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

Form #3

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2013 JUL 26 PM 3:40

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: WV Offices of the Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY WV 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: 95

TITLE OF RULE BEING PROPOSED: Utilization Review and Benefit Determination

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Authorized Signature

Insurance Commissioner
Legislative Rule
Title 114, Series 95

UTILIZATION REVIEW AND BENEFIT DETERMINATION

TITLE 114, SERIES 95

BRIEF SUMMARY OF RULE

This proposed rule would establish standards for the operation of utilization review processes used by health insurers to make benefit coverage determinations and it would apply to any designee of the health carrier that performs utilization review functions on the carrier's behalf. This rule is based upon the National Association of Insurance Commissioners' "Utilization Review Model Act" (Model 73), as amended in 2012.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 26, 2013

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: WV OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: Utilization Review and Benefit Determination
Title 114, Series 95

1. **Authorizing statute(s) citation:**

   West Virginia Code §33-16H-4 and 33-2-10

2. a. **Date filed in State Register with Notice of Hearing or Public Comment Period:**

   June 19, 2013 (notice of public comment period).

   b. **What other notice, including advertising, did you give of the hearing?**

   N/A

   c. **Date of Public Hearing(s) *or* Public Comment Period ended:**

   Public comment period ended on July 19, 2013.

   d. **Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.**

   Attached X **No comments received** _____

   e. **Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)**

   July 26, 2013

f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Timothy R. Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305
304-558-6279 Ext. 1210
304-558-1362 FAX
Timothy.Murphy@wvinsurance.gov

g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

N/A

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

N/A

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

b. Date of hearing or comment period:

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

d. Attach findings and determinations and reasons:

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

(304) 720-4073
mpickens@spilmanlaw.com

July 19, 2013

Commissioner Michael Riley
Offices of the Insurance Commission
1124 Smith Street
Charleston, WV 25301

RE: Comments to Proposed OIC Utilization Review and Benefit Determination Rule 114CSR95

Dear Commissioner Riley:

Thank you for the opportunity to file written comments on behalf of America's Health Insurance Plans ("AHIP") to the Insurance Commissioner's proposed Utilization Review and Benefit Determination rule. This rule, as well as the other rules currently proposed by the Insurance Commissioner relating to implementation of the Affordable Care Act and H.B. 2960 enacted during the 2013 regular legislative session, are complex and issuers are continuing to review them in light of the NAIC models.

AHIP offers the following comments at this time to the rule:

1) There are drafting errors in the rule that cause confusion in determining the intent of the rule in some areas, in particular where reference is made to another subsection or provision that does not correspond correctly. AHIP requests that the rule be carefully reviewed and that these matters be corrected.

2) The proposed rule uses the term "issuer" as defined in subsection 2.20, rather than the term "health carrier" as used in the model. There is no objection to the use of that term in the rule; however there are instances where "health carrier" is also used in the rule and AHIP encourages consistency.

3) The proposed rule defines "adverse determination" in subsection 2.1 and "utilization review" in subsection 2.31 differently than the model definitions. To provide necessary clarity and certainty to issuers and consistency in processes across jurisdictions, AHIP encourages use of the model definitions.

4) There are various references to time periods in the rule within which an issuer must take action. For example, a prospective review determination must be made under 7.1.c. no later than

15 days after receiving the request, and a retrospective review determination under 7.1.d. must be made no later than 30 days after receiving the request. AHIP requests that with regard to these time periods the rule specify that these are business days rather than calendar days. A 15 day time period is brief and will include weekend days. States are handling this in different ways, and AHIP submits that having certainty on this issue is important to issuers to ensure compliance. AHIP further submits that specifying business days in instances such as 7.1.c. and 7.1.d. is reasonable and would not harm covered persons. Likewise, the time periods under 7.1.f. relating to extensions of the time periods for prospective and retrospective reviews should reflect business days as well to provide consistent clarity.

5) Extensions of the time periods for the issuer to make prospective and retrospective reviews are handled separately in the model act. In 7.1.f.1. of the proposed rule, extensions of time for the issuer to make prospective and retrospective reviews are combined, presumably for drafting purposes. While the proposed rule correctly states that either type of review may be extended one time for up to 15 days, it goes on to state that the notification to the covered person of the extension must be made prior to the expiration of the initial 15 day time period. The initial time period for a prospective review is 15 days; however the time period for a retrospective review is 30 days. AHIP suggests clarification of this provision to reflect the 15 and 30 day initial time periods for each type of review as it relates to notification of extensions.

6) Subsection 7.2 of the proposed rule addresses issuer processes when the issuer receives a prospective or retrospective review request from a covered person that fails to meet the issuer's filing procedures. The corresponding model provision is similar, but also includes the following:

> *"The provisions of this paragraph shall apply only in the case of a failure that:*
>
> *(i) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and*
>
> *(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested."*

AHIP submits that this language is necessary to clarify under what circumstances the issuer is required to provide notice of the covered person's failure and to work with him/her to correct it. The proposed rule contains no limiting language, but rather refers to any failure to follow procedures. It is unduly burdensome for issuers to provide notice of every failure within five days if the failure is not a communication by or on behalf of a covered person, to the correct unit of the issuer, which refers to a specific covered person, medical condition or symptom or

specific health care service, treatment or provider. These are not unreasonable requirements, and they will bring certainty to the process. AHIP encourages including the model language noted above.

7) Subsection 7.3 of the proposed rule addresses the types of information required to be set forth in a notification of an adverse determination. In 7.3.a.7., a copy of any rule, guideline, protocol or other similar criterion relied upon by the issuer to make the adverse determination must be included in the notification. AHIP submits that the model language on this point should be used. The model requires that a notification either include the specific rule, guideline, protocol or other similar criterion used to make the adverse determination or include a statement that such criterion was used and that the a copy of it may be requested and then provided free of charge. These types of documents can be very extensive and not every covered person will want them. It is unduly burdensome to require potentially voluminous documents to be provided as a matter of routine with every notification to which they relate. The better practice is to provide the option set forth in the model, which will ease the administrative burden but preserve for every covered person the ability to obtain the documents free of charge if they want or need them.

8) Subdivision 8.1.a. of the proposed rule, similar to subsection 7.2, addresses issuer processes when the covered person makes an urgent care or concurrent review urgent care request that fails to meet the issuer's procedures. For the reasons set forth in paragraph 4 of this letter, AHIP encourages inclusion of the following model language:

> *"The provisions of this paragraph shall apply only in the case of a failure that:*
>
> *(i) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and*
>
> *(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested."*

9) Subdivison 8.3.a. of the proposed rule addresses concurrent review urgent care requests involving a request for a covered person to extend the course of treatment beyond the initial period of time or number of treatments. The model requires the covered person to submit the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and AHIP submits that the OIC should include this language as well in its proposed rule. A concurrent review urgent care request may only be effectively addressed by the issuer prior to the expiration of the period or treatments. It is by its very nature urgent, and should be made in a timely manner by the covered person.

AHIP again thanks the Insurance Commissioner for the opportunity to comment on this proposed rule.

Sincerely,

Mary Jane Pickens

MJP/sec

cc: Timothy Murphy, OIC
David Kennedy
Cindy Goff

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

(304) 720-4073
mpickens@spilmanlaw.com

July 19, 2013

Commissioner Michael Riley
Offices of the Insurance Commission
1124 Smith Street
Charleston, WV 25301

RE: Comments to Proposed OIC Utilization Review and Benefit Determination Rule 114CSR95

Dear Commissioner Riley:

Thank you for the opportunity to file written comments on behalf of the West Virginia HMO Association ("HMO Association") to the Insurance Commissioner's proposed Utilization Review and Benefit Determination rule. This rule, as well as the other rules currently proposed by the Insurance Commissioner relating to implementation of the Affordable Care Act and H.B. 2960 enacted during the 2013 regular legislative session, are complex and issuers are continuing to review them in light of the NAIC models.

The HMO Association offers the following comments at this time to the rule:

1) The proposed rule uses the term "issuer" as defined in subsection 2.20, rather than the term "health carrier" as used in the model. There is no objection to the use of that term in the rule; however there are instances where "health carrier" is also used in the rule and the HMO Association encourages consistency.

2) The proposed rule defines "adverse determination" in subsection 2.1 and "utilization review" in subsection 2.31 differently than the model definitions. To provide necessary clarity and certainty to issuers and consistency in processes across jurisdictions, the HMO Association encourages use of the model definitions.

3) There are various references to time periods in the rule within which an issuer must take action. For example, a prospective review determination must be made under 7.1.c. no later than 15 days after receiving the request, and a retrospective review determination under 7.1.d. must be made no later than 30 days after receiving the request. The HMO Association requests that with regard to these time periods the rule specify that these are business days rather than calendar days. A 15 day time period is brief and will include weekend days. States are handling this in different ways, and the HMO Association submits that having certainty on this issue is important

to issuers to ensure compliance. The HMO Association further submits that specifying business days in instances such as 7.1.c. and 7.1.d. is reasonable and would not harm covered persons. Likewise, the time periods under 7.1.f. relating to extensions of the time periods for prospective and retrospective reviews should reflect business days as well to provide consistent clarity.

4) Extensions of the time periods for the issuer to make prospective and retrospective reviews are handled separately in the model act. In 7.1.f.1. of the proposed rule, extensions of time for the issuer to make prospective and retrospective reviews are combined, presumably for drafting purposes. While the proposed rule correctly states that either type of review may be extended one time for up to 15 days, it goes on to state that the notification to the covered person of the extension must be made prior to the expiration of the initial 15 day time period. The initial time period for a prospective review is 15 days; however the time period for a retrospective review is 30 days. The HMO Association suggests clarification of this provision to reflect the 15 and 30 day initial time periods for each type of review as it relates to notification of extensions.

5) Subsection 7.2 of the proposed rule addresses issuer processes when the issuer receives a prospective or retrospective review request from a covered person that fails to meet the issuer's filing procedures. The corresponding model provision is similar, but also includes the following:

> *"The provisions of this paragraph shall apply only in the case of a failure that:*
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> *(i) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and*
>
> *(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested."*

The HMO Association submits that this language is necessary to clarify under what circumstances the issuer is required to provide notice of the covered person's failure and to work with him/her to correct it. The proposed rule contains no limiting language, but rather refers to any failure to follow procedures. It is unduly burdensome for issuers to provide notice of every failure within five days if the failure is not a communication by or on behalf of a covered person, to the correct unit of the issuer, which refers to a specific covered person, medical condition or symptom or specific health care service, treatment or provider. These are not unreasonable requirements, and they will bring certainty to the process. The HMO Association encourages including the model language noted above.

6) Subdivision 7.3.b. of the proposed rule requires a notice of adverse determination to be provided in a culturally and linguistically appropriate manner in accordance with any applicable federal regulations. The model contains additional guidance for the issuer to comply with this requirement that the HMO Association encourages the OIC to include in the proposed rule.

7) Subsection 7.3 of the proposed rule addresses the types of information required to be set forth in a notification of an adverse determination. In 7.3.a.7., a copy of any rule, guideline, protocol or other similar criterion relied upon by the issuer to make the adverse determination must be included in the notification. The HMO Association submits that the model language on this point should be used. The model requires that a notification either include the specific rule, guideline, protocol or other similar criterion used to make the adverse determination or include a statement that such criterion was used and that the a copy of it may be requested and then provided free of charge. These types of documents can be very extensive and not every covered person will want them. It is unduly burdensome to require potentially voluminous documents to be provided as a matter of routine with every notification to which they relate. The better practice is to provide the option set forth in the model, which will ease the administrative burden but preserve for every covered person the ability to obtain the documents free of charge if they want or need them.

8) Subdivision 8.1.a. of the proposed rule, similar to subsection 7.2, addresses issuer processes when the covered person makes an urgent care or concurrent review urgent care request that fails to meet the issuer's procedures. For the reasons set forth in paragraph 4 of this letter, the HMO Association encourages inclusion of the following model language:

> *"The provisions of this paragraph shall apply only in the case of a failure that:*
>
> *(i) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and*
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> *(ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested."*

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by the issuer prior to the expiration of the period or treatments. It is by its very nature urgent, and should be made in a timely manner by the covered person.

The HMO Association again thanks the Insurance Commissioner for the opportunity to comment on this proposed rule.

Sincerely,

Mary Jane Pickens

MJP/sec

cc: Timothy Murphy, OIC
Bob Kota
Colleen Cohan
Jeff Folks
John Fleig
John Muraca
Pamela Perry
Phil Wright
Tadd Haynes
Todd White

Sarah Young

From: Timothy Murphy
Sent: Friday, July 19, 2013 4:25 PM
To: Sarah Young (Sarah.Young@wvinsurance.gov); Joy Zirkle (Joy.Zirkle@wvinsurance.gov)
Subject: FW: Comments to Proposed Rules 114-95, 114-96 and 114-97
Attachments: UR.Internal Appeals.External Review Comments 7.19.13.docx

Timothy R. Murphy
Associate Counsel
WV Offices of the Insurance Commissioner
PO Box 50540
Charleston WV 25305-0540

304-558-6279 ext. 1210
fax 304-558-1362

From: Wade, Susan L [mailto:susan.wade-miller@highmark.com]
Sent: Friday, July 19, 2013 3:34 PM
To: Timothy Murphy
Subject: Comments to Proposed Rules 114-95, 114-96 and 114-97

Mr. Murphy,

Thank you for the opportunity to comment on the above referenced proposed rules. Please find our comments attached.

Thank you.

Susan Wade | Highmark West Virginia
V: 304-424-9838 | F: 304-424-9875 | Email: susan.wade-miller@highmark.com

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07.19.2013
NOT INTENDED FOR GENERAL DISTRIBUTION

Comments to Proposed Rules:
§114-95 Utilization Review and Benefit Determination
§114-96 Internal Grievance Procedure
§114-97 Standard External Review Procedures
Authority: WV Code §33-16H

General Comments – "Adverse Determination"		
Section	Subsection	Comment
§114-95-2.1 §114-96-2.1		Proposed Rule: "'Adverse determination' means a determination by an issuer or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health issuer's health benefit plan upon application of any utilization review technique does not meet the health issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated." WVOIC Proposed Rule §114-95-2.1. "'Final adverse determination' – 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 deemed exhausted." WVOIC Proposed Rule §114-96-2.1 WV Code §33-16H-1 This section defines "adverse determination" as "a determination by a health carrier 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 health carrier'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". DOL defines "adverse benefit determination" as a denial (or partial denial) of a benefit, a reduction or termination of a benefit, and a decision based on a claimant's eligibility for coverage under a plan or policy. 29 CFR § 2560.503-1(m)(4). The amended interim final rule issued on June 22, 2011 broadens the definition of "adverse benefit determination" to include rescissions of coverage. The state process does not appear to include rescissions of coverage within the scope of external review. Please clarify.
§114-95 Utilization Review and Benefit Determination		
§114-95-8	8.1.a	Section 8.1.a seems to have conflicting language relating to timeframes for notifying covered persons that additional information is necessary with respect to urgent care and concurrent review urgent care requests. The section lists both forty-eight (48) hours and twenty-four (24) hours. The current standard is 48. Please clarify.

§114-95-11	11.3	Section 11.3 requires issuers to include a toll-free telephone number for utilization review and benefit decisions. Currently, a "Member Services" number is listed which can be utilized for any information including information relating to all types of appeals. Please confirm that no additional numbers would be required.
§114-96 Internal Grievance Procedure		
§114-96-4	4.1.b	"If an independent review organization refuses to rejects 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." Should this read "refuses [or] rejects"? Does the reference to "subdivision a" mean "subdivision 4.1.a"?
	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 (I0) 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."
§114-96-5	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." Does this mean issuers have no more than three days from receipt of the grievance to send out a letter notifying the member/member representative of all the information that's listed under 5.4.a?
§114-97 Standard External Review Procedures		
§114-97-3.1		"If he or she has a medical condition where the time-frame for expedited review of a grievance under the issuer's internal grievance process, would seriously jeopardize his or her life, health or ability to regain maximum function, he or she may file with the commissioner, simultaneously with a request for expedited review under the issuer's internal grievance process, a request for expedited external review to be conducted pursuant to section 7 or, in cases involving denials based on the issuer's determination that the treatment or service is experimental or investigational where the covered person's treating physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated, pursuant to section 8 of this rule"; and 3.I.f.I. "If the covered person has a medical condition where the time-frame for completion of a standard external review pursuant to section 6 of this rule would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review pursuant to section 7 of this rule." Will the notice included in the member benefit book meet these requirements?
§114-97-13		External Review Reporting Requirements Section 114.97-13.1.d requires IROs to retain written records for at least three (3) years. Current federal guidance and business practice requires IROs to retain records for at least six (6) years.

Insurance Commissioner
Title 114, Series 95

ATTACHMENT TO QUESTION 2(d):

The Offices of the Insurance Commissioner ("OIC") received multiple comments from the WV HMO Association, America's Health Insurance Plans ("AHIP") and Highmark. These comments are addressed below.

1) AHIP notes that the proposed rule contains numerous cross-referencing and numbering errors. The HMO Association and AHIP both state that the proposed rule uses the term "issuer" as defined in subsection 2.20 as well as the undefined term "health carrier" used in the model. OIC will continue to review the rule throughout the rulemaking process and will change all references to "health carrier" to "issuer" throughout.

2) AHIP and the HMO association note that the proposed rule defines "adverse determination" in subsection 2.1 and "utilization review" in subsection 2.31 differently than the model definitions, and they urge consistency with the model in order to provide necessary clarity and certainty to issuers across jurisdictions. Highmark notes that the US Department of Labor's definition includes "a decision based on a claimant's eligibility for coverage under a plan or policy." See 29 CFR § 2560.503-1(m)(4).

The Commissioner believes the definitions of "adverse determination" and "utilization review" in the authorizing statute, W. Va. Code §33-16H-1, must be mirrored in the corresponding rules (these definitions in the rule are also applicable to 2 other proposed rules for internal grievances and external review, 114-6 and 114- 97, respectively). The rule does mirror the definition of utilization review but not of adverse determination; accordingly, the rule will be amended as follows:

> *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.*

3) The HMO Association and AHIP state that there are various references to time periods in the rule within which an issuer must take action. They point out for example, a prospective review determination must be made under 7.1.c no later than 15 days after receiving

the request, and a retrospective review determination under 7.1.d must be made no later than 30 days after receiving the request. They both request that the rule specify that these are business days rather than calendar days. A 15-day time period is brief and will include weekend days. States are handling this in different ways, and they both submit that having certainty on this issue is important to issuers to ensure compliance. Further, they submit that specifying business days in instances such as 7.I.e and 7.1.d is reasonable and would not harm covered persons. Likewise, the time periods under 7.1.f. relating to extensions of the time periods for prospective and retrospective reviews should reflect business days as well to provide consistent clarity.

The model does not address the issue of calendar vs. business days and the Commissioner believes that, absent other qualifying language, "day" means "calendar day". The Commissioner, while cognizant of the administrative difficulties in making these determinations within 8-10 business days, notes that paragraph 7.1.f.1 provides for extensions whenever "*the issuer determines that an extension is necessary due to matters beyond the its control and notifies the covered person, prior to the expiration of the initial fifteen-day time period for a prospective review and the expiration of the initial thirty-day time period for a retrospective review, of the circumstances requiring the extension of time and the date by which the issuer expects to make a determination.*" This provision effectively converts a 15-calendar day period to a 30-calendar day period or the equivalent of approximately 22-23 business days. In light of the interests at stake, the Commissioner declines to make the suggested changes.

4) The HMO Association and AHIP comment that extensions of the time periods for the issuer to make prospective and retrospective reviews are handled separately in the model act. In 7.1.f.l of the proposed rule, extensions of time for the issuer to make prospective and retrospective reviews are combined, presumably for drafting purposes. While the proposed rule correctly states that either type of review may be extended one time for up to 15 days, it goes on to state that the notification to the covered person of the extension must be made prior to the expiration of the initial 15-day time period. The initial time period for a prospective review is 15 days; however the time period for a retrospective review is 30 days. They suggest clarification of this provision to reflect the 15 and 30 day initial time periods for each type of review as it relates to notification of extensions. The OIC agrees that the time periods for notification by issuers should be clearly reflected to represent each time frame for a prospective and retrospective review and amends the paragraph to read as follows:

> *7.1.f.1. The time period for making a prospective or retrospective review determination and notifying the covered person of such determination pursuant to subdivision a of this subsection may be extended one time by the issuer for up to fifteen (15) days, provided the issuer determines that an extension is necessary due to matters beyond the its control and notifies the covered person, prior to the expiration of the initial fifteen-day time period for a prospective review and the expiration of the initial thirty-day time period for a retrospective review, of the*

circumstances requiring the extension of time and the date by which the issuer expects to make a determination.

5) AHIP and the HMO Association point out the absence in the proposed rule of qualifying language relative to issuers' duties to respond to deficient review requests. The proposed rule provides as follows:

> 7.2. Failure to meet issuer's filing procedures.
>
> 7.2.a. Whenever the issuer receives a prospective or retrospective review request from a covered person that fails to meet the issuer's filing procedures, the issuer shall notify the covered person within five (5) days of this failure and provide in the notice information on the proper procedures to be followed for filing a request ...

The corresponding model provision is similar, but also includes the following qualification of what deficient communications trigger the 5-day notice requirement:

> The provisions of this paragraph shall apply only in the case of a failure that:
>
> (i) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
>
> (ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

The proposed rule contains no limiting language, but rather refers to any failure "to meet the issuer's filing procedures." The commenters submit that this additional language is necessary to clarify under what circumstances the issuer is required to provide the 5-day notice of the covered person's failure and to work with him/her to correct it. It is unduly burdensome for issuers to provide notice of every failure within 5 days if the failure is not a communication by or on behalf of a covered person, to the correct unit of the issuer, which refers to a specific covered person, medical condition or symptom or specific health care service, treatment or provider.

The Commissioner has no objections to following the model more closely in this regard and amends the rule to add the following:

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

6) The HMO Association comments that subdivision 7.3.b of the proposed rule requires a notice of adverse determination to be provided in a "culturally and linguistically appropriate manner in accordance with any applicable federal regulations." The model contains additional guidance for the issuer to comply with this requirement and the HMO Association encourages the OIC to include such guidance in the proposed rule.

The Commissioner notes that, although at present no county in West Virginia meets the criteria that would trigger the model's requirement that notices be provided in 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'' – such provisions are included in the related rules being proposed (internal grievance and external review) and therefore agrees to include the additional language as follows:

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

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

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

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

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

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

7) The HMO Association and AHIP comment that 7.3.a.7 of the proposed rule addresses the types of information required to be set forth in a notification of an adverse determination. A similar comment to proposed rule 114-96 resulted in an amendment to mirror the model's language and the Commissioner will similarly amend this rule to read as follows:

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

8) The HMO Association and AHIP state that subdivision 8.1.a of the proposed rule, similar to subsection 7.2, addresses issuer processes when the covered person makes an urgent care or concurrent review urgent care request that fails to meet the issuer's procedures. As was done with respect to 7.2, the Commissioner amends the rule to add as follows:

> *8.1.a.1 The provisions of subdivision a of this subsection only apply in the case of a failure that is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters and that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.*

9) Highmark notes that subdivision 8.1.a has conflicting language (24 and 48 hours) relating to timeframes for notifying covered persons that additional information is necessary with respect to urgent care and concurrent review urgent care requests. The Commissioner agrees that the model is clearer and will amend the rule accordingly to read as follows:

> *8.1.a. Such procedures must include that, in the case of a failure by a covered person to provide sufficient information, the issuer shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request, and the issuer shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information.*

10) The HMO Association and AHIP comment that Subdivision 8.3.a. (now renumbered as 8.1.c) of the proposed rule addresses concurrent review urgent care requests involving a request for a covered person to extend the course of treatment beyond the initial period of time or number of treatments. The model requires the covered person to submit the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and they submit that the OIC should include this language as well in its proposed rule. A concurrent review urgent care request may only be effectively addressed by the issuer prior to the expiration of the period or treatments. It is by its very nature urgent, and should be made in a timely manner by the covered person.

The Commissioner first notes that an urgent care request that is tardy under the timeframe set forth in the rule may nonetheless proceed as a standard review request; however, he also agrees that a covered person should be held to more stringent timeframes if he/she wishes to invoke the provisions of this rule regulating urgent requests and therefore amends the rule to mirror the model as follows:

8.1.c. For concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the issuer shall make a determination with respect to the request and notify the covered person of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the health carrier's receipt of the request.

Insurance Commissioner
Legislative Rule
Title 114, Series 95

UTILIZATION REVIEW AND BENEFIT DETERMINATION

TITLE 114, SERIES 95

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).

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Utilization Review and Benefit Determination (Title 114, Series 95)

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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Charleston WV 25305-0540
Timothy.Murphy@wvinsurance.gov

TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE

SERIES 95
UTILIZATION REVIEW AND BENEFIT DETERMINATION

Section.

FILED
2013 JUL 26 PM 3:40
OFFICE WEST VIRGINIA
SECRETARY OF STATE

TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE

SERIES 95
UTILIZATION REVIEW AND BENEFIT DETERMINATION

§114-95-1. General.

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

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

1.3. Filing Date. --

1.4. Effective Date. --

§114-95-2. Definitions.

2.1. "Adverse determination" means a determination by an issuer or its designee utilization review organization that an admission, availability of care, continued stay or other 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 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.

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 sever 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 no 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.

2.16.a. "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.

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

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

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

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

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

2.16.b.5. Automobile medical payment insurance;

2.16.c.6. Credit-only insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.24. "Person" means 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.

2.25. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with an issuer's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

2.26.

2.26.a. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

2.26.b. "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

2.26.b.1. The cancellation or discontinuance of coverage has only a prospective effect; or

2.26.b.2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

2.27.

2.27.a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

2.27.b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

2.28. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than 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.

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

2.30.

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

2.30.a.1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2.30.a.2. In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

2.30.b.

2.30.b.1. Except as provided in paragraph b of this subdivision, in determining whether a request is be treated as an urgent care request, an individual acting on

behalf of the issuer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

2.30.b.2. 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 subdivision a of this subsection shall be treated as an urgent care request.

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

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

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

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

§114-95-4. Contracting.

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

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

5.1.

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

5.1.a.1. The filing of benefit requests;

5.1.a.2. The notification of utilization review and benefit determinations; and

5.1.a.3. The review of adverse determinations in accordance with W. Va. Code of St. R. §114- 96-1 *et seq.*, "Issuer Grievance Procedure".

5.1.b. The program document shall describe the following:

5.1.b.1. Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;

5.1.b.2. Data sources and clinical review criteria used in decision-making;

5.1.b.3. Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

5.1.b.4. Data collection processes and analytical methods used in assessing utilization of health care services;

5.1.b.5. Provisions for assuring confidentiality of clinical and proprietary information;

5.1.b.6. The organizational structure (e.g. utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the issuer's governing body; and

5.1.b.7. The staff position functionally responsible for day-to-day program management.

§114-95-6. Operational Requirements.

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

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

6.3. **Exhaustion.**

6.3.a. Whenever an issuer fails to adhere to the requirements of section 7 or 8 of this rule with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this rule and may file a request for external review in accordance with the procedures outlined in W. Va. Code of St. R. §114-97-1 *et seq*.

6.3.a.1. Notwithstanding subdivision a of this subsection, the provisions of section 7 or 8 of this rule shall not be deemed exhausted based on a *de minimis* violation that

does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the issuer demonstrates that the violation was for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the covered person.

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

6.3.a.3. Within ten (10) days of receiving a request from a covered person, an issuer shall provide a written explanation of why it believes that any alleged violation of sections 7 or 8 of this rule does not constitute a sufficient basis to trigger the exhaustion provisions of subdivision a of this subsection.

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

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

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

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

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

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

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

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

6.8. The issuer shall coordinate the utilization review program with other medical

management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction and risk management.

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

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

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

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

7.1. **Time periods.**

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

7.1.b. **Calculation of days.** For purposes of calculating the time periods within which a determination is required to be made under subsections 7.2 and 7.4 of this rule, the time period within which the determination is required to be made shall begin on the date the request is received by the issuer in accordance with the issuer's procedures established pursuant to section 5 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

7.1.c. **Prospective review determinations.** Within a reasonable period of time appropriate to the covered person's medical condition but in no event later than fifteen (15) days after receiving the request for a prospective review determination, an issuer shall notify the covered person of such determination.

7.1.d. **Retrospective review determinations.** For retrospective review determinations, an issuer shall notify the covered person of such determination within a reasonable period of time, but in no event later than thirty (30) days after receiving the benefit request.

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

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

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

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

7.1.f. Extensions.

7.1.f.1. The time period for making a prospective or retrospective review determination and notifying the covered person of such determination pursuant to subdivision a of this subsection may be extended one time by the issuer for up to fifteen (15) days, provided the issuer determines that an extension is necessary due to matters beyond the its control and notifies the covered person, prior to the expiration of the initial fifteen-day time period for a prospective review and the expiration of the initial thirty-day time period for a retrospective review, of the circumstances requiring the extension of time and the date by which the issuer expects to make a determination.

7.1.f.2. If the extension under this subdivision is necessary due to the failure of the covered person to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request and give the covered person at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

7.2. Failure to meet issuer's filing procedures.

7.2.a. Whenever the issuer receives a prospective or retrospective review request from a covered person that fails to meet the issuer's filing procedures, the issuer shall notify the covered person within five (5) days of this failure and provide in the notice information on the proper procedures to be followed for filing a request; such notice tolls the time periods in which

the issuer must make its determination until the earlier of the date on which the covered person responds to the request for additional information or the date on which the specified information was to have been submitted, and the issuer may deny the certification of the requested benefit if the covered person fails to respond within the extended period.

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

7.3. Adverse determinations.

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

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

7.3.a.2. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; a request for the diagnosis code and treatment information shall not, in itself, be deemed a request to file a grievance for review of an adverse determination pursuant to W. Va. Code of St. R. §114-96-1 *et seq.* or a request for external review;

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

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

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

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

7.3.a.7. If the issuer relied upon an internal rule, guideline, protocol or

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

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

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

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

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

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

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

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

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

7.3.c. If the adverse determination is a rescission, the issuer shall provide at least thirty (30) calendar days' notice to a covered person before coverage may be rescinded, regardless of whether the rescission applies to an individual only, to an entire group, or to individuals in a group, in addition to any applicable disclosures required under subdivision a of this subsection, and:

7.4.c.1. Clear identification of the alleged fraudulent act, practice or

omission or the intentional misrepresentation of material fact;

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

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

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

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

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

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

8.1.a. Such procedures must include that, in the case of a failure by a covered person to provide sufficient information, the issuer shall notify the covered person either orally or, if requested by the covered person, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request, and the issuer shall provide the covered person a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person of the failure to submit sufficient information.

8.1.a.1 The provisions of subdivision a of this subsection only apply in the case of a failure that is a communication by a covered person that is received by a person or organizational unit of the health carrier responsible for handling benefit matters and that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

8.1.b. For an urgent care request, unless the covered person has failed to provide sufficient information for the issuer to determine whether, or to what extent, the benefits requested are covered benefits or payable under the issuer's health benefit plan, the issuer shall notify the covered person of the issuer's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the

medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the issuer.

8.1.b1. The issuer shall notify the covered person of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:

81.b.1.A. The issuer's receipt of the requested specified information; or

8.1.b.1.B. The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified information.

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

8.1.c. For concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the issuer shall make a determination with respect to the request and notify the covered person of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the issuer's receipt of the request.

8.1.d. For purposes of calculating the time periods within which a determination is required to be made under subsection 8.2 or 8.3 of this rule, the time period within which the determination is required to be made shall begin on the date the request is filed with the issuer in accordance with the issuer's procedures established pursuant to section 5 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8.2.

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

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

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

8.2.a.2.A. Shall provide to the covered person 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

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

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

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

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

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

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

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

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

8.2.a.9.A. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with paragraph 8 of this subdivision; or

8.2.a.9.B. The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph A of this paragraph; and

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

8.2.b.

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

8.2.c. If the adverse determination is a rescission, the issuer shall provide, in addition to any applicable disclosures required under subdivision a of this subsection, the disclosures set forth in 7.4.c of this rule:

8.2.d.

8.2.d.1. An issuer may provide the notice required under this section orally, in writing or electronically.

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

§114-95-9. Emergency Services.

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

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

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

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

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

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

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

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

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

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

9.3.

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

9.3.b.

9.3.b.1. For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

9.3.b.2. Notwithstanding paragraph 1 of this subdivision, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the issuer is required to pay under this paragraph.

9.3.b.3. An issuer complies with the requirements of this subdivision if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

9.3.b.3.A. The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to

the covered person;

9.3.b.3.B. The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

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

9.3.b.4.

9.3.b.4.A. For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, subparagraph A, paragraph 3 of this subdivision does not apply.

9.3.b.4.B. If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subparagraph A, paragraph 3 of this subdivision is the median of these negotiated amounts.

9.3.c.

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

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

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

9.4. For immediately required post-evaluation or post-stabilization services, an issuer shall provide access to designated representative twenty-four (24) hours a day, seven (7) days a week, to facilitate review.

§114-95-10. Confidentiality Requirements.

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

§114-95-11. Disclosure Requirements.

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

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

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

§114-95-12. Penalties.

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