

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

Form #6

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FILED IN THE OFFICE OF  
THE SECRETARY OF STATE  
THIS DATE April 11, 1990  
ADMINISTRATIVE LAW DIVISION  
FILED  
APR 11 90 2 23

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

AGENCY: Department of Health and Human Resources TITLE NUMBER: 69

AMENDMENT TO AN EXISTING RULE: YES , NO

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

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

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 3

TITLE OF RULE BEING PROPOSED: Implementation of Omnibus Health  
Care Act Payment Provisions

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

AUTHORIZATION IS CITED IN (house or senate bill number) S. B. 243

SECTION 64-5-1(b), PASSED ON March 10, 1990

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON  
THE FOLLOWING DATE: April 10, 1990

  
\_\_\_\_\_  
Taunja Willis Miller

69 CSR 3

TITLE 69  
LEGISLATIVE RULES  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 3  
IMPLEMENTATION OF OMNIBUS HEALTH CARE ACT PAYMENT PROVISIONS

**§69-3-1. General**

1.1. Scope. -- This legislative rule implements those provisions of the Omnibus Health Care Act, W. Va. Code §16-29D-1 et seq., 1989, which relate to the establishment of a maximum reasonable and customary fee schedule by the Public Employees Insurance Agency, a division of the West Virginia Department of Administration, and to other reimbursement provisions.

1.2. Authority. -- W. Va. Code §16-29D-7.

1.3. Filing Date. --

1.4. Effective Date. --

**§69-3-2. Definitions**

2.1. The following words and phrases as used in these rules, unless a different meaning is clearly indicated by the context, shall have the meanings stated below.

2.2. The "Act" means the Omnibus Health Care Act which is codified at W. Va. Code §16-29D-1 et seq, as amended.

2.3. "Actuary" means the actuarial consulting firm which established the methodology and calculated the maximum reasonable and customary fee schedule described in this rule.

2.4. "Legitimate uncontested invoice" means a claim for payment for medical services delivered to a beneficiary of a department or division subject to the Act, received by that department or division in a manner prescribed and with all information, whether from the provider, beneficiary, or other third-party payor, stipulated by that department or division, and for which there is no action necessary for coordination of benefits, subrogation or other good cause to establish the legitimacy of the claim.

2.5. "CPT-4 Codes" means the listing of current medical procedure terminologies developed by the American Medical Association and used by physicians and other medical providers to describe individual services provided to patients for billing and other documentary purposes.

2.6. "Eightieth (80th) percentile maximum fee schedule" means a schedule of individual CPT-4 Code reimbursement fees set at a level that includes eighty (80) percent of the charges, by procedure, actually paid or processed for payment by the PEIA for health care services for which claims were submitted to the PEIA during the calendar year, January 1, 1988 to December 31, 1988.

2.7. "Med Index" means a fee schedule developed by Medical Data Research, Inc., Salt Lake City, Utah, for the Charleston, West Virginia, region.

2.8. "Methodology" means the manner in which the actuary analyzed the PEIA 1988 claims data and calculated therefrom an eightieth (80th) percentile maximum fee schedule.

2.9. "1988 claims data" means the computer tape of medical claims actually paid by or submitted to and processed for payment by the PEIA during the calendar year, January 1, 1988 to December 31, 1988.

2.10. "PEIA" means the Public Employees Insurance Agency.

2.11. "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

### **§69-3-3. Purpose**

3.1. The purpose of this rule is to summarize the methodology used by the actuary to develop an eightieth (80th) percentile maximum fee schedule using the PEIA 1988 claims data. The PEIA will use this schedule to implement certain provisions of the Act, namely W. Va. Code §16-29D-4, relating to PEIA preferred provider contracts with allopathic and osteopathic physicians and podiatrists, and other health care provider reimbursement. The PEIA will set the maximum rate of reimbursement under such preferred provider contracts initially at the eightieth (80th) percentile of the PEIA's 1988 claims data. The PEIA will also adopt the eightieth (80th) percentile maximum fee schedule for all health care providers which are reimbursed based on CPT-4 Code billings: Provided, that hospitals and other institutional providers shall not be reimbursed according to the eightieth (80th) percentile maximum fee schedule, but shall be paid through individual contracts as authorized in W. Va. Code §16-29D-4(e).

3.2. Adoption of the eightieth (80th) percentile schedule by the PEIA shall be accomplished through the preferred provider contracts or changes to the PEIA group benefit plan, and not through this rule. This rule is being promulgated to comply with W. Va. Code §16-29D-7, which directs the Secretary to promulgate rules to implement the Act, and provides that methodologies for determination of rates, payments and schedules are subject to legislative rule-making procedures (but that the actual rates, payments and schedules are not).

3.3. This rule also interprets the provisions of W. Va. Code §16-29D-3(i) relating to prompt payment to a health care provider on or after September 1, 1989, for the purchase of health care or health care services by the PEIA, the division of rehabilitation services and the workers' compensation commission.

3.4. This rule is to be read with an addendum to the PEIA benefit plan document which describes current benefit changes which are being made to accommodate the provisions of this rule.

#### §69-3-4. Methodology

4.1. This section summarizes the methodology employed by the actuary to develop the eightieth (80th) percentile maximum fee schedule. This rule does not attempt to delineate every task, step, computer function or calculation involved in establishing the fee schedule, but rather provides an overview of the major steps involved.

4.2. The actuary obtained on computer tape the PEIA 1988 claims data and sorted the data by CPT-4 Codes.

4.2.1. The actuary divided all CPT-4 Codes into four (4) general categories; surgery, radiology, pathology and medicine. The surgery general category was then subdivided into sixteen (16) subcategories: integumentary, musculoskeletal, respiratory, cardiovascular, hemic and lymphatic, mediastinum, digestive, urinary, male genital, intersex, female genital, maternity, endocrine, nervous, eye and ocular, and auditory.

4.2.2. For each CPT-4 Code for which the PEIA paid ten (10) or more claims in 1988, the actuary ranked the paid claims from the lowest to the highest charge. For each such code, the eightieth (80th) percentile was identified as that charge which separated the lowest eighty percent (80%) of the charges from the highest twenty percent (20%) of the charges.

4.3. The schedule of fees obtained according to subsection 4.2.1. was compared with the Med Index fee schedule to determine which fees were in the Med Index schedule, but not in the PEIA 1988 claims experience.

4.3.1. The actuary divided the Med Index fee for each CPT-4 Code by a uniform number to obtain relative values for the Med Index fees. As an illustration, if the Med Index fee for CPT-4 Code "A" was \$720.00, and the Med Index fee for CPT-4 Code "B" was \$900.00, then if both fees are divided by 600, the relative value for CPT-4 Code "A" becomes 1.2, and the relative value for CPT-4 Code "B" becomes 1.5.

4.3.2. For each of the nineteen (19) categories and subcategories of CPT-4 Codes, the actuary calculated the total dollar amounts paid by PEIA for each CPT-4 Code, each category and subcategory, and for the total 1988 CPT-4 claims.

4.3.2.1. Using the total dollar amounts calculated in subsection 4.3.2., the actuary compared these PEIA totals to totals calculated in a like manner for the Med Index fee schedule to identify a multiplier which would relate the Med Index relative values developed in subsection 4.3.1. to the actual PEIA 1988 claims experience. As an example, summary results of this calculation for one of the sixteen (16) surgery subcategories are:

(1) Total claims * PEIA fees at 80th	=	\$4,708,298.04
(2) Total claims * Med Index rel.val. at \$600	=	\$4,601,406.00
(3) Total claims * Med Index rel.val. at \$613.94	=	\$4,708,313.48
(Adjusted multiplier to equal line (1) total claims)		

4.4. The PEIA eightieth (80th) percentile maximum fee schedule was then developed for all CPT-4 Codes using the following components (in priority order):

4.4.1. The PEIA eightieth (80th) percentile fees identified in subsection 4.2.2.

4.4.2. Where the actual PEIA claims data had less than ten (10) claims paid or processed in 1988, the Med Index relative value was multiplied by the PEIA claims data multiplier calculated according to subsection 4.3.2.1.

4.4.3. Where the CPT-4 Code was one of a procedurally related series, the Med Index relative value was multiplied by a related PEIA fee identified in subsection 4.2.2.

4.5. The actuary reviewed and reanalyzed all PEIA schedule fees generated in subsection 4.4. that were 20% greater or 50% less than the current Med Index fees.

4.5.1. Each such fee was recalculated by removing the highest and lowest fees and generating a new eightieth (80th) percentile.

4.5.1.1. Where the total number of remaining claims paid or processed was ten (10) or more, the new eightieth (80th) percentile fee was used.

4.5.1.2. Where the total number of remaining claims paid after the removal of the highest and lowest fees was less than ten (10), then a fee was calculated using the Med Index relative value and the PEIA claims experience multiplier as in subsection 4.4.2.

**§69-3-5. Proprietary Nature of Fees**

5.1. Consistent with W. Va. Code §16-29D-7 and W. Va. Code §5-16-18, the actual fee schedule(s) calculated by the actuary, and any other information or calculations which would identify such fee schedule(s), are not subject to the rule-making procedures of the West Virginia Administrative Procedures Act, W. Va. Code §29A-1-1 et seq. Such fee schedule(s) and related identifying information are proprietary in nature, and will not be published or released by the Secretary or the PEIA, in order to protect and preserve competition among health care providers who may become subject to such schedule(s).

**§69-3-6. Prompt Payment**

6.1. The PEIA, the division of rehabilitation services and the workers' compensation commission shall cause to be issued, within sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, a state check in payment for health care or health care services delivered to the respective beneficiaries of such agencies on or after September 1, 1989.

6.1.1. If a state check is issued more than sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, the agency shall pay interest, at the current rate, as determined according to subsection 6.1.1.1., calculated from the sixty-sixth (66th) day after such invoice was actually received by the division or agency up to and including that date on which the state check is mailed to the vendor.

6.1.1.1. The current rate of interest will be determined by the state tax commissioner under the provisions of W. Va. Code §11-10-17(a).

6.1.1.2. Each division or agency shall record by electronic or other means the actual date of receipt on all invoices received, and, if different, the date on which each invoice is deemed to be legitimate and uncontested.