

WEST VIRGINIA  
SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #1

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OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

NOTICE OF PUBLIC HEARING ON A PROPOSED RULE

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

RULE TYPE: Legislative; CITE AUTHORITY W. Va. Code §16-29D-7

AMENDMENT TO AN EXISTING RULE: YES  NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 3

TITLE OF RULE BEING AMENDED: Implementation of Omnibus

Health Care Act Payment Provisions

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: \_\_\_\_\_

TITLE OF RULE BEING PROPOSED: \_\_\_\_\_

DATE OF PUBLIC HEARING: October 1, 1991 TIME: 9:00 a.m.

LOCATION OF PUBLIC HEARING: Building 6, Room 607

State Capitol Complex

Charleston, West Virginia 25305

COMMENTS LIMITED TO: ORAL , WRITTEN , BOTH

COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS: David P. Lambert, General Counsel

Public Employees Insurance Agency

Building 5, Room 1025

State Capitol Complex

Charleston, West Virginia 25305

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

*James W. Lambert*

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Implementation of Omnibus Health Care Act Payment Provisions

Type of Rule:  Legislative  Interpretive  Procedural

Agency Department of Health and Human Resources Address Building 3, Room 206

State Capitol Complex, Charleston, West Virginia 25305.

| 1. Effect of Proposed Rule | ANNUAL   |          | FISCAL YEAR |      |            |
|----------------------------|----------|----------|-------------|------|------------|
|                            | Increase | Decrease | Current     | Next | Thereafter |
| Estimated Total Cost       | \$       | \$       | \$          | \$   | \$         |
| Personal Services          | 0        | 0        | 0           | 0    | 0          |
| Current Expense            | 0        | 0        | 0           | 0    | 0          |
| Repairs and Alterations    | 0        | 0        | 0           | 0    | 0          |
| Equipment                  | 0        | 0        | 0           | 0    | 0          |
| Other                      | 0        | 0        | 0           | 0    | 0          |

2. Explanation of above estimates:

The proposed amendments describe the methodology for establishing a new maximum allowable fee schedule for the Public Employees Insurance Agency. The new fee schedule was designed to be budget neutral.

3. Objectives of these rules:

The objective is to describe the methodology for a new PEIA fee schedule. The purpose of implementing a new fee schedule is to eliminate inequitable payments, obsolete procedure codes, and confusion over discounts caused by the old fee schedule.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None. Phone calls and written inquiries from angry and confused PEIA insureds and health care providers should be reduced.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

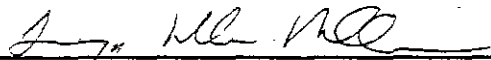
Same as A.

C. Economic Impact on Citizens/Public at Large.

Same as A.

Date: 8/30/91

Signature of Agency Head or Authorized Representative



Taunja Willis Miller, Secretary  
Department of Health and Human Resources

## SUMMARY

The amendments to 69 C.S.R. 3 describe the methodology for developing a new maximum allowable fee schedule for the Public Employees Insurance Agency ("PEIA"). W.Va. Code §16-29D-7 (part of the Omnibus Health Care Act) provides that the methodology for establishing fee schedules, but not the actual fees themselves, are subject to legislative rule-making. The statute explicitly authorizes use of emergency rule-making.

A new fee schedule is needed to: (1) base maximum fees on current (1990 - 91) charges as opposed to 1988 claims data; (2) provide a mechanism for regular updating of fees; (3) increase certain fees, especially for primary care services, which have become so low that providers are declining to see PEIA patients; (4) replace obsolete billing codes which are creating confusion and delays in reimbursement, and provide a mechanism for keeping the codes current; (5) eliminate use of non-specific, "catch all" billing codes which, if used inappropriately, enable a provider to be paid a higher fee than would otherwise occur if a specific billing code were used; and, (6) replace current discounts imposed by PEIA Finance Board which fall equally on low-cost and high-cost providers, and which cause confusion for providers and insureds alike as to what amounts are payable by the insured.

The new fee schedule is based upon a percentile of current charges for West Virginia providers as reported to the Health Insurance Association of America.

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.~~ "Claims administrator" means the third party claims administrator for the PEIA, which developed the maximum allowable fee schedule summarized in this rule.

2.4. "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.

2.5. "HIAA" means the Health Insurance Association of America.

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.~~ "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.

2.7. "PEIA" means the Public Employees Insurance Agency. ~~"Med-Index" means a fee schedule developed by Medical Data Research, Inc., Salt Lake City, Utah, for the Charleston, West Virginia, region.~~

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

### §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(c).~~ The purpose of this rule is to summarize the methodology used by the PEIA's claims administrator to develop a maximum allowable fee schedule. The PEIA will use this schedule to reimburse physicians and other health care providers who bill according to CPT-4 Codes for services provided to PEIA insureds. This maximum allowable fee schedule will replace the eightieth (80th) percentile maximum fee schedule previously used by the PEIA, which was developed using 1988 PEIA claims data. Hospitals and other institutional providers will not be reimbursed according to the fee schedule summarized in this rule, but will be paid based on separate maximum institution-specific rates established by the PEIA.

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.~~ Adoption and adjustment of the maximum fee schedule by the PEIA shall be accomplished through changes to the current PEIA financial plan or group benefit plan, as required, 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 together with ~~an addendum to~~ the PEIA group benefit plan document ~~which describes current benefit changes which are being made to accommodate the provisions of this rule.~~ and the PEIA financial plan.

#### §69-3-4. Methodology

4.1. This section summarizes the methodology employed ~~by the actuary~~ to develop the ~~eightieth (80th) percentile~~ maximum allowable 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.~~ The maximum allowable fee schedule was developed from claims data submitted by West Virginia health care providers to the HIAA during the period January 1, 1990 through June 30, 1991.

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.~~ HIAA claims data for West Virginia is divided by zip code into six geographic areas. For each area, the data is sorted by CPT-4 Codes.

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): Within each area, for each CPT-4 Code, HIAA ranks the claims from lowest to highest charge. HIAA calculates the fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-fifth (75th), and eightieth (80th) percentile charges (as well as other percentiles) for each CPT-4 Code within each area.~~

~~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. As an illustration of how these percentiles are calculated, assume that a routine office visit to a physician is represented by CPT-4 Code "A." Assume that the geographic areas into which HIAA separates West Virginia claims data are represented by "1" through "6." For area "1," HIAA ranks all claims submitted by providers in that area for CPT-4 Code "A" from lowest charge to highest charge. The seventy-fifth (75th) percentile for CPT-4 Code "A" in area "1" is that charge level at which the charges for seventy-five percent (75) of the claims submitted are equal to or below. In this same manner, a separate seventy-fifth (75th) percentile charge for CPT-4 Code "A" is calculated for each of the six geographic areas.~~

~~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.~~

~~4.6. The claims administrator then calculated a statewide or "blended" weighted average fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-~~

fifth (75th), and eightieth (80th) percentile charge for each CPT-4 Code from the percentile charges for each of the six geographic areas. In calculating the average, the percentile charge for each area was weighted by the number of claims for that CPT-4 Code contained in the claims data for that area. For example, the blended fiftieth (50th) percentile charge for a particular CPT-4 Code was calculated by taking an average of the fiftieth (50th) percentile charges for that code for each of the six areas, weighted by the number of claims for that code performed in each area.

4.7. For some CPT-4 Codes, an insufficient number of West Virginia claims existed to enable HIAA to calculate percentile charges. In these instances, the claims administrator used percentile charges from an urban area in one of the following neighbor states: Maryland, Pennsylvania, Ohio, Kentucky, North Carolina. The claims administrator adopted charges from the first of the above states, in the order listed, to have sufficient claims for the particular CPT-4 Code. For example, if insufficient data existed for West Virginia for a particular code, the claims administrator looked to Maryland. If insufficient data existed for Maryland, the claims administrator then looked to Pennsylvania, and so on.

4.8. For some CPT-4 Codes, the claims administrator could not establish percentile charges due to insufficient data even after looking to neighboring states. For these infrequently-performed procedures, an identifier was assigned to indicate no maximum fee has been calculated. A maximum fee will be calculated when and if the PEIA or HIAA receives a sufficient number of claims to calculate a maximum fee.

4.9. After establishing percentile charges according to subsections 4.6 through 4.7 above, for all those CPT-4 Codes for which such percentiles could be calculated, the claims administrator then determined which percentile level, if applied to all CPT-4 Codes, would yield approximately the same total reimbursement as that actually paid by the PEIA for the same period, under the eightieth (80th) percentile maximum fee schedule developed from 1988 PEIA claims data, as adjusted by the PEIA Finance Board. The claims administrator determined that the seventieth (70th) percentile level would yield approximately the same total reimbursement (i.e., be "budget neutral").

4.10. The PEIA plans to establish initially its maximum allowable fees at the seventieth (70th) percentile level as calculated according to this subsection. The PEIA may at some future date adjust these fees, without further amendment of this rule, by: (1) adopting a different percentile level; (2) recalculating the percentiles using more recent HIAA claims data; or (3) making such other changes, not affecting the basic methodology, as may be required by the PEIA Finance Board.

#### **\$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,~~ used by the PEIA, 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.

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. "Claims administrator" means the third party claims administrator for the PEIA, which developed the maximum allowable fee schedule summarized in this rule.

2.4. "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.

2.5. "HIAA" means the Health Insurance Association of America.

2.6. "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.

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

2.8. "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 PEIA's claims administrator to develop a maximum allowable fee schedule. The PEIA will use this schedule to reimburse physicians and other health care providers who bill, according to CPT-4 Codes for services provided to PEIA insureds. This maximum allowable fee schedule will replace the eightieth (80th) percentile maximum fee schedule previously used by the PEIA, which was developed using 1988 PEIA claims data. Hospitals and other institutional providers will not be reimbursed according to the fee schedule summarized in this rule, but will be paid based on separate maximum institution-specific rates established by the PEIA.

3.2. Adoption and adjustment of the maximum fee schedule by the PEIA shall be accomplished through changes to the current PEIA financial plan or group benefit plan, as required, 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 together with the PEIA group benefit plan document and the PEIA financial plan.

### **§69-3-4. Methodology**

4.1. This section summarizes the methodology employed to develop the maximum allowable 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 maximum allowable fee schedule was developed from claims data submitted by West Virginia health care providers to the HIAA during the period January 1, 1990 through June 30, 1991.

4.3. HIAA claims data for West Virginia is divided by zip code into six geographic areas. For each area, the data is sorted by CPT-4 Codes.

4.4. Within each area, for each CPT-4 Code, HIAA ranks the claims from lowest to highest charge. HIAA calculates the fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-fifth (75th), and eightieth (80th) percentile charges (as well as other percentiles) for each CPT-4 Code within each area.

4.5. As an illustration of how these percentiles are calculated, assume that a routine office visit to a physician is represented by CPT-4 Code "A." Assume that the geographic areas into which HIAA separates West Virginia claims

data are represented by "1" through "6." For area "1," HIAA ranks all claims submitted by providers in that area for CPT-4 Code "A" from lowest charge to highest charge. The seventy-fifth (75th) percentile for CPT-4 Code "A" in area "1" is that charge level at which the charges for seventy-five percent (75) of the claims submitted are equal to or below. In this same manner, a separate seventy-fifth (75th) percentile charge for CPT-4 Code "A" is calculated for each of the six geographic areas.

4.6. The claims administrator then calculated a statewide or "blended" weighted average fiftieth (50th), sixtieth (60th), seventieth (70th), seventy-fifth (75th), and eightieth (80th) percentile charge for each CPT-4 Code from the percentile charges for each of the six geographic areas. In calculating the average, the percentile charge for each area was weighted by the number of claims for that CPT-4 Code contained in the claims data for that area. For example, the blended fiftieth (50th) percentile charge for a particular CPT-4 Code was calculated by taking an average of the fiftieth (50th) percentile charges for that code for each of the six areas, weighted by the number of claims for that code performed in each area.

4.7. For some CPT-4 Codes, an insufficient number of West Virginia claims existed to enable HIAA to calculate percentile charges. In these instances, the claims administrator used percentile charges from an urban area in one of the following neighbor states: Maryland, Pennsylvania, Ohio, Kentucky, North Carolina. The claims administrator adopted charges from the first of the above states, in the order listed, to have sufficient claims for the particular CPT-4 Code. For example, if insufficient data existed for West Virginia for a particular code, the claims administrator looked to Maryland. If insufficient data existed for Maryland, the claims administrator then looked to Pennsylvania, and so on.

4.8. For some CPT-4 Codes, the claims administrator could not establish percentile charges due to insufficient data even after looking to neighboring states. For these infrequently-performed procedures, an identifier was assigned to indicate no maximum fee has been calculated. A maximum fee will be calculated when and if the PEIA or HIAA receives a sufficient number of claims to calculate a maximum fee.

4.9. After establishing percentile charges according to subsections 4.6 through 4.7 above, for all those CPT-4 Codes for which such percentiles could be calculated, the claims administrator then determined which percentile level, if applied to all CPT-4 Codes, would yield approximately the same total reimbursement as that actually paid by the PEIA for the same period, under the eightieth (80th) percentile maximum fee schedule developed from 1988 PEIA claims data, as adjusted by the PEIA Finance Board. The claims administrator determined that the seventieth (70th) percentile level would yield approximately the same total reimbursement (i.e., be "budget neutral").

4.10. The PEIA plans to establish initially its maximum allowable fees at the seventieth (70th) percentile level as calculated according to this subsection. The PEIA may at some future date adjust these fees, without further amendment of this rule, by: (1) adopting a different percentile level; (2) recalculating the percentiles using more recent HIAA claims data; or (3) making such other changes, not affecting the basic methodology, as may be required by the PEIA Finance Board.

#### **§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) used by the PEIA, 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.