

BWC Board of Directors  
**Medical Services and Safety Committee Agenda**

**Thursday, April 28, 2011**

**William Green Building**

Level 2, Room 3

2:30 P.M. – 4:00 P.M.

**Call to Order**

Jim Hummel, Committee Chair

**Roll Call**

Mike Sourek, Scribe

**Approve Minutes of March 24, 2011 meeting**

Jim Hummel, Committee Chair

**Review and Approve Agenda\***

Jim Hummel, Committee Chair

**New Business/ Action Items**

1. Motions for Board consideration:

A. For Second Reading

1. Vocational Rehab Fee Schedule

Freddie Johnson, Interim Chief of Medical Services and Compliance

Karen Fitzsimmons, Manager, Rehab Policy

2. C-9 Rule 4123-6-16.2 - Medical Treatment Reimbursement Requests

Freddie Johnson, Interim Chief of Medical Services and Compliance

3. Outpatient Medication Reimbursement Rule 4123-6-21

Johnnie Hanna, Pharmacy Program Director

4. Self-insured Outpatient Medication Reimbursement Rule 4123-6-21.1

Johnnie Hanna, Pharmacy Program Director

B. For First Reading

1. Outpatient Medication Formulary Rule 4123-6-21.3

Johnnie Hanna, Pharmacy Program Director

**Discussion Items\* \***

1. Medical Services Report

Freddie Johnson, Interim Chief of Medical Services and Compliance

2. Committee Calendar

Jim Hummel, Committee Chair

**Adjourn**

Jim Hummel, Committee Chair

**Next Meeting: Thursday, May 26, 2011**

\* Agenda subject to change

\*\* Not all discussion items may have materials

**Common Sense Business Regulation (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

**Vocational Rehabilitation Provider Fee Schedule**

**Rule 4123-18-09**

**Rule Review**

- 1.  The rule is needed to implement an underlying statute.

Citation:     R.C. 4121.61, R.C. 4121.441(A)    

- 2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The rule adopts a fee schedule for workers' compensation vocational rehabilitation services in accordance with R.C. 4121.61, R.C. 4121.441(A), and *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

- 3.  Existing federal regulation alone does not adequately regulate the subject matter.

- 4.  The rule is effective, consistent and efficient.

- 5.  The rule is not duplicative of rules already in existence.

- 6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

- 7.  The rule has been reviewed for unintended negative consequences.

- 8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: The proposed fee schedule recommended changes were on February 17, 2011, presented to and discussed with BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18). The proposed fee schedule recommendations were presented to the MCO Business Council on March 2, 2011. BWC also on March 8, 2011, provided the proposed fee schedule to the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF). On March 3, 2011 the fee schedule was placed on [Ohiobwc.com](http://Ohiobwc.com) with stakeholder and interested parties' feedback being accepted through March 16, 2011. On April 11, 2011, BWC sent notice to IARP, OPTA and OARF of consideration of potential unit of service changes for several codes.

- 9.  The rule was reviewed for clarity and for easy comprehension.

- 10.  The rule promotes transparency and predictability of regulatory activity.

11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
12.  The rule is not unnecessarily burdensome or costly to those affected by rule.  
If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_
13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors**  
**Executive Summary**  
**BWC Vocational Rehabilitation Provider Fee Schedule Rule**  
**OAC 4123-18-09**

**Introduction**

Chapter 4123-18 of the Ohio Administrative Code contains BWC rules providing for the vocational rehabilitation of injured workers in the Ohio workers' compensation system. The rules were first published as Industrial Commission (IC) rules in the early 1980's, and were converted to BWC rules in the early 1990's when H.B. 222 transferred authority over vocational rehabilitation services from the IC to BWC.

**Background Law**

Ohio Revised Code (O.R.C.) 4121.61 provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall "adopt rules, take measures, and make expenditures as it deems necessary to aid claimants who have sustained compensable injuries or incurred compensable occupational diseases . . . to return to work or to assist in lessening or removing any resulting handicap."

O.R.C. 4121.441(A) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP "to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease . . . ."

Pursuant to the 10<sup>th</sup> District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC is required to adopt changes to its provider fee schedules, including the vocational rehabilitation provider fee schedule, via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its vocational rehabilitation provider fee schedule and now proposes to adopt the revised fee schedule as an Appendix to OAC 4123-18-09.

**Proposed Changes**

The major substantive changes proposed for the vocational rehabilitation fee schedule include:

**Fee Increases**

- BWC proposes an overall increase of 1.36% to all established vocational rehabilitation fees for service.

**Elimination of Services**

- BWC proposes the elimination of W0638 Body Mechanics Education as this service is rarely used and may be accomplished using CPT codes 97110 and 97112, or 97530 for therapy.

**New Local Codes**

- BWC proposes the creation of a new local code for Training – Books, Supplies and Testing.
- BWC proposes the creation of two new local codes for Career Counseling – In Person and Career Counseling – Research and Reporting.
- BWC proposes the creation of a new local code for Job Development.

- BWC proposes the creation of a new local code for Labor Market Survey report written by the Vocational Rehabilitation Case Manager

#### Changes in Definitions

- BWC proposes changing the definition of Job Placement and Development as a single service to Job Placement and Job Development as two separate services.
- BWC proposes changing the definition of Physical Conditioning Unsupervised to include a cap for services.
- BWC proposes to allow Career Counselors, Job Club facilitators, Job Development Providers, and Job Placement Providers to be reimbursed for Other Provider Travel and Other Provider Mileage.
- Other Provider Wait Time adds Job Placement and Job Development as provider types who may be reimbursed
- Job Seeking Skills Training adds a requirement for internet job search and online applications to be included as part of the skills set.
- Job Modifications includes language to allow review of modifications costing over \$5000 by BWC safety and hygiene personnel.
- BWC proposes modifying the definition of RAW Services -- Other Provider Travel, Wait Time and Mileage to eliminate provider types who are not authorized to provide RAW Services.

#### Changes in Units of Service

- BWC is recommending modifying the unit of service time for codes that are currently in units of 1 or 2 hours to units of 15 minutes. This would not be a change in the overall time allowed for a service, just the increments in which it is billed. The service codes that would be modified to 15 minute units of service are:
  - W0702 Occupational Rehab Comprehensive initial 2 hours,
  - W0703 Occupational Rehab Comprehensive addition,
  - W0710 Work Conditioning,
  - W0662 Facility Based Work Adjustment,
  - W0620 Employer Based Work Adjustment,
  - W0635 Situational Assessment,
  - W0672 Job Coaching.
- For all services with a fifteen minute unit of service, providers shall round time spent providing the service to the nearest whole unit. So if 8 or more minutes are spent providing a unit of service it can be billed as 1 unit.

#### Stakeholder Involvement

The proposed fee schedule recommendations were presented to the MCO Business Council on March 2, 2011 and to BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18) on March 1, 2011.

BWC posted the proposed fee schedule for review by all interested parties and specifically notified the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF). A meeting was held with stakeholders on March 8, 2011 to discuss the fee schedule. The stakeholder groups were also contacted on April 11, 2011 for their review and comments concerning proposed changes to units of services. Stakeholders' questions, concerns and feedback were considered for any necessary revisions to the proposed rule.

## **4123-18-09 Vocational rehabilitation provider fee schedule.**

(A) Pursuant to sections 4121.441 and 4121.61 of the Revised Code, the bureau shall adopt rules for the provision of vocational rehabilitation services to injured workers. The administrator hereby adopts the vocational rehabilitation provider fee schedule indicated in the attached appendix A, developed with stakeholder input, effective ~~February 15, 2010~~ August 1, 2011.

(B) Notwithstanding the provisions of paragraph (A) of this rule, consistent with the provisions of division (C)(1) of section 4121.44 of the Revised Code, managed care organizations may enter into other arrangements and reimbursement agreements with medical, professional and pharmacy providers.

Effective: 8/1/2011

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.44, 4121.441, 4121.61, 4121.62, 4123.53, 4123.66

Prior Effective Dates: 2/15/2010

## **BWC 2011 Proposed Vocational Rehabilitation Services Provider Fee Schedule Summary**

### **Medical Service Enhancements**

Prompt, effective medical and vocational care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of dependable vocational rehabilitation service providers ensures injured workers get the prompt care they need. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical and/or vocational necessity. It facilitates faster recovery and a prompt, safe return to work.

The Medical Services Division has focused on improving its core medical services functions. Our goals are as follows: enhance our medical and vocational provider network, establish a better benefits plan, institute an updated and competitive provider fee schedule, improve our managed care processes, and establish excellent medical bill payment services.

### **Vocational Provider Fee Schedule**

#### **Introduction and Methodology**

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. The Ohio Bureau of Workers Compensation reimburses over 3600 vocational providers who are either independent providers or affiliated with a vocational rehabilitation service entity. An appropriate fee schedule is integral to maintaining an effective and comprehensive network of providers. An equitable and competitive fee for the right vocational service is essential to maintain a quality provider network across the wide range of necessary provider disciplines. Thus, the guiding principle is to ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network.

BWC Medical Services undertook a comprehensive review of the benefit plan and corresponding vocational fee schedule. The process for the comprehensive review included:

- A.** Reviewing specific service coverage statuses relative to indicators of vocational needs, and revising accordingly.
- B.** Assessing the existing number of service units for all services in relation to expected patterns of service delivery, and revising accordingly.
- C.** Evaluating current established fees for services, and adjusting accordingly.
- D.** Review proposed service fees and unit recommendations against other payers.

In applying the above process, the Rehabilitation Policy staff reviewed 77 local codes.

The method BWC uses to determine which services will be within the coverage plan and the fee schedule for those services is detailed below.

### **Determination of Coverage and Units of Services**

BWC performed an assessment to determine what rehabilitation services are needed to include and/or exclude from the vocational benefit plan. Consideration is given to whether particular services are in line with BWC's objectives which are providing services that most effectively facilitate an injured worker's return to work, or remain at work. Based on this review a decision is made to add, keep or remove any particular rehabilitation service.

BWC gathered information from several sources to complete this assessment. Sources included feedback from stakeholders and/or providers, data on trends in vocational rehabilitation services taken from seminars, literature reviews etc., and data research of services provided in other state's workers' compensation systems.

At the same time, BWC determined for each benefit plan service, what the appropriate number of units or range of units for that service should be. Importance was placed on ensuring the injured worker gets the right treatment at the right time and in sufficient quantity to maximize positive outcomes without creating program inefficiencies.

### **Setting Fees**

The fees for vocational rehabilitation services were also reviewed, and evaluated against the guiding principle as set forth above. As a result of that evaluation determinations were made whether fees should be increased, remain the same or decreased. Fees for any new services were also set during this step. The reimbursement level for any service took into account the Ohio environment, the existing fees and the determination of what change in fees would facilitate the achievement of the guiding principle.

After establishing the fees, BWC gathered service and reimbursement data from other payers and evaluated the established Ohio fees against the gathered information. The process for gathering comparison data involved performing research of various payers of rehabilitation services and of providers or vendors of equipment and tools. Because of the nature of local service definitions and the differences that can exist in services from one state to another, care was taken in comparing the gather data against Ohio's recommended plan and reimbursement levels. Thus, the evaluation of this data was used to add an additional confidence level check of BWC's recommended benefit plan design including reimbursement levels.

Once a decision is made about the need to adjust the base rates for specific services and fees to ensure delivery of quality services, BWC reviews the overall fee schedule to determine if there is a change to the cost of living that needs to be addressed within the fee schedule recommendations. A method for determining a relevant change in the costs of providing vocational rehabilitation services in Ohio is employed. A review of typical expenses of an

agency providing services similar to those provided within the BWC system found that approximately 78 percent of costs are directly related to the employment of personnel and their benefits. The other 22 percent of costs are related to operating expenses – facilities, utilities, goods and services. This split of 78/22 seems consistent based on the past experience of BWC’s reviewers and was used as the weighting basis for determination of the change in costs for voc rehab providers.

For the change in costs of employment, the U.S. Bureau of Labor Statics, Employment Cost Index, Private Industry Workers, Education and Health Services is consulted. This index reflects the costs of employment for workers in this industry grouping. (This occupational grouping was selected because vocational rehabilitation services are predominantly education, health and social services related.) This factor is weighted at 78%. For the purposes of the current recommendation, the Employment Cost Index for September 2010 is used and reflects approximately 1.5 percent increase from September 2009.

For the change in costs to operating and other expenses the U.S. Bureau of Labor Statistics, Consumer Price Index – Urban (CPI-U) Table 1. Consumer Price Index for All Urban Consumers: U.S. city average, by expenditure category and commodity and service group, Commodity and Service Groups, Services, is consulted. The aggregate of Services includes changes in costs in rents, utilities and other services. This factor is weighted at 22% of the overall change in costs. For the purposes of the current recommendation, CPI-U Table 1 from September 2010 is used and reflects approximately 0.8 percent increase from September 2009.

<b>Operating costs change</b>	<b>Sept. 2009</b>	<b>Sept. 2010</b>	<b>change</b>	<b>Percent of change</b>	<b>Weight<sup>3</sup></b>	<b>Weighted percent change</b>
Services <sup>1</sup>	260.14	262.32	2.18	0.84	0.22	0.18
<b>Employment cost change</b>						
Education & health services <sup>2</sup>	112.60	114.30	1.70	1.51	0.78	1.18
						1.36

<sup>1</sup> - U.S. Bureau of Labor Statistics, Table 1: Consumer Price Index - Urban (CPI-U): U.S. city average, by expenditure category and commodity and service group, commodity and service group, services from CPI-U September 2009 and September 2010

<sup>2</sup> - U.S. Bureau of Labor Statistics, Employment cost Index for total compensation, for private industry workers, by occupational group and industry, occupational group, Education and health services September 2009 and September 2010

<sup>3</sup> Weighting based on research showing in vocational rehabilitation provider company 78% of costs related to personnel and benefits while 22% related to operational costs and supplies.

## 2011 Proposed Fee Schedule Updates

### Fee Increases

- BWC proposes an overall increase of 1.36% to all established vocational rehabilitation fees for service.

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- Job Modifications has language added to allow review of modifications costing over \$5000 to be reviewed by BWC safety and hygiene personnel.
- BWC proposes modifying the definition of allowed providers under RAW Services -- Other Provider Travel, Wait and Mileage to eliminate those not authorized as part of RAW Services.

### Changes in Units of Service

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### Projected Cost Impact

The financial impact to the state fund is as follows:

1. Estimated at \$452,122 or an increase of approximately 1.42 percent over the vocational rehabilitation costs projected to be incurred for calendar year 2010,
2. Improvement in provider reimbursement,
3. Appropriate provision of benefits necessary to address Ohio's injured worker's needs, i.e. returning to work or remaining at work,
4. Fully support the guiding principle: *ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network.*



**Bureau of Workers' Compensation**

30 W. Spring St.  
Columbus, OH 43215-2256

Governor **John R. Kasich**  
Administrator/CEO **Stephen Buehrer**

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1-800-OHIOBWC

**Recommendations for changes to the vocational rehabilitation fee schedule from LMG Advisory Council, International Association of Rehabilitation Professionals (IARP), Ohio Association of Rehabilitation Facilities (OARF), and Ohio Physical Therapy Association (OPTA).**

<u>Line #</u>	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
1	<b>Methodology</b>	OARF -- If BWC implements the current fee schedule methodology, if either index decreases, will BWC reduce fees?		BWC considers a number of factors in setting and changing fees. BWC would not change the fees based solely upon the Consumer Price Index measure.	No modification to the fee schedule needed.
2	<b>Methodology</b>	IARP -- Did we consider using a Consumer Price Index for Rural areas?	The speaker believes the cost of doing business is higher in rural areas especially related to travel costs.	The methodology was developed with the help of BWC Actuarial. The CPI reflects the broadest, average data to reflect general changes of costs in the state as a whole.	No modification to the fee schedule needed.
3	<b>Methodology</b>	OPTA -- Appreciates the across the board fee increase for services; however, BWC needs to ensure that our rationale are tempered with other service benchmarks to account for disparity in the unique services.	OPTA and OARF are concerned that in the future on the Consumer Price Index will be considered and not the base rate.	BWC considers a number of factors in setting and changing fees. BWC would not change the fees based solely upon the Consumer Price Index measure.	No modification to the fee schedule needed.
4	<b>Methodology</b>	SI employer – After reviewing the proposed changes as a payer there are minimal changes that will affect overall claim costs.	Employer appreciates the Bureau understanding the increasing overall claim costs for insurers when taking into consideration increases in allowances	BWC appreciates this comment	No modification to the fee schedule is needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
5	<b>W0513 Ergonomic Implementation W0644 Ergonomic Study W0645 Job Analysis W0637 Transitional Work</b>	OPTA and OARF -- Recommend that providers of these services have their own travel time code with reimbursement reflecting the professional fee schedule for these services.	The "case manager" and "other provider" travel time is paid at 1/2 of their respective professional rates, so the physical and occupational therapists think they should be paid at 1/2 of their professional rates.	BWC recognizes the difference in travel time rates as raised by the stakeholders, however, at this point BWC believes the rates are reflective of the relative importance of each service provider in the service continuum. The case manager plays a critical role in coordinating all services. BWC will assess the appropriate response of moving to one flat travel time rate for all providers.	No modification to the fee schedule needed.
6	<b>W0523/W0524 Career Counseling</b>	IARP -- What professional qualifications are needed to provide career counseling? Did BWC consider CRCs?	Certified Rehabilitation Counselors (CRCs) are capable of providing this service too.	BWC evaluated the provider types and determined that licensed counselors would most effectively provide career counseling toward return to work. The rule reads: "Only professionals who are experienced with career counseling who have a working knowledge of the labor market, and who are licensed as one of the following provider types may provide Career Counseling services: Licensed Social Worker, Licensed Independent Social Worker, Licensed Professional Counselor, Licensed Professional Clinical Counselor, Psychologist, Doctor of Medicine or Doctor of Osteopathy. "	No modification to the fee schedule needed.
7	<b>W0523 Career Counseling – In Person</b>	MCO – Suggests that BWC include all of the acronyms or none when listing allowed provider types.	Old acronyms are used – LPC and LPCC and there is not an acronym for psychologists used in the rule.	BWC contacted the licensing board for Counselors, Social Workers, and Marriage and Family Therapists, and the board for psychologists and changed the wording to remove acronyms.	BWC clarified the rule language
8	<b>W0523/W0524 Career Counseling</b>	MCO – Does the inclusion of a Career Counseling code mean that Adjustment Counseling will no longer be an available service offered in a voc rehab plan? If not, will there still be \$2000.00 for non-allowed conditions?	The MCO notes that the definition of career counseling seems to encompass both career and adjustment counseling	Adjustment counseling will still be available through non-allowed conditions. BWC recognizes that some injured workers will benefit from adjustment counseling alone, while others will need to make a substantial change in employment addressed by Career Counseling. The \$2000.00 limit for non-allowed conditions is set by OAC 4123-18-08.	No modification to the fee schedule needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
9	<b>W0638 Body Mechanics Education</b>	OPTA -- Concerns were expressed that MCO's have denied CPT codes when "W" codes are in use on the same visit even though the policy indicates use of both is valid.	Providers have experienced this result in the past when using both CPT and W codes.	BWC has noticed the same MCO activity.	BWC has provided and will continue to provide education to MCOs regarding this issue. No modification to the fee schedule needed.
10	<b>W0648 Physical Reconditioning, Unsupervised</b>	OPTA -- Suggests that BWC change the name of this service to "Physical Fitness Facility Membership".	OPTA expressed concern that the current name might entail some liability to a professional if the injured worker were injured in their facility. IARP believes the name is fine and that the designation of "unsupervised" in the title removes any liability from the therapist.	BWC understands the comment and cannot validate that this would occur. The definition of this code is clear and historically there have been no problems with it.	No modification to the fee schedule needed.
11	<b>W0650 Job Seeking Skills Training</b>	IARP notes that the hourly rate (\$50.00 per hour based on \$5.00 per six minute unit of service) is too low.	None provided	BWC believes the reimbursement to be appropriate in that there has not been an access to care issue. BWC also notes that with the change in the last fee schedule, potential reimbursement for this service increased from a maximum of \$500 to a potential of \$750.00. BWC currently proposes increasing the fee from \$5.00 to \$5.07 or from \$50.00 per hour to \$50.70 per hour.	No modification to the current fee schedule is needed

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
12	<b>W0650 Job Seeking Skills Training (JSST)</b>	MCO – BWC should consider adding a caveat in that policy that teaching internet job search and on-line application strategies should be included IF an injured worker has a fundamental knowledge of computers use and/or the targeted job goal indicates the benefits of on-line identification of return to work options. In the absence of this basic knowledge, other training options should be considered to provide the level of support and guidance that is needed for a novice user	Requiring that all injured workers be taught internet job search and on-line applications cannot be accomplished if the injured worker is not computer literate.	BWC recognizes that within the limits of JSST, developing computer literacy is beyond the scope. It is the intent that online application and internet job search be introduced and the injured worker’s skills or skill deficits be noted. If the injured worker is not able to utilize this very important tool, the job placement provider will need to adapt job search strategies to compensate and may be an early indication of the need for additional time for the job placement specialist. If the person will need computer skills for their job goal, their unique training needs should be addressed.	No modification to the fee schedule needed.
13	<b>W0659 Job Development W0660 Job Placement</b>	IARP and OARF -- BWC should consider a different split in the number of units allowed for each service than the 40 - 40 proposal.	IARP believes that more time may be required for Job Placement. OARF believes that more time is required to do Job Development.	BWC understands both stakeholders’ comments and there is disagreement between the entities. In analyzing the issue BWC felt it was more important to separate the code into each service and will evaluate the usage of each later and change as needed.	No modification to the fee schedule needed.
14	<b>W0659 Job Development W0660 Job Placement</b>	OARF -- BWC should clarify the language concerning who may provide the service.	At this time, each definition indicates that if services are provided by someone other than the Vocational Rehabilitation Case Manager (VRCM), the other provider must provide both services.	BWC agrees with the comment from OARF. BWC's intent was that these services be provided by the case manager alone, a single job placement and job development provider alone, or by the case manager and one other provider for job placement or job development. BWC does not intend that two providers for these services in addition to the case manager would be involved in a plan.	BWC clarified the rule language.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
15	<b>W0659 Job Development W0660 Job Placement</b>	Provider -- BWC should not reduce the amount of W0660 Job Placement available by splitting the existing 80 hours with W0659 Job Development and offering 40 hour in each. Case managers should be allowed to choose whether to have the existing limit (80 hours) or to include job development when it is necessary.	Job development is not effective with the workers' compensation population, and stigmatizes the injured worker.	It has been BWC's intent that both job placement and job development services be provided to injured workers. By separating the codes, BWC gains the ability to systematically monitor the effectiveness and use of both services. As defined in the rule, job development occurs whenever there is a contact to an employer to identify openings for positions that are not currently advertised or when working with an employer to create a new job. It would be incumbent upon the developer to avoid stigmatizing the injured worker. In analyzing the issue BWC felt it was more important to separate the code into each service and will evaluate the usage of each later and change as needed.	No modification to the fee schedule needed.
16	<b>W0659 Job Development W0660 Job Placement</b>	MCO – Why is there an arbitrary split in job placement and job development?	Currently providers have the discretion of using up to 800 units for the combination of these services. The proposed definition recognizes the benefit and necessity of combining the two.	In reviewing the current combination of services, BWC has found limited usage of the job development aspects of the service code even when placement efforts alone are proving unsuccessful in aiding the injured worker's return to work. BWC believes that both services are critical to successful return to work, but finds that often only one is employed by providers.	No modification to the fee schedule is needed

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
17	<b>W0659 Job Development</b> <b>W0660 Job Placement</b>	MCO -- BWC should allow the MCO and the voc provider to have the discretion of approving one or both of these services to a combined usage of 800 units regardless of which one is rendered more or less than the other.	The services are not always necessary in equal quantities to meet the unique needs of the injured worker. The suggested division could add additional communication, discussion and coordination to monitor, render and / or manage the separation of these intrinsically related activities. It is not consistent in keeping with BWC's historical goal of lessening "hassle factors" and will result in unsuccessful closures.	In analyzing the issue BWC felt it was more important to separate the code into each service and will evaluate the usage of each later and change as needed.	No modification to the fee schedule is needed
18	<b>W0659 Job Development</b> <b>W0660 Job Placement</b>	IARP supports the separating the current Job Placement and Development into separate services. However, IARP believes the length of time for these services should be extended from 20 weeks to 26 weeks.	IARP reports that average length of unemployment for newly unemployed Americans with education and no disability is 6 months and believe BWC should increase funding/timeline in an effort to provide reasonable service delivery. IARP recognizes that there is a mechanism for services to be extended beyond 20 weeks but believes that many professionals are not asking for more weeks due to DMC/MCO resistance.	BWC notes that in the last fee schedule revision, the length of job placement was extended from 13 to 20 weeks. BWC also notes that there is a mechanism to extend services beyond 20 weeks based on the totality of considerations in service delivery to the individual to meet the person's unique needs. BWC believes that the intervention of placement and development specialists should shorten the length of time required for an injured worker to secure employment.	No modification to the fee schedule is needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
19	<b>W0659 Job Development</b> <b>W0660 Job Placement</b>	IARP asks how BWC came up with the 50/50 split.	IARP does not believe the 50/50 split is fair “access to care”. IARP believes that individual need not random split should determine the split. They believe reasonable objective data should support any baseline recommendation by BWC	BWC finds that when Job Placement and Development services have been utilized in a referral, the average number of units of service utilized is 377 units or 37.7 hours. As this is the average for delivery of both job placement and job development currently, it seems reasonable to split the allowed 800 units or 80 hours in half allowing 400 units of 40 hours of each. BWC intends to review the usage of these two codes until the next fee schedule review to determine if adjustment is needed.	No modification to the fee schedule needed.
20	<b>W0660 Job Placement</b>	Provider -- BWC should not require “frequent face to face contact” with injured workers.	Requiring face-to-face contact with injured workers does not work. This provider prefers daily contact with the injured worker (presumably through phone or email) with fewer mandatory in-person meetings	BWC notes that the requirement for “frequent face to face contact” with injured workers is currently part of the wording of the rule. There is nothing within this requirement that prevents a placement provider from having daily contact with and injured worker. At the same time, it is BWC’s expectation that there will be regular face-to-face meetings as well.	No modification to the fee schedule needed.
21	<b>W0702 W0703 Occupational Rehabilitation Comprehensive W0710 Work Conditioning</b>	OPTA -- Does BWC have a policy to address the priority of these services or in what order these services are to be rendered?	The speaker indicates that from the therapist's perspective the services are the same, so it should be that the service which reimburses better and is more intense be used first W0702/W0703.	BWC has no specific policy indicating in what order these particular services are to be provided. BWC evaluates the benefit plan so that the services needed to get the injured worker back to work are provided at the right time. Where BWC has determined that a specific order of service provision is the best practice, policies have been developed.	No modification to the fee schedule needed.
22	<b>W0702 W0703 Occupational Rehabilitation Comprehensive W0710 Work Conditioning</b>	OPTA – Recommends eliminating the local codes and the distinction between (W0702 & W0703 Occupational rehabilitation and W0710) and allow the providers to bill using CPT codes 97545 and 97546.	The reimbursement is not high enough for W0710 for smaller facilities to provide the required work simulation activities and the alternative, to be CARF accredited is burdensome, expensive and unnecessary.	The BWC definitions for the local codes are different from the CPT definitions of 97545 & 97546. BWC believes the higher standard of the CARF accredited Work Hardening program benefits injured workers.	No modification to the fee schedule needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
23	<b>W0702 W0703 Occupational Rehabilitation Comprehensive</b>	OPTA – Recommends eliminating the requirement for CARF accreditation for providers of Occupational Rehabilitation services.	Occupational rehabilitation programs are centered in the more populated areas of the state. CARF accreditation is burdensome and expensive. Other states do not require CARF. There are other measures of quality.	BWC research did not result in a finding that injured workers' access to quality care has been undermined by the requirement of CARF accreditation. BWC concluded that this accreditation provides a tool which ensures quality care for injured workers receiving this service. Using another guideline such as APTA, would require increased staffing and associated costs to create and execute surveys that could ensure quality.	No modification to the fee schedule is needed.
24	<b>W0690 Training – Books, Supplies &amp; Testing</b>	MCO -- Will this code be used for certification and testing outside of a training program, including background checks?	MCO notes that the title of the code begins with Training.	BWC intends that this code be used for occupational testing and certifications in addition to supplies and books for training. Occupational testing includes items like necessary background checks	No modification to the fee schedule is needed.
25	<b>W3039 Transferable Skills Analysis by the Vocational Rehabilitation Case Manager (VRCM)</b>	IARP would like BWC to create a code to allow job placement specialists to compile the transferable skills analysis	IARP notes that this would allow the transferable skills analysis to be done at a cost savings as the placement specialist is paid a lower rate than the VRCM.	In the course of job placement services, a job placement specialist could be reimbursed for a transferable skills analysis as a Career Counselor or Vocational Evaluator might be reimbursed in the course of their service delivery as part of that service. Transferable skills analysis is required of the VRCM prior to the initiation of several services so the code was added simply to track the delivery of the service rather than develop a new service that may be purchased independently of any other service. BWC will consider the addition of another code for tracking of transferable skills analysis by other provider types for future fee schedule revisions	No modification to the current fee schedule is needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
26	<b>W3039 Labor Market Report Writing by the Vocational Rehabilitation Case Manager</b>	IARP -- Suggest BWC change to name of this proposed code to be more inclusive of the entire service.	The speaker notes that prior to actually writing a Labor Market Survey, the VRCM would conduct research and the current proposed title seems to limit use to the report writing.	BWC does intend that the code be used for both the research and report writing components of the Labor Market Survey.	Changed name of service from "Labor Market Report Writing by the Vocational Rehabilitation Case Manager" to "Labor Market Survey by the Vocational Rehabilitation Case Manager".
27	<b>W3050 –W3051 Other Provider Travel and Wait Time</b>	OARF believes that the fee for these services should be the same as the rate for W3045 –W3046 Travel and Wait Time for the Vocational Rehabilitation Case Manager		BWC recognizes the difference in travel time rates as raised by the stakeholders, however, at this point BWC believes the rates are reflective of the relative importance of each service provider in the service continuum. The case manager plays a critical role in coordinating all services. BWC will assess the appropriate response of moving to one flat travel time rate for all providers.	No modification of fee schedule is needed

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
28	<b>W0635 Situational Work Assessment</b>	IARP recommends increasing the fee to \$40.00 per hour unit of service	IARP believes that the state of the economy supports higher incentive to look at consumer's true potential.	BWC has recommended an increase from \$37.50 to \$38.00 per hour and believes that there is not an access to care issue caused by this reimbursement recommendation.	No modification of fee schedule needed.
29	<b>W0692 Short Term Training Code</b>	IARP believes that BWC should add mileage allowance equal to that of PT provider for on-site services.	IARP believes that some consumers benefit from mobile training programs but are forced to travel with disabilities / chronic pain. Mobile short term training could be provided at a comparable rate. Adding the mileage reimbursement is a reasonable addition to the vocational program offering.	<p>In the short term, BWC does not agree with this recommendation at this time. Short term training programs are reimbursed by report based on the fees negotiated with the provider. Should an accredited academic, business or trade school develop mobile training, it would be anticipated that their fees would include any necessary mileage.</p> <p>Also it is noted that in order to return to work, the injured worker will be expected to tolerate some degree of travel to and from their place of employment. It appears that part of this recommendation is for support of mobile training programs. While there is nothing that prohibits accredited mobile programs of study, additional research is needed to determine if another type of training service should be defined by BWC.</p>	No modification of fee schedule needed.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
30	<b>Unallowed Conditions</b>	IARP believes that a local code should be created for adjustment counseling.	IARP notes that currently case managers are expected to use the category of un-allowed conditions for counseling services which are standard to the rehabilitation industry and should have provision. When un-allowed conditions category is used for counseling, there is usually no money left for other possible needed services that are presenting barriers to re-employment and / or rehab efforts	BWC does not agree with this recommendation at this time. Adjustment counseling alone is considered psychological in nature. The rehab rules allow for some expenditures for un-allowed conditions is to address the barriers that exist to return to work. At the same time, that amount is capped to ensure equity to the insurance fund and employers. It is expected that the vocational rehabilitation case manager will identify needs and prioritize requests to the best advantage of the injured worker.	No modification of fee schedule needed.
31	<b>Career Coaching Career Counseling</b>	IARP recommends creation of a local code for the service of Career Coaching that may be provided by a Certified Rehabilitation Counselor.	IARP indicates that the proposed Career Counseling is too restrictive in the requirements of providers. IARP indicates that given the cost focus and need to navigate efficiently, this service will allow CRC to deliver necessary guidance and coaching. IARP notes that BVR allows CRC to deliver "Career Counseling"	BWC expects the assigned vocational rehabilitation case manager to provide any needed career coaching as part of delivering rehabilitation services. BWC also recognizes that in some cases, when the injured worker requires a substantial change in employment, the more intensive Career Counseling service is needed. It is noted that rules governing counselor licensure, make exceptions for requirement of counseling licensure for schools and the rehabilitation services commission which do not at present apply to BWC.	No modification in the fee schedule needed.
32	<b>Transition of 1 hour and 2 hour service codes to 15 minute units</b>	IARP is in agreement with the fifteen minute increments for these services.	Sounds like a good cost containment plan to us.	BWC appreciates this comment.	BWC has added this modification to the fee schedule since the first reading.
33	<b>Transition of 1 hour and 2 hour service codes to 15 minute units</b>	OPTA asked what precipitated BWC to consider making this change.	Also, will there be plans to educate providers in particular so that they bill the correct amount?	BWC thinks this change to a smaller unit increment will allow a more accurate reimbursement of the services. Some questions have come to BWC regarding the rounding up of units of service for these hourly codes.	BWC has added this modification to the fee schedule since the first reading.

	<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
34	<b>Transition of 1 hour and 2 hour service codes to 15 minute units</b>	OARF also asked why we were considering this change.	OARF members are in agreement with this change and indicated they already use the 15 minute unit of service to track their time.		BWC has added this modification to the fee schedule since the first reading.

**2011 Common Sense Initiative Checklist (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

**OAC 4123-6-16.2**

**Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4121.441(A)

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The proposed changes reflect in part a collaboration of ideas between BWC and MCO staff to remove provider barriers to treatment in the workers' compensation system and provide quality improvement to the medical treatment reimbursement request process.

3.  The rule is effective, consistent and efficient.
4.  The rule is not duplicative of rules already in existence.
5.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.
6.  The rule has been reviewed for unintended negative consequences.
7.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC's proposed Medical Treatment Reimbursement Requests rule was e-mailed to the Medical Services Division's lists of stakeholders on March 7, 2011, with comments due back by March 21, 2011. Additionally, on March 8, 2001 BWC discussed the proposed rule with representatives from the International Association of Rehabilitation (IARP), Ohio Association of Rehabilitation Facilities (OARF), and the Ohio Physical Therapy Association (OPTA). Providers who attended Medical Services Provider forums in June and Nov 2010 were also provided an overview of the C9 initiative which included changes to the rule and related treatment request forms.

8.  The rule was reviewed for clarity and for easy comprehension.
9.  The rule promotes transparency and predictability of regulatory activity.
10.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
11.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

**BWC Board of Directors**  
**Executive Summary**  
**Medical Treatment Reimbursement Requests**

**Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules relating to the adoption of a provider fee schedule. BWC initially enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19) in February 1996.

**Background Law**

R.C. 4121.441(A)(5) and (A)(9) provide that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to injured workers, including but not limited to rules providing for:

- Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment; and
- Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques.

Pursuant to this statute, BWC adopted OAC 4123-6-16.2, requiring providers to request prior approval for all non emergency medical treatment from the MCO managing the medical part of an injured worker's claim on form C-9 or equivalent, in April 2007.

**Proposed Changes**

The major substantive changes proposed for the medical treatment reimbursement requests rule:

- Add a definition of "eligible treating provider" to the rule to clarify the provider types who may submit medical treatment reimbursement request (C-9);
- Provide that BWC may require providers to include the applicable Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS) codes in effect on the date of the request for the procedures or services being requested, and further provide that the MCO's review shall not be construed as approving or denying payment for the specific codes listed by the provider;
- Eliminate the reference to the timeframe for inactive claims being 13 months, since this has since been changed to 24 months, and replace it with a cross-reference to claim reactivation rule OAC 4123-3-15;
- Provide that medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in BWC's physical medicine rule OAC 4123-6-30, and that approval of such requests shall be valid for no longer than 30 days unless the approval specifies a longer period and such longer period is supported by the prescription;
- Provide that approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period;

- Add three more circumstances under which an MCO may dismiss a medical treatment reimbursement request without prejudice to those currently in the rule:
  - The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status;
  - The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules;
  - The MCO has requested supporting medical documentation from the submitting physician of record or eligible treating provider necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

## **Stakeholder Involvement**

BWC's proposed Medical Treatment Reimbursement Requests rule was e-mailed to the following lists of stakeholders on March 7, 2011, with comments due back by March 21, 2011:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

Additionally, on March 8, 2011 BWC discussed the proposed rule with representatives from the International Association of Rehabilitation (IARP), Ohio Association of Rehabilitation Facilities (OARF), and the Ohio Physical Therapy Association (OPTA).

Providers who attended Medical Services Provider forums in June and Nov 2010 were also provided an overview of the C9 initiative which included changes to the rule and related treatment request forms.

The proposed changes in part reflect a collaboration of ideas between BWC and MCO staff through the framework two Medical Services SMART Objectives workgroups: 1) Provider Barriers Removal & 2) C9 QI Improvement. Throughout the development revision to the rule and related business forms were shared and discussed with MCO Medical Directors (April 2009), the MCO Business Council and the MCO Quality of Care Committee (August – Dec 2010).

Currently received stakeholder and interested party responses are summarized on the Stakeholder Feedback Summary Spreadsheet.

## **4123-6-16.2 Medical treatment reimbursement requests.**

(A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.

For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor.

(B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement):

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

(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for medicare and medicaid services’ healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.

However, review of the request shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.

(D) Medical treatment reimbursement requests in inactive claims ~~which have not had activity or a request for further action within a period of time in excess of thirteen months~~ shall be processed in accordance with the provisions of rule 4123-3-15 of the Administrative Code.

(E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period.

~~(D)~~(F) The MCO may dismiss without prejudice medical treatment reimbursement requests under the following circumstances:

(1) The request has been submitted by ~~providers~~ a provider who ~~are~~ is not enrolled with the bureau and who ~~refuse~~ refuses to become enrolled, or who ~~are~~ is enrolled but non-certified and ~~are~~ is ineligible for payment as a non-certified provider under rules ~~4123-6-06.3~~ 4123-6-06.2 or ~~4123-6-12~~ 4123-6-10 of the Administrative Code or division (J) of section 4121.44 of the Revised Code.

~~(2)(E)~~ The MCO may dismiss without prejudice medical treatment reimbursement requests that are request is not accompanied by supporting medical documentation that the submitting physician of record or eligible treating provider has seen and examined the injured worker within thirty days prior to the request, or that the injured worker requested a visit with the provider, and such evidence is not provided to the MCO upon request (via form C-9A or equivalent).

~~(3)(F)~~ The MCO may dismiss without prejudice a medical treatment reimbursement request that duplicates a previous ~~medical treatment reimbursement~~ request that has been denied in a final administrative or judicial determination where the new request is not accompanied by supporting medical documentation of a new and ~~change in~~ changed circumstances impacting treatment, and such evidence is not provided to the MCO upon request (via form C-9A or equivalent).

~~(4)(G)~~ The MCO may dismiss without prejudice a medical treatment reimbursement request when the underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement. If the ~~medical treatment reimbursement~~ request includes both dates of service on or after the effective date of the settlement and dates of services prior to the effective date of the settlement, the MCO may dismiss without prejudice only that portion of the request relating to dates of service on or after the effective date of the settlement.

(5) The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status.

(6) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules.

(7) The MCO has requested supporting medical documentation from the submitting physician of record or eligible treating provider (via form C-9A or equivalent) necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

(H) If the MCO determines that any approved medical treatment reimbursement request is not medically indicated or necessary, is not producing the desired outcomes, or the injured worker is not responding, the MCO may notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered.

This decision shall be subject to alternative ~~medical~~ dispute resolution pursuant to rule 4123-6-16 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.12, 4121.44, 4121.444, 4123.66

Prior Effective Dates: 4/1/07; \_\_\_\_\_



**Bureau of Workers' Compensation**

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Governor **John R. Kasich**  
Administrator/CEO **Stephen Buehrer**

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**Stakeholder Feedback Recommendations for Changes to the 4123-6-16.2 Medical treatment reimbursement requests.**

<u>Line #</u>	<u>Rule #/Subject Matter</u>	<u>Stakeholder</u>	<u>Draft Rule Suggestions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
1	4123-6-16.2 Medical treatment reimbursement requests	Foot Care Associates, Inc. David A. Kutlick, D.P.M. <a href="mailto:kutlick@sbcglobal.net">kutlick@sbcglobal.net</a> 15700 St. Rt. 170 Suite B East Liverpool, OH 43920 (330) 385-2227	A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.	Requiring more paperwork for a provider's office is not conducive to effective time management. By forcing providers to request the opportunity to treat a patient prior to rendering services, you may just lose providers.	There is no change to the amount of paperwork – just better information on the C9 form to facilitate communication and negotiation upfront between providers and MCOs.	No change
2	4123-6-16.2 Medical treatment reimbursement requests	James R. Rough Executive Director Counselor, Social Worker & Marriage and Family Therapist Board 50 West Broad Street, Suite 1075 Columbus, Ohio 43215-5919	<u>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the</u>	Incorrect license title	<u>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-</u>	Correction has been made

		614-752-5161	<u>Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional independent clinical counselor.</u>		<u>physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u>	
3	4123-6-16.2 Medical treatment reimbursement requests	<u>RKaplansky@aol.com</u> Ronald Kaplansky, DPM		I concur with the changes/language of the proposed Ohio Administrative Code  4123-6-16.6, Medical treatment reimbursement request for medical services and supplies.		
4	4123-6-16.2 Medical treatment	Richard Robilotto	<u>For purposes of this rule,</u>	Strike " <u>advanced practice</u>	These provider types are	Recommend No change

	reimbursement requests	Workers' Compensation Manager Key Bank 216-689-0833 <a href="mailto:richard_d_robilotto@keybank.com">richard_d_robilotto@keybank.com</a>	<u>“eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u>	<u>nurse, physician assistant”</u> from the second full paragraph. Only the physician of record and those non-physician practitioner types listed that the physician of record referred the injured worker to and received approval from the MCO should have entitlement to reimbursement. Paragraph (C), strike the "may" and replace with "will" in the first sentence so that it reads, " <u>For informational purposes, the bureau may will require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested</u> "	currently allowed to submit C9s in policy – we are updating the rule to match current policy & practice.  The word “may” provides BWC with discretion to require CPT codes.	
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5	4123-6-16.2 Medical treatment reimbursement requests	<p>Brent Russell  <a href="mailto:brussell@ameritech.net">[mailto:brussell@ameritech.net]</a>  Brent C. Russell P.A.-C.</p>	<p>A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment</p>	<p>It sounds as if a C-9 would be required for every office visit, including rechecks. This would be an excessive burden to both provider and MCO staff, with potential delay of approving the appropriate care.</p>	<p>Office visits do not require prior authorization.</p>	<p>No Change</p>
6	4123-6-16.2 Medical treatment reimbursement requests	<p>Leslie Lansky <a href="mailto:llansky@rrohio.com">[mailto:llansky@rrohio.com]</a>  Leslie Lansky  Grandview Family Practice, Inc.  488-7929 x 24  488-3201 fax</p>		<p>Thank you for the proposed changes. Dr. May read through them and does not have any comments at this time.</p>		
7	4123-6-16.2 Medical treatment reimbursement requests	<p><b>From:</b> Dan Davis MD  <a href="mailto:dand@oehpmco.com">[mailto:dand@oehpmco.com]</a>  OEHP MCO Medical Director</p>	<p>(C) <u>For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services' healthcare common</u></p>	<p>1) in section (C) it says that the Bureau may request specific CPT's and the MCO is not guaranteeing payment for specific CPT's. It seems to me you want to say that the MCO may request the CPT's, or at least "the Bureau and/or the MCO."</p>	<p>1.) Bureau sets policy and so it is the Bureau may require ...  2.) The language is consistent with the Industrial Commission's practice of approving and denying services and</p>	<p>No Change</p>

			<p><u>procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.</u></p> <p><u>However, the MCO's review shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.</u></p>	<p>2) Also, related to the same section, I believe the MCO's do want to approve payment for specific CPT's whenever possible. We get requests, for instance, for "physical therapy" or "chiropractic care" and it would be much better to require specific codes and approve coverage only for those specific codes. I'm not sure why you want to say "shall not be construed as approving or denying payment for the specific codes" since I believe that's exactly what MCO's actually do.</p> <p>3) In (F) 7, I think adding a time frame (such as ten 10 days) would be a good idea.</p>	<p>not codes – the payment is for the services provided.</p> <p>3.) 10 days is already in the MCO policy guide and will be included in the BRM when we update to alert providers that MCOs may dismiss C-9s if information is not provided within 10 days of the C9A.</p>	
8	4123-6-16.2 Medical treatment reimbursement	<a href="mailto:stoneangel@earthlink.net">stoneangel@earthlink.net</a> Brianna Flint	<u>For purposes of this rule, “eligible treating provider” means a</u>	On your proposed changes, I do not see Licensed massage therapist listed?	No change from the current process for Licensed Massage Therapist - the	NO Change

	requests	P.O. Box 585 Lancaster Oh 43130 740 438 2337	<u>physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u>	We are not physical therapist as listed, or does BWC consider them one in the same under another regulation.  Are you asking for a prescription in place of a C9 from the physician	prescription if signed by the physician is the same as a C9.	
9	4123-6-16.2 Medical treatment reimbursement requests	William S. Pease, MD Physical Medicine and Rehabilitation <a href="mailto:William.pease@osumc.edu">William.pease@osumc.edu</a> 614-293-7604		Looks fine to me. Thanks		
10	4123-6-16.2 Medical treatment reimbursement requests	<a href="mailto:DBillock@aol.com">DBillock@aol.com</a> Dottie J. Billock, Patient Services Coordinator O&P Rehab. Engineering Centre Warren, OH 44484 330-856-2553 330-856-4619 - fax	<u>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice</u>	I am asking for clarification to the definition of "eligible treating provider". According to the proposed rules, we do not see where an eligible treating provider can mean an Orthotist or Prosthetist. Currently, as an	No change from the current process - the POR is the eligible treating provider	No Change

			<p><u>nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u></p>	<p>eligible Worker's Compensation provider, we are able to submit C-9's with the physician of record's approval/signature, for authorization of our services. Does this proposed rule change affect that? Please clarify.</p>		
11	4123-6-16. Medical treatment reimbursement requests	Theresa Roberts [mailto:trober1@att.net] Office Manager	<p><u>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u></p>	<p>it would be great if the physical therapist could submit the C-9 to the MCO for approval with records to back up the request. Would the POR still need to provide the orders for additional physical therapy, if so; that would just create more work on our end. A physical therapist would have to send the request to the physician for approval and then turn around and resubmit everything to the MCO for approval.</p>	<p>Yes – orders from the POR is still required per rule 4123-6-30 <b>4123-6-30 Payment for physical medicine.</b></p> <p>(B) Physical medicine must be prescribed by the physician of record or other approved treating provider licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, podiatry, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse</p>	NO Change

					midwife, or certified nurse practitioner. Physical medicine may be provided in the physician's office or referred to another licensed provider.	
12	4123-6-16.2 Medical treatment reimbursement requests	<p><b>Rick Wickstrom PT, DPT, CPE, CDMS</b>  President, WorkAbility Network  WorkAbility Wellness Center  7665 Monarch Court, Suite 109  West Chester, OH 45069  Work 513-821-7420  Mobile 513-382-5818  Fax 513-672-2552  <a href="mailto:Rick@WorkAbility.US">Rick@WorkAbility.US</a></p>	<p><u>E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all other medical treatment reimbursement requests shall be valid for no longer than six months</u></p>	<p>As an FYI, I have already gotten multiple emails from physical therapists who are particularly upset by the drafted wording in paragraph (E) language that singles out physical and occupational therapists as the only ones on the list of non-physician practitioners that are required to have a prescription and limit on treatment services. This language as worded is contrary to the intent of this rule to foster appropriate, cost-effective care.</p> <p>I appreciate your efforts and sensitivity to concerns about</p>	<p>The changes in the rule will delete the semantics barrier on C-9s to allow worksite therapy to take place and enhance transitional work.</p> <p>The need for a prescription is governed by <b>4123-6-30 Payment for physical medicine.</b></p> <p>(B) Physical medicine must be prescribed by the physician of record or other approved treating provider licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, podiatry, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse</p>	No Change

			<u>unless the approval specifies a longer period</u>	semantics and access barriers to cost-effective PT services. That is why the C-9 rule needs to provide latitude for physical therapists to evaluate and develop a plan of care without a requirement of a prescription from the POR. Disclosure of a treatment requests to POR makes more sense than imposing prescription requirement.	midwife, or certified nurse practitioner. Physical medicine may be provided in the physician's office or referred to another licensed provider.	
13	4123-6-16.2 Medical treatment reimbursement requests	Daniel J Brustein, MD, FACOEM Medical Director, University Comp Care Commerce Park IV  23240 Chagrin Blvd – Suite 301  Beachwood, OH 44122  216 488 4761	(B) Medical <b>treatment</b> reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement): (1) The requested services are reasonably related to the industrial injury (allowed conditions); (2) <i>The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions);</i> 3) The costs	In the absence of specific language that says that requests for DIAGNOSTIC procedures must be related to the allowed INJURY (rather than the allowed CONDITIONS) we will continue to see recommendations of denial by reviewers, claiming that the request is for a services related to conditions not allowed under the claim. I am not aware of language that specifically addresses	Diagnostics are addressed by rule 4123-6-31 (F)	No Change

			of the services are medically reasonable.	diagnostic (rather than treatment) procedures		
14	4123-6-16.2 Medical treatment reimbursement requests	10017 - Conger Karen MCO Business Council President	(C) <u>For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.</u>	They left out having CPT codes and place of service on the C9; they got HCPCS but not the others?	CPT codes are a level of HCPCS and this is consistent with 4123-6-25 (c) 1a.  Place of service is on the form as data element and not the rule.	NO Change

15	4123-6-16.2 Medical treatment reimbursement requests	Susan Clunk, PT Director of OT/PT Marion Area Health Center 1040 Delaware Ave Marion, OH 43302 Phone:740-383-8056 Fax: 740-383-7096 <a href="mailto:Clunks@smithclinic.com">Clunks@smithclinic.com</a> <a href="#">Marion Area Health Center</a>		No concerns at this time		
16	4123-6-16.2 Medical treatment reimbursement requests	Rhonda R. Simms <a href="mailto:rsimms@occhealth.com">[mailto:rsimms@occhealth.com]</a>	A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment	Please advise if follow up visits are considered part of the non-emergency treatment that would require authorization prior to scheduling	Office visits do not require prior authorization.	
17	4123-6-16.2 Medical treatment reimbursement requests	Amanda Sins Director, Government Relations Towner Policy Group 33 North Third Street, Suite 320 Columbus, OH 43215 (614)-221-7157	<u>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-</u>	I represent the Ohio Counseling Association. In reviewing your proposed rule 4123-6-16.2 (Medical treatment reimbursement request), I noticed that in the second paragraph, you	<u>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist,</u>	Correction has been made

		(614)-221-0756 (fax)	<p><u>physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional independent clinical counselor.</u></p>	<p>refer to "licensed independent clinical counselors". The term we use in our licensure is "licensed professional clinical counselor".</p> <p>Would you please correct that in the rule?</p>	<p><u>occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u></p>	
18	4123-6-16.2 Medical treatment reimbursement requests	<p>Lee Ann Zing Supervisor, Bill Processing Review Phone 479.621.2763 Fax 479.277.4342 <a href="mailto:lazingg@cmiw.com">lazingg@cmiw.com</a> Claims Management, Inc. PO Box 1288 Bentonville, AR 72712-1288</p>	<p><u>However, the MCO's review shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.</u></p>	<p>As a self insured payer for Worker's Compensation in the state of OH we have reviewed the changes to 4123-6-16.2. We would first like to verify that these changes will apply to self insured payers.</p> <p>The interpretation we have of this statement "<u>However, the MCO's review shall be directed to the treatment being requested, and shall not be construed as</u></p>	<p>Per 4123-6.01 Medical rules will apply to Self Insured Employers in accordance with 4123-6-.01</p>	NO Change

				<p><u>approving or denying payment for the specific codes listed by the provider”</u> is that if the C-9 contains HCPCS or CPT codes listed does not mean that those codes are allowed for payment under the workers compensation fee schedule. Is that the correct interpretation? If so this is an excellent change. When utilizing the National Correct Coding Initiative Edits (as stated in the fee schedule are applicable), codes are listed on the C-9 are currently being allowed as “approved”. With this change a self insured payer will have the ability to apply the NCCI Edits even when the codes are listed on the C-9 form.</p>		
19	4123-6-16.2 Medical treatment reimbursement	Jeffrey W. Harris, 513-891-3270, <a href="mailto:jh@harris-burgin.com">jh@harris-burgin.com</a> , attorney representing injured workers	<u>(7) The MCO has requested supporting medical documentation</u>	This section is of particular concern because it expands the MCO’s ability to dismiss	The rule indicates that additional medical is requested using the C-9A or equivalent. The C-9A form is	No Change

	requests		<p><u>from the submitting physician of record or eligible treating provider (via form C-9A or equivalent) necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.</u></p>	<p>requests rather than denying those requests (and thereby allowing for a procedural appeal/review). MCOs have already shown a proclivity toward abusing open ended rules which allow them to dismiss C9s rather than denying them. Section (F) (7) is problematic because it is worded in an open ended way which MCOs can interpret as they please. MCO's could abuse this rule by requesting whatever information they feel like and then dismissing a request because they don't get the response they want. The rule provides no boundaries that would check MCO's ability to claim that the information is inadequate. Moreover, if the MCOs do find a request inadequately supported,</p>	<p>very specific in what the MCO is seeking with a request for additional medical and the rule does not expand the MCO's discretion. In the MCO policy Guide which is an addendum to the MCO contract, it is clearly defined in policy exactly when MCOs may dismiss C9 requests with the opportunity for resubmission as soon as the requested information on C9a form is available.</p> <p>Additionally, C9 decisions and outcomes are reviewed by two units at BWC – MCO compliance and BWC quality assurance review unit. It is the intention of BWC Medical services to closely monitor MCOs on this particular issue.</p>	
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				there is no reason that they should not just deny the C9. If they are correct, the application will stay denied or more information will be submitted. If the MCO is incorrect, an appeal will be possible.		
20	4123-6-16.2 Medical treatment reimbursement requests	Diane Steffen <a href="mailto:dianes@commonwealthorthocenters.com">dianes@commonwealthorthocenters.com</a> Commonwealth Orthopedics Centers	Based on comment – stakeholder feedback is about the entire rule and policies relevant to the rule.	We have plenty of feedback about how your policy affects our treatment plans. Possibly your new governor is on track questioning unnecessary spending because everything we send on C9's is sent on for some type of hearing which has to add cost to. Your process is too complicated too many hands in the pot and the patient suffer with the unnecessary delays. And let's not mention if the	BWC statistics indicates that in 2010 approximately 21.9% of the 171,155 C9s were appeal.  <b><u>Appeal Timeframes</u></b> BWC 21 day timeframe IC 14 day timeframe  We agree that unnecessary appeals are costly to the system. The goal of the new C9 rule is to decrease appeals of requests when such requests are not ripe	No Change

				patient is off work you are paying lost wages and we have weeks of delays for decisions on our treatment plans	for decisions. This will reduce unnecessary appeals in the system by allowing certain requests to be dismissed and resubmitted when appropriate.	
21	4123-6-16.2 Medical treatment reimbursement requests	Lisa G. Keys, LMT AMTA Ohio Chapter 1st VP Government Relations <a href="mailto:lisa.keys@amtaohio.org">lisa.keys@amtaohio.org</a>  Phone 937-218-1462.	<u>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u>	I am representing the AMTA Ohio Chapter and have been asked for feedback. I would to clarify that the changes will not limited Licensed Massage Therapists to filing claims for reimbursement for services they have provided by referral/ prescription from an eligible treatment provider as an independent therapist operating from their own office.	The rule changes will not impact current process as a licensed massage therapist.	No Change
22	4123-6-16.2 Medical treatment	Scott Dowling M.D.	<u>Issue 1.)</u>	<b>Issue 1.)</b> The central question here is “who is	Response to	No Change

	reimbursement requests	<a href="mailto:asdowling@gmail.com">[mailto:asdowling@gmail.com]</a>	<p>B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement):</p> <p>(1) The requested services are reasonably related to the industrial injury (allowed conditions);</p> <p>(2) The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions);</p> <p>(3) The costs of the services are medically reasonable</p> <p>Issue 2.)</p> <p><u>(D)</u> Medical treatment</p>	<p>making the determination.” If it is the MCO alone, the determination will not necessarily reflect the medical needs of the patient as contrasted with the financial interests of the MCO. It is inevitable that the MCO is biased in this direction because it is in their financial interest. It does not imply purposeful cheating.. Only inevitable bias. These determinations should be done by an uninterested party, neither MCO nor the patient’s MD. They should be done by BWC physicians.</p> <p><b>Issue 2.)</b> What is the definition of “inactive?” It should not be left to the arbitrary decision of the MCO or anyone else.</p> <p><b>Issue 3.)</b> If this is followed, how are new treatments</p>	<p>1.) With the passage of HB. 107 which created the Health Partnership Program – MCOs are responsible for medical management of the claim which includes making the decision based on the Miller criteria. The check and balance is built into the due process of this system with opportunities for outsider review at BWC as well as the IC.</p> <p>Issue 2.) The definition for “inactive” is not an MCO decision. It is defined by BWC to be 24 months from last date of service or last activity in the claim.</p> <p>Issue 3.) <b>NEW MEDICAL TECHNOLOGIES and PROCEDURES POLICY</b> - MCO policy guide addresses new medical technologies and considerations for coverage by BWC’s benefits</p>	
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			<p>reimbursement requests in <u>inactive</u> claims <del>which have not had activity or a request for further action within a period of time in excess of thirteen months</del> shall be processed in accordance with the provisions of rule 4123-3-15 of the Administrative Code.</p> <p>Issue #3.)</p> <p><u>(6) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules.</u></p> <p><u>Issue #4</u></p> <p><u>(7) The MCO has requested supporting medical documentation from the submitting physician of record or eligible treating provider</u></p>	<p>approved? There should be a mechanism by which new or changed treatment recommendations can be accommodated.</p> <p><b>Issue 4.)</b> No problem with such reasonable requirements.</p> <p><b>Issue 5.)</b> This is a completely unacceptable change. It puts the MCO in a position to reject any treatment request it chooses to reject without recourse or justification. The terms “medically indicted,” “not producing desired outcomes,” “not responding” are undefined, indefinite and should not be accepted. All such determinations by the MCO must be open to appeal with final decision not in the hands of the MCO or the</p>	<p>plan.</p> <p>Issue#5 )</p> <p>This is not a change in the new rule. However, if the MCO changes the approval – they are required to notify all parties and all due process rights to appeal are preserved.</p> <p>Issue #6.)</p> <p>Alternative Dispute Resolution is the due process of the medical appropriateness and necessity decision based on the medical evidence with consideration of the allowed conditions in the claim resulting from their workplace accident.</p>	
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			<p><u>(via form C-9A or equivalent) necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.</u></p> <p><u>Issue #5</u></p> <p>H) If the MCO determines that any approved medical treatment reimbursement request is not medically indicated or necessary, is not producing the desired outcomes, or the injured worker is not responding, the MCO may notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered</p> <p>Issue 6.)</p> <p>This decision shall be subject to <u>alternative medical dispute</u></p>	<p>patient's attorney but in a more dispassionate person.</p> <p>A BWC appointed physician is the present, reasonable course that is followed. Unfortunately, many of these determinations are done by proprietary companies that assign them to physicians. If the MCO does not like the physician's determinations they refuse to allow that individual to continue. These determinations must be outside the financial reach of the MCO. Only back meets that criteria, answering to both MCO and injured workers.</p> <p>THIS IS BASIC FAIRNESS.</p> <p>Issue 6.) . DISPUTE RESOLUTION SHOULD BE</p>		
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			resolution pursuant to rule 4123-6-16 of the Administrative Code	MEDICAL, NOT THE UNSPECIFIED FORM OF RESOLUTION IMPLIED BY THIS CHANGE.		
23	4123-6-16.2 Medical treatment reimbursement requests	Katie O. Rogers Director of Government Affairs Ohio Physical Therapy Association 1085 Beecher Crossing North Suite B Gahanna, Ohio 43230 614-855-4109 phone 614-269-3088 direct 614-855-5914 fax	<u>E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval</u>	The proposed rule is still not consistent with current Ohio law that allows patients to be evaluated and receive treatment from licensed PT without a physician's prescription or referral.  The Ohio assembly in 2004 enacted Ohio Revised Code 4755.481, which allows patients in Ohio to benefit from PT services without prescription or referral. Nearly all insurers in Ohio reimburse PT services without script and referral.  Adding the requirements is a costly barrier to services	The prescription is required by 4123-6-30 of the administrative code.  <b>4123-6-30 Payment for physical medicine.</b>  (B) Physical medicine must be prescribed by the physician of record or other approved treating provider licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, podiatry, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse midwife, or certified nurse practitioner. Physical medicine may be provided	No Change

			<p><u>specifies a longer period</u></p>	<p>that will delay IW from receiving services.</p> <p>In order to amend current and proposed BWC rules to make consistent with the Ohio Revised Code and the intent of the General Assembly , OPTA supports and advocates that BWC delete the requirement of the prescription and referral in 4123-6-16.2 (E)</p>	<p>in the physician's office or referred to another licensed provider.</p> <p>.</p>	
24	Proposed changes to 4123-6-16.2	<p><b>From:</b> Angela  <a href="mailto:angief@rmatroy.com">[mailto:angief@rmatroy.com]</a>          Angie Fryman          RehabMed Associates Inc          James Hoover MD          Stephen Duritsch MD          998 S Dorset Road Suite 104          Troy OH 45373</p>	<p>(C) <u>For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services' healthcare common procedure coding system</u></p>	<p>We are getting demands from 1800OhioComp now to provide CPT codes on C9 approvals.</p> <p>On behalf of our two physicians, requiring CPT codes on paperwork that are not familiar to us and primarily used from 3<sup>rd</sup> party suppliers is unreasonable.</p>	<p>The intent of the CPT coding requirement is for MCO information and coordination purposes. By knowing exactly the procedure /treatment being requested, the MCO can then validate with BWC that the services are covered by BWC's benefits plan. This will allow for the</p>	No Change

			<p><u>(HCPCS) in effect on the date of the request, for the procedures or services being requested</u></p>	<p>Since the vendor or provider of the “approved service” is the one that will bill and the MCO is the one that will authorize payment, we believe that the MCO should provide the “approved codes on the C9 at the time of approval”. You will have a learning curve for every physician office staff member in the state vs. the MCO who is more familiar with the CPT codes that are appropriate. Obviously since this MCO is already requesting this be provided this is something the MCO’s want. With that being said, I think the MCO needs to do the additional work to provide the code they are willing to pay.</p> <p>Please let me know how or when we will learn if this change is in effect.</p>	<p>negotiation and dialogue up front before services are rendered. By being more specific up front, the system should see improvements in billing and faster payments for providers.</p> <p>MCOs cannot supply the code as it is provider’s responsibility to code what is being requested and treated and ultimately billed to BWC.</p> <p>If this issue is related to you as the referring physician, then please direct MCO to contact the serving provider.</p>	
25	<b>Subject:</b> Proposed 4123-6-16.2	<b>From:</b> Hannah Gribble Steven B. Van Auden, Ph.D.	<u>For purposes of this rule, “eligible treating</u>	Please pardon the fact that this feedback to "proposed	Psychologists are included in the definition of	No change

		<p>Psychologist  Phone: 330-867-7332  Email: <a href="mailto:hangsgrib@sbcglobal.net">hangsgrib@sbcglobal.net</a></p>	<p><u>provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</u></p>	<p>4123-6-16.2 medical treatment reimbursement requests," comes to you after the 3/21/11 cutoff date. I just noticed that your list of non-physician "eligible treating providers" (p.1, section A) does not include psychologists. I assume this was simply an oversight. Thank you for eliciting our feedback</p>	<p>“physician” in OAC 4123-6-01, which is referred to in the newly-added paragraph to OAC 4123-6-16.2(A); the new paragraph only lists those <u>additional non-physician provider types</u> who may file a C-9:</p>	
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**2011 Common Sense Initiative Checklist (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)  
**OAC 4123-6-21; OAC 4123-6-21.1**

**Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4123.66; R.C. 4121.441; R.C. 4123.35

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The proposed changes update reimbursement practices and clinical guidelines for the BWC pharmacy department and self insuring employers, introducing a clinical perspective to BWC's outpatient medication rules that is intended to improve outcomes for injured workers.

3.  The rule is effective, consistent and efficient.

4.  The rule is not duplicative of rules already in existence.

5.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

6.  The rule has been reviewed for unintended negative consequences.

7.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC's proposed revisions to OAC 4123-6-21 and OAC 4123-6-21.1 were e-mailed to the Medical Services Division's lists of stakeholders for review and comment on March 15, 2011, with comments due back by April 6, 2011. A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

8.  The rule was reviewed for clarity and for easy comprehension.

9.  The rule promotes transparency and predictability of regulatory activity.

10.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

11.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

**BWC Board of Directors  
Executive Summary  
Outpatient Medication Rules  
OAC 4123-6-21 and 4123-6-21.1**

## **Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers.

BWC proposes amending its outpatient medication rule, OAC 4123-6-21, to institute a clinical focus to the Bureau's method of operation. These amendments address the clinical issues of patient safety by giving the Bureau and its pharmacy department more control over how medications are reimbursed. In addition, the amendments proposed define the qualifications required of BWC's pharmacy program director to be consistent with those recently adopted in OAC 4123-6-21.2. The overarching concern of the outpatient medication rule can be found in paragraph (A), which allows the Bureau to

. . . deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of an allowed condition in a claim...

BWC proposes to revise rule OAC 4123-6-21 to by introducing a clinical perspective that is intended to improve outcomes for injured workers. This increased focus on the treatment being provided to an injured worker will be a part of the determination of whether or not a drug or class of therapeutic drugs is reasonably related to or medically necessary for treatment of an allowed condition in a claim.

Since self-insuring employers are required to pay benefits equal to or greater than BWC, where applicable BWC is proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers' outpatient medication rule, OAC 4123-6-21.1.

## **Background Law**

R.C. 4123.66(A) provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefore."

R.C. 4121.441(A) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP "to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies" to injured workers, including in paragraph (A)(8) "[d]iscounted pricing for . . . all pharmaceutical services."

## **Proposed Changes**

**BWC requests that the proposed changes to rule OAC 4123-6-21 be adopted.** The proposed changes to the rule update reimbursement practices and clinical guidelines for the pharmacy department. The proposed changes also address safety issues concerning reimbursement for particular noncertified physicians and utilize the pharmacy benefits manager

to prevent non-sterile drugs from being dispensed to injured workers. The most significant proposed changes to OAC 4123-6-21:

1. Provide that noncertified prescribers who prescribe outpatient medications may not be reimbursed, with three exceptions.
2. Create a separate category for drugs that may be prior authorized by and reimbursed through the bureau's pharmacy benefits management vendor:
  - a. Parenteral drugs (*e.g.*, drugs that are not administered in the body through the digestive tract but rather through intravenous or intramuscular injection) compounded in a physician's office that do not comply with United States Pharmacopeia (USP) standards for preparation of sterile parenteral compounded drug.
3. Add a defined dispensing fee component of three dollar and fifty cents.
4. Define the product cost as the lesser of the average wholesale price minus nine percent, or the maximum allowable cost.
5. Reinforce that BWC does not reimburse third party pharmacy billers.
6. Require pharmacy providers to:
  - Maintain a signature log verifying receipt of applicable covered medications;
  - Include prescriber information, to include the prescriber's national provider identifier (NPI) or the drug enforcement administration (DEA) number, on bills submitted electronically for payment;
  - Not pay or offer to pay any "kickback" to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services;
  - follow all applicable billing procedures as written in the Bureau's billing and reimbursement manual in effect on the billed date of service.
7. Allow the Bureau to determine the maximum allowable cost for single source and multi-source generic drugs.
8. Allow an injured worker to be reimbursed for a brand-name drug where it has been demonstrated that its generic counterpart (and other comparable generic medications within that therapeutic class) has caused allergic reactions or adverse events;
9. Allow the Bureau to deny refills requested before ninety percent of any published days supply limit has been utilized, with overrides for documented exceptions
10. Defines the role and qualifications of the bureau's pharmacy program director consistent with OAC 4123-6-21.2.

Where applicable, BWC is also proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers outpatient medication rule, OAC 4123-6-21.1 (see, *e.g.*, items 3-9 above).

### **Stakeholder Involvement**

BWC's proposed revisions to rules OAC 4123-6-21 and 4123-6-21.1 were e-mailed to the following lists of stakeholders on March 16, 2011 with comments due back by April 8, 2011:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups

- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

Stakeholder responses received by BWC will be summarized on the Stakeholder Feedback Summary Spreadsheet for the second reading of the rules.

## **4123-6-21 Payment for outpatient medication.**

(A) Medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication ~~must~~may be prescribed by ~~the physician of record in the industrial claim or by the treating physician, or by such other~~ any treating provider ~~as may be authorized by law to prescribe such medication. Reimbursement for prescriptions written by providers who are not enrolled with the bureau and who refuse to become enrolled shall be denied. Reimbursement for prescriptions written by by providers who are enrolled but non-certified shall be denied except in the following situations:~~

(1) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the claimant if the claimant's claim and treated conditions are subsequently allowed.

(2) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.

(3) The prescription is written by a non-bureau certified provider for a claimant with a date of injury prior to October 20, 1993, the provider was the claimant's physician of record prior to October 20, 1993, and the claimant has continued treatment with that non-bureau-certified provider.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be prior authorized by and reimbursed through the bureau's pharmacy benefits manager:

(1) Compounded sterile parenteral drug products.

(a) "Parenteral" drugs are injectable medications. They may include those intended for use by the intrathecal, intravenous, intramuscular, or subcutaneous routes of administration.

(b) All compounded sterile parenteral drug products must be prepared and dispensed by a licensed and enrolled pharmacy provider that is able to demonstrate compliance with the standards contained in chapter 797 of the United States pharmacopeia (USP) in effect on the billed date of service.

(2) Drug efficacy study implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(3) Extemporaneous or simple compounded prescriptions.

(F) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

~~(3) Drug Efficacy Study Implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;~~

~~(4) Extemporaneous or simple compounded prescriptions;~~

~~(5) Injectable~~Non-compounded injectable drugs not intended for self-administration;

~~(6)~~(4) Drugs used to aid in smoking cessation;

~~(7)~~(5) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

~~Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.~~

~~(F)~~(G) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage nine percent. ~~The percentage amount added or subtracted~~

~~from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.~~

(2) The dispensing fee component shall be ~~a flat rate fee, which shall be subject to annual review~~ three dollars and fifty cents.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

~~(G)~~(H) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. The bureau shall not reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the bureau for payment. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or ~~vendor~~ the bureau's pharmacy benefit manager's payment system must be used for billing purposes. The pharmacy provider shall:

(1) Maintain a signature log verifying receipt by the injured worker of applicable covered medications;

(2) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager for payment. The prescriber information must

include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the bureau, the bureau's pharmacy benefits manager, or MCO under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

~~(H)~~(I) The bureau may establish a maximum allowable cost for single source or multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations," in effect on the billed date(s) of service. The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the ~~medical policy department and shall be subject to annual review~~ bureau. ~~The~~For multi-source drugs, the bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list. For single source drugs, the maximum allowable cost shall be the drug's average wholesale price minus nine percent.

~~(H)~~(J) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication ~~for which has an applicable maximum allowable cost price~~ single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (I) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug minus nine percent. However, the bureau may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine percent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

~~(J)~~(K) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish a list of drugs identifying those drugs that are

~~considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.~~

~~(2)~~ The bureau may publish supply limitations for ~~acute and chronic~~ drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

~~(3)~~(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

~~(4)~~(3) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

~~(5)~~(4) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a ~~nonecontrolled~~ drug has been ~~increased~~changed and has a new prescription number.

Denials may be overridden by the bureau for the following documented reasons:

- (a) Previous supply was lost, stolen or destroyed;
- (b) Pharmacist entered previous wrong day supply;
- (c) Out of country vacation or travel;
- (d) Hospital or police kept the medication;
- (e) Pharmacy will be closed for more than two days.

~~(K)~~(L) ~~Through internal development or through vendor contracts, an online point-of-service adjudication system may be implemented. Upon implementation, pharmacy~~ Except as otherwise provided in paragraph (F) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers may be required to must submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's pharmacy benefits manager's established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape ~~may be refused upon implementation of an online point-of-service system~~ will not be accepted by the bureau or the bureau's pharmacy benefits manager.

~~(L)~~(M) Claimant reimbursement for medications shall ~~not exceed the bureau's established rate for the medication regardless of the price paid by the claimant~~ be in accordance with rule 4123-6-26 of the Administrative Code. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement

manual in effect on the billed date(s) of service. ~~Upon implementation of a point-of-service system, claimant~~ Claimant reimbursement may be limited to the following situations:

- (1) Claimants whose claims are not allowed on the date of service, but are subsequently allowed;
- (2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;
- (3) Claimants who reside out of the country.

~~(M)~~(N) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with ~~one or more of the following~~ current medical texts and peer reviewed medical literature:

~~(1) Compendia consistent of the following:~~

- ~~(a) "United States Pharmacopoeia—Drug Information";~~
- ~~(b) "American Medical Association Drug Evaluations";~~
- ~~(c) "Drug Facts and Comparisons"; or,~~

~~(2) Peer reviewed medical literature.~~

Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

~~(N)~~(O) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

- (1) Has a valid "terminal distributor of dangerous drugs" as defined in section ~~4729.02~~4729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,
- (2) Has a valid drug enforcement agency (DEA) number; and,
- (3) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and,
- (4) Has the ability and agrees to submit bills at the point of service. All state and federal laws relating to the practice of pharmacy and the dispensing of medication

by a duly licensed pharmacist must be observed.

~~(O)~~(P) The bureau may contract with a ~~vendor~~pharmacy benefits manager to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers, ~~and be responsible for maintaining a drug formulary.~~ The bureau may utilize other services or established procedures of the ~~vendor~~pharmacy benefits manager which may enable the bureau to control costs and utilization and detect fraud.

~~(P)~~(Q) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services, which may include reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the ~~bureau's medical policy department~~bureau.

~~(Q)~~(R) The bureau shall ~~secure the services of~~ retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. ~~The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services.~~ The ~~pharmacist~~pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may ~~consult~~adopt a drug formulary with the recommendation of the bureau's pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule ~~4123-6-22~~4123-6-21.2 of the Administrative Code, and may consult with the committee on the development and ongoing annual review of ~~the~~ drug formulary and other issues regarding medications.

~~(R)~~ The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. ~~At least thirty days written notice will be given prior to required changes in billing procedures.~~

Replaces: 4123-6-21

Effective: 10/1/05

Prior Effective Dates: 1/27/97, 1/1/03

## Stakeholder Feedback, Outpatient Medication Rules (4123-6-21 and 4123-6-21.1)

Stakeholder	Feedback	BWC Response
<p>Josanne K. Pagel MPAS, PA-C Director, PA Services Cleveland Clinic</p>	<p>Attached are my additions/edits to these documents. Thank you for the opportunity to participate. (Throughout both documents, changed the word “physician” to “provider”.) (received 3-16-11)</p>	<p>Where applicable, we have changed the word “physician” to “treating provider.” (sent 4-15-11)</p>
<p>Bonnie Fraser ActuComp Ohio LLC</p>	<p>1--How does the BWC enforce that the drugs are needed for the allowed injury? 2--The MEDCO-31 Request for Prior Authorization of Medication asks for the ICD-9 code and description, but Is there any person or computer program that reviews whether the requested drug is appropriate for the allowed condition? 3--The C-17 request for claimant reimbursement does not require the ICD-9 code. 4--Assuming that most prescription drugs are billed electronically, are ICD-9 codes and descriptions required? Is there any person or computer program that reviews whether the drug is appropriate for the allowed conditions? 5--The identity of the prescribing physician should be available to the employer and TPA so we can obtain the medical records and help the BWC ascertain whether the drugs are for treatment of the allowed condition. 6--Where is the language that states an employer's policy will be credited for all payments for all drugs that are inappropriate for the allowed conditions, like seizure drugs paid for in a forearm strain claim. 7—Why are infertility drugs specifically mentioned in (F)(2)? Does the BWC pay for prenatal, delivery and post partum services when the drugs work? Will adoption fees be paid if the infertility drugs don't</p>	<p>1--BWC uses a number of point-of-service automated edits to examine the appropriate relationship between drugs prescribed and the allowed condition. However, in first injury prescriptions, drugs related to trauma, infection, and inflammation are always approved. 2--All Medco-31's are reviewed by staff at the PBM. Those that do not have a clear ICD-9 relationship listed in the claim are reviewed by a clinical pharmacist. Any that cannot be determined as related by the PBM are referred to the BWC pharmacy department for further review and if necessary, sent to a physician for a final decision regarding whether or not to approve the drug. 3--The injured worker generates the C-17, and would not be expected to know the ICD-9 code. 4—See earlier answers. 5--The employer has access to the identity of the prescribing physician.</p>

	<p>work? If the claimant is receiving TT, the employer will be paying for the claimant to have and raise children. The claimant is unable to work, but can raise children? (received 3-18-11)</p>	<p>6—This question is unrelated to this rule. Employer credits are determined by policy. 7—The Infertility drug class includes those used to treat erectile dysfunction which can be a co-morbidity approved in a variety of claims. (sent 4-15-11)</p>
<p>Erin H. RN, BSN Nurse Case Manager WorkStar Health Services, Inc. 7116 Sennet Place West Chester, OH</p>	<p>The 4123-6-21 rule indicates MCO's can approve smoking cessation drugs as part of a "comprehensive treatment plan" - can we please get clarification of what BWC considers a "comprehensive treatment plan"? (received 3-21-11)</p>	<p>Via e-mail, a copy of the smoking cessation guidelines were sent. (sent 3-21-11)</p>
<p><i>Bridget E. McAuliffe</i> Barnes &amp; Thornburg LLPFifth Third Center21 East State Street, Suite 1850 Columbus, OH</p>	<p>I am seeking clarification on the proposed rules that require pharmacists to maintain a signature log verifying receipt of drugs for workers compensation patients, OAC 4123-6-21 (H)(1) and 4123-6-21.1 (G)(1). Are pharmacists required to keep a separate log for BWC patients, or as part of their current consultation logs? (received 3-22-11)</p>	<p>Via e-mail: The new rule does NOT require a separate log for BWC prescriptions, if the pharmacy has a current signature log that serves multiple purposes, that is fine with us. (sent 3-22-11)</p>
<p>Marti Panikkar RN CPUR  Medical Review Specialist Arkansas Best Corporation 479-785-6110 Direct Phone</p>	<p>I particularly appreciate your provision for paying based on the average wholesale price of the COMMONLY STOCKED PACKAGE SIZE plus or minus a percentage nine percent.” We are seeing in many states an outrageous abuse of AWP. Doctors are dispensing “repackaged, branded” medications at prices hundreds of times higher than the usual rate charged by retail pharmacies. Because the meds have been “repackaged” into small quantities, the repackager assigns extremely high Average “Wholesale” Prices which then must be used to calculate reimbursements that are based on AWP plus or minus formulas. I am sincerely hoping that your phrase “commonly stocked package size” is referring to the bulk package sizes generally stocked by retail</p>	<p>Doctors dispensing “repackaged, branded” medications – per your question – are not reimbursed by BWC. In this rule, commonly stocked package size refers to the bulk packages sizes generally stocked by retail pharmacies and can be reimbursed based on those Average Wholesale Prices. (sent 4-15-11)</p>

	pharmacies (100, 500, 1,000) so that we can reimburse based on THOSE AWP. (received 3-25-11)	
Dale Bertke	<p>As I was reading thru the proposed rule change for 4123-6-21 some questions came up.</p> <p>1. Under B - The bureau will be denied for claims written by a non-bureau certified prescribers. Is there a list of these prescribers published or listed somewhere, or available to the pharmacists and pharmacies filling the prescriptions?</p> <p>2. I am concerned with section K 4, Refills requested before 90 % of published day supply will be denied, except if ..... If the patient gets a 14 day supply, that means they could get their prescription filled no earlier than day 13. What if a pharmacy is closed normally on Sunday and say a Saturday or Monday due to a holiday. This would create a problem for a patient to get their medication. What about changing to 75 % to 80 - 85 % to accommodate those scenarios? (received 3-30-11)</p>	<p>The PBM will immediately reject a pharmacist's submission if the physician is decertified with a message that says in effect: Invalid Prescriber. The 90% level came out of discussions with the Pharmacy &amp; Therapeutics Committee last year. However, for clarification, we will add an item to that allows an override if the pharmacy is closed for two or more days. Upon consideration of additional stakeholder feedback, this change was dropped from the rule. It will be left at the 75%. (sent 3-30-11)</p>
Michelle Cope Director, State Public Policy NACDS	<p>I received notice that the Bureau of Workers' Compensation has issued proposed rules affecting outpatient medication. Under the proposed rules, language is being added that specifies the product reimbursement rate (which would be AWP-9%) and the dispensing fee (which would be \$3.50, and if a pharmacy provider accepts "assignment", then an additional \$2.50 incentive component.)</p> <p>However, because I have been unable to find the current rate schedule for pharmacy reimbursement &amp; fees, I cannot tell whether or not this represents a change in the current rates and fees, or not. Can you advise what the current rates &amp; fees are? (received 3-28-11)</p>	<p>There is no change to the current reimbursement fees. The rule now lists the actual dollar amount of the dispensing fees, and specific percentage of discount from AWP. (sent 4-15-11)</p>
Anita Miracle Operations Manager Sheakley Cincinnati, OH	<p>Will the BWC be providing the maximum allowable costs on their system? Will the "pharmacy fee schedule" be provided to upload to an employer's/TPA's system? If this is available now how do I get a copy? The packet refers to rule 4123-6-46 but I cannot find this on the BWC</p>	<p>The MAC pricing used by BWC is a proprietary product of the PBM. A self insured employer could contract with a PBM to have a MAC price list developed for their use.</p>

	<p>site. Where would I be able to find this? I appreciate your help. (received 3-23-11)</p>	<p>(sent 4-15-11)</p>
<p><b>Jill McCormack   Regional Director, State Government Affairs National Association of Chain Drug Stores 1502 Capitol View Drive   New Cumberland, PA</b></p>	<p>On behalf of its members operating approximately 1,674 retail pharmacies in the state of Ohio, the National Association of Chain Drug Stores (NACDS) thanks you for considering our comments on the proposed revisions to OAC 4123-6-21 &amp; OAC 4123-6-21.1. We appreciate the opportunity to provide input on these rule changes. We note that the proposed rules would add language under OAC 4123-6-21 (H)(1) &amp; OAC 4123-6-21.1 (G)(1) specifying that pharmacy providers must maintain a “signature log” verifying receipt by the injured worker of applicable covered medications. Maintaining records of receipt that include a signature is common practice in pharmacies. Depending on the recordkeeping system that a particular pharmacy employs, records of receipt can be recorded and maintained either in electronic or hard copy form. To clarify this point in the rule and accommodate the various types of recordkeeping systems that pharmacies employ to maintain records of receipt, we ask that language be inserted to specify that the “signature log” may be either a hard copy or electronic signature log.</p> <p>Additionally, we note that the proposed rules would add language under OAC 4123-6-21 (B) specifying that reimbursement for prescriptions written by non-bureau certified prescribers will be denied (except in limited circumstances). We are concerned with the addition of this language because this would place the responsibility on pharmacies to determine whether or not a prescription was issued by a bureau certified prescriber. This would be unduly burdensome, as pharmacies have no way of knowing whether or not a particular</p>	<p>The signature log does not need to be separate from the log currently kept by the pharmacy, so it can be a hard copy or electronic. However, if the log is electronic, it must still contain a true signature. The PBM will immediately reject a pharmacist’s submission if the physician is decertified with a message that says in effect: Invalid Prescriber. (sent 4-15-11)</p>

	<p>prescriber is bureau certified. Unless eligibility systems are set up under the program that could be checked prior to when a prescription is dispensed and would provide an alert to pharmacy staff that a particular prescription is not eligible for reimbursement because it was not issued by a bureau certified prescriber, pharmacies could be held unfairly responsible for recouping payment from claimants. Instead, the Bureau of Workers Compensation should utilize a process that holds claimants directly responsible for the cost of prescriptions obtained from non-bureau certified prescribers. (received 4-4-11)</p>	
<p>Lee Ann Zingg Supervisor, Bill Processing Review Claims Management, Inc. Bentonville, AR</p>	<p>Thank you for allowing feedback on proposed rules 4123-6-21.1 and 4123-6-21. As a self-insured payer, Claims Management Inc. appreciates the opportunity to provide comments, suggestions and or/questions. On 4123-6-21.1 we appreciate the additional information on the dispensing fee being listed in this rule as well as the provider billing and reimbursement manual. A question that I would like to pose on 4123-6-21.1 (L) If a point of service adjudication service is utilized and a third party pharmacy biller does submit billings to a payer, the denial EOB can state that the pharmacy must utilize the point of service adjudication system. Is that correct? My question comes from if Pharmacy X at location A normally submits through the point of service adjudication system and Pharmacy X at location B submits via a third party biller can these be denied? Or does each specific pharmacy location be a participant of the point of service adjudication system? We have several large chains that submit to us electronically but not all locations do. We want to ensure we are interpreting this correctly. 4123-6-21.1 (N) (3)- Increasing the percentage of the “days’ supply utilized” for 75% to 90% will assist in ensuring that drugs are being properly prescribed and utilized. This will especially be helpful in the narcotic arena that has been so publicized nationwide.</p>	<p>Yes, if a point of service adjudication services is utilized and a third party pharmacy biller submits billings to a payer, the denial EOB can state that the pharmacy must utilize the point of service adjudication system. And yes, if Pharmacy X at location B submits via a third party biller, it will be denied. The Pharmacy or company that dispensed the medication to the injured worker should be submitting the bill electronically. (sent 4-15-11)</p>

	<p>4123-2-21-Addition of the language on non-bureau certified providers will be helpful in managing the immediate and long term care of our claimants. As an insurer we appreciate the board’s understanding of taking care of our claimants. (received 4-5-11)</p>	
<p>Ernest Boyd, R.Ph., MBA Executive Director Ohio Pharmacists Association 2155 Riverside Dr. Columbus, Ohio 43221</p>	<p>Thank you for the opportunity to comment. Our concerns are limited to these: Refills denied at 90% of use is tighter than other third parties. Most allow 7 days prior to predicted time for refill need. Following that pattern would be more helpful to the patient.</p> <ol style="list-style-type: none"> <li>1. We are concerned with the following language: .” <u>Reimbursement for prescriptions written by non-bureau certified prescribers shall be denied except in the following situations:”</u> It is unclear how a pharmacy would know whether a prescriber is certified or not. This could result in pharmacies refusing to fill prescriptions for BWC, since they may or may not be paid.</li> </ol> <p>The reimbursement level is far below a pharmacy’s cost to dispense, which, in Ohio, has been calculated to be \$10.50. BWC prescriptions also carry a risk of being taken back, which other programs do not. We hope that the bureau will evaluate reimbursement rates based on the cost to fill the prescription. (received 4-6-11)</p>	<p>The refill level change to the rule is still under review, but for now, it will remain at 75%.</p> <p>The PBM will immediately reject a pharmacist’s submission if the physician is decertified with a message that says in effect: Invalid Prescriber.</p> <p>The fees listed in the rule are unchanged from the current level. The rule now spells out the specific dispensing fees and percentage of discount from AWP. The bureau will continue to evaluate its reimbursement position with respect to reported market costs. (sent 4-15-11)</p>

**2011 Common Sense Initiative Checklist (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)  
**OAC 4123-6-21; OAC 4123-6-21.1**

**Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4123.66; R.C. 4121.441; R.C. 4123.35

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The proposed changes update reimbursement practices and clinical guidelines for the BWC pharmacy department and self insuring employers, introducing a clinical perspective to BWC's outpatient medication rules that is intended to improve outcomes for injured workers.

3.  The rule is effective, consistent and efficient.

4.  The rule is not duplicative of rules already in existence.

5.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

6.  The rule has been reviewed for unintended negative consequences.

7.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC's proposed revisions to OAC 4123-6-21 and OAC 4123-6-21.1 were e-mailed to the Medical Services Division's lists of stakeholders for review and comment on March 15, 2011, with comments due back by April 6, 2011. A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

8.  The rule was reviewed for clarity and for easy comprehension.

9.  The rule promotes transparency and predictability of regulatory activity.

10.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

11.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

**BWC Board of Directors  
Executive Summary  
Outpatient Medication Rules  
OAC 4123-6-21 and 4123-6-21.1**

## **Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers.

BWC proposes amending its outpatient medication rule, OAC 4123-6-21, to institute a clinical focus to the Bureau's method of operation. These amendments address the clinical issues of patient safety by giving the Bureau and its pharmacy department more control over how medications are reimbursed. In addition, the amendments proposed define the qualifications required of BWC's pharmacy program director to be consistent with those recently adopted in OAC 4123-6-21.2. The overarching concern of the outpatient medication rule can be found in paragraph (A), which allows the Bureau to

. . . deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of an allowed condition in a claim...

BWC proposes to revise rule OAC 4123-6-21 to by introducing a clinical perspective that is intended to improve outcomes for injured workers. This increased focus on the treatment being provided to an injured worker will be a part of the determination of whether or not a drug or class of therapeutic drugs is reasonably related to or medically necessary for treatment of an allowed condition in a claim.

Since self-insuring employers are required to pay benefits equal to or greater than BWC, where applicable BWC is proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers' outpatient medication rule, OAC 4123-6-21.1.

## **Background Law**

R.C. 4123.66(A) provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefore."

R.C. 4121.441(A) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP "to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies" to injured workers, including in paragraph (A)(8) "[d]iscounted pricing for . . . all pharmaceutical services."

## **Proposed Changes**

**BWC requests that the proposed changes to rule OAC 4123-6-21 be adopted.** The proposed changes to the rule update reimbursement practices and clinical guidelines for the pharmacy department. The proposed changes also address safety issues concerning reimbursement for particular noncertified physicians and utilize the pharmacy benefits manager

to prevent non-sterile drugs from being dispensed to injured workers. The most significant proposed changes to OAC 4123-6-21:

1. Provide that noncertified prescribers who prescribe outpatient medications may not be reimbursed, with three exceptions.
2. Create a separate category for drugs that may be prior authorized by and reimbursed through the bureau's pharmacy benefits management vendor:
  - a. Parenteral drugs (*e.g.*, drugs that are not administered in the body through the digestive tract but rather through intravenous or intramuscular injection) compounded in a physician's office that do not comply with United States Pharmacopeia (USP) standards for preparation of sterile parenteral compounded drug.
3. Add a defined dispensing fee component of three dollar and fifty cents.
4. Define the product cost as the lesser of the average wholesale price minus nine percent, or the maximum allowable cost.
5. Reinforce that BWC does not reimburse third party pharmacy billers.
6. Require pharmacy providers to:
  - Maintain a signature log verifying receipt of applicable covered medications;
  - Include prescriber information, to include the prescriber's national provider identifier (NPI) or the drug enforcement administration (DEA) number, on bills submitted electronically for payment;
  - Not pay or offer to pay any "kickback" to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services;
  - follow all applicable billing procedures as written in the Bureau's billing and reimbursement manual in effect on the billed date of service.
7. Allow the Bureau to determine the maximum allowable cost for single source and multi-source generic drugs.
8. Allow an injured worker to be reimbursed for a brand-name drug where it has been demonstrated that its generic counterpart (and other comparable generic medications within that therapeutic class) has caused allergic reactions or adverse events;
9. Allow the Bureau to deny refills requested before ninety percent of any published days supply limit has been utilized, with overrides for documented exceptions
10. Defines the role and qualifications of the bureau's pharmacy program director consistent with OAC 4123-6-21.2.

Where applicable, BWC is also proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers outpatient medication rule, OAC 4123-6-21.1 (see, *e.g.*, items 3-9 above).

### **Stakeholder Involvement**

BWC's proposed revisions to rules OAC 4123-6-21 and 4123-6-21.1 were e-mailed to the following lists of stakeholders on March 16, 2011 with comments due back by April 8, 2011:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups

- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

Stakeholder responses received by BWC will be summarized on the Stakeholder Feedback Summary Spreadsheet for the second reading of the rules.

## **4123-6-21.1 Payment for outpatient medication by self-insuring employer.**

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication ~~must~~may be prescribed by ~~the physician of record in the industrial claim or by the treating physician, or by such other~~any treating provider ~~as may be~~ authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size ~~plus or minus a percentage~~nine percent. ~~The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.~~

(2) The dispensing fee component shall be ~~a flat rate fee determined by the bureau~~three dollars and ~~subject to annual review~~fifty cents, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage

forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

- (i) Cases where the physician has prescribed a second round of medication within the twenty-five day period
- (ii) Cases where the physician has changed the dosage;
- (iii) Cases where the medication did not last for the intended days supply;
- (iv) Cases where the medication has been lost, stolen or destroyed;
- (v) Controlled substances (which are limited to two dispensing fees per twenty-five days);
- (vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-6-46 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider shall:

(1) Maintain a signature log verifying receipt of applicable covered medications;

(2) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(4) Comply is required to follow all applicable line by line with all applicable billing instructions as published contained in the bureau's health care provider billing and

~~reimbursement manual in effect on the billed date(s) of service. At least thirty days written notice will be given prior to required changes in billing procedures.~~

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that

requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with ~~one or more of the following~~ current medical texts and peer reviewed medical literature:

~~(1) Compendia consistent of the following:~~

~~(a) "United States Pharmacopoeia—Drug Information";~~

~~(b) "American Medical Association Drug Evaluations";~~

~~(c) "Drug Facts and Comparisons"; or,~~

~~(2) Peer reviewed medical literature.~~

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape. Self-

insuring employers utilizing a point-of-service adjudication system may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point-of-service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

~~(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.~~

~~(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.~~

~~(b) Chronic maintenance medications may be limited by the self-insuring employer to a one hundred two day supply.~~

~~(2)~~ The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

~~(3)~~~~(2)~~ Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

~~(4)~~~~(3)~~ Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a ~~noncontrolled~~ drug has been ~~increased~~changed and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication;

(e) Pharmacy will be closed for more than two days.

(O) Self-insuring employers utilizing a point-of-service adjudication system may apply the maximum allowable cost list of the point-of-service adjudication system vendor ~~to~~ for multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations:" in effect on the billed date(s) of service. For single source drugs, self-insuring employers utilizing a point-of-service adjudication system may utilize as a maximum allowable cost the drug's average wholesale price minus nine percent.

(P) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which ~~has an applicable maximum allowable cost price~~ single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (O) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price ~~plus or minus the bureau established percentage~~ of the dispensed brand name drug minus nine percent. However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine percent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

~~(P)~~(Q) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Prior Effective Date: 2/1/10

## Stakeholder Feedback, Outpatient Medication Rules (4123-6-21 and 4123-6-21.1)

Stakeholder	Feedback	BWC Response
<p>Josanne K. Pagel MPAS, PA-C Director, PA Services Cleveland Clinic</p>	<p>Attached are my additions/edits to these documents. Thank you for the opportunity to participate. (Throughout both documents, changed the word “physician” to “provider”.) (received 3-16-11)</p>	<p>Where applicable, we have changed the word “physician” to “treating provider.” (sent 4-15-11)</p>
<p>Bonnie Fraser ActuComp Ohio LLC</p>	<p>1--How does the BWC enforce that the drugs are needed for the allowed injury? 2--The MEDCO-31 Request for Prior Authorization of Medication asks for the ICD-9 code and description, but Is there any person or computer program that reviews whether the requested drug is appropriate for the allowed condition? 3--The C-17 request for claimant reimbursement does not require the ICD-9 code. 4--Assuming that most prescription drugs are billed electronically, are ICD-9 codes and descriptions required? Is there any person or computer program that reviews whether the drug is appropriate for the allowed conditions? 5--The identity of the prescribing physician should be available to the employer and TPA so we can obtain the medical records and help the BWC ascertain whether the drugs are for treatment of the allowed condition. 6--Where is the language that states an employer's policy will be credited for all payments for all drugs that are inappropriate for the allowed conditions, like seizure drugs paid for in a forearm strain claim. 7—Why are infertility drugs specifically mentioned in (F)(2)? Does the BWC pay for prenatal, delivery and post partum services when the drugs work? Will adoption fees be paid if the infertility drugs don't</p>	<p>1--BWC uses a number of point-of-service automated edits to examine the appropriate relationship between drugs prescribed and the allowed condition. However, in first injury prescriptions, drugs related to trauma, infection, and inflammation are always approved. 2--All Medco-31's are reviewed by staff at the PBM. Those that do not have a clear ICD-9 relationship listed in the claim are reviewed by a clinical pharmacist. Any that cannot be determined as related by the PBM are referred to the BWC pharmacy department for further review and if necessary, sent to a physician for a final decision regarding whether or not to approve the drug. 3--The injured worker generates the C-17, and would not be expected to know the ICD-9 code. 4—See earlier answers. 5--The employer has access to the identity of the prescribing physician.</p>

	<p>work? If the claimant is receiving TT, the employer will be paying for the claimant to have and raise children. The claimant is unable to work, but can raise children? (received 3-18-11)</p>	<p>6—This question is unrelated to this rule. Employer credits are determined by policy. 7—The Infertility drug class includes those used to treat erectile dysfunction which can be a co-morbidity approved in a variety of claims. (sent 4-15-11)</p>
<p>Erin H. RN, BSN Nurse Case Manager WorkStar Health Services, Inc. 7116 Sennet Place West Chester, OH</p>	<p>The 4123-6-21 rule indicates MCO's can approve smoking cessation drugs as part of a "comprehensive treatment plan" - can we please get clarification of what BWC considers a "comprehensive treatment plan"? (received 3-21-11)</p>	<p>Via e-mail, a copy of the smoking cessation guidelines were sent. (sent 3-21-11)</p>
<p><i>Bridget E. McAuliffe</i> Barnes &amp; Thornburg LLPFifth Third Center21 East State Street, Suite 1850 Columbus, OH</p>	<p>I am seeking clarification on the proposed rules that require pharmacists to maintain a signature log verifying receipt of drugs for workers compensation patients, OAC 4123-6-21 (H)(1) and 4123-6-21.1 (G)(1). Are pharmacists required to keep a separate log for BWC patients, or as part of their current consultation logs? (received 3-22-11)</p>	<p>Via e-mail: The new rule does NOT require a separate log for BWC prescriptions, if the pharmacy has a current signature log that serves multiple purposes, that is fine with us. (sent 3-22-11)</p>
<p>Marti Panikkar RN CPUR  Medical Review Specialist Arkansas Best Corporation 479-785-6110 Direct Phone</p>	<p>I particularly appreciate your provision for paying based on the average wholesale price of the COMMONLY STOCKED PACKAGE SIZE plus or minus a percentage nine percent.” We are seeing in many states an outrageous abuse of AWP. Doctors are dispensing “repackaged, branded” medications at prices hundreds of times higher than the usual rate charged by retail pharmacies. Because the meds have been “repackaged” into small quantities, the repackager assigns extremely high Average “Wholesale” Prices which then must be used to calculate reimbursements that are based on AWP plus or minus formulas. I am sincerely hoping that your phrase “commonly stocked package size” is referring to the bulk package sizes generally stocked by retail</p>	<p>Doctors dispensing “repackaged, branded” medications – per your question – are not reimbursed by BWC. In this rule, commonly stocked package size refers to the bulk packages sizes generally stocked by retail pharmacies and can be reimbursed based on those Average Wholesale Prices. (sent 4-15-11)</p>

	pharmacies (100, 500, 1,000) so that we can reimburse based on THOSE AWP. (received 3-25-11)	
Dale Bertke	<p>As I was reading thru the proposed rule change for 4123-6-21 some questions came up.</p> <p>1. Under B - The bureau will be denied for claims written by a non-bureau certified prescribers. Is there a list of these prescribers published or listed somewhere, or available to the pharmacists and pharmacies filling the prescriptions?</p> <p>2. I am concerned with section K 4, Refills requested before 90 % of published day supply will be denied, except if ..... If the patient gets a 14 day supply, that means they could get their prescription filled no earlier than day 13. What if a pharmacy is closed normally on Sunday and say a Saturday or Monday due to a holiday. This would create a problem for a patient to get their medication. What about changing to 75 % to 80 - 85 % to accommodate those scenarios? (received 3-30-11)</p>	<p>The PBM will immediately reject a pharmacist's submission if the physician is decertified with a message that says in effect: Invalid Prescriber. The 90% level came out of discussions with the Pharmacy &amp; Therapeutics Committee last year. However, for clarification, we will add an item to that allows an override if the pharmacy is closed for two or more days. Upon consideration of additional stakeholder feedback, this change was dropped from the rule. It will be left at the 75%. (sent 3-30-11)</p>
Michelle Cope Director, State Public Policy NACDS	<p>I received notice that the Bureau of Workers' Compensation has issued proposed rules affecting outpatient medication. Under the proposed rules, language is being added that specifies the product reimbursement rate (which would be AWP-9%) and the dispensing fee (which would be \$3.50, and if a pharmacy provider accepts "assignment", then an additional \$2.50 incentive component.)</p> <p>However, because I have been unable to find the current rate schedule for pharmacy reimbursement &amp; fees, I cannot tell whether or not this represents a change in the current rates and fees, or not. Can you advise what the current rates &amp; fees are? (received 3-28-11)</p>	<p>There is no change to the current reimbursement fees. The rule now lists the actual dollar amount of the dispensing fees, and specific percentage of discount from AWP. (sent 4-15-11)</p>
Anita Miracle Operations Manager Sheakley Cincinnati, OH	<p>Will the BWC be providing the maximum allowable costs on their system? Will the "pharmacy fee schedule" be provided to upload to an employer's/TPA's system? If this is available now how do I get a copy? The packet refers to rule 4123-6-46 but I cannot find this on the BWC</p>	<p>The MAC pricing used by BWC is a proprietary product of the PBM. A self insured employer could contract with a PBM to have a MAC price list developed for their use.</p>

	<p>site. Where would I be able to find this? I appreciate your help. (received 3-23-11)</p>	<p>(sent 4-15-11)</p>
<p><b>Jill McCormack   Regional Director, State Government Affairs National Association of Chain Drug Stores 1502 Capitol View Drive   New Cumberland, PA</b></p>	<p>On behalf of its members operating approximately 1,674 retail pharmacies in the state of Ohio, the National Association of Chain Drug Stores (NACDS) thanks you for considering our comments on the proposed revisions to OAC 4123-6-21 &amp; OAC 4123-6-21.1. We appreciate the opportunity to provide input on these rule changes. We note that the proposed rules would add language under OAC 4123-6-21 (H)(1) &amp; OAC 4123-6-21.1 (G)(1) specifying that pharmacy providers must maintain a “signature log” verifying receipt by the injured worker of applicable covered medications. Maintaining records of receipt that include a signature is common practice in pharmacies. Depending on the recordkeeping system that a particular pharmacy employs, records of receipt can be recorded and maintained either in electronic or hard copy form. To clarify this point in the rule and accommodate the various types of recordkeeping systems that pharmacies employ to maintain records of receipt, we ask that language be inserted to specify that the “signature log” may be either a hard copy or electronic signature log.</p> <p>Additionally, we note that the proposed rules would add language under OAC 4123-6-21 (B) specifying that reimbursement for prescriptions written by non-bureau certified prescribers will be denied (except in limited circumstances). We are concerned with the addition of this language because this would place the responsibility on pharmacies to determine whether or not a prescription was issued by a bureau certified prescriber. This would be unduly burdensome, as pharmacies have no way of knowing whether or not a particular</p>	<p>The signature log does not need to be separate from the log currently kept by the pharmacy, so it can be a hard copy or electronic. However, if the log is electronic, it must still contain a true signature. The PBM will immediately reject a pharmacist’s submission if the physician is decertified with a message that says in effect: Invalid Prescriber. (sent 4-15-11)</p>

	<p>prescriber is bureau certified. Unless eligibility systems are set up under the program that could be checked prior to when a prescription is dispensed and would provide an alert to pharmacy staff that a particular prescription is not eligible for reimbursement because it was not issued by a bureau certified prescriber, pharmacies could be held unfairly responsible for recouping payment from claimants. Instead, the Bureau of Workers Compensation should utilize a process that holds claimants directly responsible for the cost of prescriptions obtained from non-bureau certified prescribers. (received 4-4-11)</p>	
<p>Lee Ann Zingg Supervisor, Bill Processing Review Claims Management, Inc. Bentonville, AR</p>	<p>Thank you for allowing feedback on proposed rules 4123-6-21.1 and 4123-6-21. As a self-insured payer, Claims Management Inc. appreciates the opportunity to provide comments, suggestions and or/questions. On 4123-6-21.1 we appreciate the additional information on the dispensing fee being listed in this rule as well as the provider billing and reimbursement manual. A question that I would like to pose on 4123-6-21.1 (L) If a point of service adjudication service is utilized and a third party pharmacy biller does submit billings to a payer, the denial EOB can state that the pharmacy must utilize the point of service adjudication system. Is that correct? My question comes from if Pharmacy X at location A normally submits through the point of service adjudication system and Pharmacy X at location B submits via a third party biller can these be denied? Or does each specific pharmacy location be a participant of the point of service adjudication system? We have several large chains that submit to us electronically but not all locations do. We want to ensure we are interpreting this correctly. 4123-6-21.1 (N) (3)- Increasing the percentage of the “days’ supply utilized” for 75% to 90% will assist in ensuring that drugs are being properly prescribed and utilized. This will especially be helpful in the narcotic arena that has been so publicized nationwide.</p>	<p>Yes, if a point of service adjudication services is utilized and a third party pharmacy biller submits billings to a payer, the denial EOB can state that the pharmacy must utilize the point of service adjudication system. And yes, if Pharmacy X at location B submits via a third party biller, it will be denied. The Pharmacy or company that dispensed the medication to the injured worker should be submitting the bill electronically. (sent 4-15-11)</p>

	<p>4123-2-21-Addition of the language on non-bureau certified providers will be helpful in managing the immediate and long term care of our claimants. As an insurer we appreciate the board’s understanding of taking care of our claimants. (received 4-5-11)</p>	
<p>Ernest Boyd, R.Ph., MBA Executive Director Ohio Pharmacists Association 2155 Riverside Dr. Columbus, Ohio 43221</p>	<p>Thank you for the opportunity to comment. Our concerns are limited to these: Refills denied at 90% of use is tighter than other third parties. Most allow 7 days prior to predicted time for refill need. Following that pattern would be more helpful to the patient.</p> <ol style="list-style-type: none"> <li>1. We are concerned with the following language: .” <u>Reimbursement for prescriptions written by non-bureau certified prescribers shall be denied except in the following situations:”</u> It is unclear how a pharmacy would know whether a prescriber is certified or not. This could result in pharmacies refusing to fill prescriptions for BWC, since they may or may not be paid.</li> </ol> <p>The reimbursement level is far below a pharmacy’s cost to dispense, which, in Ohio, has been calculated to be \$10.50. BWC prescriptions also carry a risk of being taken back, which other programs do not. We hope that the bureau will evaluate reimbursement rates based on the cost to fill the prescription. (received 4-6-11)</p>	<p>The refill level change to the rule is still under review, but for now, it will remain at 75%.</p> <p>The PBM will immediately reject a pharmacist’s submission if the physician is decertified with a message that says in effect: Invalid Prescriber.</p> <p>The fees listed in the rule are unchanged from the current level. The rule now spells out the specific dispensing fees and percentage of discount from AWP. The bureau will continue to evaluate its reimbursement position with respect to reported market costs. (sent 4-15-11)</p>

## **2011 Common Sense Initiative Checklist (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

### **Rule 4123-6-21.3**

#### **Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4121.441; R.C. 4123.66

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): This rule allows the bureau to improve the efficiency and safety of treatment for injured workers by implementing a formulary of approved medications. A formulary provides the prescriber with information regarding any restrictions or limitations to the use of an approved medication. The use of a formulary enhances medication safety by allowing for a thorough review of the clinical merits of new medications before they are approved for reimbursement. It also provides a statutory process by which the bureau may remove or limit the inappropriate utilization of medications in keeping with FDA recommendations as well as those found in current clinical literature and best medical practices.

3.  The rule is effective, consistent and efficient.

4.  The rule is not duplicative of rules already in existence.

5.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

6.  The rule has been reviewed for unintended negative consequences.

7.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC's proposed changes to the rule were e-mailed to the BWC Medical Division's list of stakeholders on April 18, 2011. Stakeholders were given until May 13, 2011, to submit comments. The proposed rule was also discussed in the BWC Pharmacy & Therapeutics Committee meeting on March 9, 2011.

8.  The rule was reviewed for clarity and for easy comprehension.

9.  The rule promotes transparency and predictability of regulatory activity.

10.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

11.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

**BWC Board of Directors**  
**Executive Summary**  
**Outpatient Medication Formulary Rule**  
**OAC 4123-6-21.3**

**Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers.

The overarching concern of OAC 4123-6-21, the outpatient medication payment rule, can be found in paragraph (A), which allows the Bureau to

. . . deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of an allowed condition in a claim...

OAC 4123-6-21(O) currently provides that BWC may maintain a drug formulary. A formulary is a list of drugs approved for reimbursement when prescribed to treat conditions allowed in the claim.

**BWC proposes new rule OAC 4123-6-21.3 to establish an outpatient medication formulary. The formulary will be developed and maintained with the recommendation of the BWC Pharmacy & Therapeutics Committee (P&T Committee) pursuant to its responsibilities as set forth in OAC 4123-6-21.2.**

**Background Law**

R.C. 4123.66(A) provides that the BWC Administrator “shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper,” and that the Administrator “may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefore.”

R.C. 4121.441(A) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP “to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies” to injured workers, including in paragraph (A)(8) “[d]iscounted pricing for . . . all pharmaceutical services.”

**Proposed Rule**

BWC proposes new rule OAC 4123-6-21.3 to improve the efficiency of treatment for injured workers by providing prescribers with a concise list of medications that can be utilized for treatment of approved conditions related to the claim. The formulary also provides the prescriber with information regarding any restrictions or limitations to the use of an approved medication. Likewise the prescriber will know that if a medication is not listed in the formulary, then it will not be reimbursed for treatment of any conditions in a claim. The use of a formulary enhances medication safety by allowing time for the P&T Committee to conduct a thorough review of the clinical merits of new medications before they are approved for use. It will also provide a statutory process by which the bureau may remove or limit the inappropriate utilization of medications in keeping with FDA recommendations as well as current clinical literature and best medical practices.

BWC requests that proposed rule OAC 4123-6-21.3 be adopted.

### **Stakeholder Involvement**

BWC's proposed rule OAC 4123-6-21.3 was e-mailed to the following lists of stakeholders on April 13, 2011 with comments due back by May 6, 2011:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

A draft of proposed rule OAC 4123-6-21.3 and a draft of the formulary appendix was reviewed by the P&T Committee at its meeting on March 9, 2011. The Committee voted to recommend that the Administrator adopt the rule and formulary.

Stakeholder responses received by BWC will be summarized on the Stakeholder Feedback Summary Spreadsheet for the second reading of the rules.

### **4123-6-21.3 Outpatient Medication Formulary.**

(A) The administrator hereby adopts the formulary indicated in appendix A to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee, effective September 1, 2011.

(B) The formulary indicated in appendix A to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of an occupational injury or disease in an allowed claim. Drugs not listed in the formulary are not eligible for reimbursement by the bureau.

(C) The formulary indicated in appendix A to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed annually and updated as necessary. The most current version will be electronically published by the bureau.

(D) Based upon current medical literature and generally accepted best clinical practices the bureau's pharmacy and therapeutics committee shall evaluate and make recommendations to the administrator regarding the addition, deletion or modification of coverage of medications listed in the formulary. Requests for pharmacy and therapeutics committee action on a specific drug may be initiated by the bureau's administrator, chief of medical services, chief medical officer, or pharmacy director.

(E) The bureau shall develop policies to perform an expedited review process for clinically or therapeutically unique medications. The bureau shall also develop policies to address the timely review of new drug products.

Effective: 9/1/11

# Medical Services Division Board Report

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The Medical Services Division coordinates BWC's health-care services through a network of providers and managed care organizations (MCOs). The goal is to ensure prompt, quality, cost-effective health care for injured workers to facilitate their early, safe and sustained return to work and quality of life. To realize this goal, the division use management, pricing and payment strategies that benefit injured workers and employers while ensuring that those benefits are related to the workers' compensation injury or injuries.

The Medical Services Division to achieve the above business goal has a focus of 4 business objectives:

1. Develop, maintain and execute quality and cost-effective medical, vocational rehabilitation and pharmaceutical benefits plans and associated fee schedules;
2. Develop and support the appropriate managed-care processes, including contract management and training;
3. Establish and maintain a quality pool of medical and vocational service providers to make certain injured workers have access to quality, cost-effective and timely care;
4. Evaluate and process medical bills, guaranteeing proper and timely payment consistent with benefits plan criteria.

The Medical Services report for this month highlights a few activities related to the 3<sup>rd</sup> and 4<sup>th</sup> business objectives.

## **I. Establish and maintain a quality pool of medical and vocational service providers to make certain injured workers have access to quality, cost-effective and timely care**

### **Developing Provider Performance Measurements**

#### **1. Medical Providers Measurement Development (WILMAPC)**

On February 10, 2010, a performance-driven approach to managing state agency workers disability was implemented. The state agencies and the labor unions share a common goal which is ensuring that injured employees receive effective and efficient care resulting in a timely and safe return to work. The program was developed by a joint effort between DAS and Ohio's labor unions representing state agency employees. BWC is providing ongoing subject matter expertise and consulting for the project. The name of the program is WILMAPC, Workplace Injury Labor management Approved Provider Committee. This program is also consistent with Deloitte recommendations for improving provider performance.

In summary, the program provides an option to a state agency employee who has been injured at work to receive 100% of their salary<sup>1</sup> or the current workers compensation indemnity rate during a lost time claim. Where an injured employee selects a provider from

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<sup>1</sup> 100% of salary reflect program of salary continuation or occupational injury leave.

## Medical Services Division Board Report

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the WILMAPC approved provider panel to manage their workers' compensation claim they will receive 100% of their salary. If an injured worker opts to select a provider outside the panel, they will have their claim managed under the workers' compensation system exclusively and receive the standard workers' compensation indemnity benefit for a lost time claim. A webpage is provided on DAS's website which provides program details and is used by injured workers to locate an approved provider to address their workers compensation medical needs.

The approved provider panel has approximately 11,000 providers. Providers can also go to the DAS webpage where a detail description of each provider performance metrics is found. As the program has progressed, provider awareness and desire to participate has continued to grow. This is evidenced by the fact that a number of providers who were not initially invited to join the panel have requested inclusion and have been included on the panel. The fact that providers are willing to be subjected to the measurement is viewed as a positive in relation to the identification of the appropriate measures and the validation of the same. Since its inception, the panel has managed about 1,100 state agency workers compensation claims. Initial results of program data indicate that approximately 750 different providers were involved in the care of workers in those claims.

Providers are being measured on 4 key metrics. The four metrics are:

1. Absence Duration 40%
2. Release Return to work (RTW) 30%
3. Relapse Rate 20%
4. Average Medical Costs 10%.

After each quarter of performance, BWC calculates the rates after a 90 day run out period and the results are published for each of the providers to review on a DAS secure website/

The BWC has calculated the providers' performance scores across the four performance measures for the periods of June 30, 2010 and October 30, 2010, with such being posted for providers to view. As of the run out period ending September 30, 2010, 744 provider's results addressing 1181 claims were included. Of the 744 providers, at the time there were 59 or 8% falling in the unacceptable category.

Scores for the periods ending December 31, 2010 and March 31, 2011 is being calculated and will be posted on the website in mid-May. Results for the period ending March 31, 2011 will be used to determine continued provider panel status as this period will mark one year of performance measurement under the WILMAPC program. Once the results for the first year has been reviewed and synthesized, BWC will be setting forth our next strategy steps for full development and rollout of a Blue Ribbon provider concept for the workers compensation environment as a whole. We anticipate that this strategy will be developed and submitted for approval to the administrator in late fall of 2011.

# Medical Services Division Board Report

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## 2. Vocational Rehabilitation Performance Measures

The Vocational Rehabilitation Policy team has been focusing on development performance measures for vocational rehabilitation service providers. There are two tiers of measurements the team is working to develop. The first tier of measurement will focus on the case managers. Case managers are responsible of the evaluation of an injured worker's needs, the development of the vocational plan to address those needs, and the coordination of services and all persons relevant to a successful execution of the plan and successful return to work. The measures, expected to be in place by June, is the first step in a broader infrastructure strategy which will include the development a "tool" to objectively assign vocational rehabilitation case managers to vocational rehabilitation cases, based upon their performance. This will address a perceived assignment bias currently reflected in the system relative to assignment of vocational rehabilitation cases, and ultimately ensure that the highest quality providers are serving injured workers within vocational rehabilitation, thus, improving outcomes. The team has identified 6 performance measurements which they are now in the process of validating and assigning weights. The 6 performance measures to be measured are as follows:

1. Return to Work (RTW)
2. Stability of RTW
3. Rate of plans approved on first submission of the plan or amendment
4. Duration of vocational rehabilitation services
5. Cost of vocational rehabilitation services
6. Injured worker satisfaction

The second tier of measurement will focus on a stratification of 2<sup>nd</sup> tier rehab providers. These are providers to whom vocational case managers will refer injured workers to for services relevant to their case management plans. These providers include professional such as job placement specialists or physical therapists. The measurement and performance results being developed for this tier of providers will be made available to case managers and injured workers based upon location. The plan is to make that "grade card" information available to voc rehab case managers who working with the vocational plan and injured worker increase the opportunity that the most appropriate provider is selected for the injured worker's needs. We are also anticipating these measures to be finalized in June. While two measures, cost and satisfaction, have been identified, the team is in the process of identifying and validating other additional measures.

## 3. MCO Performance Measures

Currently, the Medical Services Division measures and monitors how MCOs perform their responsibilities. Currently, we measure the effectiveness of their return-to-work efforts using the Degree of Disability Management (DoDM) model. In 2011, as part of the new MCO contract, we are now running in parallel to the DoDM model a new model which will be in full effect beginning January 1, 2012. The new model is called the Measurement of Disability or (MoD).

# Medical Services Division Board Report

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The current measurement model was “state of the art” when initially designed over a decade ago. In fact, workers’ compensation administrators from numerous other states and countries came to BWC to study its features. The current DoDM measure compares days absent in a claim to the well-managed and loosely-managed benchmarks for the injury (i.e., International Classification of Diseases (ICD)) and occupation (i.e., National Council on Compensation Insurance (NCCI) manual classification or Standard Occupational Classification (SOC)). The DoDM is currently used to create outcome-based incentive payments for Managed Care Organizations (MCOs) charged with medically managing workers’ compensation claims for the Ohio Bureau of Workers’ Compensation (BWC). However, a decade of experience has shown that it is not without flaws.

The new Measure of Disability (MoD) was designed to overcome those flaws. The most significant differences between the two measures include:

1. DoDM measures days absent up to the date on which the provider releases the injured worker to work; MoD measures days absent up to the actual return to work date
2. DoDM includes benchmarks for 266 ICDs; MoD expands the population to approximately 1030 ICDs
3. DoDM includes only those claims with a release to return to work within the most recent 15 months; MoD includes claims whether they have returned to work or not.
4. DoDM standards were based upon ‘loosely managed’ claims predating the Health Partnership program where return to work data on medical only claims was sparse, at best, and upon national standards that may or may not be relevant given Ohio’s workers’ compensation laws; MoD standards are based on Ohio-specific claim data of fairly recent vintage (2007-2009).

Meetings are currently taking place with the MCOs to discuss and get agreement on changes to the metrics pursuant to the contract within this beta test period. The parallel measurement testing will continue throughout 2011. In the late fall, all changes will be finalized for full implementation of the MoD measurement for compensation purposes on January 1, 2012.

## **Provider Development Activity**

### **1. Provider Recertification**

One of the findings of the Deloitte report was that BWC has not implemented a process to effectively recertify providers. Per rule, BWC may recertify providers every 2 years. Providers have not been recertified since 2005, when BWC’s effort to recertify providers was suspended due to the possible legal conflicts with the provider agreements and the elections law. Having qualified providers to address our injured workers needs is fundamental to ensuring the best possible outcomes for workers compensation injuries. Basic certification of providers is key to ensuring the quality of providers servicing our injured workers.

Currently there are 93,969 providers actively enrolled in the BWC system with 67,179 providers being certified. In March, BWC implemented a process to recertify all providers.

# Medical Services Division Board Report

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On March 30<sup>th</sup>, the first 500 recertification packets were mailed to providers. As we move forward with working out any bugs in the system, the number of packets being mailed to providers per quarter will increase. We are shooting to have 2500 to 3500 being released by the end of the 3<sup>rd</sup> quarter. The team is also working with the help desk to determine when and to how much can the load of packets going out a quarter can be increased.

## **2. Dental Provider Recruitment Initiative**

Analysis of BWC's participating dentists showed a total of 2045 dentist in the system. That number reflected 1785 dentist within Ohio, with 989 actively enrolled and 781 certified. As a result of the low numbers this provider group was identified as a key group to implement a recruitment strategy. Thus, in February, 2011, BWC mailed approximately 6,000 fliers to non-BWC certified dentists licensed in Ohio. In addition to the mailings, our Provider Relations Department is currently contacting providers in Ohio counties where the need is critical. We have also partnered with the Ohio Dental Association (ODA) in this recruitment effort and they have included our initiative in their recently published newsletter. We are working to increase the number of certified dentist by a minimum of 20%.

## **3. May 11, 2010 - Provider Meeting**

The Medical Provider Stakeholder/Interested Party biannual meetings are set this year for May 11, 2011 and November 9, 2011 from 1:30 -3:30 pm in the William Green Building. The objective of this meeting, which occurs twice a year, is to keep this key service provider partner informed about changes to rules and or bureau policies to ease improve their adoption of the same. Additionally, this meeting affords BWC the opportunity to create a stronger partnership with the provider community thereby enhancing the Provider Relations' business unit's recruitment efforts. At the May meetings, Administrator Buehrer will be sharing opening remarks.

## **II. Evaluate and process medical bills, guaranteeing proper and timely payment consistent with benefits plan criteria**

### **Other Administrative Actions**

#### **1. ICD-10**

The International Classification of Diseases (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Every health condition can be assigned to a unique category and given a code. Effective October 1, 2013, the ICD-9 coding system will become obsolete as the general health industry will adopt ICD-10. The US Department of Health and Human Services has mandated the replacement of the ICD-9 code sets used by the medical community to be replaced by ICD-10. Although HIPPA is requiring ICD-10 reporting for all entities, Ohio BWC is exempt from this mandate. However, if we decide not to convert, this would leave BWC as a separate health provider without health industry support. If BWC continued to use the ICD-9

# Medical Services Division Board Report

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coding system, it would be an additional cost for providers as they would be required to carry two dual systems for bill processing. In addition, we would be unable to receive electronic data from providers, there would be a lag time in processing claims/bills, and our current fee schedule methodology would be unusable.

ICD-10 will radically change the way injury coding is currently done and will require very significant efforts to implement. In anticipation of the extensive work that will be necessary to convert from ICD-9 to ICD-10, BWC has created a cross-enterprise project team and approach. The team has begun its work on this large-scope project and has recommended that the ICD-10 conversion be broken into five phases. The first phase, which began on January 1, 2011, consists of claimant eligibility file conversion, EDI transaction set migration, PDD file conversion, ICD coding process change, bill process change, and several other sub-projects. Phase 1 is scheduled to conclude by March, 2010.

## **2. Encoder**

The management of workers' compensation claims requires an automated process to assign appropriate International Classification of Disease (ICD) codes based on the accident description submitted on the First Report of Injury (FROI). In addition to automated ICD Processing, other medical coding features are also desired, specifically the automated coding of procedure codes through the Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS). BWC is in the process of issuing an RFP for a vendor to provide a comprehensive software package to automate medical coding during the processing of injured worker claims. The software solution will involve integration with BWC's existing processes and software applications. The current vendor, McKesson Health Solutions, has informed BWC that they will not support the ICD-10 software and will no longer provide these services as of June 30<sup>th</sup>, 2012.

## **3. BWC Medical Consultant**

The Medical Services Division issued an RFP on March 21, 2011, for a Consultant to assist with the evaluation of provider payment options, implementation of selected reimbursement methodologies and ongoing administration of BWC's provider payment systems. In addition, the selected consultant will assist with calculating the BWC Diagnosis Related Groups (DRGs) payment for inpatient services using the core elements of the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) methodology, and will assist with the design and administration of payment approaches for: Ambulatory Surgical Centers, Outpatient Hospital Services and Professional Services.

## **4. National Correct Coding Initiative (NCCI)**

The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare and Medicaid Services (CMS) to prevent payments from being made due to inappropriate CPT and HCPCS code assignment; eliminate unbundling of services; detect incorrect or inappropriate reporting of combinations of CPT and HCPCS codes; and curtail improper coding practices that lead to inappropriate increased payment.

## Medical Services Division Board Report

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NCCI edits are performed on every possible pairing of CPT and HCPCS codes. They were developed and continue to be enhanced using coding conventions defined in the American Medical Association's CPT manual; national and local policies and edits; coding guidelines developed by national societies; analysis of standard medical and surgical practice; and review of current coding practice.

In order to be compatible in the workers compensation environment, Ohio BWC plans to customize several of the Medicare NCCI edits. Once that process is complete, communication to our providers will occur regarding an expected implementation date. The edits will be then be applied to the bills submitted for payment. It is anticipated that OBWC will grant a 60 day grace period before denials begin.

# 12 - Month Medical Services & Safety Calendar

	April 2011	Notes
4/28/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Outpatient Medication Reimbursement Rule (2nd read)	
	3. SI Outpatient Medication Reimbursement Rule (2nd read)	
	4. C-9 rule changes (2nd read)	
	5. Formulary Rule (1st read)	
	6. Medical Services Report	
	<b>May 2011</b>	
5/26/11	1. Formulary Rule (2nd read)	
	2. Lock in Pharmacy Rule (1st read)	
	3. Limitation on filing of fee bills (1 <sup>st</sup> read)	
	4. Customer Services Report	
	<b>June 2011</b>	
6/15/11	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Lock in Pharmacy Rule (2nd read)	
	3. Limitation on filing of fee bills (2nd read)	
	4. Medical Services Report	
	<b>July 2011</b>	
7/28/11	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
	<b>August 2011</b>	
8/25/11	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical Services Report	
	<b>September 2011</b>	
9/29/11	1. Inpatient Hospital Fee Schedule (2nd read)	
	2. Customer Services Report	
	<b>October 2011</b>	
10/27/11	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Medical Services Report	
	<b>November 2011</b>	
11/17/11	1. Ambulatory Surgical Center Fee Schedule Rule (1st read)	
	2. Outpatient Hospital Fee Schedule (1st read)	
	3. Committee Charter Review (2nd read)	
	4. Customer Services Report	
	<b>December 2011</b>	
12/14/11	1. Conform Fee Schedules with new Medicare rates	
	2. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	3. Outpatient Hospital Fee Schedule (2nd read)	
	4. Medical Services Report	
	<b>January 2012</b>	
1/xx/12	1. Customer Services Report	
	<b>February 2012</b>	
2/xx/12	1. Medical Services Report	
	<b>March 2012</b>	
<b>Date</b>		
3/xx/12	1. Vocational Rehab fee schedule (1st read)	
	2. Customer Services Report	

## Ohio BWC Fee Schedule History and Calendar: 2007 – Current

### Inpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Sept/Oct	Jan. 1, 2009	-0.9%	-\$471,950
2009	Sept/Oct	Feb. 1, 2010	+2.9%	+\$2.4 million
2010	Sept/Oct	Feb. 1, 2011	+5.7%	+\$4.9 million
2011				

### Outpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Dec/Jan/Apr	Jan. 1, 2011	-7.2%	-\$2.55 million
2010	Oct/Nov	Apr. 1, 2011	-7.2% from base rate*	-\$10.2 million
2011				

\* BWC plans to maintain the same payment adjustment factor through Feb. 28, 2012; therefore, a total of a 7.2% decrease is expected for services rendered from January 1, 2011 through February 28, 2012.

### Ambulatory Surgical Center Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Nov/Dec	April 1, 2009	+23%	+\$1.73 million
2009	Oct./Nov.	April 1, 2010	+16%	+\$860,000
2010	Nov./Dec.	April 1, 2011	+10%	\$677,000
2011				

## Ohio BWC Fee Schedule History and Calendar

### Vocational Rehabilitation Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Nov/Dec	Feb. 15, 2010	+5.86%	+\$1.9 million
2010	N/A	N/A	N/A	N/A
2011	Mar/Apr	June, 2011	+1.42%	+\$452,122

### Medical and Service Provider Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Sept/Oct/Nov	Feb. 15, 2009	+6.0%	+\$23.8 million
2009	Sept/Oct	Nov. 1, 2009	+0.2%	+\$800,000
2010	June/July	Oct. 25, 2010	+2.9%	+\$9.2 million
2010	Dec (emergency)*	January 1, 2011	N/A	N/A
2011	Jan (final)			

\* Emergency rule to add new codes