



Ohio Bureau of Workers' Compensation Comprehensive Study

Cost Controls: Medical Payments Study

Report 2.3

Deloitte Consulting LLP

Group 2

Report Finalized: March 25, 2009

Audit • Tax • Consulting • Financial Advisory.

Contents

- Executive Summary 1**
 - Introduction..... 1
 - Conclusions..... 2
- The Situation 4**
 - Task Background 4
 - Methodology 5
 - Primary Constituents..... 5
- Information and Data Gathered 6**
 - Interviews..... 6
 - BWC Public Forum Attendance 7
 - Information/Data Request..... 7
- Review and Analysis 8**
 - Benchmarking 8
 - Leading Practice..... 17
 - Medical Payment Process 19
- Conclusions 21**
 - Findings..... 21
 - Performance Assessment 26
 - Recommendations..... 28
- Appendix A – Deliverable Matrix 30**
- Appendix B – Data and Documentation..... 36**

Executive Summary

Introduction

This task called for an evaluation of medical payments to providers in Ohio, a comparison to industry peers, and recommended changes for improvements to BWC's medical payment structure. BWC establishes a process and structure for the administration and oversight of provider medical bills received and paid by the MCOs. Duties of the Administrator for Payments to Health Care Providers are outlined in ORC 4121.121(16). In addition, BWC establishes, maintains, and publishes a fee schedule outlining payments for medical services rendered under the Ohio Administrative Code 4123-6-08.

We note recently completed and ongoing internal BWC initiatives in addressing the process and structure of medical treatment requests, Alternative Dispute Resolution (ADR), medical bill payments, and fee schedules. An internal BWC Medical Billing Payment Process Audit (MBPP) was completed in March of 2008. In addition, several SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) objectives identified by the Medical Services Division have relevance to the medical payment process and structure for medical provider reimbursement. The SMART objectives, as amended on April 21, 2008, contain appropriate improvement strategies and measurements, and implementation timelines that are responsive to the needs in this task area. In most cases, Deloitte Consulting findings and recommendations align with recommendations made by the MBPP Audit and identified SMART initiatives. SMART objectives relevant to these tasks include:

- I.A.1 Identify unnecessary barriers to participating providers for the delivery of quality medical treatment (*as it relates to medical reimbursement levels*).
- I.B.3.a. Develop a system (or revitalize current systems, for example, the MCO retro C-9 [Physician's Request for Medical Service or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease] tracking) to measure and identify non-compliance including retroactive requests for medical authorizations (C-9), and lack of quality/timely medical submission.
- II.A.2 Determine the appropriateness of fee schedules and reimbursement methodologies.
- IV.1-3 Evaluate and process medical bills, ensuring proper and timely payment consistent with the benefit plan design criteria.

It should be noted that a payment system enhancement procurement was recently completed relevant to this task, separate from the SMART initiatives noted above. The incumbent, Cambridge Integrated Services Group, was selected by BWC. System improvements are underway to the existing custom-built application for data management and networking that supports the medical payment process. It allows the BWC to receive and adjudicate MCO submissions of bills necessary to generate the funding to the MCOs, so the MCOs can in turn pay the providers. This is part of a multi-stage, comprehensive effort that extends to support all Electronic Data Interchange (EDI) transactions within the HPP, employer enrollment and MCO administrative payments. BWC plans to issue an RFP which will allow it to further expand the infrastructure and streamline the medical bill submission and review process.

At a high level we offer the following findings and recommendations based on our evaluation of medical services requests, ADR, medical payment process, and medical payment reimbursement levels (fee schedules). Fee schedules were not reviewed at a detailed medical procedure level recognizing that BWC has conducted sufficient due diligence in establishing reimbursement levels. We confirm that BWC has met leading practice standards for inclusion of inpatient and outpatient procedures, provider professional fees, ambulatory surgical center procedures and pharmacy in defined reimbursement schedules. The Diagnostic Related Grouping (DRG) methodology currently employed by BWC, and drugs reimbursed at generic levels are additional leading practice observations. Details and rationale for recommended actions are contained in text and exhibits in the report that follows. We encourage readers to also review Deloitte Consulting's MCO Effectiveness Report 5.1.2 Task #30 as it contains important companion analyses.

Conclusions

Findings

Medical Services Request and Alternative Dispute Resolution (ADR)

- Leading practices exist in the medical services request and ADR process and include:
- MCOs and the BWC use recognized industry standard treatment guidelines.
- The Utilization Review (UR) process is compliant with URAC (Utilization Review Accreditation Commission) standards.
- Administrative inefficiencies exist in processes between the MCOs, providers, and the BWC that are duplicative and cumbersome.
- Providers perceive a burdensome process for treatment authorization. BWC has proposed the use of Blue Ribbon panels as an alternative to alleviate the administrative burden of treatment requests for high performing providers.
- MCOs and the BWC indicate there are issues with the quality of provider information presented for treatment requests; C-9s are not electronically submitted by providers to MCOs and are not necessarily typed.
- Updating the “allowed condition” as part of C-9 requests works sporadically; proactive allowance requires employer waiver and an allowable timeframe of 5 to 28 days.
- Medical dispute resolution involves a process of appeals involving MCOs, BWC and the Industrial Commission (IC) where claims are escalated respectively if not resolved at each stage. Each level of appeal adds time to an ultimate decision on injured worker treatment. BWC agrees with 95+% of MCO appeal decisions providing limited value to the ADR program. Strong concurrence by BWC with MCO decisions confirms that MCOs are following appropriate BWC guidelines for rendering treatment decisions. The total annual spend on all BWC ADR-related functions is estimated at \$4,000,000 by BWC.

Medical Payment Process

- Leading practices exist in the medical payment process such as online tools that include payment look-up and resources for constituents to navigate the process. They incorporate the use of clinical edits to evaluate and control utilization as part of the bill review process.
- On average most medical payments are made well within prescribed BWC allowable timeframes, but fall short of leading industry practice (see table on Page 25).
- The administrative medical bill review process is duplicative and cumbersome. Both MCOs and the BWC review all medical bills.
- As a monopolistic fund with centralized oversight, inconsistencies and distinctions in marketplace vendor bill review software, edits, and operational processing are more apparent in Ohio than in other settings. This has led to a duplicative process of BWC reviewing all bills processed by MCOs. We agree with the MBPP Audit findings that specific costs attributable to process in this area were not available at the time of audit, and should be defined to determine ways to improve MCO performance and BWC efficiencies. BWC’s Compliance and Performance Monitoring Department is in the process of identifying BWC costs for medical bill payment.
- Providers perceive a burdensome medical payment process. Blue Ribbon panels are under consideration as an alternative that may reward the "best" providers, lessen their administrative burden and provide incentives for providers to participate in the program.

Fee Schedule

- Provider fee schedules are in various stages of review by the BWC. Select ancillary services such as Vocational Rehabilitation mileage have recently been addressed. The Professional Provider Fee Schedule has been updated and is pending review of the Board. Other fee schedules such as the Ambulatory Surgery Center are in various stages of development.
- Prior to the current initiative to update the Professional Provider Fee Schedule, it had not been updated since 2004.

Recommendations

Medical Services Request and Alternative Dispute Resolution (ADR)

- Reduce inefficiencies by implementing the following policy remedies:
 - Continue to develop the concept of a Blue Ribbon panel with provider incentives to drive improved compliance and overall performance.
 - Continue program development of EDI (electronic data interchange) submission of C-9s in order to increase quality of submissions and process efficiencies.
 - BWC should study methods to more readily accept MCO recommendations on medical treatment requests that involve adding related conditions when determining an additional covered condition. More flexibility for MCOs in making treatment authorizations will ensure more timely care for injured workers.
- The Official Disability Guidelines (ODG), as published by the Work Loss Data Institute, was designated in August 2007 as the exclusive BWC approved Utilization Review (UR) standard. We recommend that the BWC consider development of related MCO performance metrics to tie MCO results to this standard set of UR criteria. Remedy: Policy communication and adjustment for relevant metrics inclusion in MCO performance standards.
- Consider elimination of the BWC's role in the ADR appeal process. Explore the feasibility of having treatment disputes go directly from the MCOs to the Industrial Commission (IC). If this approach is pursued we recommend insistence that parties hearing appeals comply with URAC guidelines for ADR. Remedy: Rule change.

Medical Payment Process

- Continue implementation of the standardization of bill review edits. Remedy: Policy change.
- Determine ways to decrease medical payment processing duplication and achieve incremental savings given that BWC currently reviews all bills processed by MCOs, including bills for auto-adjudicated medical only claims
- Explore the feasibility and potential savings of BWC in-house bill review and elimination of MCO medical bill review process. Remedy: Policy change. OR
- Relinquish current duplicative BWC process of secondary review of provider medical payment determinations made by MCOs and adopt an audit model of bill payment monitoring. Remedy: Policy change.

Fee Schedule

- Finalize new fee schedules that support all service types, quality and access necessary in the workers' compensation system. Phase in opportunities that include Pay for Performance or a "Tiered Fee Schedule" under the Blue Ribbon concept. Remedy: Rule change.
- Medicare updates RBRVS annually. BWC should update the fee schedule more frequently and Deloitte Consulting recommends every one-to-two years. Remedy: Rule change.

The Situation

Task Background

RFP Task Reference	RFP Task Description	Task Category
Section 5.1.2 #25, page 14	Conduct a study on the medical payments to providers in Ohio and provide a comparison to industry peers. This study should recommend changes/improvements to BWC's medical payment structure in line with industry standards.	Claims

To accomplish this task, Deloitte Consulting focused on three key process areas:

- Medical services Request and ADR
- Medical payment program and structure
- Medical fee schedules

These were compared to other state, private industry workers' compensation leaders, and were benchmarked against credible industry sources.

We identified recommendations for suggested improvement initiatives. Our evaluation provided a context within which BWC can assess how they align with other industry leaders to close identified gaps. We considered that BWC is well underway in implementing SMART objectives in this area.

Components of this task involved a determination of the ability of current administrative processes and fee schedules to control costs, while supporting access to care and quality assurance in Ohio, and as compared to peer organizations/jurisdictions.

The primary objectives for this task were to:

- Verify business strategy as it relates to this task (SMART objectives, BWC Annual Reports).
- Assess processes in the context of organizational and jurisdictional environment (BWC and Ohio).
- Assess processes in the context of peer organizations and jurisdictions.
- Assess infrastructure as it relates to the task.
- Define future organizational and jurisdictional requirements (legislative / regulatory changes).
- Define approach strategy, support (infrastructure), and governance of the task activities.

Methodology

We relied upon interviews, documents, and data provided through a variety of sources that are detailed in the Appendix. We utilized our industry resources and jurisdictional knowledge to compare BWC practices of the relevant task to draw conclusions, findings and recommendations. Prior research by other organizations has explored many of the issues that need to be considered in updating and maintaining a fee schedule. We drew heavily from prior research and studies to review the current status, approach and methodology of the fee schedules and industry leading practices for the medical payment process. The methodology used for this task leverages our experience with public sector workers' compensation and the task at hand (medical payments). The methodology is considered in industry standards and leading practice frameworks. It incorporates findings and recommendations within the context of a complex and large-scale system.

Completion of our medical payment study involved the following activities:

- Key constituent interviews,
- Data extracts (Bill Review Reports),
- Documentation reviews (Billing and Reimbursement Manual),
- Review of fee schedule approach / methodology (high level)
- Industry leading practice comparisons, and
- Benchmarking of other "peer" state structures processes for medical reimbursement.

Deloitte Consulting practitioners met and interviewed BWC's Medical Services Division leadership and Management to understand the medical payment structure and how the overall process works. Drawing on our experience with other state funds, insurers and commercially available reference sources, we drafted leading industry medical payment practices and identified gaps between those and BWC's current processes.

Primary Constituents

The constituents in this task area include the following:

- **Providers** – Medical service providers are the primary constituents in the medical payment process as the provider of services and receiver of reimbursement from the MCOs.
- **BWC** – The BWC is responsible for provider certification, determination of allowable conditions, third-step clinical review of MCO ADR appeals, and final review and payment determination of all provider bills.
- **MCOs** – The provider application process is facilitated by the MCO when appropriate, and coordinated through the appropriate contact for the MCO in the BWC Provider Enrollment Unit. The evaluation of all medical treatment reimbursement requests made by the physician of record (POR) or eligible treatment provider is the responsibility of the MCO using the three part "Miller" test, including responsibility for adhering to prescribed treatment guidelines. Upon receiving funding from BWC, the MCO directly reimburses medical providers for treatment of work-related medical conditions.
- **Injured Workers** – To the extent that fee schedules and medical payments impact access and quality, injured workers are a constituency relevant to this task.
- **Employers** – Fund the workers' compensation system through premiums and assessments. Premiums are influenced by medical expenses. Employers have the right to appeal treatment approvals and claim allowances.

Information and Data Gathered

Multiple avenues were pursued to obtain collection of required data and to validate fact finding. This includes interviewing internal BWC constituents and external parties affected by BWC actions in this area. Deloitte Consulting also attended BWC Board of Director Public Forums on Medical Services on April 24, 2008 and June 26, 2008 where constituents offered statements for Board and public consideration. We reviewed data and documents provided by BWC representatives as well as those publicly available on BWC's website. Finally, we benchmarked processes, procedures, strategy, and reimbursement levels related to this task with marketplace practices and peer organizations.

Interviews

BWC

The following individuals were interviewed as part of this task:

- Chief Medical Services and Compliance
- Director MCO Business and Reporting
- Manager Medical Policy
- Provider Relations Manager
- Medical Services Administration
- Director Compliance and Performance Monitoring
- ICD-9 Analyst
- Managed Care Services Director
- IRN Administrator
- Director of Managed Care Operations
- Director, HPP Systems Support

MCO League of Ohio

- Executive Director

MCO Vendor Representatives

- MCO President and Chief Operating Officer
- Managed Care organization Ohio MCO Manager
- MCO Director of Medical Management

Union Representative

- AFL-CIO

BWC Public Forum Attendance

Constituents Represented

- Providers
- Injured Workers
- Employers
- Attorneys

System Service Providers

- Vocational Rehabilitation
- Physical and Occupational Therapy
- Physicians
- Clinical Psychologist
- Chiropractors
- Transportation Services
- Home Health Services

Information/Data Request

We have received numerous documents from BWC's Medical Services Division in addition to reviewing what is publicly available in BWC's vast online library. The documents reviewed are listed in the Appendix. All requests for information related to this task were provided timely.

Review and Analysis

Benchmarking

Information from the following sources provided external comparative data for benchmarking of medical payment and related billing process performance in Ohio.

- US Department of Labor, Bureau of Labor Statistics (BLS)
- National Council on Compensation Insurance (NCCI)
- International Risk Management Institute (IRMI)
- Workers' Compensation Research Institute (WCRI)
- American College of Occupational and Environmental Medicine (ACOEM)
- Utilization Review Accreditation Commission (URAC)
- Rand Corporation
- US Chamber of Commerce
- California Commission for Health and Safety and Workers' Compensation
- MCO League of Ohio HPP Report (actuarial study performed by The Kilbourne Company)

BWC, as a public entity, seeks to enhance and maintain financial strength and stability, service and quality, innovation and constituent satisfaction. Measuring process and performance and benchmarking outcomes and the related identification of leading practices are important activities to that end.

The major goal of our approach was to afford the BWC a broad comparative perspective of where it is positioned relative to others across a spectrum of business functions related to medical payments, and to identify steps for improvement. Deloitte Consulting compared BWC practices with marketplace standards as defined by major research and accreditation organizations. These include URAC, NCCI, and Workers' Compensation Research Institute. The benchmarking analysis led to identification of practices meeting industry standards, leading practices, gaps, and recommendations.

Ohio Summary:

Although Ohio is unique in some respects under HPP, its use of fee schedules is a common tool used in workers' compensation systems across the US. Despite their widespread use there is significant variation in the way states approach administrative and technical aspects required to maintain fee schedules. Some states opt for timelines and data sources in rules while other states elect to appoint multi-disciplinary committees. Fee schedules cannot alone control costs which make the other two processes associated with this task, Medical Services Request and Provider Medical Payment processes, important to overall cost containment. Guidance for providing medical treatment is set forth in the Ohio Administrative Code, Chapter 4123, sections 6 & 7.

Medical Services Request and Alternative Dispute Resolution (ADR)

Utilization Review (UR) is a common strategy in workers' compensation to assure treatment and its duration is appropriate. Ohio is among eleven jurisdictions (OH, AL, DE, DC, IL, ME, NV, NY, TN, TX, WA) that have, to varying degrees, recognized URAC, a leading independent UR accreditation organization. The following appeal process information was obtained from URAC and individual state websites, and details are referenced in the table below. It is benchmarked in this report due to suggestions by some constituents that the multiple levels of appeals in Medical Service Requests in Ohio are excessive, unnecessary, and delayed. Generally, the appeals process subsequent to the initial determination and first level dispute varies by jurisdiction. The ADR process in Ohio involves a multi-step appeal process involving MCOs, appeal to BWC, and subsequent appeal to the Industrial Commission if not resolved in previous steps, and finally to the Court of Common Pleas. This process is consistent with industry leading practice. In determining appropriateness of treatment MCOs' first level of review and C-9 approval may be performed by a non-clinician if treatment is within prescribed guidelines. If it is denied or falls outside of treatment guidelines it must be reviewed by a clinician, generally a nurse. The second level of review, i.e. appeal of the original decision involves a formal clinical review. If not resolved at the MCO level, cases are appealed to BWC for another clinical review, and if not resolved at that step, escalated to the IC for a formal hearing.

Jurisdiction	Statutory Reference	Utilization Review Process	MCO Appeal Process	Administrative Appeal Process
Ohio	Chapters 4121 and 4123	ODG treatment guidelines have been designated by BWC as the only approved UR standard in the MCO Reference Guide.	2 Clinical Review steps within MCO before appeal to BWC	If not resolved at MCO level, appeal to BWC, with subsequent appeal to the IC if still disputed by injured worker or employer. Parties can appeal cases beyond the IC to the Court of Common Pleas.
Alabama	Code Rule 480-5-5-.06	Technical Review First Level Clinical Reviewer (Nurse) Second Level Clinical Reviewer (Physician)	Third Level Clinical Review – Appeal (Physician)	Medical Dispute Resolution Review by an Ombudsman of medical services that are provided for which authorization of payment is sought, as defined in Code of Ala. 1975, §25577(i). Their decisions are reviewable by the Medical Services Board.
Delaware	Chapter 101, title 29	Compliance with URAC Workers' Compensation Utilization Management Standards	Compliance with URAC Workers' Compensation Utilization Management Standards	If a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for <i>de novo</i> review. If there are no current practice guidelines applicable to the health care provided, a party may file a petition with the Industrial Accident Board seeking a determination of the appropriateness of treatment.

Medical Services Request and Alternative Dispute Resolution (ADR) - continued

Jurisdiction	Statutory Reference	Utilization Review Process	MCO Appeal Process	Administrative Appeal Process
District of Columbia	Section 1-623.23	URAC Certification Workers' Compensation Utilization Management Standards	If the medical care provider disagrees with the opinion of the utilization review organization or individual, the medical care provider may submit a written request to the utilization review organization or individual for reconsideration of the opinion. The request shall contain reasonable medical justification for the request and shall be made within sixty (60) calendar days from actual receipt of the utilization review report.	If a dispute arises between the medical care provider, employee, or employer on the issue of necessary, character, or sufficiency of the medical care or service or fees charged by the medical care provider, the dispute shall be resolved by the Director upon application for a hearing. Any party adversely affected by the Director's Decision shall appeal to the D.C. Court of Appeals. Copies of all reports shall be furnished to all interested parties.
Illinois	Section 8.7	Compliance with the Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation	Compliance with URAC Standards	A utilization review will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills or treatment. If denial or refusal to authorize does not comply with a utilization review program registered under this Section and does not comply with all other requirements of this Section, then that will be considered by the Commission
Maine	90-351 Code of Maine Rules Chapter 7	URAC Accreditation - Unconditional Certification requires proof of URAC Accreditation. Conditional Certification requires verification that the entity has applied for URAC Accreditation	Compliance with URAC Standards	The health facility or health care provider may appeal to the board regarding that determination pursuant to procedures provided for under the system of utilization review. A troubleshooting program exists or informal resolution of disputes. An advocate program exists to provide assistance to qualified employees who proceed to mediation and formal hearing.

Medical Services Request and Alternative Dispute Resolution (ADR) - continued

Jurisdiction	Statutory Reference	Utilization Review Process	MCO Appeal Process	Administrative Appeal Process
Nevada	Senate Bill 320; Title 53 NRS 616A.469 and NRS 616C.363	Compliance with nationally recognized accrediting body standards e.g. URAC	Compliance with nationally recognized accrediting body standards e.g. URAC	The industrial insurance regulation section shall review medical payment dispute matters; A provider of health care or insurer aggrieved by the determination of the industrial insurance regulation section may appeal to the administrator
New York	Part 732-2.2(f) of 10 NYCRR	Consistent with the UR requirements of Article 49 OR be an entity currently certified by URAC	Compliance with nationally recognized accrediting body standards e.g. URAC	Dispute Resolution (ADR) system for employers and employees in the unionized construction industry or Board's Disputed Medical Bill (DMB) Unit or Arbitration
Tennessee	T.C.A. §§4-5-202, 50-6-124, and Public Chapter 900, §8, Acts of 1992	A system of Utilization Review compliant with standards set forth in 56-6-705 or URAC Standards	Appeal decision under the procedure established pursuant to T.C.A. §56-6-705 (Section 6 of Public Chapter 812 of the Acts of 1992).	Any party aggrieved of a decision of the employer's utilization review provider concerning pre-admission, outpatient or inpatient review certifications, who has appealed such decision under the appeal procedure established pursuant to T.C.A. §56-6-705 (Section 6 of Public Chapter 812 of the Acts of 1992), may request in writing that the Medical Director appointed by the Commissioner of Labor review the employer's utilization review provider's decision concerning certification or denial of hospitalization.

Medical Services Request and Alternative Dispute Resolution (ADR) - continued

Jurisdiction	Statutory Reference	Utilization Review Process	MCO Appeal Process	Administrative Appeal Process
Texas	Article 4 of H.B. 7, 2005 Chapter 1305 Section 10.81	Notification of an adverse determination must include: (1) the principal reasons for the adverse determination; (2) the clinical basis for the adverse determination; (3) a description of or the source of the screening criteria that were used as guidelines in making the determination; (4) a description of the procedure for the reconsideration process; and (5) notification of the availability of independent review in the form prescribed by the commissioner.	Reconsideration performed by a provider other than the provider who made the original adverse determination.	Seek review of the denial by an independent review organization. The decision is binding during the pendency of any appeal.
Washington	RFP #001C-003	If the request does not meet guidelines or criteria, it is referred for physician review. If the physician reviewer is unable to recommend approval, the requesting physician will be offered the opportunity to discuss the case with the physician reviewer. Quallis Health recommendations are then communicated to the Department's claim managers. All final decisions on authorization are made by the claim manager.	A re-review occurs when a provider or claim manager requests Qualis Health to conduct an additional review after a recommendation for denial. Re-review may be requested during the initial review discussion or after claim manager decision. Re-review is performed by a matched specialty physician.	Internal Claims Managers are responsible for authorizing treatment requests using UR contractor (Qualis Health) purchased by the State Fund who do not directly communicate with injured workers or providers. Employers, injured workers and attending medical providers who disagree with L&I decisions may submit an appeal to the Board of Industrial Insurance Appeals (BIIA).

Medical Payment Process

The timeline requirements for medical payments to providers vary by jurisdiction from 30 days to as high as 60 days, usually with a caveat that the bill must be “properly submitted” on allowed claims. Some jurisdictions do not have specific requirements; some apply penalties for late payment.

Ohio has a “prompt payment” statute that requires payment of penalties after 30 days measured from the day the MCO receives the bill to the date the check is generated. Interest payment is rare due to the elapsed time and/or billed amount required to accumulate \$10 or greater in interest, the minimum threshold for penalty payments.

The current turnaround timeline for physician payment of approximately 15 days as defined as the date received by the MCO to the date the MCO generates a check is well within prescribed regulatory timeframes for Ohio and other jurisdictions. Jurisdictional examples of requirements for provider payment timelines follow:

Jurisdiction	Provider Timelines (Days)
California	45
Colorado	30
Illinois	60
Michigan	30
Nebraska	30
New York	45
Ohio	30-Day “Prompt Payment” Statute
North Carolina	60
Pennsylvania	30
Tennessee	45

Fee Schedule:

Workers' compensation Medical Fee Schedules are used in 42 of the 50 states. The majority of state workers' compensation laws call for the agency that administers the act to establish medical fee schedules that place a maximum on the amounts health care providers can collect for treatment of injuries covered under the act. Application of fee schedules for care by out of state providers vary by jurisdiction. Usually prior authorization must be obtained from the payer for referral to out-of-state providers. Reimbursement for out-of-state services may be based on the workers' compensation fee schedule for the state in which services are provided, or the "usual and customary" fee for the geographical area in which the services are rendered.

Workers' Compensation Medical Fee Schedules

State	Fee Schedule Yes/No
Ohio	Yes
Alabama	Yes
Alaska	Yes
Arizona	Yes
Arkansas	Yes
California	Yes
Connecticut	Yes
Delaware	No
District of Columbia	No
Florida	Yes
Georgia	Yes
Hawaii	Yes
Idaho	Yes
Illinois	Yes
Indiana	No
Iowa	No
Kansas	Yes
Kentucky	Yes
Louisiana	Yes
Maine	Yes
Maryland	Yes
Massachusetts	Yes
Michigan	Yes
Minnesota	Yes
Mississippi	Yes
Missouri	No
Montana	Yes

Workers' Compensation Medical Fee Schedules - continued

State	Fee Schedule Yes/No
Nebraska	Yes
Nevada	Yes
New Hampshire	No
New Jersey	No
New Mexico	Yes
New York	Yes
North Carolina	Yes
North Dakota	Yes
Oklahoma	Yes
Oregon	Yes
Pennsylvania	Yes
Rhode Island	Yes
South Carolina	Yes
South Dakota	Yes
Tennessee	Yes
Texas	Yes
Utah	Yes
Vermont	Yes
Virginia	No
Washington	Yes
West Virginia	Yes
Wisconsin	No
Wyoming	Yes

As NCCI has noted, states that have Workers' Compensation Medical Fee Schedules employ different approaches to constructing fee schedules and to maintaining them. BWC currently uses an RVS (Relative Value Scale) approach to their fee schedule based on Medicare's RBRVS (Resource-Based Relative Value Scale), a noted leading practice.

RVS is a common approach in fee schedule design with RBRVS the most recognized and increasingly used of the RVS schedules. As of 2006, approximately 22 states (and over half of the fee schedule states) use RBRVS in fee schedules in some way. Advantages include a straightforward approach to maintaining workers' compensation fee schedules. An RVS enables many codes to be updated by adjusting a conversion factor percentage. NCCI maintains that once a schedule is in place updates can be accomplished with adjustment of this conversion factor for differentiation.

It includes relative value units (RVUs) of the Current Procedural Terminology (CPT) code such as an X-ray of the spine and conversion factor (CF) that converts RVUs to payments (i.e., dollars per RVU). Like Medicare, BWC's schedule uses the Ohio Geographic Practice Cost Index (GPCI) to adjust work, practice expense and malpractice

components of the RVU. It also contains other beneficial features such as discounts for multiples surgeries on professional and ASC bills.

The BWC recently completed fee schedule updates investigating and reviewing thousands of CPT codes. They subsequently grouped professional provider fees by CPT according to general categories of care of Anesthesia, Surgery, Radiology, Pathology, Physical Medicine, and General Medicine, which conforms to the generally used approach and American Medical Association (AMA) organization of CPT codes. For each category, BWC used a single conversion factor to translate the relative value which varies by category to the maximum allowable fee (dollar amount) on the schedule. The RVU (and BWC) approach also incorporates provider distinctions related to malpractice, education, and rent that can vary considerably for providers of services.

While the majority of medical procedures are amenable to a single fee for service, some pose technical challenges due to differences in risk, personnel, equipment and use of new technologies. Our analysis did not evaluate or validate the appropriateness of the identified conversion factor and fee schedule calculation by BWC. The current Professional Provider Fee Schedule was last updated in 2004. The BWC has submitted proposed fee schedules to the Board that will better align with current needs and facilitate updates on a more regular basis.

Service Group CPT	BWC Current Percent of Medicare	BWC Proposed Percent of Medicare	NCCI Benchmark	WCRI Benchmark
Anesthesia	239%	227%	Not Available	155%
Surgery	200%	200%	139%-255%	206%
Radiology	148%	142%	114%-259%	182%
Pathology	125%	125%	Not Available	143%
Physical Medicine	134%	132%	63%-125%	126%
General Medicine	117%	132%	89%-118%	123%

Studies by NCCI and the WCRI have documented that significant variation in fee schedules exists among states, and between service categories within a state despite a common basis (Medicare RBRVS). The current BWC fee schedule is consistent with other fee schedules in that radiology and surgery are reimbursed at higher levels relative to Medicare than other medical services.

Jurisdictional comparisons of fee schedules to Medicare demonstrate significant range in the overall ratio of workers' compensation medical fee schedules to Medicare. Generally the overall threshold identified by NCCI ratio is 140% with those states below 140% "low" and those states above 140% "high". According to WCRI, Ohio's current professional fee schedule is at 143%.

Fees schedules that are at or below Medicare levels are generally believed to be at a level that would prompt concerns about access and quality of care. Although Ohio's fee schedule compares to Medicare at 143% overall, WCRI notes that Ohio's current fee schedule for Evaluation and Management Services is within the threshold for access concerns given a reimbursement level at 13% lower than Medicare. Evaluation and Management Services refer to visits and consultations furnished by physicians.

Ohio's premium over Medicare is 43%. The overall level is comparable to Washington, an identified peer state, however Ohio is 28th out of 42 states in highest-to-lowest premiums over Medicare. Ohio had the lowest-complexity established patient office visit reimbursement of \$41 compared to Alaska who had the highest reimbursement at \$127.

BWC's proposed changes to existing fee schedules appear to address recognized low values in reimbursement schedules identified by constituents and research organizations like the WCRI that prompt access concern issues.

Leading Practice

Utilization is a key driver of costs in Workers' Compensation. Leading practice requires controls over a Medical Service Request to evaluate care according to industry standard guidelines that incorporate evidence based medicine. Key processes must be in place to ensure treatment requests and expedited appeals are addressed timely with the use of qualified peers at appropriate levels in the process. Comparisons of BWC's process to leading practices in this area follow:

Medical Services Request and ADR

 strong  weak

Medical Services Request and ADR Leading Practices

I. Medical Services Request and ADR

	Submission of Medical Services Request (C-9 / C-9-A process)
	Fast track / Automation / Technology Enablement
	MCO/Payer Coordination
	Medical Bill Payment Disputes
	Use of medical treatment guidelines
	Use of leading accreditation guidelines for utilization review
	Decision making
	Timely appeal
	Levels of appeal

Note: The above circles depict Deloitte's view of BWC's position relative to Medical Services Requests and ADR

The table that follows provides more detail on Medical Services Request and ADR processes. It identifies corresponding leading practices and gaps for each process and practice.

Process / Practice	Leading Practice	Current Gap
Submission of Medical Services Request	Electronic, automated process	Manual process (no EDI)
Fast Track / Automation / Technology Enablement	Fast Track or auto- processing features	Manual process (no EDI)
MCO/BWC Coordination	Timely, integrated claims process	“Proactive Allowance”, a process used to have a condition recognized as an “allowed condition”, is ineffective and allowable timeframe is 5 to 28 days
Medical Bill Payment Disputes	60-90 Business Days	BWC has 14 days from the time the dispute is received to make a decision on the second level appeal from the MCO decision. The appeal process for a disputed case can take between 73 to 261 days to reach resolution according to the MBPP Audit Report.
Use of Medical Treatment Guidelines	Reference of evidence-based treatment guidelines	No gap. BWC has established ODG as the exclusive set of treatment guidelines for MCO reference
Use of Leading Accreditation Guidelines for utilization review	Use of URAC prescribed three step process: 1. Initial Review – may or may not be by a clinician 2. Clinical Review (If unable to be approved at Step 1) 3. Peer Clinical Review - Appeal (If decision appealed)	No gap. MCOs and BWC follow a comprehensive and consistent process for UR.
Decision Making	Nationally accepted clinical editing guidelines	Although MCOs are required to review all bills using nationally accepted clinical editing guidelines and adhere to BWC editing requirements, inconsistencies in bill determinations remain between the MCOs and BWC.
Timely Appeal	Guidelines for standard and expedited appeal comparable to URAC; prompt subsequent administrative appeal.	The MBPP audit report identified delays in ADR decisions. BWC has indicated the identified backlog of cases referenced in the audit has been resolved.
Levels of Appeal	An MCO appeal comparable to URAC required process and an administrative appeal structure that addresses peer reviewer qualifications and expedited timeframes for rendering appeal decisions.	MCOs and BWC follow a consistent dispute resolution process that contains multiple levels of clinical review before unresolved cases reach the IC. BWC’s level of review supports MCO findings in more than 95% of cases; this makes the value of this level of review questionable. It does however demonstrate strong MCO compliance with BWC guidelines.

Medical Payment Process

Given the volume of bills paid in Ohio’s workers’ compensation system, an efficient and cost effective process is essential. Leading practices include sophisticated technology enablement to establish business rules (clinical edits) and analytics. It requires a combination of automation and analyst review to meet timelines while scrutinizing medical billing for costly errors. Comparisons of BWC’s process to leading practices in this area follow:

 strong  weak

Medical Payment Process Leading Practices

II. Medical Bill Payment and Dispute Process

	Submission of medical bills
	Use of industry standard software
	Fast Track / Automation
	Business Rules and Analytical Tools
	Time Allowable for Processing / Payment)
	Timely (Actual)
	Error rate
	Financial leakage and reconciliation (Overpayments / Underpayments
	Audit / oversight

The table that follows provides detail on Medical Payment Processes related to content and timing of critical functions. It identifies corresponding leading practices and gaps with each process and practice.

Process	Leading Practice	Current Gap
Submission of Medical Bills	Automated, electronic, EDI reporting	The MCO process of submitting provider bills to BWC, and BWC’s reimbursement to MCOs is fully automated. Electronic bill submission by providers to MCOs is not a mandated program. An EDI standard is available for providers to use but it is not used by all.
Use of Industry Standard Software	Nationally recognized software applications	MCOs are required to have a nationally recognized, medical bill editing criteria package; however, distinctions exist even in nationally recognized, industry standard software. The BWC is not prescriptive of particular sets of edits for MCOs and additionally conducts bill review on its own.

Process	Leading Practice	Current Gap
Fast Track / Automation	Fast Track or auto- adjudication features to expedite select bills	Although BWC's MBR process is nearly 100% automated, MCOs vary in their use of auto-adjudication. Lack of a mandated standard can result in inconsistency in timing and review decisions. BWC and MCOs could consider use of ODG auto-pay guidelines.
Business Rules and Analytical Tools	Standardized edits and software determinations. Example business rules include: Payment of bills on closed claims; Pending payment of bills over users authority; Flag procedures rarely performed under workers' compensation; Clinical edits supported by logic. Example analytics rules include billing incongruities between procedure codes and diagnostic codes and provider fraud and abuse.	Medical bill review software and clinical editing tools used by BWC and MCOs are not standardized. A common standard would afford options to eliminate either BWC or MCOs from the bill review process at the transactional level.
Time Allowable for Processing / Payment (from date of bill receipt to date check is issued)	7 to 10 days for routine bills and 10-15 days for complex bills are leading practice indicators. 30 days for all bill types is common across most jurisdictions.	BWC allowable process timeframes are 21 days from when an MCO receives a bill to when an MCO forwards payment to the provider. This is within jurisdictional timeframes but is more than expected for standard marketplace turnaround timeframes.
Time (Actual)	7 to 10 business days for routine bill 10-15 business days for complex or PPO/Panel bills	Actual turnaround timeframe from MCO receipt of bill to MCO check mailing is 12 days per BWC's Medical Services Division. Stratified bill review reporting can assist in evaluating timeliness of bills e.g. 95% of bills processed within 10 days.
Error rate = the amount of allowable charges for an item or service billed in error as determined by complex medical review, divided by the amount of allowable charges for that item or service.	Less than 2%	Error rates are not currently captured by BWC.
Financial Leakage and Reconciliation	Limited financial leakage	Staff completed adjustments nearing \$3 million for bill dates past the two-year filing limit per MBPP final report.
Audit / Oversight	Some audit oversight is completed in bill review process; error rates are calculated; X% of bills are audited. This varies by scale of program.	BWC reviews all bills processed by MCOs including bills for auto-adjudicated medical only claims. This is a significant duplication. BWC may be better served with a sampling audit approach.

Conclusions

Findings

The means to bridge the identified gaps discussed in the previous section follow:

Medical Services Request

Leading practices exist in the medical services request and alternative dispute resolution that are supportive of the overall process. MCOs are required to use ODG, a recognized standard in workers' compensation treatment guidelines. Ohio is one of several states that have, to varying degrees, adopted national recognized, evidence-based medical treatment guidelines like ODG to improve outcomes and reduce workers' compensation costs.

Utilization Review is a process that is part of the medical service request (C-9) and is performed on cases that are not already in case management. The process requires that MCOs use the following three step process as prescribed by the BWC to determine if a proposed medical treatment or service is medically necessary for an allowed condition:

1. Initial Review (if recommended treatment falls within prescribed guidelines it may be performed by a non-clinician).
2. Clinical Review (if unable to be approved at Step 1)
3. Second Peer Clinical Review (upon appeal of Step 2)

The above process is a noted leading practice. However, there are other opportunities for improvement. Providers perceive a burdensome process for treatment authorization. BWC has proposed a Blue Ribbon panel as an alternative to expedite the process for high-performing providers. This approach is gaining support in the industry and is a recommendation in other jurisdictions by the RAND Corporation. A "Tiered" fee schedule could be considered as a more long-range opportunity to improve quality and efficiency. Development of an effective system to evaluate provider performance is a SMART objective work-in-progress and is a key prerequisite to design of a Blue Ribbon panel and/or tiered fee schedule.

MCOs and BWC indicate there are issues with the quality of provider information presented as part of a Medical Services Request. C-9s are not electronically transmitted and not necessarily typed. This is a focus of review of a designated SMART objective. It is anticipated that electronic filings will be planned in a future phase. The move to electronic filing is key to increasing the efficiency of this process going forward.

MCOs are required to use the "Miller test" when evaluating care. The "Miller Test" contains requirements affecting medical decision making imposed by the case of *State, ex rel. Miller v. Indus. Comm., 71 Ohio St. 3d 229 (1994)*. The Miller case mandates that a three-part test be applied when considering requests for authorization of workers' compensation medical services, all of which must be met.

1. The requested medical services are reasonably related to the industrial injury (allowed conditions);
2. The requested services are reasonably necessary and appropriate for treatment of the industrial injury (allowed conditions);
3. The costs of the services are medically reasonable.

This test must be applied to all requests for medical services even if the services involve condition(s) not allowed in the claim. In the *Miller* case, the Ohio Supreme Court expressly stated that these requests cannot be denied because the conditions to be treated are not allowed in the claim. The Supreme Court's decision does not mean, however, that all requests for medical services must be authorized, nor does it eliminate the need for allowance of additional body-part specific conditions prior to treatment where appropriate.

Some treatment may be reasonably related to the condition and reasonably necessary but requires a change in the “allowed condition” and subsequently may not meet the Miller Test criteria. Changing the allowed condition on a claim for which all services are based still experiences delays despite several years of effort by BWC to expedite the process through a “proactive allowance” policy. Proactive allowance is intended to be an opportunity to provide physicians an expedited process to seek additional allowances and ultimately deliver services to an injured worker earlier, resulting in appropriate quality care and the potential for earlier return to work.

For BWC to consider a proactive allowance request, the physician must forward the following medical data to the assigned MCO who will submit it to BWC for a determination:

- Supporting medical documentation, including clinical examination and diagnostic test findings.
- Current treatment plan,
- International Classification of Diseases (ICD-9) code for requested diagnosis (include specific diagnosis description, i.e., 722.10 Lumbar HNP, L4-L5, and identify if it is a primary ICD-9,
- ICD-9 location (right, left or bilateral) when applicable,
- ICD-9 site (digits, teeth or body part) when applicable,
- A causality statement indicating how the injury resulted (i.e., is the diagnosis causally related to the industrial accident?).

There are conditions excluded from the proactive allowance process. There are inconsistencies in the internal proactive allowance process that BWC has recognized. It was reported that CSSs resist accepting MCO recommendations on proactive allowance determinations without close scrutiny. In addition there is a need to obtain an employer waiver that is a requirement for changing the allowed condition. The allowable timeframe under current guidelines is 5 to 28 days. Consequently, the “proactive” allowance process fails to provide an expedited process. Given a lack of medical expertise of CSSs that may be necessary to make a determination, MCOs recommendations should be considered more readily in the process. We do not believe that employers should be involved in allowable condition determinations due to lack of both impartiality and medical expertise, and we recommend that the employer waiver requirement be eliminated. This will require a statutory and corresponding rule change.

Alternative Dispute Resolution

The appeals process is a multi-level process involving MCOs, the BWC and the Industrial Commission (IC). Ohio’s process does involve multiple layers of appeal that appear more cumbersome than other jurisdictions although there is no overwhelming uniformity (See Chart in Benchmarking Section). The MCO uses the three-step process as described in the previous Medical Services Request section to determine if a proposed medical treatment or service is medically necessary for an allowed condition. Both MCOs and BWC reference the same set of guidelines to determine outliers and to render decisions.

The MBPP Audit of March 2008 recommended completing a review to determine the feasibility of eliminating levels of appeals in the ADR process. The report notes the appeals process for a disputed ADR could take between 73 and 261 days despite the 14- to 30-day timeframe requirement. Deloitte Consulting concurs and recommends eliminating the review at the BWC level as it adds limited value given they are using the same treatment guidelines as the MCOs with minimal disagreement (95+% of MCO appeals are upheld) and estimated at considerable expense (approximately \$2.5 million operational spend and \$1.5 million in physician fees required to render decisions). We suggest further review of the following options:

1. Once the medical treatment request (UR) has been completed to prescribed guidelines (review and appeal) at the MCO level, further appeals should go directly to the IC.

And if pursued,

2. Establish a separate expert medical panel at the IC to resolve disputes that involve medical treatment.

Medical Payment Process

- Leading practices exist in the medical payment process. Online tools for payment look-up and appropriate reference resources for all constituents are in place and easy to navigate. Provider reimbursement policies that govern the overall structure and payment process exist and are detailed in the *Billing and Reimbursement Manual* and *MCO Policy Reference Guide*. Fee schedules are on-line and easily referenced. Appropriate incentives are in place for timeliness of medical bill submission. Timelines are incorporated into the MCO Agreement and Payment Structure with 1.25% activity set-offs for bill timing.

MCOs are required to perform bill review and to use clinical editing functions to ensure relatedness, appropriateness and compliance with UR and treatment guidelines. MCOs are required to have a nationally recognized medical bill editing criteria package. MCOs perform detailed retrospective bill audit for a small percentage of bills and BWC has found inconsistencies at a detailed level. The BWC is responsible for overall claims audit of the bills paid by the MCOs.

On average most medical payments are made well within prescribed BWC and jurisdictional timeframes (approximately 11 to 15 days, depending on the dates being measured) but fall just short of leading industry practice (7-15 days), depending on bill complexity or use of Panel/PPO). Added timeframes result from the additional level of review, required provider resubmissions, and payment transfers (EFTs) performed by the BWC.

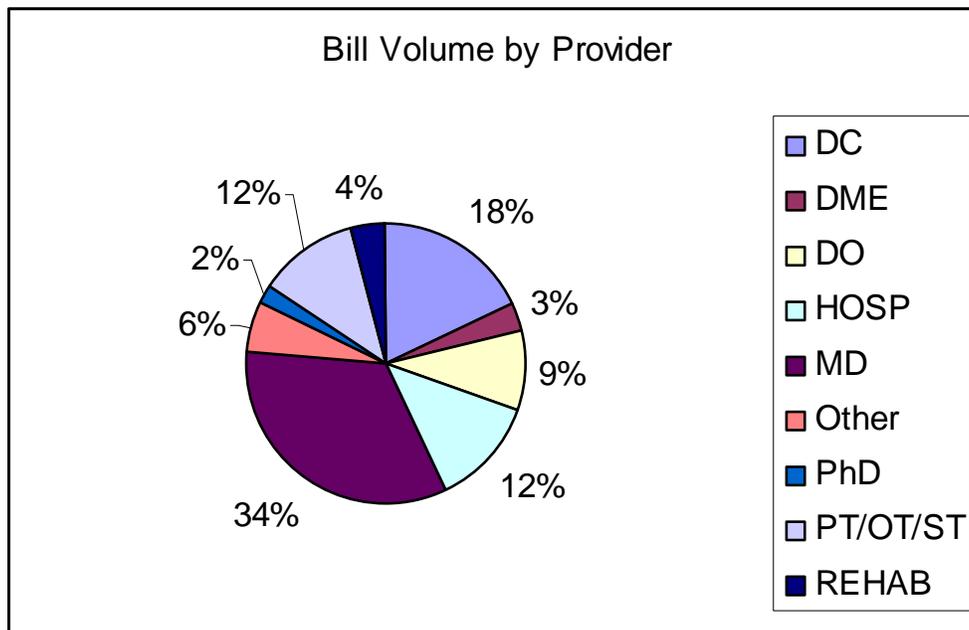
Below is detail that outlines the medical payment timeframe based on data supplied by BWC. These reflect processing of bills received by MCOs and does not include those processed directly by BWC for IMEs and pharmacy bills. Generally all date measures show improved average processing days since 2004 with the exception of the time from BWC Receipt Date to the date the 835 was sent to the MCO (includes BWC adjudication and payment authorization). Note BWC made assumptions on two dates in the process that are referenced in the Definitions Table that follows.

Average	Total Days LDOS - MCO	Total Days MCO - BWC	Total Days BWC - MCO 835	MCO 835 - Deposit	Deposit to Check	Total Process Time
2004	73.39	6.29	4.43	2.8	1.25	88.16
2005	70.76	6.32	4.35	2.8	1.25	85.48
2006	66.5	6.37	4.34	2.8	1.25	81.25
2007	66.84	6.68	4.36	2.8	1.25	81.93
2008*	68.63	6.1	4.57	2.8	1.25	83.35

*As of 6/30

Date Measure	Definitions
LDOS - MCO	Last date of Service on the bill to MCO Receipt Date of the bill
MCO - BWC	MCO Receipt Date of the bill to date bill was accepted by BWC via EDI (BWC Receipt Date)
BWC – MCO 835	BWC Receipt Date to the date the 835 was sent to the MCO - includes re-adjudication by BWC's vendor and payment authorization. The 835 is the EDI transaction that shows BWC's payment amount, EOBs applied to the bill, etc. MCOs are contractually obligated to pay amounts indicated on 835s.
MCO 835 – Deposit	There is a two business day lag between the generation of the 835 to the MCOs and when the associated money is deposited into the MCO's provider account. The 835 is issued when the EFT is initiated; the lag time is the national standard EFT lag time.
Deposit – Check	Time from the date the money is deposited into the MCO's provider account until the MCO generates the check and remit advices and mails them to the provider. This is an estimated timeframe calculated in business days, based on BWC audits. This was last audited in 2004.

3,326,595 MCO bills were processed in 2007. The following details the 2007 HPP MCO medical payment volume (number of bills) by provider type.



In 2007, most bills received by MCOs were transmitted to BWC within 4 to 7 days. BWC in turn processed most bills in the 4 to 7 day timeframe. The MCOs have some outliers (5.2% of bills with 16+ day timeframes) that suggest some improvement opportunities exist for efficiency. Some of these are explained as a result of holding medical bills until claims are allowed. Alternatively, and due to a highly automated process, BWC has very few outliers from the date BWC receives the MCO EDI to when it returns an 835 (.15%)

The administrative medical bill review process is duplicative. MCOs perform a review and the BWC rechecks and finalizes payments as part of its adjudication process. This adjudication confirms MCO, provider and claim eligibility; applies fee schedule logic; and verifies that no duplicate payments are being made. It also uses Thomson Reuters Auto Audit software to apply a limited number of clinical edits. BWC's medical bill review process is highly automated.

The process is cumbersome for providers who seek treatment requests and payment based on acceptance of ICD-9s and corresponding allowed conditions. The administrative process for updating allowed conditions is burdensome. There are retroactive requests for medical payments and poor quality / legibility documents submitted by providers. BWC reports inconsistent application of standard clinical edits as part of medical bill processing by MCOs.

As a monopolistic fund with centralized oversight, inconsistencies in marketplace vendor processing and bill review software and edits are more apparent than other jurisdictions. However, given bill review can be more than an automated process, and at times require both high level analytical and clinical skills, medical bill review also can result in different determinations. This has led to a duplicative process of BWC reviewing all bills processed by MCOs. BWC is performing the same functions as the MCOs and it is duplicative and presumably costly.

Fee Schedule

Ohio's governing fee schedule is generally viewed as requiring update to promote reimbursement sufficient for access. The proposed Professional Provider Fee Schedule has been updated and is proposed pending review of the Board and constituent input. Other medical and ancillary services covered by the fee schedule are in various stages of development. Based on proposed changes, BWC anticipates that the provider fee schedule payments of \$357,000,000 will increase by \$23,000,000 with a potential offset of enhanced clinical editing of medical bills that will reduce payments.

The BWC provider fee schedule establishes the maximum reimbursement for medical treatments and services. The provider fee schedule is derived from the Medicare RBRVS reimbursement methodology. BWC recognizes the 2008 version of the International Classification of Diseases (ICD-9-CM) and 2008 HCPCS Level I, Level II, and Level III codes.

Fee schedules are on-line at BWC's website for easy constituent reference. MCOs are required to conduct medical bill review and to adjust provider bills to the least of charges indicated, i.e. to MCO provider network fee schedule (if applicable) or to BWC fee schedule amounts.

In addition to fee schedules that contain costs, MCOs currently can create a panel of BWC certified providers within specified guidelines. Under the Ohio Administrative Code, providers that belong to a MCO provider panel are reimbursed at the least of their billed charges, the BWC fee schedule amount, or the MCO panel amount. While MCOs do not establish fees, they can discount the BWC fee schedule amount for their panel providers, which the providers agree to when a contract for panel participation is established.

BWC reimburses with a version of the Medicare DRG system for inpatient hospitalization. BWC implemented this process beginning Jan. 1, 2007 and has approximately 6,000 bills a year. The Professional Provider Fee Schedule had not been reviewed since 2004 but is currently being updated. A new schedule has been proposed and is under Board consideration.

There has been some discussion of implementing a "Blue Ribbon" approach to the fee schedule. This is a reasonable option but is a long term strategy given the need to complete the updated base fee schedule and address the challenges in a pay for performance model. The challenges include a lack of available performance measures and reporting for physicians participating in the workers' compensation system on which to base pay for performance.

Performance Assessment

We assessed the performance of the Ohio workers' compensation system compared to these four overarching themes: Effectiveness & Efficiency; Financial Strength & Stability; Transparency; and Ohio Economic Impact. Each broad study element (Ohio Benefit Structure; Pricing Process; Cost Controls; Financial Provisions; and Actuarial Department Functions & Resources) is reviewed with these themes in mind to develop a performance assessment of the current state. Our performance assessment is made on each element in the context of its contribution to supporting the overarching themes.

For these performance assessments, the following scoring method applies:

	Strongly supports system performance
	Supports system performance
	Some support for system performance
	Some opportunity for system performance change/enhancement
	Significant opportunity for system performance change/enhancement

Based on this scoring method the performance assessment for the Cost Controls area of Medical Payment follows.

Overall

	Effectiveness & Efficiency	Financial Strength & Stability	Transparency	Ohio Economic Impact
Treatment Authorization Request and ADR				
Medical Payment Process				
Fee Schedule				

Peers and Industry Standards Considered

Peers: State Comparisons – AL, DE, DC, IL, ME, NY, TN, TX, and WA
Reference Standards: State Laws, Industry Leading Practices
References: Commercially available studies (e.g., Juris Publishing, IRMI, U.S. Chamber of Commerce, U.S. Department of Labor)

- Effectiveness & Efficiency – Fee schedule methodologies meet leading practice standards but require more frequent update. Treatment authorization processes are challenged with delays. The ADR process meets industry guidelines but BWC’s overwhelming concurrence with MCO decisions results in limited value. Medical bill review is duplicative between MCOs and BWC.
- Financial Strength & Security – Medical payment policies, procedures, protocols and guidelines largely support financial strength. Fee schedules should be updated every 1-2 years to promote a “smoother” trend line of medical payments.
- Transparency – Medical payment programs support larger BWC transparency initiatives. BWC’s website provides well-documented constituent responsibilities and fee schedules are on-line for easy reference.
- Ohio Economic Impact – The overall medical payment system supports a reasonable impact on Ohio’s economy. Interests of process constituents (providers, injured workers, employers, and MCOs) are well represented.

Recommendations

The following recommendations address the opportunities identified above, listed in prioritized order:

- **Conduct Fee Schedule Update and Maintenance:** Finalize new fee schedules that support all service types in the workers' compensation system. We recommend fee schedule updates every one to two years.
- **Address Medical Payment Process Duplication:** Identify BWC medical bill payment processing costs, reduce medical payment processing duplication by advancing SMART objective initiatives and study alternative ways to achieve incremental savings.
- **Streamline Treatment Authorization Request and ADR Process:** Streamline the process by accepting MCO recommendations on medical treatment requests involving a related condition, remove the BWC level of appeal on treatment requests, and eliminate the required employer waiver in proactive allowance.

Impact

The impact (high, moderate, or low) of these recommendations as they relate to the overarching themes is shown in the following table:

	Effectiveness & Efficiency	Financial Strength & Stability	Transparency	Ohio Economic Impact
Conduct Fee Schedule Update and Maintenance				
Address Medical Payment Process Duplication				
Streamline Treatment Authorization Request and ADR Process				

Legend

High Impact	Moderate Impact	Low Impact	No Impact	Adverse Impact

The Deloitte Consulting team is available to clarify or amplify any issues raised in this report. We express our appreciation for BWC process constituents' time, effort, and guidance in completing this integral task of our comprehensive study.

Appendix A – Deliverable Matrix

Group 2 Study Elements

Ohio Benefit Structure
Award Categories
1) Compensation Types
2) Benefit and Compensation Levels
3) Number of Benefit Types

Pricing Process
Statewide Rate Level
1) Administrative Cost Calculation

Cost Controls
MCO Effectiveness
Medical Payments to Providers

Financial Provisions
Loss Reserves
1) Current Actuarial Audit Reserve Methodology
2) Independent Review
3) Expected Payments Established by Independent Actuarial Consultant
4) Loss Reserve Margins and Discount Factor
5) Performance Assessment Implications
Net Asset Level
1) Methods for Setting Net Asset Targets
2) Risk Margins
3) Disclosure
Excess Insurance and Reinsurance
1) Cost Effectiveness, Catastrophic Events, and Rate Stability

Ohio Benefit Structure Areas

Award Benefit Types	Tasks Involved
1) Compensation Types	23. Conduct a study of the benefits and compensation paid by the BWC compared to industry peers. This study would include an analysis of all compensation types and their application by the BWC.
2) Benefit and Compensation Levels	
3) Number of Benefit Types	

Pricing Process Areas

Statewide Rate Level	Tasks Involved
1) Administrative Cost Calculation	27. Conduct a study on the administrative cost calculation used in employer rates. This evaluation should include a review of the allocated and unallocated loss adjustment expenses of the BWC.

Cost Controls Areas

MCO Effectiveness	Tasks Involved
MCO Effectiveness	30. Conduct a study on the effectiveness of Managed Care Organizations (MCO) in the workers' compensation system. This analysis would include an evaluation of the effectiveness of the use of MCOs, the payments to MCOs relative to the benefits received, the advantages and disadvantages of the MCO approach, the medical cost trends since MCO implementation, and a comparison to industry standards.

Medical Payments to Providers	Tasks Involved
Medical Payments to Providers	25. Conduct a study on the medical payments to providers in Ohio and provide a comparison to industry peers. This study should recommend changes/improvements to BWC's medical payment structure in line with industry standards.

Financial Provisions Areas

Loss Reserves	Tasks Involved
1) Current Actuarial Audit Reserve Methodology	21. Review the actuarial audit reserves established by the BWC's independent actuarial consultant to establish objective quality management principles and methods by which to review the performance of the workers' compensation system.
2) Independent Review	
3) Expected Payments Established by Independent Actuarial Consultant	15. Evaluate the methodology and reasonability of the expected payments established by the BWC's independent actuarial consultant.
4) Loss Reserve Margins and Discount Factor	
5) Performance Assessment Implications	21. See above.

Net Asset Level	Tasks Involved
1) Methods for Setting Net Asset Targets	26. Conduct a study on the amount of surplus/net assets that should be held by the BWC. This study should compare the BWC to industry standards and recommend appropriate methods of setting target surplus for the BWC and the appropriate discount rate.
2) Risk Margins	
3) Disclosure	

Excess Insurance and Reinsurance	Tasks Involved
1) Cost Effectiveness, Catastrophic Events, and Rate Stability	31. Conduct an evaluation on the excess insurance or reinsurance requirements for the BWC including the need for excess coverage or reinsurance in the event of a catastrophic event. This evaluation should include the cost effectiveness of excess coverage or reinsurance, the ability of the BWC to handle a catastrophic event, and the stability in rates provided by excess insurance or reinsurance coverage. This study should include an evaluation of reinsurance requirements and a possible reinsurance program for the BWC.

Pricing Process Areas – continued

Ancillary Funds	Tasks Involved
1) Coal Workers Pneumoconiosis	7. Review and make written recommendations with regard to the Coal-Workers Pneumoconiosis Fund. This review would include a complete analysis of the rating program. This analysis should compare the methodology used in BWC’s rating calculation to industry standards the actuarial standards of practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.
2) Marine Industry Fund	10. Review and make written recommendations with regard to the Marine Industry Fund. This analysis should compare the methodology used in BWC’s rating calculation to industry standards and the Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.
3) Disabled Workers’ Relief Fund	13. Review and make written recommendations with regard to the Disabled Workers’ Relief Funds. This analysis would include a complete analysis of the funds including but not limited to the loss information, payroll information, and other rating calculations. This analysis should compare the methodology used in BWC’s rating calculation to industry standards and the Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

Appendix B – Data and Documentation

An inventory of key BWC and other source reference documents used in our analysis is highlighted below.

Constituent Sources

BWC

- Memorandum. MCO League Actuarial Report.
- Medical Services Division Smart Objectives, Last Amended April 21, 2008.
- Medical Billing Payment Process Audit March 2008.
- Agreement between Ohio Bureau of Workers Compensation and MCO: Final 12/06/07.
- MCO Policy Reference Guide, Chapter 8: Coding & Reimbursement Standards. January 2008.
- MCO Report Cards, 2000 to 2008.
- BWC Annual Report for Fiscal Year 2007.
- Draft BWC 2008 Proposed Professional Provider Fee Schedule.

MCO League of Ohio

- The Ohio Health Partnership Program. A Review of the First Nine Years (1997-2006).
- The Ohio Health Partnership Program: An Independent Actuarial Study Conducted by the Kilbourne Company, November 2007.
- 10 Years at BWC, 2005.
- Additions to the MCO Workload since the inception of HPP, Prepared September 2006.
- Understanding Ohio's Health Partnership Program (HPP) 1997-2008.
- % Change in MCO Policy Guidelines Chapter 1 to 10.

External Benchmarking Sources

Benchmarking Sources

- Workers Compensation State Laws. **International Risk Management Institute**. December 2007.
- Physician Choice/Workers Compensation MCOs. **International Risk Management Institute**. December 2007.
- Workers Compensation Medical Fee Schedules. **International Risk Management Institute**. December 2007.
- Making Workers Compensation Medical Fee Schedules More Effective. **NCCI Research Brief**. December 2007.
- Pay-for-Performance in California's Workers' Compensation Medical Treatment System. An Assessment of Options, Challenges, and Potential Benefits. **Rand Working Paper**. August 2007.
- Provider Credentialing Standard Language and Revisions for Public Comment. **URAC**. May 2008.
- Workers' Compensation Utilization Management Standard Language and Revisions for Public Comment. **URAC**. May 2008.
- Current Recognition of Best Practices Organizations. **NAIC's** Compendium of State Laws on Insurance Topics. 2007.
- Summary of Workers' Compensation Laws. Medical Benefits. **U.S. Chamber of Commerce**. 2007.
- Table 5a. Medical Benefits Provided by Workers' Compensation Statutes. **US Department of Labor**. In effect January 1, 2006.
- Multi-State Benchmarks CA, FL, IL, MA, MD, MI, NC, PA, TN, WI. **Workers' Compensation Research Institute**. 2008.
- Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006. **Workers' Compensation Research Institute**.

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu, a Swiss Verein, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.com/about for a detailed description of the legal structure of Deloitte Touche Tohmatsu and its member firms. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

Copyright © 2008 Deloitte Development LLP. All rights reserved.