West Virginia Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As of the date of this Addendum, there are no applicable laws of this type.

# **General Insurance Laws**

## As required by W. Va. Code § 33-45-2(a)(1), insurer shall either pay or deny a clean claim within 40 days of receipt of the claim if submitted manually and within 30 days of receipt of the claim if submitted electronically, except if (i) another payor or party is responsible for the claim; (ii) the insurer is coordinating benefits with another payor; (iii) the Provider has already been paid for the claim; (iv) the claim was submitted fraudulently; or (v) there was a material misrepresentation in the claim.

## As required by W. Va. Code § 33-45-2(a)(2), insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If an insurer fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received 3 business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

## As required by W. Va. Code § 33-45-2(a)(3), insurer shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within 15 days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an insurer shall either pay or deny the claim within 30 days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the insurer fails to timely notify the person submitting the claim within 30 days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims; provided, that nothing herein shall preclude such an insurer from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate § W. Va. Code § 33-45-2(a)(7). This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

## As required by W. Va. Code § 33-45-2(a)(4) interest, at a rate of 10% per annum, accruing after the 40-day period provided in W. V. Code § 33-45-2(a)(1) owing or accruing on any claim under the Agreement or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within 30 days thereafter.

## As required by W. Va. Code § 33-45-2(a)(5), insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract: (i) to promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and (ii) to determine the insurer's requirements applicable to the Provider (or to the type of health care services which the Provider has contracted to deliver under the provider contract) for: (1) precertification or authorization of coverage decisions; (2) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (3) Provider-specific payment and reimbursement methodology; and (4) other Provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. Additionally, insurer shall make available to the Provider within 20 business days of receipt of a request, reasonable access to all the policies that are applicable to the Provider or to particular health care services identified by the Provider.

## As required by W. Va. Code § 33-45-2(a)(6) insurer shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless: (i) the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or (ii) the insurer's refusal is because: (1) another payor or party is responsible for the payment; (2) the Provider has already been paid for the health care services identified on the claim; (3) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer; (4) the person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; (5) there is a dispute regarding the amount of charges submitted; or (6) the service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

## As required by W. Va. Code §§ 33-45-2(a)(7), a previously paid claim may be retroactively denied only in accordance with this subdivision.

### No insurance company may retroactively deny a previously paid claim unless: (1) the claim was submitted fraudulently; (2) the claim contained material misrepresentations; (3) the claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the Provider; (4) the Provider was not entitled to reimbursement; (5) the service provided was not covered by the health benefit plan; or (6) the insured was not eligible for reimbursement.

### A Provider to whom a previously paid claim has been denied by a health plan in accordance with this section shall, upon receipt of notice of retroactive denial by the plan, notify the health plan within 40 days of the Provider's intent to pay or demand written explanation of the reasons for the denial. Upon receipt of explanation for retroactive denial, the Provider shall reimburse the plan within 30 days for allowing an offset against future payments or provide written notice of dispute. Disputes shall be resolved between the parties within 30 days of receipt of notice of dispute. Upon resolution of dispute, the Provider shall pay any amount due or provide written authorization for an offset against future payments.

### A health plan may retroactively deny a claim only for the reasons set forth in W. Va. Code § 33-45-2(a)(7)(A)(iii) through W. Va. Code § 33-45-2(a)(7)(A)(vi) for a period of 1 year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in W. Va. Code §§ 33-45-2(a)(7)(A)(i) and § 33-45-2(a)(7)(A)(ii).

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## As required by W. Va. Code § 33-25A-7a(1), if the HMO fails to meet its obligations to pay fees for services already rendered to a subscriber, the HMO is liable for the fee or fees rather than the subscriber.

## As required by W. Va. Code § 33-25A-7a(4), the subscriber is not liable to the Provider for any services covered by the subscriber's contract with the HMO.

## As required by W. Va. Code § 33-25A-7a(7), Provider shall provide 60 days advance written notice to the HMO and the Commissioner before canceling the contract with the HMO for any reason. Nonpayment for goods or services rendered by the Provider to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation. Upon receipt by the HMO of a 60-day cancellation notice, the HMO may, if requested by the Provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent.

## As required by W. Va. Code R. § 114-50-3, to the extent the Agreement is between a HMO and an emergency medical service provider:

### The duties to be assumed by the HMO and the participating Provider, respectively are provided in the Agreement;

### The HMO will determine whether emergency medical services rendered by the participating Provider qualify as covered emergency medical services pursuant to the HMO’s policies and procedures;

### The HMO must pay the participating Provider in full under the Agreement for any valid claim for the covered emergency medical services rendered by the participating Provider to an enrollee of the HMO, but a valid claim shall not include the amount of any deductible or copayment payable by the enrollee;

### The participating Provider is required to meet all applicable standards to which the HMO is subject;

### The participating Provider will provide emergency medical services in the area that such Provider generally provides medical services to all patients;

### The participating Provider is required to maintain records of emergency medical services provided to an enrollee of the HMO; and

### The HMO, not its enrollee, is liable for covered emergency medical services provided to the enrollee and that the participating Provider may not collect or attempt to collect from an enrollee, by action at law or otherwise, any money for covered emergency medical services rendered to the enrollee, other than a deductible or copayment payable by the enrollee.

## As required by W. Va. Code R. § 114-53-5(5.4), Providers are required to participate in quality improvement activities. Hospitals and other contractors must allow the HMO access to members' medical records. The HMO must allow open provider-patient communication regarding appropriate treatment alternatives and cannot penalize the Provider for discussing medically necessary or appropriate care for the patient.