provider, as appropriate.

b. Qualified medical professionals shall review decisions for preauthorization of limited health services and concurrent review of admissions.

c. A duly licensed physician shall conduct a review of medical appropriateness on any denial of limited health services.

d. At any point during the review process a licensed physician consultant specially trained in the area of medicine in question shall be available to provide his or her expert opinion regarding medical appropriateness and necessity of limited health services whenever necessary.

6.4. Decisions regarding provision of limited health services shall be made in a timely manner depending upon the urgency of the situation.

a. The prepaid limited health service organization shall establish medically appropriate time frames for urgent, emergency and planned care cases.

b. In those instances in which a prepaid limited health service organization denies limited health services, a written notice of denial shall be sent immediately to all involved parties, which shall include, but not be limited to, the subscriber, the coordinating provider, and the facility, if appropriate.

1. The written notice of denial shall include the reason for denial and an explanation of the appeal process.

6.5. A prepaid limited health service organization may have policies and procedures in place to evaluate the appropriate use of new medical technologies, or new application of established technologies, including medical procedures, drugs, and devices. Any policies and procedures in place regarding new medical technologies shall include standards requiring:

a. Appropriate professionals to participate in the development of technology evaluation criteria:

b. The review of information from appropriate health-related government agencies, government regulatory bodies and published scientific evidence;

c. Assessment of new technologies and new applications of existing technologies;  
and

d. Periodic evaluation and update of policies and procedures as technologies and procedures expand and change.

6.6. A prepaid limited health service organization shall have mechanisms to evaluate the effects of the program using member satisfaction data, provider satisfaction data and other appropriate means.

#### **§ 114-56-7. Credentialing & Recredentialing.**

7.1. A prepaid limited health service organization shall ensure that its network has sufficient numbers and types of providers. The PLHSO shall have a written access plan outlining its strategy for maintaining an adequate network and shall implement mechanisms designed to assure the availability of coordinating providers.

7.2. A prepaid limited health service organization shall have written policies and procedures for the credentialing of all providers that include the original credentialing, recredentialing, recertification and reappointment of providers who fall under its scope of authority and action.

a. The governing body, or the group or individual to whom the governing body has formally delegated the credentialing function, shall review and approve credentialing policies and procedures.

b. A credentialing committee or other peer review body shall be established to make recommendations regarding credentialing decisions. The committee shall include providers including, but not limited to, coordinating providers and physicians, as voting members.

7.3. In terms of initial credentialing, a PLHSO shall obtain and review verification of the following from primary sources:

- a. A current valid license to practice;
- b. When applicable, clinical privileges in good standing at the institution designated by the provider as the primary admitting facility;
- c. A valid Drug Enforcement Administration (DEA) certificate, as applicable;
- d. Graduation from medical school or appropriate graduate school and completion of a residency, specialty training and board certification, as applicable;
- e. Complete work history;
- f. Current adequate malpractice insurance according to the PLHSO's policy;

g. Complete professional liability claims history; and

h. Any other information deemed necessary by the PLHSO in determining whether to contract with a prospective provider.

7.4. A prospective provider shall complete an application for membership which includes a statement by the applicant regarding:

a. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

b. Lack of present illegal drug use and alcohol abuse;

c. History of loss of license or felony convictions;

d. History of loss or limitation of privileges or disciplinary activity;

e. Any other information deemed necessary by a PLHSO in determining whether to contract with a prospective provider; and

f. An attestation to the correctness and completeness of the application.

7.5. A prepaid limited health service organization shall request information on the prospective provider from recognized monitoring organizations including: the National Practitioner Data Bank; the appropriate State licensing boards such as the Board of Medicine, the Board of Social Work Examiners, the Board of Examiners of Psychologists, the Board of Examiners in Counseling; and any Medicare/Medicaid sanctioning.

7.6. Representatives from the credentialing committee or members of their staff shall make an initial visit to the office of each coordinating provider. This process shall include documentation of a structured review of the site and of treatment record keeping practices to ensure conformance with the PLHSO's standards.

7.7. A prepaid limited health service organization shall have written policies and procedures for the initial and ongoing quality assessment of health delivery organizations with which it intends to contract. The PLHSO shall confirm that the health delivery organization has been reviewed and approved by a recognized accrediting body, if appropriate, and is in good standing with state and federal regulatory bodies. If the health delivery organization has not been approved by a recognized accrediting body, the PLHSO must develop and implement standards of participation. Health delivery organizations shall include, but are not limited to, facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

a. At least every three years, the prepaid limited health service organization shall confirm that the health delivery organization continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

7.8. In terms of recredentialing, a prepaid limited health service organization shall develop a process for the periodic verification of credentials which shall be implemented at least every two years.

a. At a minimum, recredentialing shall include verification from primary sources of:

1. A valid state license to practice;
2. Clinical privileges in good standing at the institution designated by the provider as the primary admitting facility;
3. A valid Drug Enforcement Administration (DEA) certificate, as applicable;
4. Board certification, as applicable;
5. Current, adequate malpractice insurance;
6. Professional liability claims history; and
7. Any other information deemed necessary by a PLHSO in determining whether to re-contract with a provider.

b. The recredentialing process shall include a current statement by the applicant regarding reasons for any inability to perform the essential functions of the position, with or without accommodation and lack of present illegal drug use and alcohol abuse.

c. A PLHSO shall request recredentialing information from the National Practitioner Data Bank; the appropriate State licensing boards such as the Board of Medicine, the Board of Social Work Examiners, the Board of Examiners of Psychologists, the Board of Examiners in Counseling; and any Medicare/Medicaid sanctioning.

d. The recredentialing process shall also include a review of data from member complaints and grievances, results of quality reviews, utilization management, member satisfaction surveys, treatment record reviews and site visits.

e. The recredentialing process shall include an on-site visit to all high-volume coordinating providers and shall involve documentation of a structured review of the site and treatment record keeping practices to ensure conformance with PLHSO standards.

f. A prepaid limited health service organization shall have polices and procedures in place for reducing, suspending or terminating provider privileges which shall include but is not limited to:

1. A mechanism for reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination; and
2. An appeal process for and notice thereof to the provider.

**§ 114-56-8. Members' Rights & Responsibilities.**

8.1. A prepaid limited health service organization shall demonstrate a commitment to treating members with respect by developing written policies giving them the right to:

- a. Voice grievances about the PLHSO or care provided;
- b. Have information concerning the PLHSO, its services, the providers providing care and members' rights and responsibilities;
- c. Participate in decision-making regarding limited health services;
- d. Be treated with respect and recognition of their dignity and need for privacy;

and

e. Permit the provider or other person designated by the member or a court of competent jurisdiction to make and enforce all health care decisions which the member could make if he or she had capacity or were competent.

8.2. A PLHSO shall develop a written policy addressing members' responsibilities for cooperating with those providing limited health services by giving needed information to professional staff to ensure appropriate care and by following instructions and guidelines given by those providing limited health services.

8.3. All policies on members' rights and responsibilities shall be provided in writing in clear and concise terms to all members and participating providers and, at a minimum, shall address the following procedures for, policies concerning or information regarding:

- a. How to submit a claim for covered services;
- b. How to obtain limited health services;
- c. After-hours and emergency coverage including the PLHSO's policy on when to directly access emergency care or use 911-type services;
- d. Benefits and services included and excluded from membership;

- e. Obtaining out-of-area coverage;
- f. Special benefit provisions, such as co-payment, higher deductibles and rejection of claims, that may apply to services outside the system;
- g. Member charges;
- h. Notification of termination or change in any benefits, services or delivery site/office;
- i. Notification of termination of a coordinating provider and the process for selecting a new provider;
- j. Appealing decisions adversely affecting a member's coverage, benefits or relationship to the PLHSO;
- k. Changing providers;
- l. Disenrollment of nongroup subscribers;
- m. Voicing complaints, grievances and appeals;
- n. Recommending changes in policies and services;
- o. Points of access to limited health services;
- p. The process by which a prepaid limited health service organization determines whether or not to include new and emerging technology or treatment as a covered benefit;
- q. Provider names, qualifications and titles;
- r. Confidentiality;
- s. Member satisfaction surveys that assess patient complaints, requests to change providers or facilities and disenrollments; and
- t. Policies and procedures for the care and treatment of minors as well as adults who are unable to give informed consent.

8.4. The prepaid limited health service organization shall make reasonable accommodations for providing to members with disabilities the PLHSO's policies on members' rights and responsibilities.

**§ 114-56-9. Preventive Health Services.**

9.1. A prepaid limited health service organization shall adopt guidelines for the use of preventive health services which must be based on reasonable medical evidence and the full service population. The guidelines shall be developed or adopted with the participation of the PLHSO's providers and must include a mechanism for periodic updates.

a. The guidelines and all updates shall be provided in writing to all providers and members.

b. Each guideline shall describe the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required. The prepaid limited health service organization shall document the scientific basis or authority upon which it based the preventive health guidelines.

c. Providers from the prepaid limited health service organization who have appropriate knowledge shall be involved in the adoption of the preventive health guidelines.

d. At least annually, a PLHSO shall monitor, evaluate and take action upon a minimum of two of the following preventive services as appropriate:

1. Infancy, childhood and pre-adolescent screening and educational interventions such as learning and behavioral problems in preschoolers; child abuse and neglect; and impulse disorders;

2. Adolescent screening and educational interventions such as depression, acting out, and oppositional disorders; eating disorders; alcohol and drug abuse; suicidal ideation; and high-risk sexual behavior;

3. Adult screening and educational interventions such as mood disorders; obsessive compulsive disorders; anxiety disorders; schizophrenia; eating disorders; and alcohol and drug abuse including prescription drug dependence;

4. Family and community educational interventions such as healthy lifestyle choices; parent training; stress management; dying, loss and bereavement; domestic violence; and community resources;

5. Elderly screening and educational interventions such as mood disorders; organic brain syndrome; complications from chronic illnesses; and substance dependence including prescription drug dependence; and

6. Any other preventive services deemed appropriate by the commissioner and any other state or federal regulatory authorities.

e. Preventive health service studies shall be enrollee population-based, measuring compliance as it relates to the total at-risk population.

**§ 114-56-10. Treatment records.**

10.1. A prepaid limited health service organization shall require all of its providers to have an organized treatment record keeping system. Treatment records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review. Records shall also reflect all aspects of patient care including general medical services.

a. A PLHSO shall set forth in writing appropriate standards for treatment records, the systematic review for conformance and the institution of corrective action when standards are not met. Copies of all standards and goals and any updates shall be provided to all providers.

b. Records shall be available to providers at each patient visit and to nationally and state recognized reviewing bodies sanctioned by the commissioner.

**§ 114-56-11. Severability.**

11.1. This rule is subject to the anti-discrimination provisions of W.Va. Code § 33-25A-31.

11.2. If any provision of this rule or the application of this rule to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of the provisions to other persons or circumstances shall not be affected by the holding.

**ENROLLED**  
COMMITTEE SUBSTITUTE  
FOR  
**Senate Bill No. 232**

**§§64-7-2. Insurance commissioner.**

(c) The legislative rule filed in the state register on the twelfth day of July, one thousand nine hundred ninety-nine, authorized by section ten, article two, chapter thirty-three of this code, relating to the insurance commissioner (quality assurance standards for prepaid limited health service organizations, 114 CSR 56), is authorized.