

**WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION**

Form #2

Do Not Mark In this Box

2013 JUN 19 PM 1:40

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Insurance Commission TITLE NUMBER: 114

RULE TYPE: Legislative CITE AUTHORITY W. Va. Code §§33-16H-4 and 33-2-10

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 96

TITLE OF RULE BEING PROPOSED: Health Plan Issuer Internal Grievance Procedure

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 19, 2013 AT 5:00 pm. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Timothy Murphy, Associate Counsel

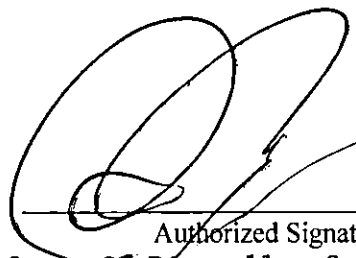
WV Offices of the Insurance Commissioner

P. O. Box 50540

Charleston WV 25305-0540

Timothy.Murphy@wvinsurance.gov

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.



Authorized Signature
Jason C. Pizatella, Cabinet Secretary

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

Insurance Commissioner
Legislative Rule
Title 114, Series 96

HEALTH PLAN ISSUER INTERNAL GRIEVANCE PROCEDURE

TITLE 114, SERIES 96

BRIEF SUMMARY OF RULE

The purpose of this rule is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this rule. Except as otherwise specified, this rule shall apply to all health carriers offering a health benefit plan. This rule is based upon the National Association of Insurance Commissioner's "Health Carrier Grievance Procedure Act" (Model 72), as amended in 2012.

Insurance Commissioner
Legislative Rule
Title 114, Series 96

**HEALTH PLAN ISSUER INTERNAL
GRIEVANCE PROCEDURE**

TITLE 114, SERIES 96

STATEMENT OF CIRCUMSTANCES

WV Code 33-16H-4(a)(2), enacted in 2013 (H.B. 2960), requires the Insurance Commissioner to "propose legislative rules for approval by the Legislature ..., including but not limited to rules to: ... (2) Establish requirements for all issuers with regard to utilization review and for internal grievance procedures and external review of adverse determinations, which rules shall be based on the corresponding model acts adopted by the National Association of Insurance Commissioners ..."

PPACA 1001 (PHSA 2719(b)) mandates that most "adverse determinations" in group health plans - no coverage, rescission of coverage, etc. - must be subject to external review by an independent review organization. A state can avoid federal preemption if it has in place a process that meets the minimum standards established by NAIC model act #76 "Health Carrier External Review"; however, HHS has determined that WV does not meet the minimum requirements and thus group plans are currently subject to the federal process in 45 CFR 147.136(d). HB2960 and this implementing rule are intended to enable WV to regain regulatory oversight of the ER process, and a proposed external review is being proposed by OIC. NAIC recommends that states adopting the external review model also enact the models for utilization review (how coverage decisions are reached by issuers) and the internal grievance model (how issuers internally resolve policyholder appeals of adverse determinations).

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Health Plan Issuer Internal Grievance Procedure (Title 114, Series 96)

Type of Rule: X Legislative Interpretive Procedural

Agency: WV Offices of the Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Albert T. Summers Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Timothy.Murphy@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

This new rule will entail some additional regulatory costs in order to monitor compliance. Currently only HMOs are subject to utilization review (114 CSR 51) and internal grievance (WVC 33-25C-5; 114 CFR 46.5) requirements; the proposed rule will expand such requirements and extend them to all issuers. OIC will have to include the new requirements in all future examinations. The proposed rule will have no impact on revenues of state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	"1/3 FTE"	"1/3 FTE"	"1/3 FTE"
Current Expenses	N/A	N/A	N/A
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

Recent federal health care reforms (PPACA) include mandatory external review by independent review organizations (IROs) of adverse determinations relative to coverage under health insurance policies. Such external reviews may proceed under state processes that meet certain minimum consumer protections; WV does not currently have a compliant process in place but is proposing a rule to bring it into compliance (114 CSR 97, based on an NAIC model act). The National Association of Insurance Commissioners recommends that states that are adopting the external review model also adopt 2 related model acts that involve how insurers make coverage decisions (utilization review, proposed rule 95) and how such decisions are disputed by enrollees through an internal process (internal grievances, proposed rule 96). Taken together, these models will add to OIC's regulatory duties that are estimated to require the equivalent of a single FTE. For instance, market conduct examiners will have to review compliance by *all* issuers with the new expanded requirements; the new external review scheme will entail approval of and assignment of IROs for the new external review scheme; OIC's consumer services division will have to review grievance reports for the entire regulated market rather than for HMOs only. The fiscal note for each of these new proposed rules includes an estimate of one-third FTE.

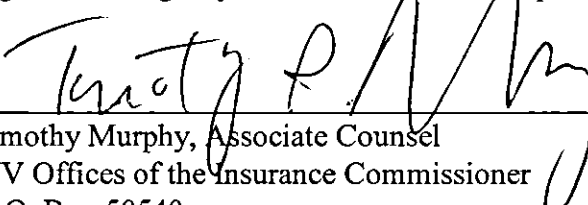
MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

n/a

Date: June 19, 2013

Signature of Agency Head or Authorized Representative



Timothy Murphy, Associate Counsel
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**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
INSURANCE COMMISSIONER
LEGISLATIVE RULE**

2013 JUN 19 PM 1:48

**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 Commissioner's "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 & 33-16G-4

1.3. Filing Date. --

1.4. Effective Date. --

§114-96-1. Definitions.

In addition to the definitions found in W. Va. Code of St. R. §114-95-2, the following definitions apply:

2.1. "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.

2.2. "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:

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

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

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

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

3.1. An issuer shall maintain written records to document all grievances received, 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 form of which shall be prescribed by the commissioner.

3.1.b. The records shall be retained for the longer of five (5) 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 of this rule 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 1 of this section, the provisions of section 5 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 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 a of this rule does not apply if the violation is part of a pattern or practice of violations by the health carrier.

4.1.a.2. An issuer shall, within ten (10) days of receiving a written request from a covered person, provide a written explanation of basis, if any, for asserting that the alleged violation of section 5 or 7 of this rule does not entitle the covered person to claim exhaustion.

4.1.b. If an independent review organization refuses to reject the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception provided in subdivision a of this rule, the covered person has the right to resubmit and pursue a review of the grievance under this rule.

4.1.b.4.B. In this case, within a reasonable time, after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, but not exceeding then (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule.

4.1.b.4.C. 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 or, if applicable, the covered person's authorized representative receipt of the notice of opportunity to resubmit.

4.2.

4.2.a. A health carrier shall file a copy of the procedures required under subsection 4.1 of this rule, including all forms used to process requests made pursuant to section 5, 6 and 7 of this rule, with the commissioner. Any subsequent material modifications to the documents also shall be filed.

4.2.b. 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, a health carrier shall file annually with the commissioner, as part of its annual report required by section 3 of this rule, a certificate of compliance stating that the health carrier 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 the date of 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 or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination.

5.2.

5.2.a. The health carrier 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 health carrier.

5.2.b. In providing for a first level review under this section, the health carrier 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 health carrier 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.

5.3.a. In the case of an adverse determination involving utilization review, the health carrier shall designate an appropriate clinical peer or peers of the same or similar speciality as would typically manage the case being reviewed to review the adverse determination. The clinical peer shall not have been involved in the initial adverse determination.

5.3.b. In designating an appropriate clinical peer or peers pursuant to subdivision a of this subsection, the health carrier shall ensure that, if more than one clinical peer is involved in the review, a majority of the individuals who review the adverse determination are health care professionals who have appropriate expertise.

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 or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

5.4.

5.4.a.

5.4.a.1. 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 or, if applicable, the covered person's authorized representative is entitled to:

5.4.a.1.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.a.1.B. Receive from the health carrier, 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.

5.4.a.2. For purposes of subparagraph B, paragraph 1 of this subdivision, 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:

5.4.a.2.A. Was relied upon in making the benefit determination;

5.4.a.2.B. 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.a.2.C. Demonstrates that, in making the benefit determination, the health carrier 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.a.2.D. 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.

5.4.b. The health carrier shall make the provisions of subdivision a of this subsection known to the covered person or, if applicable, the covered person's representative within three working days after the date of receipt of the grievance.

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 health carrier in accordance with the health carrier's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5.6.

5.6.a. A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in subdivisions b and c of this subsection.

5.6.b. With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier 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 (30) days after the date of the health carrier'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 health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to

subsection 5.1.

5.7.

5.7.a. Prior to issuing a decision in accordance with the timeframes provided in subsection 5.6 of this rule, the health carrier shall provide free of charge to the covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

5.7.b. Before the health carrier issues or provides notice of a final adverse determination in accordance with the time-frames provided in subsection 5.6, of this rule, that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, 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, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

5.8. The decision issued pursuant to subsection 5.6, of this rule, shall set forth in a manner calculated to be understood by the covered person or, if applicable the covered person's authorized representative:

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, a health carrier:

5.8.c.1. Shall provide to the covered person, or if applicable, the covered person's authorized representative, 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 State Rules §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 health carrier'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 of this rule that 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 health carrier'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 paragraph 2, subdivision a, subsection 5.4 of this rule, to the covered person's benefit request;

5.8.g.4. If the health carrier 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 was relied upon to make the final 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;

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 4 of this subdivision; and

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

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 of this rule;

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.

5.9.a. A health carrier shall provide the notice required under subsection 5.8 of this rule in a culturally and linguistically appropriate manner in accordance with federal regulations.

5.9.b. To be considered to meet the requirements of subdivision a of this subsection, the health carrier shall:

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

5.9.b.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.c. 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 (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.

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

6.1. A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

6.2.

6.2.a. The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under this section.

6.2.b.

6.2.b.1. 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 or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection 6.3 of this rule to consider when conducting the review.

6.2.b.2. The health carrier shall make the provisions of paragraph 1 of this subdivision known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receiving the grievance.

6.3.

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

6.3.b. The health carrier shall 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.c. The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address and telephone number of a person designated to coordinate the standard of review on behalf of the health carrier.

6.4.

6.4.a. The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision with twenty (20)

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.b.

6.4.b.1. Subject to paragraph 2 of this subdivision, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to subdivision a of this subsection within twenty (20) working days, the health carrier may take up to an additional ten (10) working days to issue a written decision.

6.4.b.2. A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with paragraph 1 of this subdivision, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative 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 health carrier'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 of this rule; and

6.5.e.2. The written procedures governing the voluntary review, including an 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.

8.1. A health issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

8.2. In addition to subsection 8.1 of this rule, a health 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.

8.3 The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

8.4. A health 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.

8.5. In an expedited review, all necessary information, including the health carrier's decision shall be transmitted between the health issuer and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile or the most expeditious method available.

8.6.

8.6.a. An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with subsection 8.8 of this rule as expeditiously as the covered person's medical condition requires, but in no event more than seventy two (72) hours after the receipt of the request for the expedited review.

8.6.b. If the expedited review of a grievance involving 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.

8.7. For purposes of calculating the time periods within which a decision is required to be made under subsection 8.6 of this rule, the time period within which the decision is required to be made shall begin on the date the request is filed with the health issuer in accordance with the health carrier's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8.8.

8.8.a. A notification of a decision under this section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized

representative, set forth:

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

8.8.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;

8.8.a.3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, a health carrier:

8.8.a.3.A. Shall provide to the covered person or, if applicable, the covered person's authorized representative, 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

8.8.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 State Rules §114-97-1 et. seq.;

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

8.8.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 health carrier's position;

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

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

8.8.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 health carrier's standard, if any, that was used in reaching denial;

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

8.8.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;

8.8.a.7.D. If the health 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;

8.8.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;

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

8.8.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 D, paragraph 7, of this subdivision;

8.8.a.7.F.2. The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph E, paragraph 7 of this subdivision;

8.8.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.;

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

8.8.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

8.8.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.

8.8.b.

8.8.b.1. A health issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

8.8.b.2. To be considered to meet the requirements of paragraph 1 of this subdivision, the health issuer shall:

8.8.b.2.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;

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

8.8.b.3. 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.

8.8.c.

8.8.c.1. A health issuer may provide the notice required under this section orally, in writing or electronically.

8.8.c.2. If notice of the adverse determination is provided orally, the health issuer shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

§114-96-9. 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.